

**Globalising Disorders: Encounters with  
Psychiatry in India**

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A thesis submitted in partial fulfilment of the  
requirements of the Manchester Metropolitan  
University for the Degree of Doctor of Philosophy

Education and Social Research Institute  
Manchester Metropolitan University

2012



## **Globalising Disorders: Encounters with Psychiatry in India**

*This is a thesis on Global Mental Health, on what it means for mental health to be 'global'. It is a thesis about encounters; about research encounters, about psychiatry's encounters with the global South, about colonial encounters. It's about crises both individual and global, and the political rationales at work in the mediation of these crises. It's about becoming and unbecoming psychiatric subjects, it's about psychiatrization, about psychiatry's creep out of asylums and across borders, into everyday life, globally.*



## **Abstract**

Amid calls from the World Health Organization (WHO) and Global Mental Health to 'scale up' psychiatric treatments, globally, there are other calls (sometimes from those who have received those treatments), to abolish psychiatric diagnostic systems and to acknowledge the harm caused by some medications. This thesis elaborates a space for these arguments to encounter and to be encountered by each other. This is a thesis about encounters; about psychiatry's encounters with the global South; about research encounters in India with mental health Non-Governmental Organisations (NGOs); and about colonial encounters more generally.

Drawing on analysis of interviews and visits to a range of mental health support provision in India, this thesis traces some conceptual and material mechanisms by which psychiatry travels - across borders - into increasing domains of everyday experience, and across geographical borders, into low and middle-income countries. It explores the claims of Global Mental Health, 'to make mental health for all a reality', as being particular mechanisms of psychiatrization - ones that may employ similar codifications to those of colonial discourse. Global Mental Health and WHO mental health policy often mobilise psychiatric interventions in response to a 'crisis' or an 'emergency' in mental health, globally. Yet while this current incitement suggests an abnormal deviation from a normal order, mental illness may also be read as a 'normal' reaction to the (dis)order of globalisation. Nevertheless, in making the claim that mental health problems, such as Depression, are a 'normal' response to inequitable market relations in the global South, may also be normative, as it glosses over a simultaneous globalisation; that of bio-psychiatric explanations of distress.

Thus, while Global Mental Health marks an explicit making political of psychiatry through its conceptualisation of mental health as key to an agenda of international development, it simultaneously disavows psychiatry as political through its universal application of psychiatric technologies. To claim the universality of psychiatric diagnoses is different from making the claim that distress, manifest in myriad forms, is universal. This is because psychiatric frameworks are mediators of that distress, they provide but one way of understanding yet they are often framed as being the 'truth', globally.

Reading Global Mental Health psychopolitically, then, enables an engagement with the double process through which conditions of inequality and alienation may become internalised –how inequality may come to play on the body, to be made flesh. This move occurs alongside another process that reads the mechanisms by which socio-economic crisis comes to be rearticulated and reconfigured as individual crisis, as mental illness. To read Global Mental Health as a colonial discourse is to trace how particular knowledge is mobilised in the creation of a space for psychiatric ‘subject peoples’, a global space. This research traces some of these ‘on the ground’, often powerful, techniques of recruiting subjects and fixing them. It also interrogates the knowledge base of Global Mental Health to create a space to read this alongside alternative ways of knowing; specifically psychiatric user/survivor and critical psychiatry critiques. This works to explore how psychiatry encounters difference (both within the global North and South), and to (re)think how Global Mental Health might be encountered differently.

This thesis thus explores how the colonial relation is mobilised within psychiatric treatment in order to think through how the violence of colonialism may enable a re-thinking of contemporary forms of psychiatric treatment as being violent, the violence of psychiatrization - violence in the name of ‘treatment’. Using the post-colonial theory of Frantz Fanon, Ashis Nandy and Homi Bhabha, as conceptual tools, alongside research encounters (interviews, ethnographic field work, policy documents) in India, enables exploration of how psychiatrization may allow relationships of domination and resistance to continue after formal colonialism has ended. It also enables engagement with how strategies of resistance to colonialism may be read alongside and used to illuminate resistance to psychiatry – resistance that may be secret, sly, covered up.

This research concludes by attending to emerging counter-hegemonic ways of knowing distress, epistemologies of the South, in order to creatively re-think the work of Global Mental Health and psychiatry in countries of the global South. To imagine a global mental health that attends to the heterogeneity and complexity of local, indigenous ways of knowing distress, that rethinks issues of consent – specifically around the use of psychiatric terminology and the provision of non-medical (and non-‘western’) spaces

of healing, and that recognises psychiatry as one of many approaches, questioning whether it can, or should, be global.





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## **Acknowledgements and Thanks**

This thesis is in many ways the product of a collective (re)thinking of issues around psychiatrization, colonisation, violence and alternatives – a search for other ways of knowing. While I may be the author, my writing is haunted by many voices - whispering throughout.

In India, so many people offered me their time and their kindness. I want to say thank you to the people I met, and who met with me - many of them surprise encounters - who gave me their time to chat, who invited me for dinners, who whizzed me round on scooters and motorbikes, and who told me where I could get a strong coffee. The people who translated my workshops so beautifully and showed me round their organisations, their homes, their lives. To the organisations that let me visit and took me in, I hope they think this is a fair representation of their work, even though we didn't always agree. Particularly I would like to thank the staff at Bapu Trust, Iswar Sankalpa, The Banyan, the Schizophrenia Awareness Association, and the Shraddha Foundation. I owe a great debt to Bhargavi Davar and Sarbani Das Roy - you both scare me a bit, not least because your dedication and your kindness is overwhelming.

And thank you to; Reshma Val and Lavanya Seshasayee – for surviving and sharing your stories; to Yogita Kulkarni for your lovely way of explaining things, your patience is endless; to Sonia Soans - for Koshi's and for potatoes that smile – a wonderful introduction to Bangalore. And for getting me into NIMHANS and getting me out. To Ranjita Biswas, Diptarup Chowdrey, Kimberley Lacroix and Sabah Siddiqui.

Thank you to Anup Dhar and those who made it possible for me to share my work at Ambedkar University Delhi - where discussion rendered me literally speechless due to the wonderful suggestions of the participants and a simultaneous throat infection. And to those who let me share my work at the Indian Association of Women's Studies Conference in Wardha, 2011; and at CSCS, in Bangalore.

So many conversations, stolen moments, haunt this work – my memory doesn't do them justice, but thank you to; all those who make up the wonderful discussions at the Asylum North-West Collective, the Discourse Unit, and the Education and Social

Research Institute. And particularly, thank you to, Ian Parker, Dan Goodley, Shaun Grech, Donna Reeve, Dean Smith and Helen Spandler. Thankfully, I shared the struggle this journey has sometimes been with a few others on the same journey - Hannah Berry, Steve Graby, Anat Greenstein, Jen Slater, and Jemma Tosh. A struggle shared over cheap food in pubs, and often many many pints. And thank you to the Education and Social Research Institute for funding me, and giving me the space for my thesis change; and to John Schostak, for believing in it.

For much of the time while writing this thesis I have had no fixed place to live, I became a 'house sitter', and it has been wonderful, unsettling and means I now immediately feel at home in other people's houses, and never at home in my own. A variety of homes, then, have provided the setting for writing this thesis, endless cups of coffee from other people's mugs have given me the energy and the shakes, and Laurie Anderson and Radiohead (played on other people's stereos) have provided the soundtrack. For those who trusted me with their homes (or let me live with them) – a million thanks.

Some people deserve a special mention – for more reasons than I could ever say; The O'Hanrahans, and especially Elaine and Sean, my Mancunian family, for so much love. My dads - Paul and Mimmo, for delicious dinners in chilly surroundings, for living the way that makes you happy. Julie Downs and Becky Harper, for showing me what bravery is, and courage. For showing me other ways of understanding. Michael Toth, for your ever-lasting friendship and your gravity defying hair. Jen, for your company, your mutual love of port and for the sanctuary of your flat. David, for interrupting me, for making me laugh, and for teaching me how to build a good den.

There are three people in particular for whom thank you is simply not enough.

Erica Burman - how can I express what having you as a supervisor - so much more than a supervisor - has been like? Your support and belief have left me speechless.

Jane – for everything. Not least for being a wonderful mum.

Liam – I couldn't have written this without you, and I have struggled to finish it without you. You have been my harshest critic and the most wonderful companion - I hope we will travel together again in the future.

*This thesis is dedicated to the memories of Marion and Arthur - my Grandparents – for stories and butterfly buns, and well kept secrets - for everything*

*And to,*

*Bhargavi Davar and Sarbani Das Roy – for believing that another world is possible, and for doing something about it*



## **Preface**

*Not so very long ago, the earth numbered seven billion inhabitants; 450 million of them developed a mental illness every year;<sup>1</sup> and 290,500 of them were psychiatrists.<sup>2</sup> The latter had the Word; the others had the use of it.<sup>3</sup>*

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<sup>1</sup> WHO (2001). Mental Health: A Call for Action by World Health Ministers. Ministerial Round Tables, 54<sup>th</sup> World Health Assembly. WHO, Geneva.

<sup>2</sup> Based on Mental Health Atlas (2005) estimates of 4.15 psychiatrists per 100 000 [online] <http://www.who.int/mediacentre/news/notes/2005/np21/en/> (Accessed 2.8.2012); and on world population being approx. just over 7 billion, according to the UN Department of Economic and Social Affairs [online] <http://esa.un.org/unpd/wpp/index.htm> (Accessed 2.8.2012).

<sup>3</sup> This is a reworking of Sartre's (1963) preface to Frantz Fanon's 'Wretched of the Earth' (Penguin Books). The original reads, 'NOT so very long ago, the earth numbered two thousand million inhabitants: five hundred million men, and one thousand five hundred million natives. The former had the Word; the others had the use of it' (Sartre, 1963:7).



## Chapter One

### **De-familiarising Global Mental Health: a methodology of Encounters**

*A Chapter on encounters, psychiatry's encounters with the global South, my encounters with methodology, on the identity of a woman spoken in foreign terms, on making the familiar strange, on writing messily, on psychopolitics.*

## Encountering the 'psychiatric patient' -

### Story Number one (one way of telling the story)

At the Banyan, a Non-Governmental Organization (NGO) that works with and houses people with mental health problems, in Chennai, India, the staff began asking Meesha<sup>4</sup> (a woman with a Schizophrenia diagnosis who lives at the centre) some questions. They asked her about her family. She told them, in Tamil (a South Indian language), that her mother had heard voices, like she does, and had been a 'psychiatric patient'. Meesha said those two words, 'psychiatric patient' in English. That was the only English she spoke that day. When the staff asked her if she was a 'psychiatric patient', she said 'No', because 'psychiatric patients' had wild unbrushed hair – unlike her. 'If you're not a psychiatric patient' the staff said, in Tamil, 'why do you take medication? 'To be cured', Meesha replied, 'to be cured of The Banyan'. [Field notes, January 10<sup>th</sup>, 2011].<sup>5</sup>

Meesha's words, without her ever knowing it, illuminate many of the concerns, the messy spaces of this thesis. I want to draw upon Meesha's words as lens.

#### *Lens 1: 'psychiatric patient'*

What does it mean that Meesha, who speaks only Tamil, said the words 'psychiatric patient' in English? In those two words, spoken in a foreign language, it is possible to hear echoes of psychiatry's colonial history, brought to India in the form of asylums built by the East India Company in the late 18<sup>th</sup> Century (Ernst, 1997). It is possible to glimpse the multiple translations at work within psychiatry; the translation of experiences and local idioms of distress into psychiatric categories, into English – into different languages. Her words show that here, when we speak and write of mental distress (or 'mental illness'), what we call 'it' matters, language matters. Her words call on us to grasp the hegemony of 'western' psychiatry, a psychiatry developed in specific

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<sup>4</sup> Names have been changed throughout to ensure confidentiality, except where stated, and where permission was given.

<sup>5</sup> These notes are taken from a workshop that I facilitated at the Banyan, on January 10<sup>th</sup> 2011. I do not speak Tamil, and thus Meesha's words were translated for me by the staff.

High-Income Countries (HICs) of the global North (yet always haunted by their colonial intertwinings). Her words hint at psychiatry itself as colonial, as enacting a colonial relation through its multiple translations, a colonisation of the mind (Thiong'o, 1981). Finally, Meesha's words are suggestive of the globalisation of psychiatry, how psychiatric ways of understanding distress, health, illness - what it means to be a person - 'travel' across the globe. Her words even hint at one of the ways that psychiatry may travel, through the work of NGOs like the Banyan.

*Lens 2: 'To be cured', Meesha replied, 'to be cured of The Banyan'.*

And so Meesha said that she needed to be 'cured', but for her the 'problem' that required a cure was the place that claimed to be 'treating' her of the thing that they 'knew' she had but she said she didn't have – a 'mental illness' called Schizophrenia. Meesha's words locate the 'problem' in need of 'cure' in the social world, in the environment, in psychiatric interventions. The psychiatrists who have intervened in Meesha's life think that the 'problem' lies inside Meesha, in her brain, in her biochemicals. In her understanding, Meesha takes psychiatric medications in order to get out of the Banyan, the very place that provides her with that medication. For the staff, Meesha takes medication because she has Schizophrenia, a diagnosis made by The Banyan.

What does it mean to take psychiatric medication to be 'cured' of psychiatry? How do psychiatric medications broker subjectivity? If some of those subjected to psychiatry want to be 'cured' of it, then what role should psychiatry play in responding to people's distress, in the global South and North? Meesha's words also happen to be the only words spoken in this thesis by someone who receives psychiatric interventions within an Indian NGO; people who are often referred to as the 'destitute mentally ill'.

### **Encountering Global Mental Health, 'scaling up'**

This thesis was initially supposed to be something very different. But one day, when I was in Kolkata doing research with a mental health NGO for my PhD, I encountered three words - 'Global Mental Health' - and lots of things changed. This was a surprise encounter, a seminar I heard about only half an hour before it was due to take place and that I didn't really fancy going to at the time because I felt really hot and a bit fed

up that day. I had been in India for about four months by then and I was getting frustrated with sitting in hot rooms listening to languages I couldn't understand (and I desperately wished I could) and having to laugh when everyone else did even though they all knew I didn't know what was going on. Anyway, in the end I had a cup of sugary chai and went to the seminar. It was titled, 'Scaling up Services for Priority Mental Disorders in India – Challenges and Possibilities'. The event was organised by the Forum for Mental Health Movement.



*My first encounter with Global Mental Health was through these gates and in this room, in Kolkata.*

The first part of the seminar was in Bengali, which I don't speak. I laughed when everyone else laughed, even though I knew they knew I couldn't understand. I wished I hadn't gone. Then Sudipto Chatterjee started to speak, in English, and that's when the focus of this thesis began to change. That day Sudipto Chatterjee talked about the need to 'scale up' psychiatric interventions from High to Low- and Middle-Income countries (LAMICs).<sup>6</sup> He talked about the treatment gap between rich and poor countries; the lack of psychiatrists in India; the need to integrate mental health interventions at all levels of healthcare; and the need to increase access to psychiatric medications. Hearing Sudipto's talk set me off in a whirlwind of research into Global Mental Health. Then I realised this wasn't just about India and when they said 'global', they meant global.

Sudipto Chatterjee seemed like a nice man, but I was worried by what he said. I had in part come to India to explore how NGOs worked with people who are distressed or have labels of mental health problems, and also to explore the emerging user/survivor movement there.<sup>7</sup> My interest in this lays in my own involvement, as an ally of the user/survivor movement in the UK, particularly through the Hearing Voices Network and Asylum – a magazine for democratic psychiatry.<sup>8</sup> It also lies in my personal encounters with madness, through my family and those who became my friends at the Hearing Voices Network. I am going to interrupt the narrative of this thesis with field notes, ideas, quotes from people I've met - I don't want it to be linear because that's not how it came about. Here's an interruption.

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<sup>6</sup> Chatterjee, S. (2011). 'Scaling up Services for Priority Mental Disorders in India – Challenges and Possibilities', a talk organised by the Forum for Mental Health Movement, Kolkata (March 20<sup>th</sup>, 2011).

<sup>7</sup> I use 'survivor' here to refer to those who have used psychiatric services, or been subjected to psychiatric categories and interventions themselves; and to refer to the self-organizing of these people into movements and groups that challenge psychiatric hegemony. Such groups vary widely, and by no means constitute one homogenous group, or even one shared understanding of what survivor might mean for those who self-identify as such.

<sup>8</sup> See The Hearing Voices Network website - <http://www.hearing-voices.org/>; and The Asylum website - <http://www.asylumonline.net/>.

*There are so many ways I could tell the story of the journey that writing and researching for this thesis has been, and how it all began. One way to tell it would begin long before I was born when my Granddad Arthur was in the British Army in India (before the Second World War). My dad and then me were brought up on stories of an India that both of us would grow up to visit; both the same India as in the stories and not the same at all. As my Granddad's stories continued, long before I would visit India, my Grandma, who had never left the house without fresh make-up on, went outside in her nightie, in the middle of the night, to tell the next door neighbours that she knew they were inserting recording devices that read our minds through the wall above the phone. My Grandma was later given a diagnosis of Schizophrenia.*

*At a similar time, my uncle, who drove an open-backed truck, smoked weed and chased me around until I was dizzy with joy, rolled up the carpet in his room to make a tunnel in which he lived to shut out the flies that were making formations and spelling out words, speaking to him. My uncle was diagnosed with Schizophrenia.*

*I have lived close to madness for most of my life. While the people in my family were given diagnoses of Schizophrenia, we lived alongside them. I had conversations with my Grandma where many more people than just us were present, even if I couldn't see them. Sometimes I wondered if actually she could really see something that I couldn't. The psychiatrists my Grandma encountered did not seem to share this thought – she didn't have a very nice time in the psychiatric hospital – I remember curling up behind the big box where the Christmas decorations were kept, and listening to her crying, quietly.*

*I have also had periods of what I would now call melancholy, and what my Doctor when I first tried to tell her, called Depression - something for which she prescribed anti-depressants within the first five minutes of me*



*telling her, anti-depressants that took many months for me to stop taking (something I did without telling her).*

*Since my family encounters with distress, I have encountered so many more stories, and have heard things I will never forget - things that haunt me still. But I am haunted not only by the abuse that the people who told me the stories had suffered, or by the voices they started to hear, the ways they tried to injure themselves, the fact that some of them wanted to die, some of them did die. I am haunted by how professionals, particularly psychiatrists, but many others too, often reacted to these people, how they treated them, how they didn't believe them, and forced or persuaded them to have treatments they didn't want.*

*I always thought there must be another way. I still think there must be another way. Perhaps if all this hadn't happened I wouldn't have wanted to go to India and find out about mental health.*

This is one way of explaining why I felt worried by the 'scaling up' of psychiatry that Sudipto Chatterjee spoke about that hot day in Kolkata. I hadn't heard the word 'psychopolitics' yet, but at the time I felt anxiously excited. I felt anxious because the thought of scaling up something that had caused harm to many people I had met was deeply worrying. I felt excited because here was the explicit making political of psychiatry through its conceptualisation as key to an agenda of international development, and yet somehow a simultaneous disavowal of psychiatry as political through its universal application.

### **Encountering the 'Epidemic'-**

#### **Story Number Two (another way of telling the story)**

There's another way of beginning, of telling the story of Global Mental Health - the official way. The World Development Report (1993) and the Global Burden of Disease report (1996) compared health conditions on combined disability and mortality statistics, 'these reports showed, to the surprise and disbelief of many in the international public-health arena, the huge burden of disease imposed by mental disorders, not only in rich countries but also in low-income and middle-income countries' (Saraceno et al, 2007:76).

In 2001, the World Health Organization (WHO) reported that over '450 million people worldwide are estimated to be suffering at any given time from some kind of mental or brain disorder' (WHO, 2001b:6), and that '14% of the global burden of disease has been attributed to neuropsychiatric disorders' due to their 'chronically disabling nature' (Prince et al, 2007:1). The World Health Report, carried out by the WHO, in 2001, was dedicated to mental health, finding that 'mental disorders represent four of the 10 leading causes of disability worldwide' (p3), and that 'mental and neurological conditions account for 30.8% of all years lived with disability' (p26).

According to the WHO (2001a:x) '[m]ajor depression is now the leading cause of disability globally and ranks fourth in the ten leading causes of the global burden of disease'. And '[c]urrently 121 million people suffer from depression and the burden of depressive illness is rising' (WHO, 2002:1). The World Health Report documents that despite its findings of the global 'burden' of mental disorders and their growing prevalence, '[m]ore than 40% of countries have no mental health policy and over 30% have no mental health programme.' (WHO, 2001a:3). Thus, according to the Report, 'there is no psychiatric care for the majority of the population' (WHO, 2001a:xvi).

Drawing on the evidence presented in the World Health Report (2001), the executive board of the WHO approved 'mental health' as the theme for the Round Table Discussions at the 54<sup>th</sup> World Health Assembly. This 'provided a forum for health ministers to review jointly the major challenges they face in addressing mental health problems in their countries' (WHO, 2001b:10). Further, the objectives of the discussions were to 'raise awareness of the urgent need to address the mental health burden; to place mental health firmly on the national and international health and development agendas; and to generate political commitment for increasing support to mental health policies' (WHO, 2001b:10). In 2002, the Executive Board of the WHO approved the resolution to strengthen mental health (WHO, 2002) by adopting the World Health Report's (2001:xi) set of 'far-reaching recommendations that can be adapted by every country according to its needs and its resources'. These are the recommendations.

1. Provide treatment in primary care
2. Make psychotropic drugs available
3. Give care in the community
4. Educate the public
5. Involve communities, families and consumers
6. Establish national policies, programmes and legislation
7. Develop human resources
8. Link with other sectors
9. Monitor community mental health
10. Support more research

(World Health Report, 2001:pp. xi-xiii).

### **Mapping mental illness**

For Graham Thornicroft (2002:608), a key figure within Global Mental Health, the

scale of the global challenge posed by mental illness has become increasingly clear in recent years. The inadequacy of our international response is only now apparent with the publication of three ground breaking reports from the World Health Organization.

These reports are; the World Health Report (2001); the Atlas Project, - 'the first ever global profile of mental health services', bringing together 'comparative data from 185 of the 191 WHO member states, totalling 99.3% of the world's 6057 million population' (Thornicroft and Maingay, 2002:608);<sup>9</sup> and a volume depicting the findings from the Atlas project in a series of global maps (WHO, 2001c). To Thornicroft and Maingay (2002:608), these reports show 'comprehensively that mental illness, in most countries of the world, is simply not taken seriously'. Thus, this global mapping of mental illness has marked a move to take mental illness seriously on a global scale - setting the scene

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<sup>9</sup> Some other international studies in mental health prevalence; The International Pilot Study of Schizophrenia (IPSoS) (Sartorius et al 1977;Sartorius et al. 1972); The Collaborative Study on Strategies for Extending Mental Health Care (Harding et al. 1983); The Collaborative Project on Psychological Problems in General Health Care (PPGHC) (Sartorius et al. 1993); The World Mental Health Survey (Demyttenaere et al. 2004; Kessler et al. 2006).

for a growing focus on Global Mental Health, evident in the launch of the Lancet series on Global Mental Health, in 2007.

This consisted of ‘a major new series of articles documenting key issues in global mental health’; including, ‘the scarcity, inequity and inefficiency of global mental health resources; [and] the evidence for the treatment and prevention of mental disorders in low and middle income countries’(Launch of the Lancet Series on Global Mental Health, 2007). The series was made up of six articles,<sup>10</sup> and ended with a call to action ‘to scale up a basic, evidence based, package of services for mental disorders...in all countries, but especially in low-income and middle-income countries’ (Launch of the Lancet Series on Global Mental Health, 2007). This also saw the formation of the Lancet Global Mental Health Group, with the aim over the following two years for the Lancet to ‘make mental health one of its campaign focal points’ (Lancet Global Mental Health Group, 2007).

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<sup>10</sup> Here is a list of the articles making up the Lancet series on Global Mental Health (2007):

Article 1: Prince, Martin., Patel, Vikram., Saxena, Shekhar., Maj, Mario., Maselko, Joanna., Phillips, Michael. R. and Rahman, Atif. (2007). No Health Without Mental Health. *The Lancet*, Vol. 370, pp.859-877.

Article 2: Saxena, S., Thornicroft, G., Knapp, M. and Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *The Lancet*, Vol. 370, pp. 878-889.

Article 3: Vikram. P, Araya, Ricardo., Chatterjee, Sudipto., Christholm, Dan., Cohen, Alex., De Silva, Mary., Hosman, Clemens., McGuire, Hugh., Rajas, Graciela. and van Ommeren, Mark. (2007) Treatment and Prevention of Mental Disorders in Low-income and Middle-income Countries. *The Lancet*, Vol. 370, pp. 44-58.

Article 4: Jacob, K.S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J.J., Sreenivas, V. and Saxena, S. (2007). Mental health systems in countries: where are we now? *The Lancet*, Vol. 370, pp.1061 – 1077.

Article 5: Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D. and Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet*, Vol. 370, pp. 76-86.

Article 6: Lancet *Global Mental Health Group* (2007). Scale up services for mental disorders: a call for action. *The Lancet*, Vol. 370, pp. 1241-1252.

Also one year follow on article: Patel, V., Garrison, P., de Jesus Mari, J., Minas, H., Prince, M. and Saxena, S. (2008). The Lancet's Series on Global Mental Health: 1 year on. *Lancet*, Vol. 372(9646), pp.1354–1357.

The World Health Report (2001) and the WHO Atlas Project (2001), and particularly the diagnostic tools of measuring prevalence that they employed (such as the Disability Adjusted Life Year, DALY, discussed in more detail in the following chapter) were key in documenting discrepancies and inequalities in global access to mental health interventions and policy. The World Health Report thus acted as a surface of emergence for the 'treatment gap' (discussed in chapter 2) in mental health, between HICS and LAMICS, and within countries, to emerge. The Lancet (2007) series continued the focus on this 'treatment gap', with PLoS Medicine (2008) then producing a series on 'packages of care' for different mental health problems. Then, in 2008, the Movement for Global Mental Health was launched, made up of,

a coalition of individuals and institutions committed to collective actions that aim to close the treatment gap for people living with mental disorders worldwide, based on two fundamental principles: evidence on effective treatments and the human rights of people with mental disorders. (Patel et al, 2011:88).

The 'scientific foundation' of the Movement emerges from 'a wealth of evidence' (consisting of the reports discussed above), and is framed as a follow-up strategy to the Lancet's (2007) call to action (Patel et al, 2011:88). In the same year (2008) came the launch of the WHO's Mental Health Gap Action programme (mhGAP) (discussed in more detail in the following chapter). In 2009, came the Global Mental Health Summit, followed by another in 2011, which saw the launch of the second Lancet series in Global Mental Health (2011). This second series follows on from the 2007 series, tracks progress, and is, according to the Lancet (2011, online), an 'indispensable resource for health workers and policymakers...a benchmark of progress and a renewed call to action'.

## NGOs

One of the key sites for putting this knowledge into action in LAMICs, hinted at by Meesha at the beginning of this thesis, is NGOs.<sup>11</sup> The objectives of the WHO (2001b:10) discussions were to 'raise awareness of the urgent need to address the mental health burden; to place mental health firmly on the national and international health and development agendas; and to generate political commitment for increasing support to mental health policies'. The WHO and the Movement for Global Mental Health thus both push for national Governments to recognize the 'burden' of mental illness and increase public spending on mental health interventions and resources. Yet they both see Non-Governmental Organisations (NGOs) as having a key role to play in the delivery of mental health services.

Non-governmental organisations in the mental health sector are active in almost all parts of the world, including in 86% of LAMICS, and are often the pioneers of mental health service reform (Thorncroft and Maingay, 2002:609).

Nongovernmental organizations are also a valuable community resource for mental health. They are often more sensitive to local realities than are centrally driven programmes (WHO, 2001b:100).

NGOs may also act as key sites in adapting the WHO (2001) recommendations to enable LAMICs to meet them and are thus framed as being key mechanisms in spreading Global Mental Health advocacy, meaning that they are also a central focus of this thesis. While this research is interested in Global Mental Health more generally, then, it is particularly grounded in the grassroots work carried out by a number of mental health NGOs in India. It is centred around the putting to work of Global Mental Health and WHO policy 'on the ground' - the minutiae, the capillary networks, that these particular ways of understanding distress travel along.

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<sup>11</sup> There is quite a comprehensive list of mental health organisations in India on The Banyan website – see <http://www.thebanyan.org/html/resources.html>. See also Thara, R. and Patel, V. (Eds). (2003). Meeting the Mental Health Needs of Developing Countries: NGO Innovations in India. Sage, New Delhi, Thousand Oaks and London.

The research is in part about the ways in which some NGOs in India encounter people who are distressed, how they understand them, how they work with them or intervene upon them. It is also, then, about my encounters with these NGOs; about meetings, workshops, interviews, field notes. Centrally then this research is about encounters, encounters with people, with countries, with psychiatry, with policy, with history, with colonialism, with the familiar and the unfamiliar, and with methodology. It makes methodology strange, following Fanon ([1967]1986:14),

It is good form to introduce a work in psychology with a statement of its methodological point of view. I shall be derelict. I leave methods to the botanists and mathematicians. There is a point at which methods devour themselves.

This research does not claim to be derelict, to abandon method; it seeks to dwell in this space where 'methods devour themselves'. Its point of departure, then, is to foreground a methodology of discomfort enabled through three interrelating lens; encounters, psychopolitics, and defamiliarising. This is done in order to explore how Global Mental Health may employ similar codifications to those of colonial discourse and thus how it can be mapped as a colonial force. This begins, as it ends, with a methodology of encounters.

### **A methodology of encounters**

*I wanted in this thesis to tell a story of encounters, encounters arranged and chance, and all that's in-between; a story that isn't linear and may at times not really make much sense. The chance encounters; the book you picked up by accident thinking it was the one you wanted; the misspelling of a name that led to another name; when you typed your own name into the internet and found someone with a similar name who wrote something that you wish you'd written. This is a story of seeming coincidences, strange juxtapositions, where the hurling of a Homi Bhabha book across the room, in a fit of incomprehension, knocks another book off the shelf, making for surprise and strange co-readings. Where it may matter that Radiohead provided the soundtrack to my reading of*

*Agamben, or maybe not. The misspellings, the errors; the emails you send and the people who never reply, and the people who do.*

Before I went to India, as part of this research, I scoured the internet for people and organisations that I might contact there to ask about mental health. The first person I plucked up the courage to contact was Bhargavi Davar. Bhargavi founded the Bapu Trust, in 1999, naming it after her Mother, Bapu, who was subjected to violent psychiatric interventions and indignity because she heard voices. Bhargavi is herself a survivor of the psychiatric system in India. Bapu Trust frames mental health as being a social matter, they move away from labels of ‘severe’ illness, and promote self-advocacy and community work.<sup>12</sup> Back in England, when Bapu Trust seemed far way, I emailed Bhargavi.

*Dear Ms Bhargavi Davar,*

*I hope you don't mind me emailing you.*

*I have read some of your fascinating work and have recently found out about the Bapu Trust. I am currently studying for a PHD in Manchester UK, and as part of my research I am exploring user and survivor run movements and organisations within mental health and disability, and the intersections and disjunctures between these movements, in the UK and in India. I am particularly interested in exploring possibilities for collective action and activism, and asking questions around what it means to act politically within mental health and disability.*

*I am really keen to explore how work in the UK on hearing voices might be useful in some contexts in India and equally how work in this area in India could inform future work in the UK. I feel a particular pull towards India as I have worked in Tamil Nadu before, at a user-run organisation for people with disabilities. In January I am coming to India for four months to explore some of these issues and am hoping to visit and talk with more people connected with such movements, particularly within mental health.*

*I have been reading about the work of the Bapu Trust and I share many of the same values and hopes for work in mental health in India. I would love to come*

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<sup>12</sup> See the Bapu Trust website <http://www.bapucamhindia.org/>



*and visit the Bapu Trust and to meet you, and perhaps do some work with you, if you think it would be useful to the Trust. I am very passionate about doing work that is collaborative and useful to the people with whom the research is done. I have experience of running workshops and training about hearing voices / seeing visions, supporting voice hearers, running groups, working on a helpline, and particularly in training around the issue of children's mental health. I would be keen to share resources and to set up alliances and networks to fight oppression of people with mental health problems more widely. Perhaps most importantly, I would love to learn more about the work of Bapu Trust and be useful to you if I can. I come from a family of survivors and users of mental health services and feel very passionate about working politically and critically for the recognition and rights of people who experience distress or unusual experiences.*

*Thank you for taking the time to read this, and I hope to hear from you,*

*Warmest regards,*

*China Mills*

A day later, Bhargavi replied;

*Dear China,*

*I was most touched to hear your 'voice' through the internet!! :-) Thank you for writing. Your email is very timely in the growth of my work in India as well as that of the Bapu Trust. I have much to say on the topics that you mention, but feel that it is impossible to convey a lot through this medium.*

*At a time when our website is down and out, it is an amazement to me how you got in touch. That is a miracle.*

*I have been (in the last year and a half) consistently working with voice hearers and have been much influenced by the Alternatives movement as well as Intervoice. I am well aware of some of the developments in recent times on voice hearing.*

*In our own counselling and psychotherapeutic work, we recently realized that voice hearers are the most stereotyped and marginalized, and even in liberal services such as our own, they get pushed into institutions or into antipsychotic*

*medications without choice. It was a big disturbing finding for me that about 30% of our service clients were treated with the rather routine stereotype of 'severe mental disorder', and taken by the hand for a dose of medicines.*

*We closed down our 'politically inspired' services. Now I run peer support groups for voice hearing people and other people in need. We also included, in our new vision, our desire for the full inclusion of people seen as 'severely disturbed'. I have used art based methods for providing support to voice hearers with excellent results...I also used art methods to manage crisis non medically. These experiences have been very useful for me.*

*We have other work that we do, but more of that when you are here, or perhaps over other long emails.*

*Thank you so much for getting in touch, it was lovely to receive your message,*

*Warmly,*

*Bhargavi.*

I have included these emails not only because they mark my first encounter with a mental health organisation (and a survivor-led organisation) in India but also because Bhargavi's email dispels any assumptions that it is only psychiatry that travels to LAMICs. Survivor-led approaches, and ideas that are critical of, or anti-psychiatry - counter-hegemonic ideas - travel too.

This first encounter with Bhargavi led to me spending nearly a month buried in the Centre for Advocacy in Mental Health (CAMH) - Bapu Trust's archives and library in Pune. Here, with fingertips dusty from books and inky from incessant photocopying, driving Yogita, who manned the office with a quiet determination that I longed for, to distraction - I began to trace what I was coming to understand as the psychiatrization of India. This encounter shaped and interlaced with all my other encounters. Bhargavi knows a lot about mental health in India, perhaps too much. Sometimes her name was a passport into this world, other times it meant 'access denied', expulsion, sometimes I had to whisper the word 'survivor' - no wonder Bhargavi is so softly spoken.

## **Im/possible 'Methodologies' - Encountering Global Mental Health**

Here, then, Global Mental Health is a site to be encountered and of encounters, and this research, this thesis is a site to encounter Global Mental Health, multiply, differently. Thus, a methodology of encounters is part of a project of thinking about what it would mean to write research differently and of writing about what one has researched differently – writing Global Mental Health differently. The research itself becomes a site of encounter between Global Mental Health and those who critique it, a site to encounter those critiques alongside what counts as official, to encounter the familiar alongside the unfamiliar.

I got thinking about these encounters, and then I began encountering 'encounters' everywhere. I encountered Kate McCoy (in person and through her work), and she talked about traversing edges and cracks, about 'being on the lookout, remaining open to encounters' (Stivale, 2009:3, cited in McCoy, 2010:617). Sara Ahmed writes about the element of surprise and 'the "more than one" of an encounter,' (Ahmed, 2006:551) about strange encounters (Ahmed, 2000). McCoy's work pointed me to Illuminati's (2005:1) exploration of Althusser's 'aleatory materialism' or 'materialism of the encounter'. This led me to re-read Althusser, as Illuminati (2005:2) does, attending to chance, hinting at a methodology 'of taking initiative whilst counting on nothing and occupying the place of the impossible, and operating on a rupture that connects novelty and beginning'.

This research does not claim to be methodologically derelict; however it remains wary of methodological claims, aware of the colonial complicity of much research. Research, "'writing of/about the people" in a field of difference, struggle, contestation' (Schostak, 2006:45), has been a central tool for colonial and imperial projects (Tuhwai Smith, 1999) (this is perhaps particularly the case for interviews and ethnographic methods – both put to work in this research).

For Schostak (2006:15), 'the interview is not a tool but an encounter' one that involves 'negotiations, calculations, interpretations',<sup>13</sup> it is an 'inter-view', a dilemma.

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<sup>13</sup> The power to 'fix' a particular interpretation onto the interviews troubled me deeply. I was particularly worried about somehow imposing a conceptual and critical analysis

Ethnography, too, historically, is an encounter, a way for the global North to encounter the 'exotic', a method for 'making the strange familiar' (Goodley, 2004). Thus, both interviews and ethnography imply a voyeurism, a way of becoming familiar with 'what constitutes an "insideness" to a way of life' (Schostak, 2006:23). This is the colonial past of much research, of ethnography as a method to render familiar the dark, hidden, unknown and exotic culture of the 'native' (Goodley, 2004).

A key element to this research has been to trace through the mechanisms by which Global Mental Health may encounter difference and yet disavow it; rendering the strange familiar, domesticating it. It is thus problematic in such a project to draw upon methods that also enable this domestication, for both cross-cultural psychiatry and ethnography share their beginnings in traveller's tales of the 'unknown' and in anthropology's encounters with the 'exotic'.

However, in my own research in India something strange seemed to be at work, something strangely familiar. The practices I encountered at the NGOs I visited, the 'insider' accounts from the interviews, were not encounters with the 'exotic'; they were often encounters with psychiatry – a psychiatry that seemed strangely familiar. Perhaps, then, this project invokes a different use of ethnographic research, as it has sometimes been used in policy and organisational settings, to 'render the familiar strange' - a way to 'look again at the cultures we feel we know so well' (Goodley, 2004). Here I seemed to be looking again at a psychiatric culture I felt familiar with but in the context of a culture I didn't know so well – India. This is a methodology that defamiliarises - both psychiatry and methodology.

It is part of a project of decolonising methodologies (Tuhiwai Smith, 1999), away from a 'pathology approach to research' (and to distress), resisting the commodification of knowledge to be consumed by those in the global North (Bishop, 2005:111). This is

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onto one particular interview (with Sarbani Das Roy) because the interview had felt so close and had marked the beginning of our friendship. In my anxiety, I sent a copy of the interview, and of my analysis of it, to Sarbani – terrified of what she'd think. She replied quickly, saying she was 'deeply touched' by the analysis. I felt better. But what would I have done if she hadn't liked it?

research that is situated, that is messy. Schostak (2006:3) points out that the actual experience of interviewing ‘un-does’ ‘the how-to-do prescriptions’ of introductory methods textbooks – books that invite a deceit that covers over gaps and messy spaces. This research dwells in those messy spaces – ‘worrying away’ at contradictions and binary oppositions, challenging the taken for granted in order to ‘open up textual spaces that seem closed’ or to ‘tangle up’ those that seem distanced, to make them grate and chafe against each other (Burman and MacLure, 2005:286).

I’m not going to pretend that these encounters; the interviews and field notes that make up parts of this research, took place in quiet idyllic locations. They didn’t. It was usually noisy, it was hot, often I sat there and worried that the ceiling fan would disrupt the recording as it churned hot air around the room. Often my field notes blurred under the stain of a coffee cup, or a splash of blood when used as a mosquito swot. Writing this research messily, then, is in part an attempt to situate the encounters that make up the research - the interruptions, the heat – ding dong - the interruption of a doorbell or a phone ringing. Many of the interviews took place while having a ‘tour’ of an organisation, or were shouted in the back of a rickshaw - interrupted by a screeching halt on a motorway flyover.

There is no ‘methodology chapter’ to this thesis. The ‘methods’ are entangled, interlaced, throughout each chapter – with the messy spaces and problematisations that emerge laid out in the conclusion. Therefore this is an attempt to decolonise methodology, to employ a methodological pluralism, to be creative in the act of research and in the writing of it (Schostak and Schostak, 2008), to defamiliarise what is meant by mental health through research that also becomes unfamiliar in the process. This is a ‘method’ with inverted commas round it, a ‘method’ ‘under erasure’ (Derrida, 1982), one of those ‘impossible things’ I cannot do without (Burman and MacLure 2005:286), a method I cannot not use .

### **The ‘psychic life of colonial power’: Psychopolitics**

To speak of a methodology of encounters goes further, to Althusser’s encounter with the police officer (explored in chapters 6 and 7), the ‘Hey, you there!’ - the centrality of the encounter in being hailed, interpellated. Of Frantz Fanon’s encounter with the

white child, where he was pointed at, hailed, through a look, 'Look, a Negro', a look that was 'an amputation, an excision, a haemorrhage that spattered my whole body with black blood (Fanon, 1967[1986]: 112). Thus, encounters seem central to subject formation – key to exploring how the subject of Global Mental Health comes into being, and in tracing the links between colonial and psychiatric subject formation

Fanon's encounter with the White gaze is indicative of a much larger encounter – the colonial encounter and the 'identity violence' (Hook, 2005:480) it induces in the colonised as they come to understand themselves in the terms of the coloniser – alien terms. Terms that may echo the foreign terms by which Meesha speaks of and yet refuses her identity - a 'white mask psychology' (Hook, 2004:136-7). Fanon's encounter, then, is a central element in the analysis of power relations and political factors within the field of the psychological – this is Fanon's 'psychopolitics' (Lebeau, 1998).

Psychopolitics then marks a constant shifting between the socio-political and the psychological, a continuous 'to- and fro- movement, whereby the political is continually brought into the register of the psychological, and the psychological into the political' (Hook, 2012:17). Thus, importantly not dissolving the two or abandoning one register in favour of the other, but employing a 'psychology of critique' (Hook, 2012:18). Hook (2004; 2012) further foregrounds a psychopolitical analysis as falling into three forms,

- 1) the placing of seemingly psychological concerns within a political register - 'the explicit politicisation of the psychological' (Hook, 2004:85).
- 2) the deployment of psychological and psychoanalytical concepts to describe the workings of power, aiming to enable strategies to intervene in the 'psychic life of colonial power' (Hook, 2012:18). (For Hook, 2012, Homi Bhabha extends Fanon's work in this vein drawing widely on a psychoanalytical vocabulary).
- 3) The putting to work of psychological concepts politically and as 'a means of consolidating resistances to power' (Hook, 2012:18).

This research traverses all three layers. The first layer is mainly worked through in the first half of the thesis – with a further interrogation of how certain phenomena come to be understood as psychological, or more specifically here, psychiatric, and the

rationales this may serve. Thus, what might usually be read as psychological comes to be read in political terms, as the 'nervous condition' of being colonised (Sartre, 1990:17). The violence of colonial subject formation is juxtaposed uneasily throughout with the processes by which psychiatric subjects are formed – thus speaking of the 'psychic life of colonial power' (Hook, 2012:18) is both a reference to the use of the psychological to explore workings of power, but also hints at how the colonial shapes and makes possible psychic life. This enables a psychopolitical reading of Global Mental Health, an exploration of the intertwining of subjectivity and the politico-economic.

The second and third layers of this psychopolitical project come into play in the second half of the thesis, putting Fanon's language of pathology, of the psychopathology of colonialism, of alienation, to work on psychiatric encounters with the global South. This is particularly mobilised through an exploration of how psychiatry travels, its anxious repetitions, its play of desires, and its ways of 'seeing'. While the third psychopolitical layer is interwoven throughout – Chapter 9 uses a post-colonial lens of resistance to colonialism, resistance that is veiled, that covers its tracks, an 'infrapolitics' of resistance (Bhabha, 1994; Scott, 1990), to (re)read resistance to psychiatry. Furthermore the chapter will engage with whether this resistance, played out at the level of the body, and of the psyche, can be mobilised for wider political resistance.

### **De-familiarising - Methodology and Global Mental Health**

This research, then, is a project of strange encounters (Ahmed, 2000), of encountering the familiar in the strange and the strange in the familiar - the things I found strangely familiar about psychiatry and mental health in India. To de-familiarise is to make unfamiliar both the mechanisms by which mental health and illness are conceptualised and put to work in India through the project of Global Mental Health and psychiatry, while simultaneously mobilising dilemmas that are arguably constructed as 'Indian' to make unfamiliar the practice of psychiatry in other parts of the world. However, promoting a critical (re)reading of Global Mental Health is, within this project, not necessarily to abandon it altogether; it is to explore alternatives, other ways of knowing.

It is interesting to trace the mechanisms by which Global Mental Health stakes out a space that is 'global' as a site to encounter the interlacing of distress and international politics, and sometimes to not encounter these connections, to foreclose them. This space is implicated then in the geopolitics and global marketplace of (mental) health. I often felt anxious researching in India, despite being asked by one academic if I was always this enthusiastic when in England, or was I 'blossoming in the Orient'? On reflection I wonder if this anxiety was in part haunted by a colonial anxiety that marked my own experiences and that haunts the work of Global Mental Health and psychiatry, in India (something I will explore throughout this thesis). While this anxiety gave me sleepless nights, it was in many ways productive, it spurred me on, it made me bite my nails, it made me wonder.

What [critique] is really about is opening up the possibility of questioning what our assumptions are and somehow encouraging us to live in the anxiety of that questioning without closing it down too quickly. Of course, it's not for the sake of anxiety that one should do it...but because anxiety accompanies something like the witnessing of new possibilities. (Salih and Butler, 2004:331).

Dwelling in my anxiety, then, and continuing my work in India did enable 'something like the witnessing of new possibilities', of alternatives. Just as international comparative studies by the WHO, such as the Determinants of Outcome in Severe Mental Disorders (DOSMED) (1978), have consistently found that LAMICs actually show better long-term outcomes for people with a diagnosis of Schizophrenia (WHO, 1973, 1979; and Hopper and Wanderling, 2000). This research (however problematic) also hints at a pluralism in understandings of and approaches to mental distress in the global South, which may account for the better outcomes for people with a schizophrenia label, in the so-called 'developing' countries of the WHO studies (Halliburton, 2004). And which also begins to problematise the replacement of these approaches with a single approach - psychiatry.

### **Globalising Psychiatry**

If approaches to distress in other cultures, or the presence of a pluralism of approaches, leads to better outcomes for those who experience distress then it seems



important for the discipline of 'cross-cultural' psychiatry to explore this. However, psychiatry itself may work as a mechanism of globalisation; exporting disorders that are arguably 'western' to other parts of the world (Kirmayer, 2006). In 1977, Arthur Kleinman (an anthropologist and psychiatrist, who has worked with Vikram Patel and the Movement for Global Mental Health) called for a 'new cross-cultural psychiatry' that had stronger links with anthropology and ethnography, in comparison to conventional psychiatric epidemiology. Kleinman (1977, 1987) was particularly concerned with the issue of 'category fallacy' – the assumption that categories and diagnoses mean the same in different cultural contexts.

However, despite these efforts to situate cross-cultural psychiatry within socio-cultural and economic contexts, a focus on being 'practical' has meant much work has tended 'to assume the cross-cultural portability of psychiatric theory and practice in order to achieve practical outcomes' (Kirmayer, 2006:128). Equally, much critical work has remained largely theoretical, and not concerned itself with more practical everyday encounters with distress.

Thus, the push by the WHO and the World Psychiatric Association (WPA) to 'broker international consensus on diagnostic nosology', the application of psychiatric diagnostic systems, and the increased push for 'evidence-based medicine' thus lead to the dominance of Euro-American psychiatry, and the exclusion of local knowledge and plural ways of knowing and responding to distress (Kirmayer, 2006:136). This Euro-American psychiatry itself does not offer much pluralism in understanding distress, tending to portray mental health problems as biochemical.<sup>14</sup> Thus, '[g]lobalization has brought with it many ironies for cultural psychiatry' (Kirmayer, 2006:126). For Kirmayer,

psychiatry itself is part of an international subculture that imposes certain categories on the world that may not fit equally well everywhere and that never completely captures the illness experience and concerns of patients. (Laurence Kirmayer, cited in Watters, 2010:197).

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<sup>14</sup> However, it is worth noting that there are some alternative approaches within HICs, for example; Open Dialogue in Finland; The Soteria Network; The Philadelphia Association; (and others), as well as a number of user-run crisis centres worldwide.

Psychiatry's failure to ever fully capture the experience of distress, and its imposition of categories that may never fully contain those placed within them, seems to resonate with some user/survivor experiences within the countries where psychiatry is dominant, just as much as for those countries where it is not (yet). Engaging with psychiatric user/survivor critiques of psychiatry from within usually HICS (something I do in detail in chapters 2 and 3) hints at psychiatry as colonial in a number of different ways. Here not only is the globalization of psychiatry and the pharmaceutical industry understood as a colonizing or imperial move (see Thomas et al, 2005; and Tsao, 2009). But psychiatry's translation of people's distress into technical and often pathological terms, both 'at home' and 'abroad', may be understood as alienating and colonizing.

It also begs the question of why bio-psychiatry with its biochemical explanations for, and ways of intervening in, distress are pushed onto LAMICs over other approaches. This is a key issue for those who question the scientific evidence base of Global Mental Health, and the psychiatric frameworks it draws upon, arguing that these understandings should not be routinely applied to populations of the global South (see Summerfield, 2008: and Thomas et al, 2005). (A discussion of this is taken forward in the following chapter). Bearing in mind its questionable evidence base and interpretations from the WHO DOSMED (1978) studies, we might wonder why biochemical understandings of distress are dominant within WHO and Global Mental Health policy, and whose interests does this serve? This is a key point for those who are critical of, or promote caution in, globalising 'Western' psychiatric systems. For Thomas et al (2005:23), as the WHO and the World Psychiatric Association extend 'biomedical accounts across the globe', it becomes evident that '[n]ationally and internationally, the interests of psychiatry and the pharmaceutical industry are becoming ever more tightly-woven'.

### **'Scaling up' or getting rid?**

Global Mental Health starts to become a messy space here, fraught with frictions and tensions that will be teased out throughout this research. A space for an uneasy, anxious bricolage of ideas that differ and grate against each other. For example, while the WHO and Global Mental Health make statements, such as,

We know that mental disorders ... have a physical basis in the brain. We know they can affect everyone, everywhere. And we know that more often than not, they can be treated effectively. (WHO, 2001a:x).

Schizophrenia is a psychotic disorder...which is often chronic and very disabling. (Patel, et al, 2007:48).

Critical psychiatrists, such as Sami Timimi, seek to abolish psychiatric diagnostic systems, based on evidence that, in summary; psychiatric diagnoses are not valid...they increase stigma ... [they] do not aid treatment decisions [and they] impose Western beliefs about mental distress on other cultures (Timimi, 2011, online). (See Chapter 2 for a more detailed discussion). How can we read campaigns such as the Campaign to Abolish Psychiatric Diagnostic Systems such as ICD and DSM (CAPSID), and the Campaign for the Abolition of the Schizophrenia Label (CASL),<sup>15</sup> alongside Global Mental Health's and the WHO's call to 'scale up' psychiatric diagnoses and interventions globally?

One of the arguments of this thesis is that Global Mental Health and psychiatry recognise difference only to disavow it, to domesticate it. Thus, I want this thesis to be a space that encounters alternatives and does not attempt to synthesise or accommodate them within terms that make them familiar. This is research that envisions and opens up a new space - a 'third space' (Bhabha, 1994; Rutherford, 1990), a space that maps a language of dissent, of no-sense (Nandy, 1983). Employing the 'third space' as a conceptual tool is a strategic move in my refusal to be comparative, to compare India and the UK, risking hierarchy. Instead the thesis aims to open a space to examine psychiatric practices and frameworks in both contexts, exploring how the application of psychiatry in India may demand a rethinking of its interventions in the UK (and vice versa). This is not to imagine India, or the trope of India, as a 'third space',

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<sup>15</sup> See Timimi, S. (2011). No More Psychiatric Labels. See <http://www.criticalpsychiatry.net/?p=527> (Accessed, January 20<sup>th</sup> 2012). And Hammersley, P. and McLaughlin, T. (undated) Campaign for the Abolition of Schizophrenia Label. <http://www.asylumonline.net/resources/campaign-for-the-abolition-of-schizophrenia-label/#.UCjJ26FIQzA> (Accessed, May 12<sup>th</sup> 2012).

somehow 'pure' from psychiatry, or 'outside' Neoliberal frameworks. For Nandy (1983), the 'West' (and this could include psychiatry) is not 'outside', but always already incorporated, digested by India.

Enabling Global Mental Health policy to encounter its critiques, alternatives, and creating a space for these areas of tension to rub up against each other, is thus a central element in this project of de-familiarising Global Mental Health. This thesis, then, is not 'anti' Global Mental Health or anti-psychiatry – it seeks to examine Global Mental Health from alternative positions not usually taken, and subject it to questions not usually asked – (post)colonial questions.

### **Colonial Discourse Analysis**

Psychiatry is a colonial legacy in India (Ernst, 1997). Yet it is not only a colonial legacy, just as the pre-fix 'post' in the putting to work of post-colonial theory does not imply that colonialism is somehow finished, in the past (Loomba, 1998; Ashcroft, Griffiths and Tiffin, 2006). In fact, much post-colonial theory emphasises how colonialism is 'perpetuated and renewed through economic and other means of domination' (Grech, 2011:97). Therefore this thesis seeks to explore how psychiatry, through WHO policy and Global Mental Health interventions may be one such mechanism to enable this 'perpetuated coloniality' (Grech, 2011). In translating distress into technical pathological terms, in identifying and categorising certain people as 'mentally ill', in transposing these systems of categorisation onto countries of the global South, and its mechanisms for tempting those who oppose it to do so through its own register, there are hints of how psychiatry (and Global Mental Health) may work through power relations that are interlaced with colonialism.

Thus, post-colonialism is used here as a conceptual tool to explore relationships of domination and resistance that continue after formal colonialism has ended (Van Zyl, 1998), and that sometimes continue from within. In fact, after Independence in India, many colonial institutions were closed down or re-organised, yet mental health legislation and the asylums were kept intact.<sup>16</sup>

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<sup>16</sup> Interview with Bhargavi Davar, in Pune, February 2011.

One of the key points of departure of this thesis, then, is the exploration of how Global Mental Health policy could be read as a form of colonial discourse, and how mental health NGOs in India may operate as sites through which this discourse travels, and is put to work. Delving further into how psychiatry travels, it seems that Global Mental Health advocacy and WHO policy are mobilised as justifications for the travelling of psychiatry at a policy level (the need for it to travel). This travelling is made possible at ground level by diagnostic and classificatory tools (such as the Diagnostic and Statistical Manual – DSM, and the International Classification of Diseases – ICD), which are translated in order to travel across geographical borders, signifying a ‘diagnostic creep’ (Rose, 2006:478). This ‘creep’ is a form of psychiatrization, the framing of increasing numbers of experiences, globally, in psychiatric terms and codifications, as concerns for psychiatry. Thus,

[i]n shaping our ethical regimes, our relations to ourselves, our judgements of the kinds of persons we want to be, and the lives we want to lead, psychiatry, like the rest of medicine is fully engaged in making us the kinds of people who we have become (Rose, 2006:481).

Yet many people in LAMICs have not - yet - become these kinds of people, and thus this thesis seeks to trace some of the processes by which they might; it maps the ‘creep’, and it does so through a lens of post-colonialism. Here I want to pick up the work of Homi Bhabha, pick it up from where I hurled it in a fit of frustration, and explore how we might read Global Mental Health and WHO policy as forms of colonial discourse, as enacting colonial relations in potentially multiple ways through psychiatrization. This analysis will be taken up throughout the thesis through a series of problematisations, both practical and conceptual, that emerge from each chapter, and are brought together to rub against each other in the final chapter. However, here I want to briefly outline what is meant by colonial discourse, drawing upon and summarising Bhabha’s (1983:23) ‘minimum conditions and specifications’. Thus, according to Bhabha, colonial discourse;

- Is an apparatus that ‘turns on the recognition and disavowal’ of difference.

- Its 'strategic function is the creation of a space for a "subject peoples" through the production of knowledges'.
- In 'marking out a "subject nation"' colonial discourse operates as a form of governmentality, that 'appropriates, directs and dominates its various spheres of activity'.
- While there is a 'play' at work that is crucial to colonial discourse's exercise of power, it 'produces the colonised as a fixed reality which is at once an "other" and yet entirely knowable and visible'.
- Through this knowledge surveillance is exercised, and 'a complex form of pleasure/unpleasure is incited'. These forms of knowledge are drawn upon to authorise colonial discourse.
- 'The objective of colonial discourse is to construe the colonised as a population of degenerate types on the basis of racial origin, in order to justify conquest and to establish systems of administration and instruction.'
- It 'resembles a form of narrative whereby the productivity and circulation of subjects and signs are bound in a reformed and recognisable totality'.
- 'It employs a system of representation, a regime of truth, that is structurally similar to Realism'. (Bhabha, 1983:23).

The chapters of this thesis interlace and layer in their analysis of how the psychiatrization at work through Global Mental Health and WHO policy may be conceptualised within Bhabha's (1983) 'minimum conditions' above (with a more explicit outline in the final chapter). Broadly, the thesis is about how the psychiatrization enabled by certain policies and the work of particular NGOs in India, may function to recognise difference and yet to disavow it, to come to terms with it. The particular modes of this domestication will be explored throughout, making reference to three specific techniques; sublation, inoculation, and Said's 'median category' (Said, 1978[1995]).

More specifically, Chapter 2 traces the production of particular knowledge about mental health, drawing upon alternative evidence bases to examine some of the claims

of Global Mental Health and the implications of these claims. Taking this further, Chapter 3 examines a key issue in the framing of distress as an 'illness like any other'; issues of 'unsound mind' and competence – exploring how children with mental health problems function as limit figures to universalist child rights discourse. Connections to other 'limit figures' within psychiatry and Global Mental Health (the 'treatment unresponsive' patient, the 'poor country', and the individual and national 'emergency') are then traced in Chapter 4, which explores how the mobilisation of particular tropes may work to enable a violence not usually read as being violent, a 'normal' violence, violence with a 'civilising mission'. The sometimes violent implications of locating mental illness in the brain will be further examined, in Chapter 5, through the lens of farmer suicides in India. While Chapter 2 mapped how particular knowledge is mobilised in the creation of a space for 'subject peoples', a global space, Chapters 6 and 7 trace the 'on the ground' techniques for the formation of these 'subject peoples', particularly through NGOs mental health camps and mental health literacy.

Reading colonial subject formation alongside psychiatric subject formation begins to highlight the potential 'identity violence' (Hook, 2005:480) at work in both – a key theme in Chapters 7 and 8, explored through the lens of Indian NGOs work on the streets with the 'homeless mentally ill'. In Chapter 9, resistance to colonialism is used as a lens to read resistance to psychiatry – resistance that is veiled, that is sly, resistance that pretends to be something else.

In his reading of colonial discourse, Bhabha (1983:18) initiates a shift in the point of intervention, 'from the identification of images as positive or negative, to an understanding of the processes of subjectification made possible (and plausible)'. This enables a move away from analysis of psychiatrization as good or bad, to how it may operate as a field of subjectification, bringing into being particular ways to be a person, 'engaging with its effectivity; with the repertoire of positions of power and resistance, domination and dependence that constructs the colonial subject (both coloniser and colonised' (Bhabha, 1994:19).

In understanding colonial discourse as an 'apparatus', Bhabha is drawing upon Foucault (1980:196), for whom an apparatus consists in 'strategies of relations of forces

supporting and supported by, types of knowledge'. In Bhabha's (1983:26) reading of Foucault, the power relations at work within an apparatus 'are always a strategic response to an urgent need at a given historical moment.' This opens up a reading of Global Mental Health as an apparatus, as a colonial discourse operating as a 'strategic response' to the contemporary 'urgent need', the global 'emergency' and 'epidemic' of mental illness (BBC, 1999).

To say that mental illness constitutes a global emergency is to make a statement. Global Mental Health literature and WHO policy make many statements.<sup>17</sup> They say that '450 million people worldwide are estimated to be suffering at any given time from some kind of mental or brain disorder' (WHO, 2001b:6), and that '[d]epression is 'leading cause of disability worldwide' (WHO, 2012 - online).

For Foucault (1972:130), such statements mark the 'authorised utterance' and occur in an archive, 'an organised body of statements', or for Said (1978[1990]:58-59) an 'internally structured archive'. Therefore Foucault is interested in the relation between different statements, how they are grouped together 'and the conditions under which certain statements can emerge' (Mills, 2003:24). Sets of statements thus make up a discourse, regulated by sets of practices that either work to distribute such statements, or to restrict their circulation (Foucault, 1972). Different institutions thus 'work to exclude statements which they characterise as false and they keep in circulation those statements which they characterise as true' (Mills, 2003:58). Here Foucault takes as the object of his analysis not a sentence but a statement, the taking place of discourse through a statement's enunciation. The focus here is not on the individuality or origin of the statement but the conditions that make up the operational field of speaking.

Such statements, then, the official statements and statistics of Global Mental Health and the WHO, form a key focus of analysis here. As do the mechanisms that enable these statements to circulate as 'true', and those that prevent or foreclose other statements from circulating. This is to pay attention to how certain statements and

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<sup>17</sup> By Global Mental Health literature I am referring to the Lancet Series (2007; 2011) on Global Mental Health, and a body of articles written by members of the Lancet Global Mental Health group and/or the Movement for Global Mental Health.



terminology 'become a way of thinking—a way of life—that threatens to eclipse all other ways of thinking' (Murray, 2009:12). Or, for Segal (2005:116), how 'the terms of a discourse constrain not only the outcomes of debate but also what it is possible to argue at all'.

Here a focus on discourse enables power relations to be read into the circulation of the 'truth' of mental health, important for Global Mental Health when we consider the interlacing of psychiatry and the pharmaceutical industry in a global (mental) health marketplace. This is to read the statements and the enunciative addresses of Global Mental Health and psychiatry, the everyday acts that enable psychiatry to 'travel' (for example, international policy, the work of NGOs, pharmaceutical industry marketing, and the diagnosis of an individual with a mental illness on the streets of Kolkata). Yet it resists a reading of Global Mental Health as simply transposing psychiatric concepts onto countries of the global South, as though this flows only one way, as though people and populations cannot rework and resist such ideas.

### **Writing messily**

Is this thesis anti-psychiatry? Am I? I have been asked this so many times and I don't know what the answer is. For me the answer to this involves firstly exploring what one means by psychiatry. *What is psychiatry in this thesis? What do I mean when I write psychiatry?*

This research understands psychiatry broadly as a medical, legal, economic, socio-cultural and political system of understanding and intervening with those who are distressed or different that often, but not solely, works on the individual body/brain, through frameworks of diagnostic categories that frame distress or difference as pathology, as 'illness'. Centrally to this thesis, these understandings and ways of categorising people seem increasingly to be applied to individual bodies within the global 'body', and to populations of low and middle-income countries. When I write bio-psychiatry I am thinking specifically of the privileging of bio-chemical, 'within brain' understandings of 'mental illness' within certain branches of psychiatry and of the pharmacological interventions used. I am also alluding to the ties between psychiatry

and the pharmaceutical industry, the industry that manufactures, markets and supplies the medications prescribed by psychiatrists.

To write messily about Global Mental Health and psychiatry, then, is to move away from questions of being 'for' or 'against', 'pro' or 'anti'; it is to ask what these particular frameworks prevent us from seeing, and what alternative ways of intervening they might foreclose. It is to explore what is meant by evidence, and what other evidences might mean for the practices of Global Mental Health and psychiatry. For Nandy (1983:3), the pervasiveness of colonialism, the 'ultimate violence which colonialism does to its victims, [is] namely that it creates a culture in which the ruled are constantly tempted to fight their rulers within the psychological limits set by the latter'. This pressure to be the obverse of the West, thus binds the Indian 'even more irrevocably to the West' (Nandy, 1983:73). This evokes for me one of the parallels between colonialism and psychiatry – the setting of limits, the temptation to fight using the terms of the hegemonic and the binding together of the oppressed with the dominant even through opposition. Here to be 'anti-psychiatry' could be read as being tied to, bound to psychiatry even more tightly. Therefore this research wonders, with Lather (2007:13), 'how can writing the other not be an act of continuing colonization?'

As an Indian political psychologist, Ashis Nandy, could also be said to be 'psychopolitical' in his concern with the 'psychology of colonialism'. His work is markedly absent from many discussions of psychopolitics, yet in his attention to the production of 'official dissent' to colonialism (Nandy, 1983:12) he bears a resemblance to another psychopolitical figure - that of Peter Sedgwick. Sedgwick (1955) first used the term 'psychopolitics' in reference to the explaining away of political activism through individual psychology, but later turned it to work on the 'conservative undercurrents' of the so-called radical theorists of the 'anti-psychiatry' movement, in the 1960s (Cresswell and Spandler, 2009:4). If we read psychiatry as echoing colonial relations, then we might read these conservative undercurrents as mapping onto the temptation for the colonised to fight the colonisers on their own terms.

Avoiding this temptation means speaking another language 'a language of dissent which would not make sense - and will not try to make any sense in the capitals of the

global knowledge industry' (Nandy, 1998:147). In a world where 'critique has become an element of capitalist productivity' (Mouffe, 2007:1), writing messily may be one method to make no sense within a world that privileges capitalist productivity (over, for example, interdependency). Thus, I want to write messily not in opposition to or to be 'anti' Global Mental Health or psychiatry, but to use the research, the thesis itself, as a space to encounter Global Mental Health differently. It is also a refusal to meet psychiatry's criteria for what counts as 'evidence', through the intertwining of the above three psychopolitical layers that form the body of this thesis. A body formed, like Hook's reading of Fanon's 'Black Skin/White Masks', through a 'traumatic assemblage', an 'uneasy bricolage', the grating and chafing of different styles and texts, a 'body-in-pieces' - a text in pieces (Hook, 2012:46).

This is to read and write Global Mental Health, as Homi Bhabha reads colonialism, and as he reads the work of Frantz Fanon, on a different register, poetically, messily. In seemingly (yet purposefully) making a 'category error', 'applying inappropriate reading techniques to the texts of colonialism', Fanon and Bhabha are 'challenging the lifeless statements of colonialism', invoking the poetic itself as a form of resistance to colonialism (Huddart, 2006:9 & 18). However, the statements of WHO policy and Global Mental Health, while rarely read poetically, are not 'lifeless'. In many ways, 'as the product of relational practices, but also as productive of social relations', these policies, these statements are living' (Hunter, 2008:507). Just as for Said (1978:94), 'texts can create not only knowledge but also the very reality they appear to describe'.

This is to change the focus of the analytic gaze onto 'the relations of meaning that are internal to the discourses embedded in policies themselves rather than to seek an objective truth "out there" which the policy documents then describe' (Lewis, 2000:11). It is to trace how policy works performatively, how policies 'travel across time and space' (Hunter, 2008:508), the doing of policy, what policy does. What does Global Mental Health and WHO policy do? How might we trace the performativity of these policies, the staking out of a space that is 'global', and the making possible, the 'making up' (Hacking, 2006) of those who will inhabit that space – global psychiatric citizens? (See Chapters 2 and 6).

This marks a move away (as much as possible) from essences, linearity, origins, rationality, 'it rejects the Whole in favour of dissemination and disorder, it thinks of origin as nothingness and shapeless, it "catches a moving train"' (Illuminati, 2005:2; Althusser 2006:290-291). Like the moving trains I learned to jump onto in India, at speed, I want through this research to jump on and off, and in-between, Global Mental Health advocacy and the criticisms made against it, 'without knowing where it comes from or where its going' (Illuminati, 2005:2). Like Fanon's refusal, in *Black Skin White Masks*, 'to remain within one discourse, and to stick to one approach to its defined problem' (Huddart, 1006:20), I want to 'to fold and layer concepts in ways that are multiple, simultaneous, and in flux rather than presenting them as linear and discreet' (Lather, 2007:4). This is not just to read policy differently, but also a poetic play of methodology, against a traditional assumption of method as 'a metaphysical tool for mastering uncertainty and providing access to presence' (MacLure, 2003:123). Therefore how does one make use of a 'method' that aims to embrace uncertainty, to dwell in the messy spaces of research encounters?

Layering and folding concepts through a bricolage, the thesis (here borrowing heavily from Huddart's (2006) reading of Fanon, and bearing unmentioned debts to Deleuze and Guattari, and Derrida) aims to use the tools, methods and concepts that are ready to hand (and some that are not in such easy reach), force them to their limits, drop them and then return to them later. The text is 'unwilling to confine itself within a single mode of theorizing', it is 'hybrid and impure', and this 'formal mix is more than a choice of style: it also destabilizes any claims to being an authoritative narrative' (Huddart, 2006:20). To write in this way is also to destabilise any of the claims to authority made by Global Mental Health and psychiatry; it reflects a commitment to de-familiarising both the act of writing and researching (disrupting what counts as evidence, what makes sense), and of Global Mental Health. It is the writing of a text that both 'interrupts itself and gathers up its interruptions into its texture' (Lather, 2007:4). Here's another interruption.

Writing like this is making me anxious. To make claims for writing messily should not, I feel, defend writing that excludes. I have loved reading Homi Bhabha, whose richly conceptual post-colonial theory I make use of throughout this

thesis. However, I am aware that his writing has been criticised for being esoteric, 'dense' and 'clotted' (Hook; 2005:10) and my copies of some of his books bear the multiple wounds of being thrown across rooms.

To write poetically of colonialism, of WHO policy, of psychiatry is to write outside of their frames of reference, from within other registers. To write mysteriously or partially may mimic the strategies of resistance and survival sometimes tactically (and often psychically) employed by the oppressed in order to survive (see Chapter 8 and 9 for an exploration of this). However, writing mysteriously and esoterically when written from a position of power can exclude those who are being written about, it can serve to keep ideas at a purely conceptual level within the confines of the Academy (Norton, 2004).

Then I often hear in my head the voice of Sarbani Das Roy, the co-founder of Isawar Sankalpa, one of the mental health NGOs I worked with in India, and she says; 'this critique all sounds lovely, but the people you are writing about must be able to read this, what use is it if people can't understand'? She has a point.

Therefore, this thesis is written in a hybrid textual style – enacting a layering of texts; of ethnographic fieldwork from India; interviews (conducted in busy offices, on buses); of 'official' literature on Global Mental Health and WHO policy; of stolen moments in rickshaws, passing comments, whispers.<sup>18</sup>

### **Doing 'real' research**

I travelled to India in January 2011 and stayed for five months. I visited many organisations that work around mental health, and interviewed a number of people; psychiatric survivors, founders and staff of NGOs, psychiatrists, lawyers, students, academics (see appendices 1, 2 and 5, for a complete list of interviews, workshops, and organisations visited). I facilitated workshops at different NGOs in many of the major cities of India, usually talking to people about approaches seen as alternatives to psychiatry. When I first made contact with mental health organisations in India, I told them a little about my experience, and offered to share resources or facilitate workshops. Admittedly, much to my initial dismay, all of them asked me to run workshops, sometimes with a day's notice, after hours on a train, and often with no

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<sup>18</sup> See the auto-ethnographic work of Carol Rambo-Ronai (1997).

electricity. I was dismayed because I worried that this would take up all my time, and somehow take me away from the 'real' research I imagined I had come to do. Then I wondered if this itself couldn't be a form of 'doing' research; if the workshops and the many discussions within them, might not be recorded (with permission) and used as a lens to explore some of the tensions at play in NGO's mental health interventions in India, and how alternative / counter-hegemonic approaches from HICS might be used in India. Thus I facilitated workshops on alternative approaches to understanding what psychiatry calls 'mental illness', particularly the approach of the Hearing Voices Network,<sup>19</sup> at a number of NGOs and mental health institutions (see appendix appendix 5 for an outline of the workshops). The discussions that occurred during these workshops were rich with arguments and different view points that seemed to reflect tensions beyond simply those between the individuals who attended.

Below are some photos of a workshop I facilitated at Iswar Sankalpa, Kolkata, on March 22<sup>nd</sup> (2011).



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<sup>19</sup> The Hearing Voices Network is an international network of people who hear voices (see visions and/or have unusual experiences) who are interested in alternative ways (that are non-pathologising) of understanding and living with the experience of hearing voices. The Network is more broadly part of a 'hearing voices movement', 'a philosophical and social trend in which networks of voice-hearers organised outside the psychiatric system seek and elaborate ways to support one another, empower themselves and work towards recovery in their own ways. The foundation of such networks have created possibilities for acknowledging and supporting voice-hearers and, crucially, spread the forgotten revelation that people can learn to live with their voices' (May and Longden, undated, online). The emphasis within this movement is on accepting and making sense of voices, often seeing them as personally meaningful, and on self-help groups and peer support.



*Photos from a Hearing Voices workshop at Iswar Sankalpa, Kolkata.*

Back in the UK, in August 2011, I attended a course in Global Mental Health, at the Institute of Psychiatry, in London. I spent five rainy days eating pastries and meeting and listening to some of the key figures within Global Mental Health advocacy. In many ways this was invaluable because in meeting them I realised I shared many of their concerns, and that many of these people are very aware of some of the problems of using psychiatry to intervene in the lives of people in LAMICs. I learnt about the stance they were taking, the assumptions, what they were taking for granted, and also simultaneously confronted some of my own assumptions.

These encounters appear in more detail throughout this thesis. No particular encounters are privileged over others; interview extracts, WHO policy, ethnographic field notes appear alongside each other, horizontally. This project, then, is to write about psychiatry and Global Mental Health from a number of different positions. Here

writing itself, is an encounter, 'more accidental than intentional... produced by unintended juxtapositions', distractions and daydreams (St. Pierre, 1997:409).

Let me pause and make a list.

### **What this research is not about**

It is not an extensive overview of Global Mental Health and WHO policy. It is an exploration of particular mobilisations within these policies, a map of some of the rationales these ways of thinking may align with, and what alternative frameworks they may hide.

It is not a romanticisation or glorification of alternative or 'traditional' healing systems, or of survivor-led approaches.

It is not anti-psychiatry, nor is it 'against' Global Mental Health. It comes from a position that is critical of many psychiatric practices, a position that can't work out (because I can't work out) whether there is a need to retain a role for psychiatry within distress.

### **'I' – white woman, 'white knowledge'**

This thesis, then, was born of multiple encounters. In a methodology of encounters 'I' am situated throughout. But who is this 'I' who writes? 'For whom is the writing being done? In what circumstances' (Said, 1983:7)? Who constitutes the 'I' and the 'we', and how do these pronouns exclude those being written about (Tuhiwai Smith, 1999:37)? This is important in this research, which does not claim to be collaborative, and barely contains any voice of those in India who live under the labels discussed throughout.

Thus this work is also an encounter with myself, with reflexivity. I am conscious of feminist critiques of the 'doing' of reflexivity in order to claim transparency, in appealing to experience to 'mask authorial privilege', and in so doing covertly reinstilling assumptions of the possibilities or goals of rational objectivism (Burman, 2008:13). I have not engaged in critical reflection (or reflexivity) in an attempt to claim validity or in an effort to somehow reify the 'real'. Like Fanon ([1952]1986:86), 'I have not wished to be objective. Besides, that would be dishonest: It is not possible for me to be



objective'. For, as Nandy (1983:80) states, in the end, '[a]ll interpretations of India are ultimately autobiographical'.

For me to confess now that I'm white and I'm a woman seems to mean everything and nothing. However, as a white British woman researching in India, I was often reminded of these categories that I visibly occupy. Indian friends and colleagues told me I only gained access to certain psychiatric institutions and psychiatrists in India because I am white. Once inside these prestigious institutions, those I met told me that what I was talking about had no application in India because it was 'white knowledge'. (These are issues that I will return to throughout the thesis). This is a project of reading myself into the text - as text (Burman and MacLure, 2005) - where more than concerns of how to position myself (for example, as a 'professional stranger'), or to 'go native' (Tedlock, 2001), there emerged a particular problematic of whether to 'present' myself as a psychiatric survivor or not (a problematic I encountered directly in a number of interviews – see chapter 6).

In an attempt to produce an account that 'performs what it announces' (Lather 1991:10-11), I have pushed myself to contest whatever seems certain, questioning my taken for granted knowledge about mental health and illness, about psychiatry and medication. The fragmented knowings this has led to have been uncomfortable for me in some ways and I have found what I have always assumed as truth to be unexpectedly difficult to 'give up'. A few things changed as I travelled. In the UK, I am a little critical of the social model of disability. In India, where the medical model is still dominant I often told people about how useful the social model is and, I became more of a feminist.

Writing now, from the UK, so far away in distance and time from my research in India, writing in 'afterwardness', gives a force and yet an absence to my reflections. This is an absence different from the feelings of troubled presence I felt in India, evident in a note I found scribbled furiously in the back of my fieldwork diary,

Today a group of cognitive behavioral therapists and psychiatrists told me that what I discussed in my workshop (on the psychiatric survivor movement and the

Hearing Voices Network) was “white knowledge” and colonial...I feel like India is becoming psychiatrised before my very eyes, and I’m somehow complicit.<sup>20</sup>

Even in opposition to some of the practices I encountered I am painfully aware of my own complicity in that which I critique. And thus how I, we, as researchers need to read ourselves into the problem (Parker, 1999), grappling with the ways that we ‘are inscribed in that which we struggle against’ (Lather 1991:20). This thesis sets out with an agenda of exploring how we might think Global Mental Health ‘otherwise’ (Lather 2007:7). Both from the spaces designated ‘other’; those with mental health problems and countries of the global South; and in other ways, other possibilities, alternatives. This is to explore the assumptions of Global Mental Health, and my own, and to make them ‘shudder’, to bring about ‘epistemological shudders’ (Losinsky and Collinson, 1999:3).

This research then is about encounters; it is a post-colonial reading of psychiatry’s encounters with the global South, and specifically India. It is worth pointing out here that there may be no need to travel to encounter the global South, ‘[t]he South is here, right next door....in various types and spaces of exclusion’ (Santos and Alvarez, 2011 - online). Here Santos (2011) is mapping an ‘abyssal line’ that excludes many of those that we live alongside, thus the global South is not a clear geographical space, it is a ‘metaphor of exclusion’, just as ‘mental illness’ might be understood to be. Just as the ‘West’, in Nandy’s (1997:170) conceptualization, is more than a temporal entity, it is a ‘psychological category. The West is now everywhere, within the West and outside; in structures and in minds’.

This research, then, is about two types of encounter – encounters that make the strange familiar, and encounters that make the familiar strange. This thesis aims to work as a site to encounter what is taken for granted as the familiar as being strange. Global Mental Health and the WHO seem to work in the opposite direction, encountering what could be read as strange as being familiar – preventing alternative

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<sup>20</sup> From my field notes, and reproduced in Kumar and Mills (in press, 2012).

frameworks from disrupting hegemonic knowledge systems. This encountering of difference only to defer it, to 'come to terms' with it, to make it palatable (framing such encounters in the language of Fanon) will be discussed throughout (and particularly in the final three chapters).

Key to the staging of these encounters is the staking out of a space that is global, that provides the 'conditions of possibility' for such encounters to occur. A central tenet of Global Mental Health is its evidence base, how this evidence is used, and the frameworks of intelligibility that enable certain things to count as evidence and to discount others. I now want to turn to this 'evidence base', to make it confront alternative 'evidence', to make it shudder, and in so doing to explore how mental health is staked out as global, as 'Global Mental Health'.



## Chapter Two

### **Sublation and the Brain: Burdens, Markets, Gaps:**

*A chapter on illness, distress and disability, on what counts as evidence, on mental illness as a burden, and on burdens as markets, on universals and synthesis and sublation, on gaps, and on asking questions about gaps, like, 'is there a gap?', 'a gap between what and what'?*

## **An illness like any other**

Mental disorders are not the exclusive preserve of any special group; they are truly universal...they have a physical basis in the brain...they can affect everyone, everywhere. (WHO, 2001a:22 & x).

Long have debates raged (mainly in the global North) over whether 'mental illness' is an 'illness like any other'; whether mental illness should be understood as a disability; whether it is more usefully understood as distress as put forward in much psychiatric survivor literature; or drawing on the anti-psychiatry arguments of the 1960s, whether mental illness is a 'myth' – signifying not pathology but 'problems in living' (Szasz, 1960:114). These are important debates because they frame what demands can be made in regards to mental health, and the logic and site of interventions. I started thinking about these issues in global terms when I was invited to attend and speak at a symposium titled 'Distress or Disability' that sought to address current debates in the UK about whether mental distress can be usefully conceptualised using the social model of disability.<sup>21</sup> It occurred to me that while we debate these issues in the UK, the World Health Organization (WHO) already conceptualises mental distress as a disability, as 'mental illness', on a global scale (Mills, 2012b).

It is not my intention to describe these debates as they have played out in the global North – as they have been well rehearsed and documented elsewhere.<sup>22</sup> Instead, the aim of this chapter is to explore how the distress / illness / disability debate plays out within the literature on Global Mental Health, WHO policy, and mental health interventions in India. This is important because how we conceptualise mental distress frames the ethical terrain from which responses and interventions are made possible. This also enables an analysis of the various political rationales that may align with or mobilise particular claims to/about mental illness or distress; including how similar frameworks may be put to work by projects with very different underlying rationales.

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<sup>21</sup> 'Distress or Disability'. Lancaster University, UK. (15-16<sup>th</sup> November, 2011). Symposia organized by Bob Sapey, Helen Spandler, and Jill Anderson.

<sup>22</sup> See Sapey, B., Anderson, J. and Spandler, H. (Eds). (2011).

Key to this chapter, then, is the question of what the framing of mental distress through a disability register *does* on a global health agenda, what it performs; what problems and solutions does it bring into being, and make visible, what politico-economic rationales might it align with, and what psycho-political demands does it make possible or disallow? Simultaneously this brings into focus questions of what a global arena of mental health *does* to the distress / illness / disability debates often played out within the global North.

### **The Mental Health Gap Action Programme**

The World Health Organisation's (WHO) Mental Health Gap Action Programme (mhGAP, 2008), launched to address the 'lack of care' for people 'suffering' from 'mental disorders', with the objective of 'scaling-up' services for mental health problems in LAMICS (WHO, 2010:iii). The launch video for the programme, made by the WHO, was shown as part of the Global Mental Health course I attended at the Institute of Psychiatry, in August 2011, in London (and is available on the Internet).<sup>23</sup> Below I have transcribed most of the video, and included some stills, in order to explore some of the strategies at work in the construction of certain experiences as illnesses and the implications that this has for what ethical frameworks are made visible in regards to intervention.

*The Video begins with white writing on a black background, a woman's voice;*



*'50 million people suffer from epilepsy.'*

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<sup>23</sup> WHO Mental Health Gap Action Programme's Launch Video (2008). Directed by Iqbal Nandra. <http://www.youtube.com/watch?v=TqlafjsOaoM> (Accessed, August 25<sup>th</sup>, 2011).

*Depression haunts and hurts 150 million people.*

*Almost 3000 people commit suicide every day.*

*In low and middle-income countries, 75% of people do not get the mental health services they need. [music comes on].*

*To reduce this huge gap, WHO developed Mental Health Gap Action Programme (or mhGAP) in 2008.*



*An epilepsy project in rural China integrated a simple model of epilepsy control into the local health systems and achieved excellent results.*

*[a Chinese doctor then explains about educating the doctors, and public education for the people to let them 'know what is epilepsy'.]*

*Zhaoming He, a man who has epilepsy is then introduced.*



*He says; 'When I first got the illness everyone thought I was a wicked person or possessed by evil spirits. I could not get work because people didn't know what to do if I had a seizure. In 2011, I started to take this medicine and started*



*feeling much better. I started my own business and now sell these woollen carpets. Life is now good.'*



*Female narrator; 'The trial project that started in 6 provinces has now been extended to 15 provinces, and tens of thousands of epilepsy sufferers have been treated...'*

*MhGAP, scaling up resources for mental, neurological and substance-use disorders. Services like the Cape Mental Health Project, in Cape Town, South Africa, which offers care for children with intellectual disabilities'...*

*Woman speaker; 'mhGAP; tackling priority conditions like alcoholism, child mental health disorders, dementia, depression, drug abuse, epilepsy, psychosis, suicide'.*

*On screen it says; 'One suicide every 40 seconds in the world'.*

*Then Dr Laksmi Vijayakumar, founder of SNEHA [an NGO in Chennai], says; 'In India particularly, owing to failure in exams, almost 2,300 students commit suicide. So, we have taken this as an issue and we are very happy to say that the Tamil Nadu government has made a new rule in which a student who has failed in the 12<sup>th</sup> exam, can write the failed subject within one month after the results, so that he doesn't lose a year.'*

*Female narrator's voice; 'Low cost suicide prevention programmes, like SNEHA's, are now being initiated in other parts of India, China, and Sri Lanka. The Schizophrenia Research Foundation (or SCARF) is also based in Chennai, in South*

*India. A WHO collaborating centre, SCARF provides care for a range of chronic mental disorders.'*

*Dr. R Thara, founder of SCARF, then speaks; 'I think we eminently fit into this pattern of a low-resource setting working towards or delivering mental health care to just about everybody who comes within our fold. We have developed a rehabilitation strategy, which is fairly tailor made for each person. The focus could be on training of social skills, how to get into the bus, how do you buy a ticket, how do you go to the bank, how do you draw your money? Or it could be on getting a job.'*

*Then Suresh Sunderasan is introduced, as 'a person with psychosis'.*

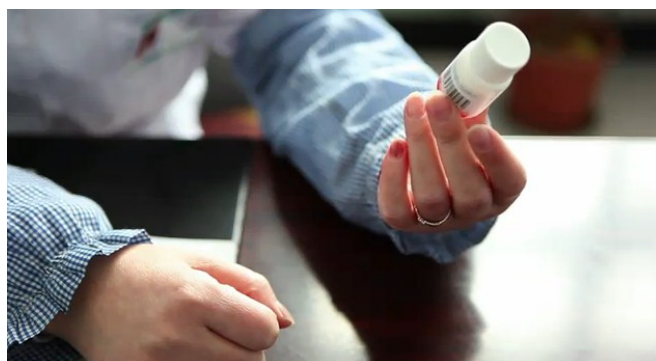


*He says; 'My name is Suresh, and I'm working as a manager in a public limited company...My case manager...I tell her about my problems, she talks with doctor and they give me medicine. And I'm normal now, thanks to my doctors.'*

*Then, a quote, on-screen, from Dr Margaret Chan, at the WHO; 'WHO's goal is to see that mental health is integrated into primary health care systems across the world. We have the knowledge. Our major challenge now is to translate this into action and to reach those most in need. We need to change policy, practice and political perspectives. Governments across the world need to see this as a health priority.'*

*Female narrator; 'The cost of providing basic care for these priority conditions is as low as \$2 per person, per year, in LAMICS.... 1 in 4 people will be effected by mental, neurological and substance-use disorder at some point in their life.'*

*These stories clearly show that with proper care, assistance and medication millions can be treated.'*



*Dr Thara, from SCARF, says; 'My desire is that every Indian should be able to go somewhere close to his home and get mental health care.'*

*Switches to mother and carer of a child with intellectual disabilities, 'They [children with intellectual disabilities] didn't ask to be here, they didn't ask to be like this. So they can't say I need your help. So I'm giving my help to them in the best way that I can.'*

*Back to Zhaoming He, the Chinese man who has epilepsy; 'Everyone in my village, including my family, now knows I am normal. They changed their opinions of me. Life is now much better.'*

*Female speaker; 'There is no health without mental health'.*

*[End of film]*

### **'No Health without Mental Health'**

'No Health Without Mental Health' is the title of the first article in the Lancet (2007) series that marked the launch of the Movement for Global Mental Health (Prince et al, 2007) (and it is also the title of a UK Government strategy paper).<sup>24</sup> This article argues that estimates of the global burden of mental illness are likely to be inaccurate because 'they stress the separate contributions of mental and physical disorders to disability and mortality', with little appreciation of the interconnections between mental and physical illness (Prince, et al, 2007:1). Because of this, mental health comes to be

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<sup>24</sup> See HM Government and Department of Health. (2011). No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages. HM Government.

alienated from more general interventions to improve physical health and alleviate poverty.

In estimating and comparing the contribution of different disorders to global disability, the Disability-Adjusted-Life-Year (DALY- the sum of years lost to early death and years 'lost' due to disability) has become a key tool. To make these comparisons and to measure the global 'burden' of mental health problems, the Movement for Global Mental Health and the WHO employ a strategy of grouping together neurological, mental and substance-use disorders into one disability category, as 'neuropsychiatric disorders'. This framing of distress as 'neuropsychiatric disorders', thus immediately understands these experiences within a bio-psychiatric register. In the Global Burden of Disease Report (2005) the contribution of neuropsychiatric disorders to global disease were then measured using the DALY; finding that about '14% of the global burden of disease has been attributed to neuropsychiatric disorders' due to their 'chronically disabling nature' (Prince et al, 2007:1).

Framing mental health problems within a register of disability thus enables those who call for Global Mental Health advocacy to identify 'priority disorders' (such as Depression, Schizophrenia and Dementia), 'on the basis that they represent a high burden (in terms of mortality, morbidity, and disability), cause large economic costs, or are associated with violations of human rights' (Patel et al, 2008:1355). Global Mental Health advocates can then mobilise the call for Government's to take 'mental illness' more seriously through increasing public spending on mental health and 'to scale up the coverage of services for mental disorders in all countries, but especially in low-income and middle-income countries' (Lancet Global Mental Health Group, 2007:87), where '75% of people do not get the mental health services they need' (WHO, 2008, mhGAP launch video). For Patel (2006:1312), the idea that there is 'no health without mental health' means that 'mental health interventions must be tied to any program dealing with physical health'. Therefore, the 'WHO's goal is to see that mental health is integrated into primary health care systems across the world' (Chan, 2008, mhGAP launch video).

If we accept that there is 'no health without mental health' then we might infer that there is 'no illness without mental illness', taking us to the conclusion that mental health problems are 'illnesses', and that 'mental illnesses' have underlying biological components comparable to those for dementia and epilepsy. In terms of interventions this invokes parallels between access to psychiatric medications and to medication for epilepsy. This parallel is apparent in the mhGAP Action video (2008) in the first two slides that read, '50 million people suffer from epilepsy' and 'Depression haunts and hurts 150 million people'. It is also made apparent in the stories in the video. Zhaoming He, who has epilepsy, says, 'I started to take this medicine and started feeling much better'; Suresh, who has psychosis, says 'I'm normal now, thanks to my doctors.' Here Epilepsy and mental health problems, such as psychosis, are placed alongside each other as examples of illnesses that are comparable to each other. The logical progression implied here is that interventions, including medications, should be made accessible to those in LAMICS for both of these disorders equally. Perhaps contrary to this, the WHO (2001a:x) readily acknowledge that '[e]pilepsy is not a mental problem', but they 'have included it because it faces the same kind of stigma, ignorance and fear associated with mental illnesses'.

Thus Patel, et al (2006:1312), then call for a move beyond the 'scientific evidence base' of particular treatments (which are taken as well-established), and push the 'moral case'; 'that it is unethical to deny effective, acceptable, and affordable treatment to millions of persons suffering from treatable disorders'.

### **Whose Evidence Base? What Counts as Evidence?**

However, let us first briefly examine the 'scientific evidence base' that Patel et al (2006:1312) are urging us to 'move beyond'. There are some problems in making the argument above, particularly because the evidence for the organic basis of mental health problems, such as Schizophrenia, is not as considerable as certain claims suggest (Chua and McKenna, 1995), and research shows inconsistent and contradictory evidence for links between Serotonin and Depression (Moncrieff, 2009). Thus according to Summerfield (2008:993) the term Depression, should not be used as it is by the WHO to denote a 'universally valid mental disorder that is amenable to a standard mental health toolkit'. Similarly there is much research that questions the validity and reliability

of the Schizophrenia label (see Boyle, 1990/2002; and Bentall, 2003), a label which many feel should be abolished altogether - not exported globally (Hammersley and McLaughlin, 2010).

Thus Summerfield (2008:992) points out that 'claims for the universality of a particular psychiatric category would be compelling if a straightforward biological cause had been established' – of which very few ever have. Sami Timimi (2010 - online) and the Critical Psychiatry Network take this further in their campaign to abolish psychiatric diagnostic systems, based on evidence that;

1. Psychiatric diagnoses are not valid.
2. Use of psychiatric diagnosis increases stigma.
3. Using psychiatric diagnosis does not aid treatment decisions.
4. Long term prognosis for mental health problems has got worse.
5. It imposes Western beliefs about mental distress on other cultures.
6. Alternative evidence based models for organizing effective mental health care are available. (Timimi, 2010 – online).

This needs to be taken very seriously when we consider the push to 'scale up' psychiatric treatments globally.

### **The Moral Argument**

Furthermore the Movement for Global Mental Health also urges HIV/AIDS activism to be used as a model for Global Mental Health advocacy, with Patel, et al (2006), connecting mental health to the 'moral argument' made by some HIV/AIDS activists, that led to reductions in the price of anti-retroviral medications by pharmaceutical companies, and the free provision of such medications by many Governments. Thus Patel et al (2006:1314) call on us to,

Consider the moral argument that persons with HIV/AIDS in developing countries had the right to access antiretroviral drugs, that the state had to provide them for free, that drug companies had to reduce their prices...that apparently complex treatment regimens could be provided by primary health

care providers...that discrimination against people with HIV/AIDS had to be combated vigorously, and that knowledge about HIV/AIDS was the most powerful tool to combat stigma. These arguments were moral and human rights based....We believe that the time is ripe for such a global mental health advocacy initiative that makes the moral case for the mentally ill.

Here HIV/AIDS activism and interventions operate as a framework for mental health advocacy, within which access to anti-retroviral medications for HIV/AIDS is situated as parallel to access to psychiatric medications, in the fight for global social justice and equality. This is further complicated by the fact that while research that uses placebos, for example in HIV/AIDS, has been widely criticized because it denies participants the best currently available treatment (Shah, 2006); in many trials for Depression, drug-placebo differences have been found to not be statistically significant (Kirsch, 2009), and significant adverse effects have been found in the drug groups of a number of trials, including increased risk of suicide (Healy, 2006). This is not the case for the use of placebos in HIV/AIDS research.

Or so I thought, and wrote, in an article titled 'Resisting the Movement for Global Health', that was published in *Asylum* magazine (see Mills, 2012c). Then I received an email from Roger Swan, a member of the Alberta Reappraising AIDS Society, who told me of the enormous controversies surrounding HIV/AIDS, in part because HIV/AIDS medication, like psychiatric medication, is marked by a questionable history, one intricately interlaced with the pharmaceutical industry.

Despite the fact that a single cause has never been isolated, in parts of Africa there reached a point where a positive HIV test wasn't required to diagnose AIDS, only for people to present with a few common symptoms, symptoms also common to malnutrition (see work by David Crowe at [www.aras.ab.ca](http://www.aras.ab.ca)). Lauritsen (1993) charts how a failed cancer therapy, Azidothymidine (AZT), was pushed as the only treatment for AIDS; one that he documents killed more people than did AIDS itself. This was despite the fact AZT had been found to be too toxic for short term use as chemotherapy, and yet was being recommended for long term use against HIV.

However, the push by the pharmaceutical companies that make AZT has encouraged many charities to call for increased access to cheaper drugs. Here again, then, with HIV/AIDS as with mental illness, there is an alternative evidence base that struggles to compete with the pharmaceutical industry lobby on knowledge. Interestingly, those who seek to question the research into HIV/AIDS and call for acknowledgement of *all* the evidence are often labelled as ‘denialists’, where ‘irrationality’ is mobilised to dismiss their claims.

It seems, then, that there are indeed interesting parallels between HIV/AIDS and mental health, however these do not appear to justify a moral argument for increasing access to medications, as mobilised by Global Mental Health. Instead, as Roger Swan said, in his email to me, they might be compared to make clear ‘what can go wrong when such a global strategy is undertaken, rather than as an example of a real biological illness to contrast with the pseudo biological nature of mental illnesses’ (Swan, 2012, personal communication).

### **‘Scaling up’ what?**

A further complexity in the call for Global Mental Health is that findings from international comparative studies by the WHO, and the World Mental Health Survey, suggest that LAMICS actually have better long-term outcomes for mental health problems (such as Schizophrenia) (WHO, 1973; 1979) (see chapter 6 for a discussion of this); and despite so few people in LAMICS receiving treatment, prevalence of mental illness appears to be much lower than in HICS (Kessler and Ustun, 2008). Also findings from within HICS similarly point to better long-term outcomes for people with a diagnosis of Schizophrenia who are not medicated, and worse outcomes for those who are (Rappaport, 1978).

In the UK, a HIC, where access to psychiatric medication is relatively high, David Healy et al (2001:26-27) point out that since the development of modern psychotropic drugs; we ‘now compulsorily detain three times more patients... [and] admit fifteen times more patients’. Robert Whitaker (2010) shows that since the advent of psychotropic drugs, 50% of children registered as disabled in America have been diagnosed with mental health problems. A further layer of complexity in the relation between mental



illness and impairment is the wide evidence that long term use of psychiatric medications may lead to iatrogenic impairment, impairment caused by the medication, for example tardive dyskinesia, motor tics and headaches (Gardos and Cole, 1978), and in the long-term may alter brain weight, and lead to early death (see an extensive account of this research literature in Whitaker, 2010).

However, rather than calling into question the long-term efficacy of medication, iatrogenic impairments are often framed by psychiatry as 'symptoms' of an underlying disorder, just as increased suicide is often read as being due to 'mental illness' (Whitaker, 2010). This begins to hint at the power of psychiatric frameworks to frame what counts as evidence and as truth, and it begins to call attention to the question of what exactly is Global Mental Health 'scaling up'? Summerfield (2008:994) highlights these shaky foundations and thus the dubious applications of Global Mental Health's 'scale up' of psychiatry, claiming that the WHO's prevalence figures 'lack credibility and would seriously mislead health planners and providers'. Similarly, Thomas et al (2005:25) find the statistical base of Project Atlas (widely drawn upon by the WHO) 'misleading and questionable'. Summerfield (2008:993) points out the irony of the WHO's use of checklist technologies to estimate prevalence of mental illness globally, 'when the strength of their evidence base even in Western societies remains controversial'. Such issues problematise the push to conceptualise mental illness as an 'illness like any other'; and the framing of the administering of anti-psychotics as being parallel to administering anti-epileptic medication (WHO, 2008).

This alternative evidence base also problematises the WHO's framing of distress through the lens of disability, the push to make distress understandable within a social model of disability framework. The Union of the Physically Impaired Against Segregation (UPIAS) originally defined impairment as 'lacking part of or all of a limb, or having a defective limb organism or mechanism of the body' (UPIAS, 1976). However, the research discussed above points to little evidence of an organic base or defective mechanism of the body linked to mental health problems. This raises the uncomfortable question of what is the 'impairment' in mental health problems as conceptualised through the social model of disability, a model employed globally by the WHO?

Thus, Ann Plumb (a key figure in the UK survivor movement) asks whether something fundamental to the survivor movement has been lost in the framing of distress as disability, particularly in the bending of survivor demands to fit the disability discrimination agenda, underpinned by the social model of disability, opening up the potential for 'unsound mind' to creep into global disability discourse (Plumb, 2011). However, in India, one of the few survivor-led organisations, Bapu Trust, sees real hope in making stronger links with the Disability Movement. Bhargavi Davar, the founder of Bapu Trust, told me in an interview that,

More and more user/survivors are making their linkages with the disability movement. Compared to the mental health sector which is small, the disability movement is huge. And so what we are trying to do as user/survivors is to get the disability movement to support us...so that's a real push back for carers organisations, they would like to continue with present arrangements under the Mental Health Act, whereas we are saying we don't want to be under the mental health act, we want to be under the disability act....we need to move firmly into the disability sector, advocate as strongly as possible for the new disability act, which will grant legal capacity and no force.

According to Bhargavi, 'the disability sector have been extremely supportive', and in the close work that Bapu Trust has been doing with them, she has 'seen their positions change once they have read what we have sent them. It's really looking good, that's where my hope is'. In part, the Bapu Trust are keen for mental health to come under the Disability Act because they feel it will mark a move away from the designation of 'unsound mind' (though as we have explored this may not always be the case), which works to sanction violent treatment, and aids a marketisation of psychiatry and mental health, a market to fill the 'treatment gap'.

### **Is there a gap?**

Ecks and Basu (2009:68) note that there 'can be little doubt that the overall assessment of a psychiatric "treatment gap" is correct, if one accepts the premises of DALYs, the efficacy of drugs, and the lack of government spending in this area'. However, they

argue that this 'gap' has been constructed on a tenuous evidence base, made up of data that is over 25 years old, and that by focusing solely on licensed providers of antidepressants overlooks the 'actual availability and affordability of antidepressant drugs in India' – which are often sold without a prescription (Ecks and Basu, 2009:69). The WHO mhGAP is based on psychiatric epidemiological assessments of disease prevalence. While bracketing out the issue of whether antidepressants are as effective as the WHO claims (and the evidence discussed earlier in this chapter would suggest perhaps they are not), Ecks and Basu (2009:78-79) point out that

in the case of depression, there is no specific pathogen (as for TB/rifampicin) or clinical situation (as for delayed labour/oxytocin) that could vouch for these findings to be valid independent of a complex web of cultural, economic, and historical circumstances.

Ecks and Basu (2009) make these claims based on a different evidence base to that of the WHO data sets; evidence from ethnographic studies 'on the ground' in India. They make the point that interviewing the staff at local medicine shops about their sales of antidepressants can yield very different sets of information than large-scale 'official' epidemiological studies, making clear that 'in the case of depression and its treatments in South Asia, it is more truthful to work with less exact numbers than with misleadingly precise ones' (Ecks and Basu, 2009:79). Their findings about the wide availability of antidepressants in India are challenging to the WHO mhGAP initiative as they render 'its claims about the treatment gap undependable', and point to the 'misplaced effort to make antidepressants more widely available through government health services' (Ecks and Basu, 2009:79). They also make clear that over-prescription may be just as problematic as a lack of access to antidepressants, and thus if 'there is a problem, it seems to be neither the scarcity nor the price of antidepressants, but their overuse and wrong prescription' (Ecks and Basu, 2009:79).

This ethnographic (re)reading of the 'treatment gap' challenges the very idea that there is a gap, and calls for different ways of approaching and reading issues of prevalence of mental illness and of access to psychiatric medications. Here the calling into question of the evidence base of the 'treatment gap' can be further supplemented by a reading of

the 'conditions of possibility' that enabled the 'gap' to emerge; a partially post-colonial reading of the means by which psychiatry travels.

### **The coming into being of the 'Gap'**

Back in the days of the 'old cross-cultural' psychiatry, before Kleinman (1977) spoke of the 'new'; the discipline was divided by two opposing approaches - the 'etic' and the 'emic'. This was explained to me by Vikram Patel (a key figure in the Movement for Global Mental Health) on a course I attended in Global Mental Health, at the Institute of Psychiatry (in August, 2011).<sup>25</sup> The etic approach, Vikram explained, assumes that mental illnesses arise from pathological biological processes and are thus universal. This approach gives rise to international diagnostic systems, such as the DSM and the ICD, and to the application of these across cultures. Conversely, those who adopt an emic approach consider mental illnesses as subjective experiences, influenced by culture, meaning they should be studied within their particular cultural context. Within the 'new cross-cultural psychiatry' (Kleinman, 1977) and within Global Mental Health, there is a call to bring together these two approaches – the etic and the emic. Thus Vikram Patel told us that '[m]ental health research across cultures must integrate etic and emic methodologies and perspectives'. Here's what it said on one of Vikram's presentation slides;

- 1993: started my first research work on culture and depression in Zimbabwe, convinced that depression was a cultural artefact of the west.
- 2009: am now leading the largest trial for integrating a package of treatments for depression in routine primary care in India, convinced that depression is a real, and universal, cause of human suffering, deserving of public health action.(Patel, 2011).

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<sup>25</sup> Patel, V. (2011). The social determinants of mental disorders: implications for international mental health research. Lecture delivered as part of Global Mental Health Summer School (one week course) at the Health Service and Population Research Department of The Institute of Psychiatry, London (22<sup>nd</sup>-26<sup>th</sup> August 2011). (23<sup>rd</sup> August).

Why the change? What happened between 1993 and 2009? The synthesis of the emic and etic approaches within the 'new cross cultural psychiatry' and within Global Mental Health, thus make visible the 'treatment gap', or from a different register, they provide the surface of emergence for the 'gap' to come into being, they constitute it. This is because such a synthesis in part justifies the application of psychiatric diagnostic systems comparatively across, and within, cultures (as long as these tools have been made 'culturally sensitive'), then making visible the differences between (and within) different cultures, for example in their access to psychiatric treatment, or in their prevalence of a particular disorder.

This approach is a central part of the WHO Project Atlas (2000-2001), which surveyed 185 countries covering 99.3% of the world's population. Project Atlas found that over 70% of the world's population had access to less than one psychiatrist per 100,000 people. Two fifths of those countries surveyed had no mental health policies. In over a quarter of surveyed countries, patients had no access to basic psychiatric drugs in primary care (WHO, 2001; 2005). Here the synthesis of the etic and emic approaches forms part of the 'conditions of possibility' for the 'treatment gap' to emerge, for the formation of the Movement for Global Mental Health, and the justification for 'scaling up' interventions to close that gap.

### **Universals**

Thus calls to close the treatment gap emerge from the closing of another gap, the gap between the etic and the emic. This synthesizes the differences between the two approaches (differences that may cause friction, that grate against each other) into a seemingly higher category, seen to transcend cultural differences, one that is universal. For Global Mental Health I would argue that a key trope by which this synthesis has been made possible is the brain. For example in the WHO World Health Report (2001:x),

We know that mental disorders are the outcome of a combination of factors, and that they have a physical basis in the brain. We know they can affect everyone, everywhere. And we know that more often than not, they can be treated effectively.

While anthropology and cross-cultural research has shown that cross-culturally people have different understandings of what we might call the 'mind' (for example, see Kakar, 1982) particularly around mind/body relations and dualisms); the brain is seemingly assumed to be universal - everyone has a brain. There's even been a Decade of the Brain, from 1990-1999, where the National Institute of Mental Health (in America) sponsored campaigns 'to enhance public awareness of the benefits to be derived from brain research'.<sup>26</sup> Because everyone has a brain, and according to the WHO (2001a:x), mental disorders 'have a physical basis in the brain', it becomes possible to understand mental illness in universal terms. That the WHO and Global Mental Health advocacy see mental illnesses as universal is evident in many of the statements they make within their policy documents, such as,

Mental disorders are not the exclusive preserve of any special group; they are truly universal. Mental and behavioural disorders are found in people of all regions, all countries and all societies. They are present in women and men at all stages of the life course. They are present among the rich and poor, and among people living in urban and rural areas. (WHO, 2001a:22).

Universality is claimed here, staked out in the very concept of mental health as 'global', in the three words 'Global Mental Health'. However, much WHO policy and Global Mental Health literature doesn't overlook cultural differences, it encounters them as different expressions of an underlying physical component to mental illness. This approach is evident in a study by Wilcox, Washburn and Patel (2007) that examines how the explanatory models used by parents whose children have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) affect help seeking, in India. The research found that, for many families, seeking biomedical help was the last step and that parents preferred non-medical interventions that framed their children's behaviour as being psychological or as a learning issue. Thus the research revealed,

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<sup>26</sup> Project on the Decade of the Brain [online] <http://www.loc.gov/loc/brain/> (Accessed 1.7.2012).

resistance to the use of an illness model or a psychiatric label for their problem, and supports the hypothesis that a biomedical psychiatric label may not be an acceptable strategy for meeting mental health needs in Indian culture (Wilcox et al, 2007:1607).

Here there is recognition that a psychiatric label may not be useful in certain cultures, and indeed that such labels are themselves strategies. However, the study concludes that,

Nevertheless, it [is] also clear from our study...that children with a clinical diagnosis of ADHD are identifiable in developing countries and that they show similar problematic behaviors as in developed countries, notably behavioral, academic, and peer problems (Wilcox et al, 2007:1608).

Thus while explanatory models may vary across cultures, these different models do not seem to disrupt psychiatric frameworks, which are taken as being identifiable globally. As with the treatment gap, Wilcox, et al (2007) identify a wide gap between biomedical ways of understanding children's behaviour, and between parent's understandings, in India. A gap that may narrow as more families have increased contact with doctors, a trend that tends to lead to an adoption of biomedical explanations of children's behaviour as 'chemical imbalances' and ADHD (Wilcox et al., 2007).

### **Arationality and Relationality**

While advocates of Global Mental Health and WHO policy emphasise closing such gaps, the very allusion to a 'gap' suggests that different ways of understanding do exist (though these other frameworks are often denigrated as being 'non-scientific' in a hierarchy where psychiatric knowledge is privileged at the top). In his exploratory account of different healing traditions in India, Sudhir Kakar (1982:31) (whose book I plucked miraculously from a shelf of a book house in Bangalore) suggests that the line of cleavage between different healing systems, that which cuts across cultures, 'is not simply between "traditional" and "modern" or between "Western" and "Asian", [it seems to be] between those whose ideological orientation is more towards the biomedical paradigm of illness...whose self-image is close to that of a technician, and

others whose paradigm of illness is metaphysical, psychological or social', those who recognize arationality.

While there are multiple and conflicting understandings of, and approaches to, what might broadly be termed mental health in India, what marks many of these as different to 'Western' approaches is, for Kakar (1982), their emphasis on the relational. The prescriptive lists of Ayurvedic medicine, for example, emphasize the relation of the person who is distressed with others, framing distress as 'disorders of relationships', and thus the role of healing as aiming to restore lost harmony between that person and their community (Kakar, 1982:274-275).

Furthermore, in many non-western languages, such as Tamil, there is no dualistic separation between the psychological and somatic aspects of experience (Kleinman and Kleinman, 1985). And in Ayurvedic medicine any disturbance, physical or mental, is understood as present both at a somatic and psychic level. Thus alongside recognising physical symptoms, ayurveda also recognises three other classes of disease;

- 1) 'diseases of primarily mental origin with predominantly mental symptoms' this includes unmada – a term that encompasses many mental disorders, particularly psychosis;
- 2) 'diseases of primarily mental origin and predominantly physical symptoms' (such as epilepsy);
- 3) 'diseases of primarily physical origin and predominantly mental symptoms' (such as some 'delusional' states) (Kakar, 1982:242).

Thus other ways of understanding distress exist, and are prominent in India, meaning that the construction of a psychiatric 'case', in India, involves 'multi-level linguistic and cultural translation', i.e. between Hindi and English, Western psychiatric theory and its cross-cultural practice, and 'between the world of Indian psychiatrists and their clients' (Addlakha, 2008:45).



### **An illness like no other?**

It is possible, then, alongside the strong push to see mental illness as ‘an illness like any other’, to read another story, an alternative ‘evidence base’, that forces us to question why having a physical impairment should accord increased status, or reality, to a particular experience or disability. It may be that mental illness is an illness like *no* other, or indeed better not conceptualized as an illness at all. This revisits arguments from the early days of anti-psychiatry; Szasz’s assertions that mental health problems should be read not as illness, but as ‘problems in living’; as sane reactions to an insane, unequal society (Szasz, 1960:114; 1972).

However, Peter Sedgwick (1982:31) takes issue with Szasz’s acceptance of a mental/physical binary, and his assumption that medicine and physical illness are value-free. For Sedgwick (1982:31), medicine is ‘not simply an applied biology, but a biology applied in accordance with the dictates of social interests, and thus always value-loaded’. In any debate as to whether mental illness is an ‘illness like any other’, we must first address our assumptions as to what constitutes an ‘illness’. In this framework mental illness could be seen as an illness like any other, without implying biological determinism (Sedgwick, 1982).

Critical disability studies might also be a useful resource in thinking beyond the binary positions of the social model of disability and to deconstruct impairment (and distress) as neither a ‘presocial nor pre-cultural biological substrate’ (Thomas, 1999:124). This would then enable a reading of how the dictates of social interests ‘apply’ and make claims to biological and medical knowledge and what political rationales are being served by constructing mental distress as a biochemical impairment, particularly as (mental) health emerges as a global marketplace. Also there are other ways of understanding - alternative frameworks from user/survivor literature, critical psychology and critical psychiatry, and critical disability studies that enact a different reading of mental health problems - as distress, not illness.

### **Language - of burdens and markets**

Ann Plumb (1994:5) notes how users and survivors have historically pushed for a ‘widespread shift away from talk of “illness”, “disorder”, or “defective mechanisms”

(chemical imbalances) to talk of distress or dissent', a language that places us firmly 'in a relationship with our society and culture'. Many user/survivor organizations in HICS, such as the Hearing Voices Network, explicitly reject the framing of experiences such as hearing voices within an illness model - as 'symptoms'. Such groups have usually mobilised around the discursive ensemble of 'trauma/abuse/distress', rather than illness (Cresswell and Spandler, 2009:138), situating people's experiences within their personal life history. However, this language does not seem to have made it into Global Mental Health and WHO policy, as evident in the excerpts about Schizophrenia below,

Schizophrenia is a psychotic disorder of low prevalence, which is often chronic and very disabling. Although effective treatments for schizophrenia are available, the accessibility, equity, and acceptability of services that deliver such interventions are inadequate in countries of all income levels (Patel, et al, 2007:48).

Schizophrenia causes a high degree of disability. In a recent 14-country study on disability associated with physical and mental conditions, active psychosis was ranked the third most disabling condition, higher than paraplegia and blindness, by the general population (Üstün et al. 1999, cited in WHO, 2001a:33).

'Chronic and very disabling', more disabling than paraplegia and blindness - this is the 'official' story of Schizophrenia within WHO accounts. This stands in direct contrast to the new focus on recovery in some HICS, such as the UK, which while arguably now rearticulated within a neoliberal agenda, originally came out of a sustained grassroots critique by users and survivors against psychiatric assumptions of pathology and deficit. What does this language of chronic disability feel like to those so labelled? Pete Bullimore, a key figure in the UK Hearing Voices Network, was told by his psychiatrist 'you are a chronic schizophrenic, you will never ever work again, go away and enjoy your life". To him 'the words were so damning...you may as well have just ripped my heart out'.<sup>27</sup>

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<sup>27</sup> Interview was part of the research project, 'Young People's Stories about Hearing Voices', that I carried out in 2008, funded by the Research Institute of Health and Social Change, at Manchester Metropolitan University.

In fact, in the UK, recovery has become the 'driving force' behind the Government modernisation agenda and 'the vision that will guide the mental health system in this decade' (Anthony, 1993:521). What is meant by recovery here, and who decides is a key area of contestation within the survivor movement in the UK and elsewhere. However, this critique highlights how psychiatry has worked to deny the recovery concept to many people, constructing certain 'disorders' as basically untreatable, such as the category of 'Treatment Resistant Schizophrenia' in DSM-IV-TR (2000). This chronic, disabling language is explicit throughout the texts of the WHO, and in the very conceptualisation of mental illness as a 'burden'. This is apparent in the World Health Report, which,

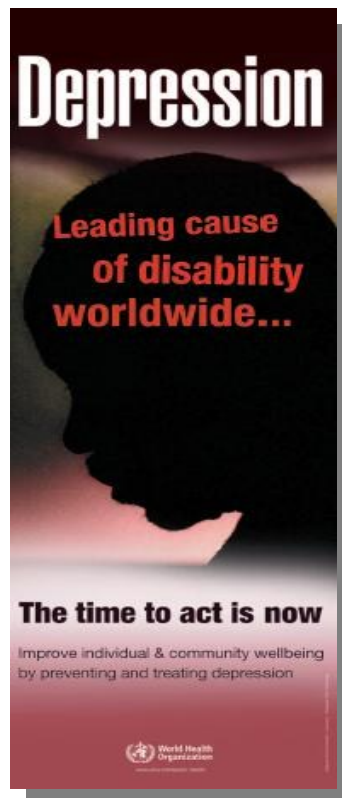
focuses on a selection of disorders that usually cause severe disability when not treated adequately and which place a heavy burden on communities (WHO, 2001a:22, Box 2.1).

It is also apparent in the WHO (2003:4) document - 'Investing in Mental Health',

The magnitude and burdens of the problem

- As many as 450 million people suffer from a mental or behavioural disorder.
- Nearly 1 million people commit suicide every year.
- Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder).

Furthermore, for the WHO, mental illness is not only an individual burden, evident in the leaflet / banner below, which states that Depression is the 'leading cause of disability worldwide. The time to act is now. Improve individual & community wellbeing by preventing and treating depression'.



WHO 'The time to act is now' poster<sup>28</sup>

More than this, mental illness is constructed not only as a burden on individuals, families and communities, but as an economic burden, a burden that costs society. This is evident in the following two statements from the WHO.

Given the prevalence of mental health and substance-dependence problems in adults and children, it is not surprising that there is an enormous emotional as well as financial burden on individuals, their families and society as a whole. The economic impacts of mental illness affect personal income, the ability of ill persons – and often their caregivers – to work, productivity in the workplace and contributions to the national economy, as well as the utilization of treatment and support services. The cost of mental health problems in developed countries is estimated to be between 3% and 4% of GNP. However, mental disorders cost national economies several billion dollars, both in terms of expenditures incurred and loss of productivity (WHO, 2003:5 – Investing in Mental Health).

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<sup>28</sup> See WHO website for a full range of 'The time to act is now' posters - [http://www.who.int/mental\\_health/mhqap/mental\\_health\\_posters.pdf](http://www.who.int/mental_health/mhqap/mental_health_posters.pdf)

The economic cost of schizophrenia to society is also high. It has been estimated that, in 1991, the cost of schizophrenia to the United States was US\$ 19 billion in direct expenditure and US\$ 46 billion in lost productivity. (WHO, 2001a:33).

'Years of life lost', death, suffering, disorder, economic cost - this is how the WHO and Global Mental Health frame mental illness. And thus people's identities emerge from 'a tangled web' of Global Mental Health and WHO policy, pharmaceutical industry lobbies and Government agencies, as 'bodies that cost the state a certain amount of money' (Murray, 2009:12). It is worth noting here however that there are problems in how the 'cost' of Schizophrenia is calculated, as the prices charged by pharmaceutical companies for medications and their push for doctors to prescribe non-generic drugs that are still in patent, are all done for profit and thus do not mark 'real' costs.

These statistics are then used to make projections and predictions about the 'burden' of mental illness in the future.

Projections from 1990 to 2020 suggest that the portion of the global burden of disease attributable to mental and brain disorders will rise to 15%. (WHO, 2002:1).

If projections are correct, within the next 20 years, depression will have the dubious distinction of becoming the second cause of the global disease burden (WHO, 2001a:x).

However, according to Davar (2007), within this economics of mental health, there are other 'hidden costs';

- The cost of psychiatric diagnosis and innumerable "wrongful confinements".
- The cost of creativity, learning and productivity lost to people due to long term of repeated institutionalization.
- The cost of receiving false diagnosis.

These are costs that do not seem to figure in the official story of Global Mental Health.

## **Burden**

The discourse of burden is used here by the WHO and the Movement for Global Mental Health to convey to Governments (worldwide, but particularly in LAMICs) the need to increase spending and allocation of resources on mental health.

Despite the relatively high contribution to the total burden of disease, 28% of nations have no specified budget for mental health. About one third of people (33 countries with a combined population of two billion) live in nations which invest less than 1% of their total health budget in mental health. (Thorncroft and Maingay, 2002:608).

Perhaps the WHO feels Government's are more likely to listen when this plea is framed within a discourse of the economic costs of mental illness. They may well be right. However, is the language of burden the only, or even the most useful, way to frame mental distress? While the user/survivor movement provides other languages to speak of distress, not illness, this remains largely absent from WHO policy.

To speak of distress, not illness, has been an important move for the user/survivor movement. Also within disability studies there emerges other ways to speak of distress and disability – as 'affirmative'. Overboe (1999), inspired by a Deleuzian stance of 'difference for itself', calls for such an understanding of difference, disability and distress – as affirmative. This marks a move away from the 'normative shadows' that haunt attempts at making disabled people 'fit' in, towards rethinking '[d]isabled expressions of life' (Overboe, 2007:27). This is not to emphasize only the 'positive' aspects of disability or distress but to rethink concepts of dependency as 'burden'. Similarly, Shildrick and Price (2006:22) seek to contest the 'privileging of independence, which in any case is not a cross-cultural given, but a specific outcome of a very western way of understanding the relations between subjects'.

For Shildrick and Price (2006:20), disabled people are not unique in their dependence on others, however for 'the normative majority such a need, inevitable as it is, may be covered over – particularly in the domain of western hegemony'. The realisation of this, the shift in focus from separation to connection, to dependency as a mode of

interconnectivity, calls for a different framing of disability as 'burden' (Shildrick and Price, 2006). This does not imply that we cannot seek to understand distress and disability as at times urgent, and differentially distributed globally – it does however call for a serious questioning of how we can conceptualise urgency outside of the language of burden.

In taking this affirmative stance of interconnections, both Shidrick and Price (2006), and Overboe (2007, 2009), are drawing upon and speaking a Deleuzo-Guittarian (1984, 1987) language. This is a language also spoken by Hardt and Negri (2000:152) who trace this affirmative recognition of difference in the neoliberal market economy, and in the practice of marketing, where '[e]very difference is an opportunity', a market opportunity. This is the market potential of difference, of burden, that affirms difference and simultaneously posits the consumer as lacking (see Chapter 7). Here while mental illness in Global Mental Health policy is an economic 'burden', for the pharmaceutical industry, this burden is a market.

### **Burden as Market**

Thomas et al (2005:26) question global strategies to 'scale up' psychiatric interventions (such as Project Atlas) based on their foregrounding of biomedical understandings, which mean that cultural interpretations of distress 'are downplayed and regarded as secondary to conquering the 'scientific' challenge of mental illness'. While it is key that the lives of those who live in distress are improved, and while the WHO may play a key role in this, Thomas et al (2005:26) argue that 'the WHO, in foregrounding the role of biomedicine, is inadvertently playing into the hands of a different set of interests. Kirmayer (2006:131) shares this concern that 'the tendency to portray mental health problems as fundamentally biological (or, even more reductively, as genetic) is an ideological move that serves certain political and economic interests'. It further enables a sidestepping of any critique of the deleterious effects of social arrangements (Kirmayer, 2006).

Seemingly then the hands being played into through the mobilisation of biochemical, 'within brain' explanations of distress, are the hands of the pharmaceutical industry, for whom LAMICs, such as India are an 'untapped market' for psychiatric drugs (Equity

Master, 2004), a 'new promised land for drugmakers'...who are 'targeting the subcontinent's countryside for expansion'...as 'part of pharma's new focus on emerging markets' (Staton, 2009). This points to another reason for the deployment of the 'unitary concept of illness' as 'part of a strategy of 'psychiatric expansionism' (Castel et al, 1979; Cresswell and Spandler, 2009:138). And a profitable one – because as Bhargavi Davar told me, in India, 'people make money out of asylums, 10,000 – 50,000 Rupees a month for private ones...Huge money to be made out of the Mental Health Act.' And mental health is not only profitable in India, with worldwide sales of psychiatric drugs totalling \$82 billion (New Internationalist, 2012).

This financial incentive casts a strange light around the ethics of many WHO calls to 'make psychotropic drugs available', such as in the World Health Report (2001:xii),

Essential psychotropic drugs should be provided and made constantly available at all levels of health care. These medicines should be included in every country's essential drugs list...These drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent relapse. They often provide the first-line treatment, especially in situations where psychosocial interventions and highly skilled professionals are unavailable.

Here attempts by the WHO and the World Psychiatric Association (WPA) to 'scale up' the availability of psychiatric drugs and to develop standardised global approaches to diagnosis are highly biased towards 'Western' psychiatric constructs, meaning that such international collaborations have

largely amounted to concerted efforts to export the practices of British and Anglo-American psychiatry to far corners of the world, including some of the culture-specific syndromes and bad ideas that plague western psychiatry (Kirmayer, 2006:136).

This is not only the globalisation of psychiatry but the recognition that 'psychiatry itself is an agent of globalization' (Kirmayer, 2006:136). For example, Kirmayer (2006) charts the role of cultural psychiatry in the marketing of anti-depressants in Japan, where



somatic symptoms and distress are reinterpreted as being amenable to drug treatment. Thus,

In the last few years, the market for antidepressants in Japan has grown exponentially. To some extent, this reflects a much-needed transformation of Japanese mental health care that is finally providing treatment to many people suffering from depression who were hitherto unrecognized or inappropriately treated. At the same time, it also involves a reconfiguring of other forms of suffering in ways that suit the interests of the pharmaceutical industry (Kirmayer, 2006:137).

Thus it seems the privileging of one framework of understanding – the bio-psychiatric, serves particular political interests and financial incentives, leading Summerfield (2008) to query how much of the impetus for the ‘scale up’ of psychiatry has come from those on the ground in comparison to interests from the outside. This also points to the process by which other frames of reference for distress, such as the somatic, or bodily experience of distress, are encountered by psychiatry and made sense of in a different language - as ‘symptoms’ of an ‘illness’ located in the brain.

### **Sublation and the Brain**

Another way to tell this story is as a story of encounters. The ways psychiatric and biomedical frameworks encounter alternative healing systems and ways of understanding in the global South. It seems possible here to trace a key way that this encountering takes place, a method of encountering difference as being the same, encountering difference through the creation of a ‘median category’, where,

Something patently foreign and distant acquires, for one reason or another, a status more rather than less familiar. ... a new median category emerges, a category that allows one to see new things, things seen for the first time, as versions of a previously known thing...a method of controlling what seems to be a threat to the established view of things. The threat is muted... (Said, 1978[1995]:58-59).

Here difference is encountered only to be made familiar, to be accommodated and domesticated, meaning that the threat such difference might pose to the hegemonic is muted. How this simultaneous recognition yet deferral of difference is enacted in the work of many NGOs in India in their encounters with the leaky bodies of the those who are homeless and distressed (the 'homeless mentally ill'), is explored in further detail in chapter 8.

However, it is worth attending here to some of the mechanisms of this 'median' encounter, reading it alongside Said's Orientalism, as 'a way of ... coming to terms with the orient in terms of occidental categories' (Chakrabarti and Dhar, 2009:26). That is, in the Orientalism at work in Global Mental Health, a way of 'coming to terms' with the populations of LAMICS in terms of bio-medical and psychiatric categories. In this process, 'the occident [the 'West'] first transforms the orient into an image (albeit lacking) of itself and then shows that the orient is the *same* as the occident, *but not quite*' (Chakrabarti and Dhar, 2009:26).

Within Global Mental Health literature, the 'orient' or LAMICs are constructed as having the same mental health problems, the same biochemical imbalances, the same brains, as in HICS (the occident). The same, that is, *but not quite*, for there is a lack, not just of accessibility to professionals and services but a lack of scientific knowledge about mental health problems (see Chapter 6). This universality - the WHO's construction of mental disorders, and their 'physical basis in the brain' (WHO, 2001a:x), then 'occidentalizes the orient in terms of a "shared telos" and a "shared worldview"' but where the occident is still somehow more advanced, a step ahead in this developmental telos' (Chakrabarti and Dhar, 2009:26).

The call to 'to scale up a basic, evidence based, package of services for mental disorders' (Launch of the Lancet Series on Global Mental Health, 2007) 'in all countries, but especially in low-income and middle-income countries' (Lancet Global Mental Health Group, 2007:87), is not only problematic because it assumes the superiority of Western 'scientific' knowledge. But because it also presents this scientific 'evidence base' as exclusive to the global North, despite the fact that those in the global South 'often suffer the consequences of the application of this knowledge, in the form of

initiatives, actions, policies or agencies of the global North or in the case of the South, local elites who are acting in the interests of the global North' (Santos and Alvarez, 2011). Global Mental Health then, like Orientalism, could be seen as that,

which at the same time produces sameness and also a certain difference and distinction between the occident and the orient; on the one hand, it homogenizes and, on the other, it hierarchizes the occident and the orient (Chakrabarti and Dhar, 2009:26).

This homogenizing / hierarchising may also be at work in another synthesis that is central to the emergence of Global Mental Health – the bio-psycho-social model. The World Health Report (WHO,2001:xiv) states that,

Advances in neuroscience and behavioural medicine have shown that, like many physical illnesses, mental and behavioural disorders are the result of a complex interaction between biological, psychological and social factors.

Within WHO policy, the bio-psycho-social model is often referred to, not only for emphasizing mental illness as akin to physical illness in order to assess their comparative 'burdens' and compare level of Government spending (as discussed earlier), but also to point to the links between mental and physical health, for example, between Depression and Heart Disease. In fact the integration of these three areas (bio-psycho-social) has become increasingly dominant. However, according to Read (2005), this model has been heavily influenced by concepts of 'vulnerability-stress', which accord a role for social stressors as being 'triggers' for an assumed underlying genetic predisposition. For Read (2005:597), then, this 'is not an integration of models, it is a colonisation of the psychological and social by the biological'. Such colonisation is enabled by ignoring or, to come extent, 'coming to terms' with research that emphasises contextual (socio-economic, political) factors as contributors to distress, such as trauma (or political reforms as we will explore in chapter 5), or preventing this research from being seen as 'evidence'. This resonates with Steven Sharfstein's (2005) (an ex-president of the American Psychiatric Association) comment, that 'we must

examine the fact that as a profession, we have allowed the bio-psycho-social model to become the bio-bio-bio model' (cited in Read, 2005:597).

### **Re-biologising Psychiatry**

This rebiologising of psychiatry, for Lakoff (2005), is made possible through psychiatry's attempts to achieve equivalence between mental and physical or somatic illnesses. The WHO claims this equivalence between mental and physical health to mobilise increased Government recognition of and spending on mental health.

Unfortunately, in most parts of the world, mental health and mental disorders are not accorded anywhere near the same degree of importance as physical health. Rather, they have been largely ignored or neglected (WHO, 2003:4).

This is also evident in the World health Report,

Mental health is as important as physical health to the overall well-being of individuals, societies and countries. Yet only a small minority of the 450 million people suffering from a mental or behavioural disorder are receiving treatment (WHO, 2001a:2).

However, while these claims help to point out the discrepancies in Government spending between physical and mental health, they also (through framing mental illness as universal and within the brain) frame mental distress as largely biochemical. This hints at how the WHO may increase their focus on the social determinants of mental health, while largely focusing 'solutions' within the brain. These chains of equivalence, then, between physical and mental illnesses seem to work as methods of synthesis, like the synthesis of the emic and the etic, and of the bio-psycho-social.

Reading this through a lens of Orientalism, it seems such syntheses may simultaneously homogenise and hierarchise different explanatory models of mental distress. Here this means that the presumed biological causes of both physical and mental illnesses become privileged, resting on the 'assumption that biology is universal and culture local' (Kirmayer, 2006:129). This also appears to be the case for the integration of emic

and etic approaches, as it is arguable that within an emic (relativist) framework there could be no 'global' mental health. Thus in their very integration, seen as the base to Global Mental Health, the etic has already been privileged. This coming together of seemingly contradictory or opposing approaches could also be read as a process of sublation (a Hegelian term) – the creation of a synthesis, which forms a 'higher category', presumed to be universal.

Through this sublation, this synthesis, Global Mental Health interventions and WHO policy thus encounter what is seemingly strange (for example, forms of indigenous healing, and the better outcomes for those with a Schizophrenia diagnosis in the WHO DOSMED [1973/1979] studies) through the register of the familiar, domesticating these potentially disruptive alternative ways of knowing. Here it would seem that sublation or synthesis works through Said's 'median category' – as a way to accommodate opposing or alternative approaches through an integration that is hierarchical. This brings into focus different sets of questions, then, about WHO mental health discourse. For example, the World Health Report (2001) states,

WHO is making a simple statement: mental health – neglected for far too long – is crucial to the overall well-being of individuals, societies and countries and must be universally regarded in a new light (WHO, 2001a:ix).

This suggests that every country needs to change how they regard mental health. However, it also hints that the new light that mental health will be regarded through will be a universal light. So whose version of the 'universal' will be prominent here? Through whose light will mental health be illuminated? What colour light, how bright? Is there nothing about current or past understandings that are worth keeping? Is the new light actually all that new?

### **Non-Medical Spaces**

Furthermore, if there is no impairment or biochemical aetiology to mental illness; if it is not illness, and perhaps more usefully understood as distress; if we attend to evidence of the disabling iatrogenic effects of some psychiatric medications; and to research that points to increased stigmatisation of people when biogenetic explanations are

employed (Read et al 2006); we may come to a different conclusion as to what constitutes ethical intervention. This raises further questions; what is Global Mental Health 'scaling-up'? If mental illness is better understood as distress, then should this be responded to through global health legislation?

Echoing much survivor testimony, Ann Plumb (1999:463), asserts that,

there is only one way to safeguard our rights and to provide genuinely sound and effective services. This is the pioneering of, provision and resourcing of non-medical sanctuary and support without drug treatment for a person during, and following a crisis, where consent to medical treatment is not given. This is what genuinely new legislation should be about.

However, in India, where such non-medical spaces for healing are widely available in the form of religious and traditional healing sites, the Indian Government is attempting to prevent people with 'mental illness' from seeking treatment at such sites, sometimes forcibly removing them and taking them to local psychiatric hospitals (Davar and Lohokare, 2009) (see chapters 5 and 6 for a discussion of the growing psychiatration of India). Within Global Mental Health literature, 'expenditures on ineffective or inappropriate care outside the formal health-care system' is seen to be a key economic consequence of mental disorder (Patel et al, 2007:51-52), thus framing treatment that lies 'outside' the formal health care system as ineffective and inappropriate.

In fact, Global Mental Health advocacy sets 'mental illness' firmly within a public, global health agenda, advocating 'to ensure the inclusion of mental health on the global public-health policy agenda, and the effective integration of mental-health care into every level of general health care' (Patel et al, 2008:4). Thus a key programmatic aim of Global Mental Health advocacy is that 'mental health care must be piggybacked onto all existing health programmes' (Patel, 2007:13).

What are the implications of these debates for Global Mental Health advocacy and practice, particularly at a grassroots level? Perhaps labelling distress as mental illness limits the mechanisms for responding to it solely within a medical register, eclipsing

alternative non-medical interventions. In fact we might question whether there is 'a legitimate role for doctors in relation to madness and distress' at all (though Bracken and Thomas, 2008:220, maintain that there is). Thinking this through on a global scale, then, is there a legitimate role for psychiatry in relation to responding to distress in the global South? We need to think through what the mediation of distress within a disability register makes possible, and what psycho-political demands it might foreclose. Can and should we make an argument for taking mental health seriously within national and international policy, without medicalising it? And perhaps more centrally, what function does conceptualising mental suffering as impairment and illness serve? What interventions does it make visible, and what ways of intervening does it foreclose?

In recognising critiques of psychiatry and the sometimes harmful effects of psychiatric medication, further ethical challenges arise. For while there is a responsibility to make this knowledge public, particularly to those who are effected by these drugs, what can people do with that knowledge once they know it? We might ask the same question of the alternative evidence base explored in this chapter – what can we do with this knowledge on a global scale?

This question haunted my work in India, where I facilitated a number of workshops about these alternative ways of knowing and specifically about the approach of the Hearing Voices Network, and about survivor-led approaches more generally. I want now to recount some of these workshops and meetings, riddled with anxieties and complications. The day after I arrived in Chennai (from the UK) I attended a meeting at the Banyan, a mental health NGO.

### **A Meeting at the Banyan**

From my field notes;

I didn't haggle as much as I should have for the rickshaw drive to The Banyan's head office in Chennai, and I arrived 15 minutes late. But I got a friendly welcome and was ushered into a meeting room upstairs – where the presence of a working fan was to my as yet un-acclimatised body more than enough. Three women came to the meeting, including Vandana Gopikumar, who co-

founded The Banyan, back in 1993. The meeting was a bit odd. I felt like I was selling the approach of the Hearing Voices Network, to three rather sceptical buyers. All of them obviously cared deeply about the people with whom they work, and could understand the reality of hearing voices to those hearing them. However, they worried that talking about the voices with people would make the voice hearer 'fixate' on the voices. They were concerned about the urgency, the crises, the destitution of the women with whom they work, whom they 'rescue'. How could they rescue as many women if they put so much time in with each person (time that they felt the hearing voices approach would require)? They wondered if it's not better to use medication because it allows them to 'rescue' more women, as it's more economical. They also found the idea of self-help groups difficult on a practical level – how can women with mental illness form groups if they live far from one another in rural villages and don't know where their next meal is coming from?

When Vandana said that the Hearing Voices approach was a 'luxury' because the women they work with are destitute, living in poverty (and they could rescue more women using medication), she not only invoked an economic analysis, she made me aware of how the mobilisation of 'poverty' can sometimes work to trivialise other issues, silence other issues through comparison, forming a hierarchy of oppression. But how can we think about poverty in relation to mental health without comparison, hierarchy? Also, while I don't like the assumption that rescuing more is better – I'm starting to have a niggling doubt about how the approach of the Hearing Voices Network could work in situations of extreme poverty and destitution. [Field notes - The Banyan head office, January 6<sup>th</sup> 2011].

Despite my doubts, and before the arrival of many more, even stronger doubts, the Banyan asked me to do a workshop with them in January, followed by a further more formal workshop about the hearing voices approach, in April (see appendix 5 for an outline of the content of these workshops).



### **The first workshop**

The following are taken from my field notes, made after a workshop I facilitated at The Banyan (on the 13<sup>th</sup> of January, 2011).

Though incredibly nervous, I feel thankful to be alive after an hour in a rickshaw on motorway flyovers, with a driver to whom every honk of another vehicle's horn was a personal affront. He happily and indiscriminately took on anything, from bicycles to lorries. It was terrifyingly life-affirming. Anyway, I arrived alive and the room for the workshop was nice and the Powerpoint worked – like magic. The workshop lasted a couple of hours, and generally went well. One woman was very confused about how the illness model could be disempowering, but others in the group helped to explain. A quote from Peter Bullimore [a key figure in the Hearing Voices Network, and a voice hearer], on the Powerpoint, sparked a discussion about the idea that a person might commit suicide because they've been given a Schizophrenia diagnosis. Many people at the workshop felt that this would only be the case for, as they put it, patients who had 'strong cognition' and 'insight'. They felt that in India, and for the women they work with, the label 'Schizophrenic' didn't have a strong meaning or much stigma attached to it. However, while 'Schizophrenic' may not arguably have acquired the stigma, from what happened later with Meesha, towards the end of the workshop, the stigma of being 'mentally ill' and a 'psychiatric patient' became clear.

As the workshop was, I thought, drawing to a close in time for lunch – one of the social workers was sent to go and fetch one of the women who stays at the 'transit centre' where the workshop was held. What then followed happened in Tamil, a language that I don't speak. Bits were translated to me during and after. The group had decided, unbeknown to me, that they would practice the Hearing Voices approach on a couple of the women patients. One participant suggested that she would use the approach and talk with a patient about the reality of the voices, while another staff member used a different approach – denying the reality of the voices. My despair was evident. I explained it just didn't work like that – it was about building up trust and respect, a relationship.

It wasn't an experiment. I was starting to realise I must be a terrible workshop facilitator.

This lady, who is being 'treated' at The Banyan, talked about the shame she felt when her father took her to the General Hospital in Chennai, handing her over to the doctors, saying she was mad – a mental patient. She had been so ashamed to be spoken of like that. After hearing the woman's story, the staff began to discuss how the voices the women they work with hear and the shadows that one of them sees, may relate to what has happened to them in their lives. For one woman, the voice she heard was her Father's – strict and reproving and yet she said she would miss it if it went away, she'd get bored. When she got cross at the voice it would go for a while but she'd rather have the voice there, even if it was horrible, than not have it at all. For another lady, it seemed the voice represented her strict religious upbringing, the rules of her childhood. It was interesting to see the staff talking about hearing voices in this way – from that brief conversation with one of their 'patients', they found out things from their lives that they hadn't known about – perhaps there is a flash of hope for the Hearing Voices approach here. [Field notes, January 13<sup>th</sup>, 2011].

However, as the discussion continued my anxiety returned.

### **'Upstairs'**

One psychiatrist at the workshop explained to me that,

These are our regular staff so they will be able to tell you...some of our clients, upstairs, would bash somebody on the head or intrude into somebody's physical privacy, absolutely do any nasty thing and would say, 'it wasn't me, the voice told me that. [Comment from a workshop at The Banyan, on the 13<sup>th</sup> January, 2011].

Instead of focusing on the mobilisation of people with mental health problems as being violent as a justification to keep these people heavily medicated (something I will explore in the following two chapters), I want to focus on one word, 'upstairs'. 'Upstairs' in Addaikalam, the building where the workshop was being held and the

Banyan's 'transit centre', was where many of the women at the Banyan slept and spent much of their days. 'Upstairs' stood 'Acute Ward A', with locked rooms, women heavily medicated, and some kept in isolation (see Chapter 7 for a more detailed discussion of Addaikalam). This allusion to 'upstairs' within the workshop suddenly placed me, it made me aware of my surroundings. Surrounded by women, many brought here against their will, heavily medicated, many unable to leave, or may never leave, and there I was talking about self-help and survivors. Afterwards, in the rickshaw home, I kept asking myself if I should have done the workshop in those surroundings, should I have refused. Wouldn't refusal have been worse? Did it make me complicit? I still feel unsure. However, my anxiety at this complicity was only to deepen, the mosquitoes wouldn't be the only thing keeping me awake at night.

### **The Second Workshop**

The second workshop at the Banyan was organised through the Banyan Academy of Leadership in Mental Health (BALM). This initiative was established in 2007, to conduct research and advocacy, and to disseminate information on best practice.<sup>29</sup> Initially this day long workshop was going to be part of a three-day training programme titled, 'Clinical, Psycho-social and Alternative Interventions for Mental Illness' (see appendix 8). The first day of this event was set to be about Electro-Convulsive Therapy (ECT) and the second day about psychosocial interventions. In the end, only my workshop ran due to time constraints. However, when I initially heard that a workshop on hearing voices was going to be preceded by training on ECT, I emailed Bhargavi as my blood pressure soared. She said this approach was quite typical, that often such events were '80% medical', leaving 20% for other approaches. So I was relieved when the other workshops were cancelled, now I could relax and sit in the local internet café and think about what kind of workshop I would facilitate under the the sparkling eyes of the many local children who came to watch me typing, and giggle when I moved my lips as I read. But I couldn't relax. Should I do a workshop at an organisation that was also organising workshops about ECT? And the women would still be there, 'upstairs', locked in, while I talked about relationships of trust and equality, and consent.

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<sup>29</sup> See BALM's website <http://balm.in/html/about.html>.

I did do the workshop, despite my anxiety. At the second workshop, after doing a hearing voices simulation exercise and going through the approach, we watched the first part of Rufus May's Channel Four (2008) documentary, 'The Doctor Who Hears Voices'. This is an in-depth account of one to one work with a young woman who is hearing voices. With the group's permission, I recorded the discussion that ensued. Here are some of the comments.<sup>30</sup>

### **The 'Luxury' of time**

'So to get to the psychodynamic meaning, the symbolism, the latent meaning, all that requires a lot of skill from the best of us. So when you, especially in a place like India where you have very few people [professionals] anyway, and of them how many are so sophisticated, or so literally articulate'.

'No luxury of time'.

'But we need to think of our large population, which is not so articulate'.

'we also have a problem of people who may not be that intelligently engaging with it, you know even a person who is intellectually, lets call it, subnormal or challenged or retarded or whatever you want to call it. They also have that. Or they might not exactly be retarded, but maybe not so...and you need to be very sophisticated and articulate to come out with all this with some clarity to make meaning.'

'the worse thing would be when the person has these experiences and is not able to articulate it because of his less than normal intelligence and coloured by a very, erm, explosive affect, you know this explosive effect where the person is listening to the voices and doing all kinds of things, he's not able to articulate so how many people would you be able to train in this kind of thing?'

Time as a 'luxury', 'large population', 'few professionals' – these are some of the themes used to question the applicability of the hearing voices approach in India that emerged from the workshops I facilitated. Interestingly, while issues over language do seem to pose problems for the hearing voices approach because the approach is led by users and survivors, issues over access to professionals becomes secondary if not

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<sup>30</sup> Workshop at the Banyan 30.4.11 (from recorded discussion after the workshop).

obsolete. In these terms the hearing voices approach may actually be more economically viable than psychiatric interventions, and could also potentially make more use of local and indigenous knowledge.

### **'Doctors are treated as Gods'**

Towards the end of the [first] workshop talk turned to the subject of the male psychiatrist that visits the Banyan, and how the women patients had blushed when they spoke about him. The staff told me that many of the women at the centre, when asked about doing chores – washing clothes, learning life skills etc, say that they are doing it for him. Everybody laughed about this, saying they couldn't understand it. Nobody mentioned relations of power; the power to medicate; to discharge; the power of men over women. The staff said that in India, doctors are treated as Gods. [Field notes, January 13<sup>th</sup>, 2011].

While power relations between psychiatrist and patient went unmentioned in the first workshop, at the second workshop I facilitated at the Banyan, a few months later, this issue was explicitly discussed. Here a male psychiatrist and a female researcher discuss power.

Psychiatrist – 'we need to separate the wheat from the chaff. Hundred to one a lot of them are innocuous, we know that, in our clients we see almost 90 to 99% are not going to be like, and we are not admitting them either, and that's what our OP [outpatient clinic] is all about...our out patients...'

Female researcher - 'I think to some extent that's what they are saying. Is it that psychiatrists have to play that role of god in that person's life, shouldn't it be that individual?'

Psychiatrist – 'The thing is it's not the psychiatrist, it's a whole panel, a whole team you know...'

Female researcher - 'Minus that individual'.

Psychiatrist – 'Not always minus the individual...The individual has to put forth his case.' [Comments from a workshop at The Banyan, April 30<sup>th</sup>, 2011].

Doing chores and taking medication to please the male psychiatrist hints at a 'double colonisation' at work in psychiatric institutions in India, and experienced by many

women of the (post) colonies – the interweaving of colonial and patriarchal domination (Ashcroft, et al, 2000). This foregrounds further analysis of the multiple colonialisms that are inscribed on the body of the ‘mad, colonial woman’. It points to the need for conceptual tools to explore how women are ‘subordinated by intersecting structures of domination’ (Ghai, 2011), such as colonialism, patriarchy and psychiatry. This marks a move away from debates in post-colonial feminisms about the comparable urgency of fighting patriarchy or colonialism; and seeks to examine those structures, of which psychiatry may be one, where both forms of domination interweave.

### **‘White Knowledge’ - A workshop at NIMHANS**

My anxiety only grew when, later in my travels, I leapt aboard a moving train from Kolkata to Bangalore, to accept an invitation to facilitate a workshop at the National Institute of Mental Health and NeuroSciences (NIMHANS), in Bangalore.<sup>31</sup> NIMHANS was a ‘lunatic asylum’ established in 19<sup>th</sup> Century colonial India, heavily influenced by the practice of psychiatry in England, and proud of the ‘modern’ treatment methods that it provided (Radhika, 2011). It still seems proud of the treatments it offers, and, according to the many references that people I met with made to NIMHANS, it is seen as a ‘beacon’ of psychiatry in India, and one that dominates much of the psychiatry carried out in the country. I had been asked to facilitate a workshop at NIMHANS that would mainly be attended by Clinical Psychologists and would be about alternative approaches to understanding and working with people who hear voices.

When Bhargavi heard that I was doing a workshop at NIMHANS she laughed; she said it would be impossible for her to be asked to speak there – she’d tried many times to run workshops on alternative approaches and been denied. She said, echoing what other friends and colleagues told me throughout my trip, that I was only given access to some of the institutions I spoke at because I was western and white (‘fair and lovely’ as one of India’s biggest brands of creams to whiten skin is called). When another friend who runs a mental health NGO in Kolkata heard I was doing a workshop at NIMHANS, she said I must be ‘madder’ than her.

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<sup>31</sup> See NIMHANS website <http://www.nimhans.kar.nic.in/>

However, I had allies. Bhargavi had put me in touch with Lavanya Seshasayee, who identifies as a psychiatric survivor – having had a diagnosis of Schizophrenia, and who had just started her own organisation to promote recovery. Lavanya lived in Bangalore, I was dying to meet her, and so I invited her to the workshop, explaining that considering I was talking about survivor approaches to hearing voices it would be very fitting to have someone who actually heard voices and had survived the system at the workshop. She came along. However, during the course of the workshop she was not made to feel very welcome. Lavanya had previously been a ‘patient’ at NIMHANS.

I arrived on the evening of the workshop on the back of my friend, Sonia Soans’, scooter. When she and I got lost wandering the clean white halls of one of the buildings, we wondered if we’d ever get out. Despite my invite (and being White), once inside NIMHANS, and many of the other organisations I ran workshops at, what I presented was rejected. Discussion at these workshops often centred around how what I had presented (often information about the survivor movement within mental health in the UK, recovery, and that for example hearing voices may be meaningful and not a symptom of a pathology) were ‘western concepts’, ‘alien to Indian culture’ and ‘a luxury’.<sup>32</sup> Survivor-led approaches wouldn’t work in India, I was told, because ‘it’s a different culture’, ‘our patients are more severe than in the UK’, because ‘those women, the ones who’ve languished in asylums for the last 30 years, those are your survivors’. A friend who attended a talk told me ‘you may be white, but what you talked about isn’t white knowledge’.

I found it infuriating to be told by a Psychiatrist and a Cognitive Behavioural Therapist, after the workshop at NIMHANS, that the approach of the Hearing Voices Network was colonial. In part, I felt annoyed because NIMHANS had started out as an asylum in colonial India. During colonialism such asylums were seen as ‘citadels of European progress—symbolic strongholds of Western reason standing up against the maddening abyss of Eastern irrationality’, the benefits they brought were seen to outweigh the oppression of colonialism and to justify the presence of the colonisers – part of their ‘civilising mission’ (Ernst, 1997:172). Thus to have someone who works

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<sup>32</sup> Quotes from participants at various workshops conducted by the author in India, from January – May 2011. Quotes have been kept anonymous.

within such a 'citadel', a 'symbolic stronghold', whose job is a colonial legacy, telling me that my workshop about hearing voices, an approach critical of psychiatry, was colonial, was hard to take. I bit my lip because I shouldn't bite my nails.

I became immediately defensive and I felt angry – but in the space of reflection that 'afterwardness' affords, I wonder if this reaction is itself haunted by an uncanny colonial anxiety that also haunts psychiatrization (further explored in Chapters 7 and 8). Here it seems fruitless to engage in an argument over whether the work I did in India was colonial or not, but instead to begin to recognise that 'the difference is not between colonial and non-colonial structures, but between different sorts of colonial structures' (Derrida, 2001 -online). This brings up the issue of identifying the various different colonial structures at work within psychiatry and their modes of operation.

As already noted, the very fact that I was able to facilitate workshops at institutions, such as NIMHANS, was marked and made possible by a colonial, and to some extent racial, relation. However, those who attended the workshops already took for granted psychiatric and psychological knowledge – repeating to me theories that I am familiar with from the West. Was it in part this repetition that I found uncanny?

Thus although I was given speaking rights because I am white and western, what I spoke about was rejected as 'western' knowledge – which worked to undermine it as colonial, as an attempt to impose western knowledge on to a different culture. Here the mobilisation of anti-colonial discourses worked to undermine a counter-hegemonic position (arguably from the global North), and to bolster the hegemonic knowledge of psychiatry, itself a colonial legacy in India. Thus while remaining sceptical of unthinkingly importing 'western' models onto diverse contexts, we also need tools with which to be sensitive to how disciplines such as psychiatry and psychology may call upon a nationalist discourse of resistance to colonialism, to defend their own forms of neo-colonial activities from critique. Here it seems that psychiatric approaches to distress within India (as colonial legacies) can enact colonialism, while approaches from the global North may be anti- or decolonizing (for example, the hearing voices approach). This opens a space to encounter knowledge from the global North that may not fit the needs of colonialism, knowledge that is 'non-Occidentalist', in the sense of it



being knowledge that is marginalized within the West (Santos, 2005). (These issues are returned to in the final chapter).

### **‘Survivor’ as an identity, as a claim**

However, these other, ‘non-occidental’, counter hegemonic ways of knowing travel too, as evident in the work of The Bapu Trust. Bhargavi Davar (the founder of Bapu Trust) invited me to her house so we could record our interview somewhere quiet. I asked her about Bapu, she explained ‘it’s about creating spaces within India which will allow people living with mental illness to feel safe, express choice and have fun in the process of their own recovery’. Bapu Trust, unlike many organisations in India, claims to be ‘survivor-led’, and most of the workers at Bapu have been through mental illness. However, Bhargavi explained that ‘it’s very difficult for people in India to speak out as a user/survivor’ because the laws are very exclusionary of people seen as of unsound mind; in marriage and property laws, and in participation and giving testimony (Dhanda, 2000).

For this reason Bapu first decided not to ‘put out our identities’ (as survivors) but to fight on a social justice platform. But over a period of time, they were challenged by people with labels of mental illness, who said that as a third party the organisation shouldn’t claim to speak on the behalf of people in distress. So they went through a restructuring, ‘we closed lots of programmes that were clearly coercive’, all the programmes that worked closely with institutions (such as the family courts) and that meant that people had no choice. Because ‘we were getting co-opted into a coercive regime and so we shut those programmes down’, keeping only those based in the community. This was because they felt they were dealing more with trauma rather than mental illness, ‘we were basically treating institutionally linked trauma, the trauma of being institutionalised’, and being brought in forcefully by the police.

This dilemma of working with/in institutions also became evident in an interview with Sarbani Das Roy, the co-founder of Iswar Sankalpa (a mental health NGO in Kolkata), who reaches different conclusions from Bhargavi. Sarbani said,

We don't believe in criticising systems from outside, if there is some change that we would like to bring into a system, we would like to work for it inside. So if there's something that I don't like about the way the police is working I would rather talk it with the police system and I would like to make suggestions from inside, work through that. Rather than stand outside police stations on the lal bazaar or the police headquarters and stage a demonstration, you know, I don't believe in that kind of advocacy. (Sarbani Das Roy).

Here advocacy involves working 'within and against' the system (Bondi, 2005:106). In fact, for Sarbani, the fact that Iswar Sankalpa do not stage protests outside police stations or report bad practice to the media, means that the police will engage with them.

Back to Bhargavi's house, where I asked her, 'what changed your decision to come out as survivor led'? 'It was around the time the CRPD came in', Bhargavi remembered, 'the identity question, before that I explored my identity as a woman, through the woman's movement, and then there was the lesbian movement, I was a part of that, and after that I joined the World Network of Users and Survivors of Psychiatry (WNUSP), and then I realised that the name to give to my internal world is that of a survivor'. She continued,

these words are not known to us very much, though I tracked anti-psychiatry for a long time...it was as if I was being haunted by a literature that was all geared towards bringing down the asylums, and of course it links back to my childhood memories...childhood traumas...It doesn't so much matter now if I am specifically a psychiatric user, use psychotropics etc that's really by the way...What really makes me a survivor is that as a child my family survived mental asylums. I survived my own memories of mental asylums. And I also survived a Depression.

In this sense, Bhargavi and I shared some of our experiences, our 'survival'. Her 'survival' was haunted, by anti-psychiatry, by the memory of asylums; just as I am haunted by memories of my Grandma's encounters with psychiatry, of a sadness that

sticks like a stain; and just as this thesis will explore how psychiatry may be haunted by its colonial past.

At first, Bapu Trust conceived of themselves as a professional agency, and did not discuss identity issues, and they brought in professionals who had no personal interest in mental health, and it was 'suffocating to be surrounded by people who were reflecting the biases of the larger mental health system in India, particularly about those who are seen as disturbed.' Bhargavi was frustrated by this, she kept trying to address identity issues - 'I don't want to run another NGO that puts out the same message that mentally ill people deserve to be taken without their consent into treatment.' Also,

when people come into an organisation as a social worker or as a clinical psychologist, they don't stop to ask whether you need some help, they just jump in and start helping you...there was a huge conflict with user/survivors visiting us just to be, they were not asking for help...and then there was this group of counsellors and psychotherapists who were sort of jumping in ...it really bugged me a lot. We closed down our services at the centre, we now do it in the community.

Then '[p]eople started speaking out as survivors' and meeting others, 'this is going to be big'. The Bapu Trust now calls itself a survivor-led organisation, 'we are well known among the survivor groups around the world', and are well connected to other groups, such as in parts of Africa and America. In fact, there are a growing number of organisations in India led by survivors or users.

But at Bapu we are using our identity as survivors to reform the system from custodial institutions to more healing based, more person centric options...Whereas the other survivor organisations are using their survivor identity to say that, "look medicine has helped us, so we need medicines, and institutions are okay".

China - What does the claim of the survivor identity mean for an organisation?

*(Ding dong, the doorbell rings...then we stop for a cup of chai, the recording is full of sighs and sips and 'mmm, that's lovely').*

Then Bhargavi continues,

In my country it has no value. I think I was better off not putting my identity out. You know because people knew I was a PhD and I'd published books, and there was a little bit of respect for me, particularly the mental health professionals, they could relate to me as a professional at that point...In India, as probably elsewhere the psychiatric profession is at the centre of the discourse, they are leading the discourse and all other professions, and organisations, they are in the shadow of psychiatry...So I earned much better respect as a professional than as a survivor...As I soon we put out our identity as based on survivor experiences, it was as if my entire range of publications just went out the door, it's like these are a group of disgruntled patients, so that was the message. I hope the UNCRPD will restore that respect back.

China - Is it the survivor identity seen as a western concept in India?

Bhargavi – Yes, that true. But in many of our meetings we've had people coming from remote villages, saying that their rights have been violated...it may be true that as an identity it's a new thing, and so you don't really know what you're supposed to do once you've identified yourself as a survivor...But the experiences have been there for as long as the current psychiatric system has been in place, so quite a long time...I think it's like a place to peg your advocacy work...It's a place for people who have been violated by the mental health system...you can't build anything on just a survivor identity, you need layers of expertise on the identity.

Thus claiming the identity of 'survivor', personally and organisationally, is a fraught process – one that brings people together and helps them to understand the ways they may have been violated, yet simultaneously is also used (by professionals) to discredit those claims. This takes us to the next chapter, where concerns over what we can and

cannot recognise as being violent, work to frame what can be understood as suffering, and those who can be seen to have been violated.

And so this chapter ends on more questions than answers. Calling for the need to grapple with how we can conceptualise the urgency of some situations of oppression, while resisting the inevitable hierarchies of comparison between LAMICS and HICS, and between physical diseases, impairments and mental health problems without privileging one category or collapsing all into one. This calls for an exploration of what frameworks we might employ to respond ethically to distress or impairment within LAMICS, without solely transposing bio-psychiatric and western knowledge systems, and of grappling with the project of taking mental health seriously globally and responding ethically, while retaining an understanding of the complexity, meaningfulness, and politicisation of distress. A part of this project needs, according to Summerfield (2008:994), to emphasise qualitative research that seeks 'more grass roots ownership of the terms of reference' around distress, to enable a more relevant knowledge base to emerge. A knowledge base that is not violent.



## Chapter Three

### **Special Treatment, Special Rights: Children who can't refuse**

A chapter on children who can't refuse and who are not believed, children as limit figures, on 'normal' childhoods and global childhoods, on children as the 'future' and as a 'target', on who's lives are worth living, and who's lives are 'bare', on what counts as 'treatment' and what counts as violence.

## **'Violating Enablements'**

I think I'd have liked them to believe me about everything...The abuse and the voices because it's real to me (Kate, research interview).<sup>33</sup>

It is virtually impossible to envisage a situation where a child or young person with a negative mental health label could ever refuse treatment (Coppock, 1997:157).

childhood [is] a metaphor for institutionalized violence visited upon humanity in the name of progress (Nieuwenhuys, 2009:149).

This chapter takes up from the last through highlighting a key issue in the framing of distress as an 'illness like any other'; issues of 'unsound mind' and competence. While within a Sedgwickian (1973) framework (explored in the previous chapter) it may be possible to understand mental distress as an illness without implying biological reductionism – in UK law, children and adults with physical illnesses can refuse medical treatment, while those deemed of 'unsound mind' due to mental illness often cannot.

This chapter will focus on how children with labels of mental health problems function as limit figures within UK case law, and universal child rights discourse. This is important when we consider that the Movement for Global Mental Health, firstly, sees children and young people as one of its target groups; and secondly, aims to 'scale up' interventions and understandings of children's mental health from the global North, to the global South based on the fact that 'over 90% of countries have no mental health policy that includes children and adolescents' (WHO, 2001b:6).

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<sup>33</sup> All quotes, unless otherwise stated, are taken from research undertaken by the author into 'Young People's Stories about Hearing Voices' (funded by the Research Institute of Health and Social Change, at Manchester Metropolitan University, in 2008). (All names have been changed throughout to ensure anonymity).



In focusing this chapter specifically around children, I am aware that I am also working to reify the category of the 'child' as separate or 'special', in my very act of seeking to critique this. However, an analysis of how children are framed as 'special' in legal rights on mental health in the UK not only enables an interrogation of what this might mean for Global Mental Health policy (which draws on 'Western' models to 'scale up' mental health care), but may also help in rethinking normative conceptions of mental distress more generally. This forms part of a project of using mental health user/survivor experience and literature to rethink Global Mental Health; and thus this chapter draws in part on research that I carried out prior to starting my PhD – with young people who hear voices (and adults who heard voices when they were children).<sup>34</sup> I want, in the first part of this chapter, to begin to use the stories told to me by these young people and adults, putting them to work in interrogating legal rights discourse around young people; and the implications of this for Global Mental Health policy, and the children it targets.

While the recognition of children as subjects of rights is mandated in legislation, this chapter begins to query the medico-legal frameworks for such recognition. It seeks to question what such frameworks take for granted and what they may foreclose. In doing this I want to attend to how rights discourse, psychiatry, and developmental models of the 'normal' child can converge to embody disciplinary effects that regulate children's lives and discursively frame certain children as 'problems'. It seems that in appearing before the law and within psychiatry as 'mentally ill', such children enter into specific realms of appearance and frameworks of recognition that delimit and foreclose what sort of subject that child can be and how that child can come to understand their experiences. In fact sometimes the frames that children draw upon to make sense of their experiences and the strategies they develop to survive inequality and distress become pathologised within psychiatric frameworks of understanding as being 'symptoms' of mental illness.

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<sup>34</sup> 'Young People's Stories about Hearing Voices' (research funded by the Research Institute of Health and Social Change, at Manchester Metropolitan University, in conjunction with The Hearing Voices Network, in 2008). Also, see Mills (2012a).

In this way, the medical model through its conceptualizations of children's behaviour as pathological, as 'illness', can work to divest children's behaviour of any political significance. In attending to this process we might begin to recognise and trouble the ways in which children are subjected to 'treatment' (often in the form of medication) that is justified within a normative matrix that sets the parameters of what counts as a 'normal' child, and childhood (a prescriptive normative framework that often becomes transposed onto all children, including children of the global South).

How does this construction of the 'normal' child condition our responses to children who have unusual experiences or who are distressed? How do terms such as 'normal' and 'child' work? What do they foreclose, and what are they used to justify? As more and more children are framed as 'mentally ill', with increasing amounts of medication prescribed to children, and with children being a 'target group' of Global Mental Health's push to 'scale up' this psychiatric model to countries of the global South, such questions are pertinent.

Centrally an exploration is called for of the processes by which children framed as being 'mentally ill', and particularly here children who self-injure or hear voices, present us with a limit figure to current child rights discourse. In engaging with this limit figure, this chapter aims to examine the parochial frameworks drawn upon within legal decisions around children's rights to refuse 'treatment'. In fact, it aims to interrogate how psychiatric frameworks foreclose what can be understood as 'treatment' in the first place.

In contesting the frameworks by which the 'child with mental health problems' comes to be constituted, it will engage with young people's own stories, to enable dissonant and plural frames of recognition to come into view. Reading these stories alongside the work of Giorgio Agamben and Judith Butler, particularly their theses around 'bare' and 'precarious' lives, enables further understanding of how dominant schemes of intelligibility may work to medicalize childhood experience; normalizing the absence of children with mental health problems and pathologizing their presence within rights discourse (Phoenix, 1987). Thus we might explore how child rights may operate as a 'violating enablement' for many children (Spivak, 1993:44).

### **Children with mental health problems as ‘veto clauses’**

Within UK law, children under the age of 16 years have the right to consent to or to refuse medical treatment without parental consent, as a result of the landmark Gillick ruling (initially made around access to contraception) (*Gillick v West Norfolk*, 1986:224). However, reinterpretations of Gillick within Court of Appeal rulings have meant that this potentially progressive legislation carries ‘veto clauses’. Significantly such vetoes are particularly visible in cases that have involved young people (under 18 years old) who are understood to have mental health problems. This section thus aims to trace certain themes that have emerged in case law as lens through which to explore constructions of the child with mental health problems as a limit figure to understandings around child rights and competence.

According to Shaw (2002), two rulings by the Court of Appeal have been particularly significant in reinterpreting Gillick, in setting the precedent for current legislation, and for largely curtailing young people’s ability to refuse treatment. In both these cases the Court of Appeal decided that any person with parental responsibility, or the High Court, could in certain situations override a child’s right to refuse medical treatment. It is relevant here that these cases involved young people with mental health problems and in both cases the child’s right to refuse treatment was overridden - both young people were given compulsory psychiatric treatment (medication) against their wishes.

One of these cases (*Re R*, 1992:190) involved a young woman (aged 15 years) who experienced ‘auditory and visual hallucinations’, and who refused medical advice to take anti-psychotics. Despite the Gillick decision, Lord Donaldson, within the Court of Appeal, stated that ‘no minor of whatever age has the power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor’ or by the Court (Lord Donaldson, cited in Roberts, 1999:159). He went onto to say that, ‘parental power to consent to medical treatment on behalf of a child was not lost when the child acquired competence to give consent’ (Lord Donaldson, cited in Masson, 1991:528). Such parental power could be used to authorize treatment when a child refused. Thus, despite the Gillick decision, Lord Donaldson’s guidance assumes that ‘children under 16 are never competent, even if

they are Gillick competent, to refuse treatment as long as someone else with a concurrent power of consent agrees to it' (Fennell, 1992:311).

Lord Donaldson went on to justify his stance in saying that he felt that R (the young woman) could not possibly have understood the implications of medical treatment because even if she understood on 'a good day', her 'mental disorder' 'was such that on other days she was not only Gillick incompetent, but actually sectionable. No child in that situation can be regarded as Gillick competent' (Lord Donaldson, cited in *Re R*, 1992:603.) Similarly Lord Justice Farquharson (another of the three Lord Justices that reviewed the case in the Court of Appeal) argued that the Gillick test was 'not apt to a situation where the understanding of the child varies from day to day according to the effect of her illness', and he went on to say that he would reject the use of the Gillick test in such a situation (cited in Fennell, Harpwood and Ngwena, 1991).

However, the recognition that children are subjects of rights is mandated in legislation, embodying a normative conviction that children have particular rights, and should be treated as such. Dickenson (1994:206) points out that '[i]f people have rights, it is not because they pass a rationality test'. Competent adults can refuse medical intervention for reasons that are 'rational or irrational or for no reason' at all (Ford and Kessel, 2001:384), and case law shows that adults with mental health problems, including Schizophrenia, are not always assumed to be incompetent (*Re C*, 1994). Thus while adults are presumed to be competent unless there is evidence to the contrary, children are not.

### **Children who can't refuse**

It seems here that in their very refusal certain children come to be framed as 'irrational', where the refusal comes to be seen as 'part of their illness' and can thus be overridden, meaning that a 'competent child under 16 has the right to say "yes" but not to say "no" to medical treatment' (Fennell, Harpwood and Ngwena, 1991). While statute law appears to constitute children as subjects of increasing numbers of rights; case law, on which much clinical practice is based, gives children fewer and fewer choices regarding their own treatment, meaning that young people under 18 'now have no right to refuse treatment' (Dickenson, 1994:205). This provides a lens through which

to see the implicit psychiatric underpinnings of the concept of competency; where, to be viewed as competent children seem to have to demonstrate illness acceptance or treatment compliance. Devereux, Jones and Dickenson (1993:1459) note the 'catch 22 by which patients whose competence is in doubt will be found rational if they accept the doctor's proposal but incompetent if they reject professional advice'. This tacit acceptance of psychiatry defines the parameters of consent and competence, and means that within current case law a child can never be conceptualized as competent if they are simultaneously framed as mentally ill.

Fennell (1992:311) goes onto question 'the automatic assumption that refusal is irrational and can be overridden whether or not the patient is competent'. Similarly, Dickenson (1994:205) argues that any power to give consent must also mean the right to withhold consent, otherwise 'the right to consent would seem to be no more than the right to agree with the medical practitioner'. Indeed, if 'meaningful consent implies the possibility of saying "no" and having this refusal respected' (Roberts, 1999:15), then the denial of children's ability to say 'no' would seem to stand in direct contradiction to rights discourse, where children have a right to express, and have, their views given due weight 'according to age and maturity' (UNCRC, Article 12). But who decides what age is 'old enough', or who is and is not mature? Such conceptualizations of rights to refuse and consent to treatment do not currently seem to take into account the asymmetrical power relations weaved into the fabric of children's everyday lives.

### **Doubly Diminished Identities**

This inequality needs to be taken particularly seriously in relation to dilemmas around medical treatment when they involve children, where power relations between adult professionals and children labelled as 'mentally ill' are particularly unequal. LeFrancois (2008:212) notes that 'nowhere is the acceptance of children's irrationality more prevalent, in terms of legislation, policy and practice, than in the area of child and adolescent mental health'. In this arena not only does the position of 'child' delegitimize the young person's views, but the deeming of that young person as 'mentally ill' (by an adult professional) constructs their beliefs and demands as irrational; positioning them as doubly incompetent, doubly diminished identities.

In this context, adults hold sole discretionary power in defining children as irrational, based both on their age and their psychiatric diagnosis, thereby stripping them of any rights they might otherwise have to make decisions that could influence their treatment (LeFrancois, 2008:213).

Current case law then puts adults in the sole position to determine children's 'rationality' and to veto children's wishes. This is made explicit by Lord Donaldson, who in discussing the Gillick ruling, stated that 'in a case in which the "Gillick competent" child refuses treatment, but the parents consent, that consent enables treatment to be undertaken lawfully' (cited in Shaw, 2002:48). It is thus 'virtually impossible to envisage a situation where a child or young person with a negative mental health label could ever refuse treatment' (Coppock, 1997:157). This makes visible the paternalism of child rights discourse, where bio-medical definitions of welfare are privileged over children's autonomy and self-determination. Here appeals to the principle of working in children's 'best interests' may serve as 'an additional adult veto to children's decision making in the name of protection', diverting attention from the maintenance of adult interests and inequality (LeFrancois, 2008:213).

It is worth attending to the political significance of delegitimizing someone's experiences through rendering them 'irrational' and 'pathological', particularly when we consider that many people who hear voices may have experienced physical and sexual abuse (often as children) (Romme et al, 2009). This leads us to question how children's right to their bodily integrity, asserted in the UN Convention on the Rights of the Child (UNCRC), is violated yet again through forced 'treatment' and detainment by medical professionals, repeating previous traumas that children may have experienced - the other times they weren't able to refuse.

Shaw (2002:50) argues that a young person should not be treated against their will unless they are more than likely to 'suffer significant harm without treatment'. Taking this further, I suggest that there is a need to attend to medical and psychiatric frameworks of recognition of what is constituted as a 'crisis' or an 'emergency', what can be understood as 'harm', and what can be conceptualised as 'treatment'. While decisions around competency claim neutrality, Roth, Meisel and Lidz (1977:279) argue

that judgments of competency are not straightforward applications, but rather 'reflect social considerations and societal biases as much as they reflect matters of law and medicine'.

### **Hearing voices: pathology or survival?**

Thus dominant medical frameworks for understanding the experience of hearing voices and self-injury tend to conceptualize these experiences as 'symptoms' of an 'illness'. However, many young people who hear voices and/or self-injure do not understand their experiences in this way. In stories from survivor literature and in those that the young people and adults involved in my research told me, some of them had always heard voices and to them the experience was 'normal'.

At first I thought everyone shared this experience, but when I talked to a friend about it she said she had not had this experience and she thought I was strange because she had not heard about anyone who heard voices. At the same time, I thought she was strange because to me hearing a voice was normal (Young girl, cited in McLaughlin, 1993).

Similarly, Ellie wasn't threatened by the voice that she heard when she first started university, she found that, 'far from being some sinister psychiatric symptom, the phenomenon was probably no more than my own externalised thoughts...a useful indicator to me of how I was really feeling' (Longden, cited in Campbell, 2008). It also became apparent, in my research, that many young people understood hearing voices as a coping strategy; an aid to survival in an unequal and often abusive adult world. For example, Jenny had heard voices for as long as she could remember and at first they helped her and reassured her when her Mum neglected her, they told her 'you'll be okay, you'll survive'. Pete's voices reminded him he should tell someone about the abuse he had experienced. Ellie's voices serve as a reminder to her when she's stressed. These young people seemed to be speaking a very different language from that of the Diagnostic and Statistical Manual (DSM IV-TR, 2000:312) whose 'diagnostic criteria for Schizophrenia' these children were found to meet,

A. Characteristic Symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) delusions

(2) hallucinations . . .

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

Children and young people's own understandings of hearing voices highlight a major paradox within psychiatry. Here voices which may actually be a coping strategy (even though sometimes unpleasant); and which have enabled the voice hearer to survive through abuse or trauma, are framed by psychiatry as in need of eradication, often through medication. Thus children's coping strategies are pathologized, diverting attention from exploring the often difficult and traumatic lived realities of children's lives, and the very reasons why they may hear voices in the first place.

The young people and adults whom I spoke to during my research highlighted how the responses of adults, professionals and services often contributed to their distress through denying them a voice, framing the voices they heard as problematic or pathological, and not believing them (both about the voices, and about the things happening in their lives). In fact many psychiatrists refused to engage in conversation about the voices the young people heard; '[t]he doctors told the other staff not to pay attention to me when I spoke about the voices; they said it would be playing into my delusions' (Hadjimatheou, 2009).

For a number of people, the voices they heard actually only became distressing after telling others about them, as Pete pointed out, 'quite often people have no issues with the voices until they disclose'. This was, as one young man said, because his voices 'were worried the doctors were gonna medicate them away'. He felt that before taking any medication he first needed to understand what the voices were trying to tell him and why they were there in the first place.



**'They said it was all in my head but I tried to tell them it was real to me'**

Smith (1995:169) describes how hegemony does not operate solely, or sometimes at all, through brute force but entails,

the delimitations of the intelligible . . . To fail to achieve an adequate fit within an officially recognised position is to be de-authorised—to be denied recognition as an author of the text and to have one's text dismissed from the start as incoherent, illegitimate or unbelievable.

Smith could easily be referring here to the hegemony of bio-psychiatry, where diagnosis works to dismiss children's own texts - the voices they hear, the pain they feel - labelling them as irrational and unbelievable from the start. This urges us to contest the limits that are placed on who is able to speak with authority about children's lives and what they can say. For many young people and adults whom I interviewed, being believed would have made all the difference when they disclosed to people that they heard voices as children;

They did'nae believe things I was saying, they said it was all in my head but I tried to tell them it was real to me, that was what was happening.

I tried to tell people but I was never believed about the abuse. And I sort of shut up and I stopped talking about them. Because nobody was believing me, I stopped talking about the voices.

I think I'd have liked them to believe me about everything . . . The abuse and the voices because it's real to me. I mean I'm not saying they have to say 'Oh aye we hear them as well' but if they said well you know 'Well I can understand that must be frightening'.

The above quotes make clear that belief does not mean saying you can hear the voices too, it means accepting that the voices are 'real' to that child, that they may be distressing, that they may be personally and politically meaningful, and thus engaging

with that meaningfulness. It means acknowledging that children's survival strategies and ways of understanding the world are not represented by the language of pathology that underpins many children's mental health services and legal assumptions (Billington, 2006). It also begs the question at 'what point does such mental activity become pathological ... as opposed to necessary, creative, imaginative or even pleasurable' and who decides? (Billington, 2006:8). This also 'means accepting a child's knowledge of terrible experiences' (Sinason, 1992:209), their knowledge of things that adults' don't think they should know. While children may indeed speak or communicate to us, it may be in a language that professionals deem socially unacceptable, such as communicating distress through self-injury or hearing voices. This means adults and professionals need to attend to narratives of experience that are not restricted by a psychiatric vocabulary of deficits and pathologies; but to a multi-voicedness or heteroglossia of ways of understanding children's lives and distress.

While legal definitions of capacity emphasize rationality, this does not solely determine children's and adult's decision making; emotion, social context and experience also all play a part (Dickenson, 1994). Attending to children's experiences and other worlds may enable dissonant and disruptive frames of what it means to be a normal or rational child to come into view, pushing current frameworks of recognition to the point of rupture. We thus need to acknowledge, with Butler (2004:90) that, '[w]e make a mistake . . . if we take a single definition of the human, or a single model of rationality, to be the defining feature of the human'. It seems that this 'single definition' of rationality may here be implicitly dominated by psychiatry and the pharmaceutical industry, psychiatrically framing conceptualisations of 'best interests', 'treatment' and violence. While the rendering pathological of experiences, such as hearing voices, may be read as symbolically violent (and as colonial), other forms of violence are then enabled, violence not always recognised as violence - violence in the name of 'treatment'.

### **Violent 'Treatment'**

In 1993, 3,500 prescriptions were given in the UK for Ritalin; by 2006 the NHS gave out approximately 250,000 prescriptions; and in the USA doctors write 2 million prescriptions a month (Fowler, 2010). If we bear in mind that the National Institute for

Health and Clinical Excellence (NICE) estimates that using the DSM-IV criteria, ADHD is thought to affect 3–9 per cent of school-age children (NICE, 2008:72), then we can glimpse the wide impact of this medicalization of certain (and increasing numbers) of childhood experiences. On a UK television documentary about ADHD, one mother reported that her son was first medicated at age five with little effect, so the doctor upped the dose by six times the norm. When he was 14 he was put on Risperdal, an antipsychotic drug, used for Schizophrenia. The mother said it was like her son had been replaced by a zombie (BBC Panorama, 2007). By 2008, around 8000 children and young people in the UK were being treated with Risperdal or Zyprexa, despite side effects (including brain tumours) (Fowler, 2010). There are further reports that GPs prescribe anti-psychotics inappropriately, which is worrying for drugs with such severe side effects (Fowler, 2010).

It thus seems that psychiatric-legal constructions of incompetence or ‘unsound mind’ work to construct ‘bare life’ (Agamben, 1998), or what Judith Butler (2004) understands as precarious lives that are ‘already lost’, meaning children can be subjected to often aggressive medical interventions justified in the name of ‘treatment’ to restore that person to a ‘normal’ life. This is also significant for disabled children (Scope, 2009).

### **The ‘Ashley Treatment’**

A few years ago a ‘treatment’ for ‘severely disabled’ children came to light in the USA, causing much controversy (CNN, 2008). This centred on a young girl named Ashley. Ashley developed static encephalopathy shortly after being born, meaning that she requires intensive support from her parents. Her parents, concerned that puberty would cause Ashley discomfort and that if she grew to adult size they may not be able to care for her, approached doctors about growth attenuation therapy and surgery in order to ‘significantly elevate Ashley’s adult quality of life’ (See Ashley’s parent’s online blog).<sup>35</sup> Under the agreement of the hospital ethics board, this procedure was then carried out, and outlined in a blog by Ashley’s parents,

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<sup>35</sup> Ashley’s parent’s online blog: <http://ashleytreatment.spaces.live.com/blog>. (Accessed 11/10/2010).

The Ashley Treatment is the name we have given to a collection of medical procedures for the improvement of Ashley's quality of life. The treatment includes growth attenuation through high-dose estrogen therapy, hysterectomy to eliminate the menstrual cycle and associated discomfort to Ashley, and breast bud removal to avoid the development of large breasts and the associated discomfort to Ashley (Ashley's parent's blog).

The issue that has emerged as particularly problematic in debates around the ethics of this procedure is the notion that it is 'acceptable to render disabled children's bodies "more convenient" for care givers' (Scope, 2009, online). However, Ashley's parents have reacted against accusations that the procedure was carried out to make their lives easier in caring for Ashley, and firmly state that it was done to alleviate unnecessary suffering on their daughter's part. They say, in a different blog, that, 'given Ashley's mental age, a nine and a half year old body is more appropriate and provides her more dignity and integrity than a fully grown female body' (The Ashley Treatment, undated:4).<sup>36</sup> The 'Ashley Treatment' has since been recommended in medical journals as a viable 'treatment' option for other children who are 'developmentally disabled'; in fact Schmidt (2007:248), one of the doctors making this recommendation, asserts that;

a developmentally disabled child may have only a minimal right against interference with her growth. In those instances, parents may be acting ethically if they use medical interventions to inhibit the growth of their child for the purposes of facilitating better care. But they may so intervene only when the child's disabilities are so profound that the child has no personal interest in developing an adult size.

What does it mean to have no 'personal interest' in developing an adult size, and how does one ascertain this? This raises questions of '[w]ho has the right to decide to change an individual into a different entity?' (Yee, cited in Pilkington and McVeigh,

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<sup>36</sup> The "Ashley Treatment": Towards a Better Quality of Life for Pillow Angels', (undated). (p 4) [online] <http://pillowangel.org/Ashley%20Treatment.pdf>. (Accessed 16.05.2012).

2012). Many in the disability community have expressed similar concerns, summed up by Cohen (2007),

David is a young man with severe cerebral palsy. He can't walk, he can't talk, he can't sit up by himself, but he can blog. This week, David blogged about Ashley, "Ashley's parents have committed the ultimate betrayal," he writes. "They have treated their daughter as less than human, not worthy of dignity".

Increasing numbers of children are now undergoing the 'Ashley treatment' amid much critique and protest from many disability rights groups, who are calling for the procedure to be banned. However, Ashley's father makes the claim that judicial barriers will only harm the children and mean that 'many families are not able to provide the treatment, so severely disabled children are deprived and the treatment becomes exclusive to the wealthy and powerful' (Pilkington and McVeigh, 2012). This evocation of the discourse of access has parallels to the justifications of the aggressive promotion of clinical trials in India, where people who are poor are encouraged to become test subjects on the grounds of helping those who are 'medicine deprived' (Shah, 2006:36).

It is hard to deny that access to psychiatric drugs (and to growth attenuation therapy – the 'Ashley treatment') is much lower or indeed impossible for poor people in both the global South and the many Souths within the North. However, in attending to the alternative evidence base discussed so far in this thesis, we may be led to wonder whether lack of access to certain 'treatments' may in fact be more desirable. This raises difficult issues around global access to healthcare and medical treatments, particularly around disparities and inequalities between countries. What ethical frameworks can we draw upon to think through some of these difficult issues?

### **Psychiatry, children and 'bare life'**

It thus seems that psychiatry, and more generally biomedicine, may work to depoliticize self-injury, hearing voices and disability, through placing these experiences, and difference more generally, as being explicitly *outside* the realm of human experience and thus outside the parameters of human rights (Spandler and Calton,

2009). This helps us to understand how violence against children in the name of 'treatment' can coexist alongside the strong push for children's rights, through a process of framing hearing voices as 'psychotic', as outside the realm of 'normal' childhood experiences and thus outside the parameters of child rights. Schrag and Divoky (1981:36) note that due to psychiatric diagnosis, 'millions of children are no longer regarded as part of the ordinary spectrum . . . but as people who are qualitatively different from the "normal" population'.

The bio-psychiatric framing of hearing voices, mandated and funded by pharmaceutical companies, monopolizes media representations and public understandings, regulating what can be seen and heard, deciding 'what will and will not be publicly recognizable as reality' and as normal (Butler, 2004:147). Within this framework anything outside of this limited boundary (based on assumptions of a unitary rational subject) comes to be framed as irrational and mentally ill. Thus medico-legal judgments of competency are invested with cultural assumptions of what constitutes a 'good' childhood and a 'life worth living'.

Children with mental health problems do not feature much in the work of Italian philosopher Giorgio Agamben (1998:137-8), yet drawing upon his work we might begin to explore how these children's lives and behaviour are discursively framed within a medico-legal matrix as 'bare' lives, lives 'unworthy of being lived'. Agamben (1998) points to how every society determines the threshold beyond which life is devoid of meaning, cast outside the polis and constructed as apolitical. This is particularly the case in India, where despite the fact that universal adult suffrage is within the Constitution, 'a person shall be disqualified for registration in an electoral roll if he is of unsound mind' (Representation of the People Act (RPA) 1950, cited in Dhanda, 2000:298). Such life then ceases to have any juridical value and is thus portrayed as 'incurably lost'; as 'bare life' (Agamben, 1998:138).

I would like to explore how Agamben's work may enable us to theorize how psychiatry constructs certain children as 'bare life', depoliticizing their experiences and their refusals by framing them as 'symptoms' of illness. Similarly, what do such children, framed as mentally ill, do to Agamben's thesis? I want to engage with these conceptual

resources to examine how they may help us to make sense of and to understand psychiatric and legal constructions of children, and particularly the frequent overriding of children's refusals and psychiatry's subsequent legitimization of force.

To do this we need to examine the mechanisms and techniques within psychiatry by which particular behaviour comes to be discursively framed as problematic and pathological. One key framing device within developmental psychology, psychiatry and legal discourse is the medicalization of children's behaviour, 'where individual actions come to read as "signs" of a more enduring problem' and thus of a pathology (MacLure et al, 2008:3). Such pathologization and subsequent medicalization of children's behaviour and experiences was very apparent in the stories that people told me during my research with people who heard voices as children.

In asking people to focus their narrative around their experiences of disclosing that they heard voices, and of other people's responses and reactions to this, it was possible to partially explore how hearing voices was discursively framed by those people to whom the children had disclosed their experiences of voice hearing. Often the framing device took the form of pathologization of children's experiences of hearing voices, and the construction of these voices as a 'problem'. One voice hearer explained that 'the voices are not always the problem, it's other people's reactions'; another said that the voices 'meant more to them [professionals] than what it did to me'.

The frequent reports by children of having their experiences framed in this way may be partly explained by the dominance of psychiatry and the pharmaceutical industry to mediate particular experiences within a specific medical framework of intelligibility. Such frameworks, given medical legitimacy in the DSM (IV-TR, 2000:299), construct the experience of hearing voices as 'auditory hallucinations', seen to constitute the 'psychotic dimension' of 'positive symptoms' of Schizophrenia. In this way children's experiences come to be framed within a psychiatric lens. One young woman described how 'these very ordinary feelings of adolescent insecurity were immediately interpreted as symptoms of a diseased mind' (Longden, cited in Campbell, 2008). This then affected how children went onto frame their own experience of hearing voices, as one young woman noted, 'now something is happening to me that I think people think

is abnormal and which I am also seeing as being more abnormal too' (Young woman, cited in McLaughlin, 1993).

Thus it is on contact with society's prescriptions of normality that many young people come to be concerned about their experiences and through psychiatry's constructions of these experiences as pathological, to be alienated from them. This resonates with the alienation at work within colonialism, where for Fanon (1967[1986]:142), 'a normal Negro child, having grown up in a normal family, will become abnormal on the slightest contact with the white world'. This bringing into being of the abnormal through the gaze of the 'normal' enables glimpses to be caught of the similarities between the violence of colonialism and psychiatry (glimpses which we will catch throughout this research).

#### **'His normalcy was a crime they could not forgive'**

This violence is evident in a story by Mahasweta Devi, called 'Shishu', meaning 'children' in Bengali. In the story, a government officer, Mr Singh, encounters the tribal peoples he meets as mysterious, uncivilized, backward; replicating colonialist views, even though he is himself Indian. Mr Singh encounters the starving, stunted bodies of these 'children', only to recognize 'they are not children at all but adult citizens of free India, and stunted by free India', they have been 'literally and figuratively crippled in post-independence India' (Loomba, 1998:14-15). This reflects the destruction of indigenous forms of life - the making flesh of economic reforms (evident in the farmer suicides documented in Chapter 5 and in the Indian Government's demonizing of traditional healing in Chapter 7).

Thus these children who are not children steal food because there is no food left; 'our bodies have shrunk without food...Don't you see we need food to grow to a human size again?'... they cackle, they rub their organs against Mr Singh, and he realizes that '[t]hey hated the normal growth of his body. His normalcy was a crime they could not forgive' (Devi, 1993: 248-250). This story reminds us that Independence in India was not equal for all, and that even when a country is 'post' colonial, colonialism continues, 'duplicated from within' (Loomba, 1998:16).



In fact, psychiatry may constitute one of the 'withins' from which the colonial relation may continue. Johnstone (1997) summarizes the philosophy of the psychiatric approach as removing power and control from a person, denying their feelings and ignoring the meaning behind that person's actions. She points out that these are the very circumstances that are likely to have led a person to self-injure, or indeed to hear voices, in the first place. Psychiatry's removal of power and control, and denial of meaning, seems akin to the anxiety induced by living in a colonial society, and to that of children who live unequally alongside adults. This hints at a different way of reading distress, discussed later, a Fanonian reading of anxiety (and hearing voices) not as a 'symptom' of an underlying disorder, but as a symptom of oppression – Sartre's (1990:17) 'nervous condition' - this is a psychopolitical reading.

### **The limit figure of the child**

The Mental Health Act ([1983]2007:183) frames children's experiences and refusal of treatment as irrational, as part of an illness, delegitimizing and depoliticising such refusals through decontextualizing them, where the 'the reasonableness (or unreasonableness) of the objection is irrelevant'. Using Agamben (1998), we could say that children's refusals are cast outside the polis and deemed apolitical. Not only does this push us to question who has the power to make such decisions, but to attend to the public frame of what constitutes 'reasonableness' and to what can be understood as being 'treatment'.

Here we can see some of the implications of a creeping medicalization and biopoliticization of childhood and of children's rights. This establishes specific parameters of human intelligibility, framing certain experiences (particularly psychosis and self-harm) as 'outside' of 'normal' childhood experience, and thus as in need of 'treatment', usually through medication. This is despite much research and service user testimony that suggests that children are more likely to recover when they don't accept an illness model of hearing voices (Escher et al, 2004).

It seems, then, that hearing voices and self-injury act as tropes in which children undergo a suspension of their ontological status as children, where the absence of such children in legislation is normalized, while their presence is seen as pathological

(Phoenix, 1987). Such children are then subjected to 'treatment' that outside of this psychiatric 'state of exception' would be constituted as legal battery and child abuse (Spandler and Calton, 2008). The lives of children who are mentally distressed thus work to belie the assumption that adults are best situated to protect children and act upon them in their 'best interests'. Children with mental health problems seem to operate as a limit case to universalist claims of child rights discourse. Here children with labels of mental health problems act as zones of indistinction between adult and child, and human and non human, exposing the limitations of rights-based conceptions that employ 'modalities of exception' (Parr, 2008:175).

When professionals begin to question the normality of a child or of a particular experience, such as hearing voices, they are calling on a parochial frame for understanding normality, drawing on a restricted framework for understanding what it means to be 'normal' and to be a child. If this single parochial model (applied with little problematization from developmental psychology, to all children, globally) is employed within legislation and child rights discourse then we will be led to wonder if those children who do not 'fit' with dominant understandings of rationality (arguably Western and patriarchal), or those children who do not fit within our normative boundaries and definitions of childhood, are still children (or still human), or if they are 'exceptional' or 'special', thus presenting us with a limit case of the child.<sup>37</sup> Such 'special' rights, according to Shildrick (2005:36-7), denote a person's failure to achieve particular normative standards, positioning their 'difference as an inadequacy', and constantly re-interpellating them within the law as a devalued identity marked out for regulation. This becomes even more problematic when these models are transposed onto countries of the global South, and on to children who live within the many 'souths' of the global North.

In research with young people who self-injured, conducted by Spandler (1996:99), one young person said that services should provide, 'recognition that it's your way of coping even though they might not agree with it'. Another urged professionals to, 'let people

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<sup>37</sup> See Judith Butler (2009) for further discussion of limit cases in constructions of 'terrorism'.

hang onto the control that they've already took by whatever means (self-harm if they want)' (young person, cited in, Spandler, 1996:95). The medicalization and pathologization of children's lives may work to impede children's resistance and survival being read politically. It may also repeat the initial trauma that children may have experienced through forcibly 'treating' them (arguably infringing on their right to their bodily integrity) or through denying the legitimacy of their experiences. Here children's very resistance and distress becomes pathologized and sanitized through medical and legal understandings and diagnoses. This explicit denial of the personal and political meaning of children's experiences and distress could indeed more helpfully be seen as a process of constituting 'bare life'.

### **Troubling the 'normal' child**

Seemingly such frames of pathologization and medicalization are given coherence through assumptions of a normal developmental trajectory for children. Thus those children who do not 'fit', who do not meet the developmental milestones described (and prescribed) within developmental psychology are constructed in deficit, and often pathologized. However, such milestones and norms are developed from statistical analysis – the means, medians and modes - that strip children from all that tied them to their context and render their lives into abstraction, reducing life 'to one aspect of its being' (Diken and Lausten, 2002:3). It is thus possible to see how we might usefully expand the conception of bare life to conceptualize how legal and medical understandings of children as statistics, abstracted and atomized from their everyday lived realities, can render children's lives as 'bare'.

Such statistical measurement is fundamental to the biopolitical paradigm (Diken and Lausten, 2002), and to the governance of subjects, including children. Thus 'children are regulated and measured . . . in relation to fictitious norms elaborated by dominant models' (Burman, 2008:176), making 'childhood ... the most intensively governed sector of personal existence' (Rose, 1989:123). The requirement of a certain kind of subject within child rights legislation and discourse institutes a slip from description of that subject to prescription, and diagnosis, of who and what that subject, and thus that child, should be. In this process, certain lived experiences and subjectivities are dismissed, or rendered solely as pathological.

The construction of children with mental health problems as 'bare life' could thus be seen as a tactic by which to 'manage' and regulate those children who do not 'fit' developmental psychology's and psychiatry's fictitious norms. Here the medicating of such 'problem' children may work as a techno-political technique to render certain children's bodies as docile, and thus as governable. In this way, psychiatric frameworks work differentially to 'manage' specific populations through derealizing the humanity of particular subjects, such as children with mental health problems. One such technique for managing a population, then, is to construct them as less than human, or as in the case of hearing voices and self-injury, as outside of what is publicly recognized as 'normal' human experience. Thus 'managing' children with mental health problems (or any population) is not just a process whereby subjects are constituted as a subject (i.e. as psychotic), it is also a process of de-subjectivation and regulation (Butler, 2004). This, for Butler (2004:163) raises the 'question of how power forms the field in which subjects become possible at all or, rather, how they become impossible'.

Here we might fleetingly glimpse how 'the law is never impartial but always caught up with strategies of power and with a discursive violence that seeks to grasp and domesticate the troublesome other' (Shildrick, 2005:31). In this way, the law, shot through with psychiatric assumptions, works to domesticate those 'troublesome' children who don't easily 'fit', often through psychiatric 'treatment'. Here attempts to make children 'normal' raise important ethical questions around what we claim to 'treat' children for.

It is paradoxical and dangerous that professional and medical claims to take children's best interests seriously, an assertion key to the UNCRC, often conflict with children's actual interests and can work to deny children's lived experiences. Difficult issues need to be addressed here. What are the ethical implications of 'treating' or 'fixing' children if we conceptualize their experience psychopolitically - not as a pathology or mental illness but as an emotional protest to social inequality, or as survival strategies and resistance to traumatic conditions?

Rather than asking what tools we need to bring such children's lives into the public domain, based on recognition and identity struggles, we need to begin by 'calling into question the framework that silences the question of who counts as a "who"—in other words, the forcible action of the norm on circumscribing a grievable life' (Butler, 2004:164) and a livable life. As Butler (2009:42) remarks, in relation to the experiences of Palestinians living under Israeli occupation, and in which here we might see in relation to children's realities, these 'are not undifferentiated instances of "bare life" but highly juridified states of dispossession'. Lives constructed by psychiatry as lost, or not yet lost, but almost lost, are then 'both expelled and contained . . . saturated with power' (Butler, 2009:40). This calls for the need to develop new conceptual understandings of how children's lives that are constituted as 'lost' may be cast outside the polis while remaining explicitly politicized. (I return to this question through a different lens in Chapter 5).

While exploring how psychiatry may construct these lives as 'bare', it seems important from the point of view of young people's stories to resist such a conceptualization. Although Agamben (1998) may say that resorting to acts of resistance through the body epitomizes 'bare life' (Diken and Lausten, 2002), for example through self-injury, it seems key for young people to conceptualize their experiences and strategies as politically significant. Thus we must recognize children's experiential right to develop their own understanding of their experiences. In this way, 'bare life' is not just a description of certain children's experiences, it is a critique of psychiatry's frameworks of intelligibility, and a call to action. This will involve engaging with children's experiences and behaviour, survival strategies and acts of resistance, as meaningful, psychopolitical, and often coherent, responses to material and discursive violence.

Such issues lead us to grapple with how those children who serve as limit cases to the 'normal' child, challenge us to rethink our notions of child rights and what it means to be a child. Instead of framing children in terms of deficit within a pathogenic model, we might explore what new conceptualizations of life might mean, to embrace a pluralism of what it can mean to be a child, what it can mean to be distressed, and of more equitable ways for children and adults to exist together in the world. Here 'the final

test for our skill to live a bicultural or multi cultural existence may still be our ability to live with our children in mutuality' (Nandy, 1987:75).

### **Global Mental Health / Global Childhoods**

To draw upon children labeled as having mental health problems as 'limit figures' that trouble assumptions of the 'normal' child is also key in questioning the exporting of 'Western' (often American) developmental psychology to India. This calls for the need to explore the interlinking tropes of developmental norms that govern both constructions of child development, and of international and economic development (see Burman, 2008). Such troubling should be central to a critical analysis of the Movement for Global Mental Health, which targets children and adolescents as a 'special group' for intervention (WHO, 2001b:25). As within much Global Mental Health advocacy, children are justified as a target group through calculations of prevalence, such as the Global Burden of Disease Report (1996). This found that 10-20% of children and adolescents are affected annually by psychiatric disorders, with their psychiatric morbidity accounting for five of the top ten leading causes of disability for those aged 5 and above (Murray and Lopez, 1996). Thus research suggests that 'mental disorders are the major contributor to disease burden in this age-group' (Patel et al, 2007:1302).

Focus on children and young people is further justified because most mental disorders begin early in life, though are usually detected later, and because 'suicide is a leading cause of death in young people' (Patel et al, 2007:1302). However, despite this high 'burden' of mental illness among young people, 'provision of mental-health services is weakest during adolescence and youth' (Patel et al, 2007:1308). This is framed as a public health concern through a largely economic register, where mental disorder is seen to reduce the likelihood of young people completing school and establishing themselves in the job market.

This tying together of mental health and education occurs not only through mental illness being framed as adversely affecting education, but also in the educating of young people about mental health, through 'psychoeducation' and mental health and emotional literacy campaigns. It is unsurprising then that Global Mental Health advocates often call for the embedding of mental health services for young people into

schools and generalized youth settings, and that for the WHO, (2001) 'schools are becoming the most appropriate venue for health related interventions for children' (WHO, 2001b:25). (This is discussed in more detail in Chapter 6).

Thus Patel et al (2007:1306 & 1309-10) argue that 'mental disorders in young people have a substantial effect on economic and social outcomes into adulthood' and that 'youth mental health is not just a psychiatric issue, but affects all sectors of society'. Here '[a]ddressing young people's mental-health needs is crucial if they are to fulfill their potential and contribute fully to the development of their communities' (Patel et al, 2007:1302). This ties young people's (mental) development to the development of their communities, and arguably to the nation-state, where 'the soul of the young citizen has become the object of government through expertise' (Rose, 1989:134). It also highlights how the trope of the child as the future, as an 'idea and a target' (Rose, 1989:123), as a 'window of opportunity', works as a 'strategy for political abstraction' (Burman, 2008:5). Here Burman (2008:5) is alluding to how 'childhood' may operate as 'a retroactively constructed life stage formulated as futurity such that culture and history are erased', deferring political action onto the child, the next generation.

Patel et al (2007:1306) further advocate for the incorporation of the principles of developmental psychopathology into epidemiology, what they term 'developmental epidemiology'. However, if we attend to the previous attempt to trouble assumptions of a normal developmental trajectory for children (and particularly to Burman's ([1994]2008) work on deconstructing developmental psychology), it becomes worrying to apply this model to epidemiology - the study of populations. If such models of development are problematic even within those countries from which they emerge, then their global application seems in need of rethinking. Furthermore, for Burman, (2008) as development discourse (both child and economic) fails to deliver what it claims to know, it thereby, precisely through this failure, paradoxically creates increasing technical devices for its proliferation. This proliferation enables the slipping away of markers of difference (gender, culture and so on) in the very presumption of the models' global applicability.

### **'McDonaldization'**

This global application, alongside policies that promote aggressive capitalism, affect how we understand children and their health and tend to promote, according to Timimi (2010:686), narrow biomedical understandings, which often facilitate a rapid growth in psychiatric diagnoses, and in technical, often pharmaceutical, interventions - the 'McDonaldization of children's health'. We have seen how these bio-medical understandings work to construct certain people as 'outside' of rights discourse through the trope of the 'unsound mind', preventing certain people from being able to refuse or meaningfully consent to often technical, pharmaceutical interventions that many experience as violent.

Patel et al's (2007) call for 'developmental epidemiology' thus seems to be an example of the proliferation of particular models of development, and their assumed global applicability. However, Global Mental Health has been greatly influenced by anthropology and often makes reference to the importance of 'cultural factors', which are seen as 'a major influence on mental health, as evidenced by the large variations in the prevalence of mental disorder between different cultures' (Patel et al, 2007:1304).

Here the recognition of culture centres on differences in prevalence, seemingly omitting recognition of any differences in understandings of mental health and illness itself. Here mental illness is assumed to exist, but in different rates according to culture (with certain cultural factors portrayed as acting as 'protective factors') (Patel et al, 2007:1304). Thus operating in a similar vein to how Escobar (1997) sees development discourse, as working through a 'perpetual recognition and disavowal of difference' (Escobar, 1997:93). (This process is discussed further in chapter 8, in reference to the work of NGOs in India with people labelled as the 'homeless mentally ill'.)

This echoes Nieuwenhuys (2009:148) assertion that development agencies push the global South for 'the emulation of a kind of childhood that the West has set as a global standard', and any move against this standard is dismissed as 'cultural relativism' - 'as attempts to challenge the innate, universal rights of children'. This leaves the role of Indian researchers into studies of childhood as solely to 'fill in the gaps in quantitative knowledge, not to question underlying assumptions about the problematic aspects of



childhood in India' (Nieuwenhuys, 2009:148). Nieuwenhuys (2009:147) further points out that the construction of the 'innate' rights of children was also invoked to justify colonial assumptions of cultural superiority, with 'Indian ideas about childhood discarded as irrelevant, or at most bizarre, to be tolerated only as long as civilization had yet to perform its mission'. Thus perhaps 'the greatest injustice done to children is claiming ownership over what childhood is or ought to be', globally (Nieuwenhuys, 2009:151).

Thus cultural differences are recognised, taken note of, and then to some extent disavowed, preventing them from being used to question the assumptions of psychiatry, or development; or from disrupting the very frameworks that operate to 'recognise' difference in the first place. This process then enables the WHO (2001b:33) to make statements such as,

Since child mental health symptoms do not differ significantly across cultures, it is feasible to use expertise from child psychiatry services in developed countries to compile training packages for primary care workers in developing countries.

Despite recognition, in this statement, of the possibility that cultural differences may be a factor, this is then taken into account by the WHO, in order to be pushed to one side in favour of an assumption of the universal applicability of mental health, and of the expertise of those in 'developed countries'. Part of the lack of expertise in LAMICs is attributed, by the WHO (2001), to a lack of trained child mental health professionals. Only 7% of countries have a specific child and adolescent mental health policy, there are large variations in terms of children's mental health policy between HICS and LAMICS, with 78% of HICS having such policy, while no LAMICS have one (Patel et al, 2007). For Patel et al (2007:1309-10),

It is ironic that, although substantial investment has been made in mental health promotion and interventions for young people in many developed countries, no equivalent acknowledgement of mental health needs of young people exists in developing countries. The priorities for young people seem to

be different in rich and poor countries. We disagree with this dualism. Young people in every society have mental health needs.

In this way, Global Mental Health advocacy comes to call for the recognition of the universality of mental illness, and of a category of people called 'children' and 'young people'. It does this in order to call for global equality in access to mental health treatments. This is not the only equality called for, as not only are countries of the global South seen as lacking in comparison to the expertise in those of the global North; psychiatric services for children are seen to 'lag behind' those for adults (WHO, 2001b:25). Here the argument is that 'children and adolescents with diagnosable serious mental illness require treatments analogous to adult treatments' (WHO, 2001b:33). Thinking back to UK mental health case law, this is interesting because while adults with a diagnosis of mental illness may technically be able to refuse psychiatric treatment (though this in reality may be rare), children seemingly have no right to refuse. Thus while the treatments are evoked as being the same, suggesting that the underlying 'illness' is also the same, the rights that adults and children are accorded vary widely. Seemingly, also at work here within Global Mental Health is a process by which countries of the global North come to stand in as the figure of the adult, and the South as the child (who often may not be able to refuse).

## Chapter Four

### **Normal violence: Violence with a Civilising Mission**

*A chapter on the adult/child and the north/south; on the figure of the child-like and the primitive; on when we do and do not feel horror, on constructions of crisis and emergency – both individual and national, on violence that we see as normal, natural, necessary, banal and bureaucratic, on violence with a civilising mission.*

### **The Child-like – infantilizing the global South**

While the last chapter traced how individual children with a label of mental health problems may operate as limit figures within UK law, it is also worth noting how the trope of the 'child' or the 'child-like' may more generally function to justify governance through a discourse of protection and 'best interests'. Taking this further this chapter will focus on how the child who cannot refuse treatment connects to other 'limit figures' within psychiatry and Global Mental Health - the 'treatment unresponsive' patient, the 'poor country', and the individual and national 'emergency'.

In colonial constructions of non-Europeans (and women more generally) the trope of the child was a key mobilization, in that such constructions framed non-Europeans as being,

ripe for government , passive, child-like...needing leadership and guidance, described always in terms of lack-no initiative, no intellectual powers...; or on the other hand, they are outside society, dangerous, treacherous, emotional, inconstant, wild, threatening, fickle, sexually aberrant, irrational, near animal, lascivious, disruptive, evil, unpredictable (Carr, 1985:50).

Thus colonial constructions of the Orient as 'backward' and 'wild', populated by irrational, primitive natives in need of civilizing and rescue, for their own good, has its parallels with psychiatry's construction of particular categories of people as 'irrational', 'violent' and 'dangerous'. Here the trope of the child may operate to diminish assumptions of self-determination, linking to colonial constructions of the Orient as 'backward' and 'wild'. While the child labelled with mental health problems may represent a normalised absence / pathologised presence within legislation (Phoenix, 1987), for Cannella and Viruru (2004:2) the child is an 'invisible presence' within colonial discourse, raising concerns about the epistemic violence of 'labeling younger human beings as "children"'. Nandy (1983:11) seeks to examine this 'subsidiary homology between childhood and the state of being colonized', and for Nieuwenhuys (2009:149) this 'colonial conflation of the colonized with the figure of the child' needs to be interrogated to enable a deconstruction of 'childhood as a metaphor for institutionalized violence visited upon humanity in the name of progress'.

Thus as psychiatric treatments and concepts of childhood are globalised in the name of 'progress', increasing numbers of people come to be cast as 'outside' normality, and outside humanity; a set of people who can be intervened with, rescued and 'treated' by others in their 'best interests', with or without their consent. This raises the fundamental question of, '[w]hat gives some people the right to determine *who* other people are and to decide what is right for others?' (Cannella and Viruru, 2004:9).

Burman (2006) explores how the 'needy' child (appearing within much charity advertising) works through not only being generalised to all children of the global South, but comes to stand as an idiom of 'need' for the whole of the global South. The interrelation of binary pairs such as adult / child and North / South come to equate the South and the child as the same, constructing them as 'other', showing how binary pairs can get their meaning from each other. The binary oppositions that create this 'other' can then be used politically to construct the privileged position, Northern adult, reinforcing this groups' knowledge and competence over the 'other' and justifying their 'help' and intervention.

Thus the North is seen as adult-like while similarly adults come to represent the values of the North, resulting in the South being constructed as child-like: the infantilisation of the global South (Burman, 2006). In this way boundaries between Northern adult and child are reproduced through relations of paternalism between the North and South (Burman, 1994) (a paternalism echoed in case law around children with mental health problems). This can lead to a double bind for Southern children, who are not only represented and conceptualised as subordinate to adults because they are children, but are doubly subordinated because they are children of the South, and arguably triply subordinated by a label of mental illness (resonating with the 'double colonisation' experienced by many women of the global South) (Ashcroft, et al, 2000).

While the child acts as a trope through which the global South is understood - marking the infantilisation of the South; madness also comes to be equated with the global South, invoking the colonial construction of 'the madness of native India', the maddening colonial encounter that 'induce[s] madness, they are madness itself'

(Loomba, 1998:117). This is reflected in the common practice in colonial India of the coloniser's sending their children back to Europe to spend most of their childhood, as it was presumed that if they stayed in India they would become 'stunted in growth and debilitated in mind' (Lord Roseberry 1843, cited in Ernst, 1997:167). Here India comes to represent the figure of madness, the figure in need of 'treating'.

### **'Treating' the 'Poor Country'**

It was a brilliant cure but we lost the patient (Ernest Hemingway, who committed suicide shortly after receiving ECT in 1961, cited in Hotchner, 2005:280).

One psychiatric 'treatment' that has sparked numerous debates (particularly in India) is Electro-Convulsive Therapy (ECT). ECT involves passing an electrical current through the brain, eliciting a seizure. This seizure is characterized by convulsions, caused by the simulated brain activity due to the electrical current. Generally, a muscle relaxant is administered to minimize muscular contractions, which can cause bone fractures and dislocations. However, the muscle relaxant paralyzes the respiratory muscles, and so the person undergoing ECT is artificially ventilated during the procedure (Andrade et al, 2012).

Recent reports from the USA document the use of ECT for 'correcting' the behaviour problems associated with autism, telling the story of an eight year old boy who self-injured and who was thus given 15 sessions of ECT (Chieco, 2009). The fact that the ECT reduced his self-injury was thus seen as a justification to develop this 'therapy' for use on more children with Autism. But why is self-injury constructed as an act of violence while ECT is constructed as 'treatment', despite some of the injuries it causes (see below)? Seemingly then the irony of conceptualizing ECT as a 'treatment' to stop self-harm is lost, calling into question what can be recognized and defined as violence, and who decides?

In 2001, Saarthak, an NGO working for people with mental illness in India, filed a petition to the Supreme Court of India highlighting their concern that 'mentally ill persons are being subjected to some of the most inhuman and callous treatment in

State and private institutions' (Saarthak vs Union of India, 2001:14). A key area of their concern was with the use of direct (unmodified) ECT.<sup>38</sup> This is ECT without the use of an anesthetic - widely practiced in India (Agarwal, Andrade and Reddy, 1992). The petitioners highlighted some of the problems associated with direct-ECT, including bone fractures and dislocations due to uncontrollable motor seizures; and memory loss (both temporary and permanent) (Davar, 2003). Thus the petitioners called 'to prohibit direct-ECT, making it a penal offence' (Saarthak vs Union of India, 2001:16). However, in response to Saarthak's petition, the Delhi Psychiatric Society (2002:9) filed for impleadment to the Supreme Court, saying that,

there are certain situations where it becomes imperative, for the health and well being of the patient himself/herself that he/she cannot be given modified ECT because the patient cannot be administered anesthesia.

The 'certain situations' constructed by the Delhi Psychiatric Society, fall loosely into two threads; the construction of the 'violent' patient, and the argument that India is a 'poor country'. Thus the Delhi Psychiatric Society (2002:9) argue that,

If the patient is so violent, an intravenous injection of anesthetic can't be given [because the patient] is continually disrupting the procedure...it is not an easy task to give an injection in the veins to a violent patient.

They go onto say that,

suicide is a common complication of depression...hence, it is a serious medical emergency for severe depressed patients. Suicidal patients, therefore, require active, intensive and prompt care so that their lives can be saved, this direct ECT would save the life of the patient. Thus, one needs to recognize that there is a continued role of unmodified/direct ECT for treatment of severely ill (Violent, Suicidal, treatment unresponsive cases) patients (Delhi Psychiatric Society, 2002:10-11).

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<sup>38</sup> The petition also called for changes in the use of physical restraint and single isolation cells in State Mental Hospitals.

Alongside these 'violent, suicidal' and 'treatment unresponsive cases', literature justifies direct-ECT in India because anesthetists aren't always available and anesthesia raises the cost of ECT, meaning that direct-ECT is the most 'cost effective' form of psychiatric treatment (Andrade, 2003). However, Pathare (2003:11-12) calls into question the argument 'that there is a special case for permitting direct-ECT in India because of the lack of facilities for anesthesia and to reduce the costs of treatment'. Such arguments tend to be framed around the premise that,

in a resource poor setting, we have to compare existing alternatives, use the cheapest means available for cure, and not go for the most ideal. If the choice were between no ECT and direct ECT, then direct ECT is considered to be the more "ethical" alternative (CAMH, undated:14).

Here then the issue is not whether India is or is not a poor country (or whether some people who are distressed are sometimes violent or not), but what the mobilization of it as a 'poor country' serves to legitimate and justify. As the Center for Advocacy in Mental Health, at the Bapu Trust in India, point out,

On the basis of the argument that India is a "poor country" and the poor need quick alternatives, justifications have also existed for various invasive and undignified "treatments", such as mass sterilization, and hysterectomies, in the case of mentally challenged girls (CAMH, undated:20).

Pathare (2003) highlights that the routine prescription of direct-ECT in India, based on the 'poor country argument', works to prevent the development of alternative psychological and community-based resources and services. Also, the debate becomes limited to the pros and cons of direct versus modified-ECT, silencing debates about the ethics and indeed scientific validity of ECT at all as a form of psychiatric treatment. In fact, the Delhi Psychiatric Society frames ECT as a controversy 'sustained by the persistent activities of the anti-psychiatry movement that find ECT a sensitive and vulnerable target' (writ petition 562, 2002:8). Drawing on a citational matrix of Western (particularly UK and American) psychiatry to show that ECT is both safe and efficacious,



they claim that the only issue is around consent to invasive treatment. For the Delhi Psychiatric Society (2002:9), 'old is gold' and ECT remains a key treatment.

### **When we will and will not feel horror**

How do these 'certain situations'; the tropes of the violent individual and the poor country, work to enable ECT to be justified as ethical, 'imperative' and 'life saving'? Leonard Roy Frank (2011 -online), a survivor of ECT asks,

Why is it that 10 volts of electricity applied to a political prisoner's private parts [genitalia] is seen as torture while 10 or 15 times that amount applied to the brain is called "treatment"?

In fact, the Convention for the Prevention of Torture (2002) recognizes and prohibits the use of electric shocks as a form of torture. Thus it would seem that the evocation of the 'poor country', and the 'violent', 'suicidal' and 'treatment unresponsive' individual, as well as the 'mentally ill' child (of the previous chapter), work alongside each other to change our normative recognition of violence, and to legitimate and sanction violence in the name of 'treatment'. 'Noah' – a survivor of ECT from India - describes this experience; 'I was bundled into the car and driven off to a government psychiatric facility. A long and unending night of torture in the name of treatment awaited me' (Noah, cited in Minkowitz and Dhanda, 2006:44). Thus the 'violent' and 'irrational' individual work as powerful devices in changing direct-ECT from a method of torture into what the Delhi Psychiatric Society justify as 'a necessary evil' (Delhi Psychiatric Society, 2002).

### **'Nothing Shocking about Shock'**

More than simply justifying ECT, Chaitanya Mental Health Care Centre, in Pune, organized a seminar day on the 'Myths and facts of Electro Convulsive Therapy (ECT) or shock treatment in psychiatric care', in 2007. Held on April Fool's day, the invitation letter explained that the seminar aimed 'to eradicate foolish myths and phobias on ECT', and a large poster declaring, 'Nothing Shocking about Shock' was widely distributed (Bapu Trust, 2007). Members of the Bapu Trust organized a protest on the

day, and reported the day's occurrences in an article on the MindFreedom website (which I will briefly summarise here).<sup>39</sup>

The day began with a talk by Dr Yusuf Macheswalla (a co-organizer of the event), and a psychiatrist in Mumbai. He advised that ECT may be used as the first line of treatment in the management of Schizophrenia and related mood disorders, and that it can be used safely in young children and pregnant women. According to Dr Macheswalla, he uses ECT on children, noting 'that the treatment works wonders with "young people who seem aimless and are drifting"' (Bapu Trust, 2007). He said there were no side-effects to ECT and that the use or not of anesthesia makes little difference. In his practice, he commonly administers up to 14-16 ECT treatments, but there is no upper limit, and he has given up to 208 ECT treatments on one patient. He charges between Rs. 1000 to 5000 per ECT, but if bought 'in bulk' (30-40 ECTs) patients 'may receive one or two ECTs free of charge'. Dr Macheswalla went onto explain that ECT is easier to subsidize and less time consuming than psychotherapy. When questioned about consent for ECT 'he pointed out that the nature of mental illness is different from the nature of physical disease: Anyone suffering from the former has no insight' (Bapu Trust, 2007). Not only are those with a label of mental illness assumed to lack insight, but fear of the 'procedure is treated as an irrational symptom of mental illness, and sedation or anaesthesia is used to remove this particular symptom' (Bapu Trust, 2007).

I wasn't in India to attend Dr Macheswalla's seminar day on ECT. However, I was there when Masina Hospital, housing one of Mumbai's oldest and foremost psychiatric wards, where Dr Macheswalla worked as the head of the psychiatry ward, was 'slammed by the Directorate of Health Services (DHS) for rampant violations of the Mental Health Act (1987)' (Moghul and Shelar, 2011). Here are some statements from the report in the Mumbai Mirror:

City's foremost mental hospital uses banned therapies, detains patients illegally...forcefully administering psychotropic drugs to the detainees...detained many patients without their consent and in all possibility, they are

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<sup>39</sup> See MindFreedom website - <http://www.mindfreedom.org/kb/mental-health-abuse/electroshock/pune-india>

administering drugs which may be worsening their condition (Moghul and Shelar, 2011).

Committee members of the Directorate of Health Services said that at the hospital 'relatives were overcharged. Often the patients are being drugged even when it was not required', meaning that the hospital 'makes money for itself and pharma firms, by extending their stay' and prescribing unwanted medications (Dr Vinayak Mahajan, cited in Moghul and Shelar, 2011). For the Bapu Trust (2007), it is this commercial incentive for administering ECT that needs examining.

Despite the matter coming under the purview of the Human Rights Commission, Dr Macheswalla said that, 'ours is the only psychiatric ward in the city. We cannot close down because of such minor drawbacks' (Dr Macheswalla, cited in Moghul and Shelar, 2011). Further 'minor drawbacks' emerged as Bapu Trust (2007) alleged that Dr Macheswalla administered ECT to children as young as 4 years old, and drove a mobile ECT van under the guise of a 'community service' that 'picks up "unmanageable" patients at the doorstep and delivers shock in the van'. More than highlighting the horrifying practices of some 'bad' psychiatrists, such stories make evident how particular tropes – 'unmanageable' patients', 'aimless' children - work to justify violent acts in the name of treatment. It also serves to highlight the financial incentive in providing certain psychiatric interventions, the economics of mental health (discussed by Bhargavi Davar in an editorial of the mental health advocacy newsletter 'Aaina').

While the 'treatment' at Masina Hospital in Mumbai came to be recognized within media reports as horrifying and violent, and thus not counting as 'treatment', other acts that mobilize tropes of 'mental illness', the 'unmanageable' and the 'irrational', may not be recognized as violent. Healy points out that,

the drugs used to treat ADHD are the same [chemically] as speed and cocaine. We react with horror to the idea that our kids would use such drugs, but don't react about drugs such as Ritalin being given to them', by doctors (Healy, cited in Fowler, 2010:21).

This raises important ethical questions around what governs our affective responses to different forms of violence and what regulates when we will and will not feel horror. The limit figure of the 'mentally ill' thus seems to work as a powerful device to change normative recognitions of violence. According to Judith Butler (2009:159), "[h]orror and 'outrage' are differentially distributed' and we thus need to examine the occasions on which we feel horror as our dominant affective response and those where feelings of horror are absent. Although Butler is discussing these issues in relation to acts constructed as terrorism, such dilemmas have particular relevance for what is constructed as 'treatment' for people who are distressed, and when and how this can be understood to be violent. This raises questions of how we can conceptualize contemporary forms of 'treatment', how we can compare them and name new normative judgments, and in what vocabulary we will make these judgments (Butler, 2009).

### **When one of the side-effects is death**

The violent, suicidal patient also figures in some pharmaceutical companies' justifications for clinical trials and in the promotion of drugs. For example, 'physicians speaking for Glaxo [Smith-Klein] exhort doctors to detect and treat depression on the basis that treatment will reduce risks of suicide' (Healy, 2006:23). However, David Healy (2006:23) documents how psychiatric drugs trialed on children were actually found to increase suicidal behavior and yet remained unpublished. Internal company documents, not made public, showed that in one trial, 9% of children given the anti-depressant Zoloft made suicidal acts. While in Glaxo's trials of Paxil (another anti-depressant), there was a 5% suicidal act rate, compared to 1% in children taking the placebo (Keller et al, 2001). Here anti-depressants are evoked as humane violence, violent interventions that reduce suicide, thus enabling increases in prescribing (in the UK, from 9.9 million in 1992, to 27.7 million by 2003) (Mental Health Foundation, 2005). This, then, occurs alongside growing evidence of the increased incidence of 'side effects,' ranging from self-harm and suicide to alleged homicide (Bendelow, 2010).

Here the fact that children (and adults) are actually statistically more likely to be violent after having taken medication, and more likely to attempt and commit suicide, is then not considered as knowledge and is subsequently not made public. In the process of

publication of trial results, arbitrary numbers and percentage levels are used to establish what pharmaceutical companies will count as relevant. Thus, in one publication of the Zoloft trial, with its 9% occurrence of suicidal behaviour in children, the authors decided that they would only report on side-effects (of which suicide was one) that occurred at a rate of 10% or more (Healy, 2004). After viewing one of Astra Zeneca's adverts for Seroquel XR, an anti-psychotic, on YouTube, there is a comment referring to the long list of side-effects mentioned in the advert. The comment says; 'You may end up dead, but at least you won't commit suicide'.<sup>40</sup> And indeed if you do commit suicide it will seemingly be because you are 'mentally ill'.

Due to the dominance of pharmaceutical frameworks for understanding behaviour, non-medical alternatives rarely figure as a choice for those who are distressed. In fact the medical profession constitutes the key target of pharmaceutical company marketing strategies, and research consistently shows that marketing strategies and interaction with drug company representatives largely influences doctors' prescribing practices (Wazana, 2000). Joanna Moncrieff (2003) points to how the influence of the pharmaceutical industry on psychiatry reinforces narrow biological conceptions of experience, drives expansion of bio-medical frameworks of understanding into wider areas of everyday life, and forecloses public debate about the adverse effects of psychiatric drugs. Such pharmaceutical colonization and medicalization of adult's and children's everyday lives is particularly worrying because the huge commercial incentive to construct particular experiences as 'mental illness' changes our view of what it means to be a child, and ultimately to be human. This financial incentive is apparent in the fact that while AstraZeneca were fined \$520 million for illegal promotion of anti-psychotics to children and the elderly; between 1997 and 2009 their total sales made on Seroquel (an anti-psychotic) equalled \$21.6 billion (Wilson, 2010).

### **'Normal' Violence**

It is in these banal calculations of what count as side-effects and how many suicide attempts are seen as statistically significant - the considerations as to what counts as acceptable collateral damage - that psychiatric violence has its political effect. Here a statistical, 'normalized, everyday, "rational" and bureaucratized violence' (Burman,

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<sup>40</sup> Comment on Youtube [http://www.youtube.com/watch?v=vUBjO7J\\_UpM](http://www.youtube.com/watch?v=vUBjO7J_UpM)

2010:47) is perpetrated; a banal violence that renders certain children's lives as necessary collateral damage within pharmaceutical research. In fact, increasing numbers of lives are becoming pharmaceutical collateral damage with the growth of the clinical trials industry in countries of the global South; testing drugs on the world's poor (Shah, 2006 ). (See chapter 7 for a more detailed discussion of this). This is both a violence that is rendered 'normal' and a violence that is apparent within techniques of normalization.

For Yep (2003:18), '[n]ormalization is a symbolically, discursively, psychically, psychologically, and materially violent form of social regulation and control'. Akin to Hook's (2005:478) description of the violence of colonialism; 'the colonial moment of epistemic, cultural, psychic and physical violence makes for a unique kind of historical trauma... [meaning that] the violence of the colonial encounter is absolutely unprecedented'. This is a historical trauma that is arguably also at work in the multiple layers of violence that occur in the name of psychiatric 'treatment' traced in this and the last chapter.

If we assume that some violence is justified, by the law, the state and by psychiatry, then normative judgments about what can be understood as violence and as 'treatment', and who counts as human, are built into our very definition of 'treatment'. Some of the terms in which violence and normality can be conceptualized, then, may 'dispose us in advance towards certain kinds of moral responses and normative conclusions' (Butler, 2009:156). This is particularly important in debates about what constitutes 'treatment' and what counts as an emergency.

### **Bapu Trust and the 'severely disturbed'**

This need to rethink definitions of crisis and emergency is key even when a system has been put in place to prepare for a crisis, such as the use of Advance Directives/Statements,<sup>41</sup> for as Bhargavi Davar explained to me (in an interview),

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<sup>41</sup> Advance Directives/Statements enable people to plan out their care in advance, for the times when they are distressed or in 'crisis'.

if you are refusing treatment for mental illness then your advance directive is not valid, and someone can take over decision making. And under emergency situation advanced directive is cancelled. I would think that an advance directive is of critical value in an emergency situation.<sup>42</sup>

For furthermore, alongside the construction of the individual 'emergency' within psychiatry, is the mobilization of 'mental illness' itself as a global emergency, with urgent calls that we are currently 'facing a global human rights emergency in mental health' (BBC, 1999). Thus the mechanisms by which certain forms of distress are framed as 'mental illness' (particularly psychosis or Schizophrenia) and understood as 'outside' of normative conceptions of human experience, may work to de-familiarize the discourse of global emergency. This helps us to understand how violence against those labeled as 'mentally ill' in the name of 'treatment' can coexist alongside the strong push for human and children's rights, through a process of framing hearing voices and self-injury as 'psychotic', as outside the realm of 'normal' experience and thus outside the parameters of human and child rights (Spandler and Calton, 2009). Here labels of 'irrationality' and 'violence', along with hearing voices and self-injury, act as tropes in which humans undergo a suspension of their ontological status as humans.

Once constructed as 'mentally ill', of 'unsound mind' or as 'dangerous', people seem no longer to be regarded as subjects, they are 'humans who are not conceptualized within the frame of a political culture in which human lives are underwritten by legal entitlements, law, and so humans who are not humans' (Butler, 2004:77). This enables a different reading of a 'global human rights emergency' created by an increase in mental illness; to a 'global human rights emergency' created by bio-psychiatric conceptions of mental illness as 'outside' of normality, and thus outside of human rights legislation.

It is perhaps because of this and their focus on human rights, that Bapu Trust (a survivor-led mental health organisation in India) has decided to specifically include such 'limit figures' within their organisational vision.

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<sup>42</sup> Interview with Bhargavi Davar, in Pune, February 2011.

And one of the things that we added to the vision, this year, was that those who are seen as severely disturbed, we would like society to create spaces to include them as well. This we did not have in our vision statement before. But over the years what we figured out is that other people with the so called CMD, that's common mental disorders, and phobias, fears and traumas, for a period of time they do have half a chance of integration, unless they've been so totally doped out with medicines that's impossible. But by and large they do have the half chance to pop back into mainstream life, go back to employment, and get on with life. But it's the so called severely disturbed, that's people who are diagnosed with psychosis, they get pushed out of the margins, so that's why we included them. We've used a lot of psychological approaches in Bapu Trust, but I don't think psychological approaches have been effectively used in addressing the recovery and healing needs of people who are seen as psychotic. Because even in my programmes, it never worked because professionals are trained to think of medicine when it comes to psychosis.<sup>43</sup>

From within a different register, the mobilization of human rights discourse has also been key for Global Mental Health and central in calling for more 'humane' conditions in psychiatric facilities in India, for example in making illegal the chaining of people with mental health problems. A key mechanism in this advocacy, as we have seen, has been to frame mental illness as an 'illness like any other illness', a biochemical imbalance that could happen to anyone. However, labelling people as 'irrational' and 'incompetent' due to mental illness has also been found to increase stigmatisation of such people, despite claims that 'within-brain' explanations reduce stigma. Read et al (2006:313) found that biological explanations may imply that those who experience distress are less human; strengthen the stereotype that they are dangerous and unpredictable; and provoke harsher treatment from others, in comparison to an explanation that emphasises the psychological or the social, such as distress as a response to trauma.

Similarly, Fernando (2010:39) points to the stigmatising assumption that Schizophrenia 'is a medical condition...associated with dangerousness...and, more than anything else,

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<sup>43</sup> Interview with Bhargavi Davar, in Pune, February 2011.



alienness that renders people afflicted with it being beyond understanding, irrational and bizarre; that is the way they are'. The construction of a person as 'beyond understanding' and of 'unsound mind', as alien, may thus prevent the application of human rights to such people and lead to interventions not subject to normative understandings of what counts as violence. If biochemical explanations of mental illness produce increased stigma this has strong implications for Global Mental Health advocacy.

For Patel et al (2007:1309), stigma is one of the key challenges to implementing specialist youth mental health services globally. However, the research above (by Read et al and Fernando) would suggest that it may be psychiatry's framing of mental illness as bio-chemical that contributes to increased stigmatization. This begins to defamiliarise WHO statements such as the following,

As the world's leading public health agency, WHO has one, and only one option – to ensure that ours will be the last generation that allows shame and stigma to rule over science and reason. (WHO, 2001a:x)

The theme of World Health Day 2001 was "Stop exclusion – Dare to care". Its message was that there is no justification for excluding people with a mental illness or brain disorder from our communities (WHO, 2001a:ix).

Here 'shame and stigma' are placed opposite 'science and reason' – and into binaries, as though shame = stigma, and science = reason. However, Read et al's (2006) and Fernando's (2010) research disturbs this binary, suggesting that perhaps science (or particular mobilisations of the scientific) = stigma. Furthermore, if understandings of mental illness as a 'brain disorder' lead to the rendering of those people so labelled as 'alien', provoking harsher treatment from the public, then the statement - 'there is no justification for excluding people with a mental illness or brain disorder from our communities' – becomes strange. Seemingly, then, it is the invocation of a 'brain disorder' that enables an exclusionary logic - both excluding people from their own understandings of their distress, and their exclusion from communities who see them as being alien.

Thus it seems that the category of 'unsound mind' may work in contradiction to calling for more humane treatment, as it renders those who are distressed as being 'outside' normative conceptions of human rights and violence, as 'outside' humanity. So in the very mobilization of distress as being 'unsound mind', Global Mental Health seemingly draws on a similar discourse to that used to justify inhumane or violent treatment within, for example, some practices of temple-healing, in India.

Practices of temple healing in India are regularly publicly denounced as violent and inhumane, often through an 'annual media ritual' to highlight 'the plight of the mentally ill' through exposing the human rights abuses at work in traditional healing sites (Kalathil, 2007). Human rights abuses in psychiatric hospitals in India are also sometimes exposed. For example, here is a summarised excerpt from a report by the National Human Rights Commission of India (1999), cited by the WHO (2003:23).

The National Human Rights Commission of India investigated the 37 public mental hospitals in India housing nearly 18 000 patients...[it found] gross human rights violations occurring in these institutions. ...patients had to sleep on cold damp floors...patients were expected to urinate and defecate into an open drain in public view...Many hospitals had problems with running water, often reflecting a scarcity of waste in the state concerned...Safe drinking-water was not easily available in some hospitals. A shared bucket of water was located outside each ward. During the night, when they were locked up, the patients in many hospitals had to reach through the bars of the ward in order to scoop water into a shared mug. Some of the hospitals did not provide hot water for bathing, even during the winter. Open baths were common...many patients were confined in a single cell. In others, there was one patient to a cell. Many single cells lacked water, linen, beds or toilets. Patients were locked in all the time and had to urinate and defecate in their cells.

There is recognition here by the WHO of the human rights abuses at work in psychiatric institutions, in India. The WHO Atlas Survey found that 65% of psychiatric beds are in mental hospitals 'where conditions are extremely unsatisfactory' furthermore

'violations in psychiatric institutions are rife...many psychiatric institutions have inadequate, degrading and even harmful care and treatment practices' (WHO, 2003:5). Often hospitals become dumping grounds for 'chronic' patients, and places where ECT and drugs come to be relied upon (Higginbotham and Marsella, 1988). A note from my field work diary,

I have been told stories, heard whispers about life in some of the Indian psychiatric hospitals. A lady who regularly visited those detained in psychiatric hospitals told me the women she visited were often kept naked or in loose sacks, their heads were shaved, they weren't allowed to wear bras because they might use them to hang themselves. Sometimes the women, in the 'women only' wards, became pregnant.

But institutionalised care is not only an issue for the psychiatric hospitals. Bhargavi Davar explained to me that NGOs can be custodial too, because

It's easy for a private NGO to start a mental asylum, so a large number of NGOs working in this area are providing custodial services. And so the battle now is between NGOs that are providing custodial services and NGOs that are providing community services. This is a major dilemma. Because the Mental Health Act has allowed only custodial services. We have an almost defunct policy on community mental health, it is not working. We have budgets for community mental health which is not utilised, we have lots of money for community mental health, people don't know what to do with the money. The choice between custodial services and community services is of course also the choice between whether you want to treat someone using force and coercion, or whether you want to leave it to the person to access services that they feel they need.<sup>44</sup>

The WHO (2001a:ix) states that 'every patient shall have the right to be treated and cared for in his or her own community', and that 'broad public support for community care must be secured' (WHO, 2001b:3). The WHO (2003 –front page) says that

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<sup>44</sup> Interview with Bhargavi, in Pune, February 2011.

'[m]ental health care should be provided through general health services and community settings. Large and centralized psychiatric institutions need to be replaced by other more appropriate mental health services'. Many NGOs in West Bengal follow this motto (Das and Chakraborty, 2006). The WHO make this argument because according to the World Health Report,

Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders... [it is] cost-effective and respects human rights... [it can] lead to early intervention... [meaning that] Large custodial mental hospitals should be replaced by community care (WHO, 2001a:xi-xii).

While the WHO recognizes the violence enacted in the name of treatment here, both within traditional healing settings and in psychiatric institutions, this seems bound to a denouncement of institutional care as being open to human rights abuses. Here it does not seem to be psychiatric practices more generally that are being recognized as potentially violent. Thus psychiatry still remains the 'solution'; however it is the site of intervention that needs to be moved from large institutions to the community. However, Peter Campbell, a psychiatric survivor, points out that,

If we are made to feel victims and powerless by methods of dispensing care, if we are made to appear inferior by the systems supporting us, it is more than optimistic to expect that relocating the service-points will miraculously end our isolation. It is what the psychiatric processes are doing to our status and self-image that is important, not where it is happening (Campbell, 1996:60).

There is not space here to develop this discussion. However, this provides another example of how critiques and survivor experiences from some countries in the global North may be usefully taken up to examine some of the problems associated with care in the community before it is 'scaled up' to countries of the global South. In those countries where community care has been enacted, it has not always been particularly successful, and has, in the UK, often led to different forms of control and coercion within the community, including forced medicating (Bracken and Thomas, 2005). Even

the UK Department of Health has justified the push for a recovery model based partly on 'the chaos of community care' (DoH, *The Journey to Recovery*, 2001:4). And in India, while the Central Government's National Mental Health Programme has the goal of providing community-based care for those with mental illness, in practice (and in research) there are many law and public policy barriers to the achievement of this (see Cremin, 2007).

Furthermore, practices such as chaining and beating that sometimes take place at traditional healing sites, are often justified by mobilizing similar tropes to psychiatry's justifications for direct-ECT and forced medicating; through the trope of the violent patient. In a newspaper interview with a member of staff at a Dargah (a traditional healing site, in India), the chaining of over 100 people was justified because 'otherwise they are uncontrollable and pounce on anyone' (Times News Network, 2001a). In another interview, an owner of an Ashram explained that chaining was due to violence, and people were given daily sleeping pills, 'necessary to treat them' (Times News Network, 2001b). Similar claims are mobilised in the Delhi Psychiatric Society's (2002) justification of direct-ECT as a 'necessary evil' (in writ petition 562), and in a comment from a psychiatrist at one of the workshops I facilitated at The Banyan, explaining why the approach of the Hearing Voices Network would not work for the people that The Banyan works with,

some of our clients, upstairs, would bash somebody on the head or intrude into somebody's physical privacy, absolutely do any nasty thing and would say, 'it wasn't me, the voice told me that'.<sup>45</sup>

Here it seems that the 'violent' individual/patient thus works to justify both psychiatric and traditional healing interventions that could both be read as violent.

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<sup>45</sup> Quote from a participant at a workshop I facilitated at The Banyan, on the 30<sup>th</sup> April 2011.

### **'Humanitarian Violence'**

For Kristeva (1982), there is a power to feeling horror, through its capacity to unsettle, to cross borders; its inciting of the abject (a concept discussed in more detail in chapter 8). Such feelings of horror, of disgust, seem to have a visceral quality, they seem to be 'natural' bodily responses that are almost instinctive. Yet examining those times when we do not respond with horror calls attention to the symbolic frameworks that structure these seemingly 'natural' responses, hinting that the bodily and the affective are always tied to dominant normative frameworks of intelligibility. The mechanisms that frame when we will and will not feel horror are then also key to what governs global affective responses to suffering worldwide, particularly as they prevent certain experiences as even being conceptualised as being 'suffering'.

### **Violence with a Civilizing Mission**

This chapter has traced how the mobilization of the interrelating tropes of the 'poor country', the 'mentally ill' child, and the 'violent patient', work to change our recognition not only of what counts as violence but also of who counts as human, evoking the colonial discourse of the 'human and not wholly human' (Lord Roseberry, 1900, cited in Bhabha, [1994]2005:122). In fact, if ECT is 'necessary' and 'life-saving', if it *reduces* violence, then we are prevented from seeing it as violent at all, and are thus unable to recognise those who undergo it as being violated.

This works to prevent 'victims of direct-ECT' from being 'considered as victims of medical torture and brought within human rights and medico-legal jurisprudence' (CAMH, 2003:7). It may also work to obstruct them from being seen, or understanding themselves as survivors of psychiatry, potentially preventing the formation of alliances between those who have undergone ECT or other forms of psychiatric 'treatment'. It would also seem that the mobilization of the 'mentally ill' child and 'treatment resistant' patient, work in a similar way to the framing of mental illness as a 'global emergency', and the trope of India as a 'poor country'; to change the normative frameworks through which it is possible to understand what counts as liveable and grievable lives; for what counts as violence and what counts as 'treatment'; and thus of what counts as being 'ethical'.

Drawing similarities with Weizman's (2010) exploration of justifications for military attacks, psychiatry's use of ECT (both direct and modified) are often presented as a kind of violence that is necessarily employed to *reduce* violence. This is evident in Dr Macheswalla's justification for ECT, as 'the only weapon' he has to treat mentally ill patients (cited in Bapu Trust, 2007). Here ECT is a weapon, then, but not of torture, a weapon in the battle against mental illness, a humanitarian weapon, a weapon of treatment. This is a 'humanitarian violence', sanctioned by the law, to pre-empt and prevent further violence (Weizman, 2010). It is a violence that resonates with colonialism, it is violence with a 'civilizing mission'.

This raises questions of how we can conceptualize contemporary forms of violence. How will we negotiate these different forms, and should they all be understood as violent? By what ethical frames can we recognize and respond to the ordinary, everyday maneuvers of violence, the banality of violence within psychiatric 'treatment', violence constructed as normal, necessary and legitimate (Dhar, 2004). How we can compare and judge such forms of 'violence'? How can we recognize our own complicity? Does this violence secure the ground for wider, more pervasive violence - the violence of normalization, and the normalization of violence? Violence, for example, in the name of economic development, in the name of neoliberal reforms.

Thus reading 'symptoms' such as hearing voices psychopolitically, enables an exploration of them as not only personally meaningful but politically meaningful, in that they may constitute 'rational and resistant reactions to maladaptive environments' (Goodley, 2001:215). It may also enable a way of reading the farmer suicides, in the next chapter, as being 'rational and resistant' reactions to maladaptive global socio-economic environments. To rural India we go.





## Chapter Five

### **'Harvesting Despair'<sup>46</sup> – Writing Suicide Notes to the State**

*A chapter on pesticides and suicides, on global markets and cotton prices, on suicide notes written to the Government, on patenting drugs, on recognition and inoculation, and on the messiness of Neoliberalism.*

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<sup>46</sup> I have taken this from the title of the book by Perspectives (2009). *Harvesting Despair: Agrarian Crisis in India*. Perspectives, Delhi.

## The Suicide District

An increasing number of suicide notes today directly address the Prime Minister...taking the form of a public statement accusing the state of betrayal (Perspectives, 2009:2).

A society that drives its members to desperate solutions is a non-viable society, a society that needs to be replaced (Fanon, 1968:53-54).

Society is much more comfortable dealing with poverty as a mental health problem rather than a social issue (Furedi, 2004:27).

This chapter aims to approach some of the questions that have emerged in the previous two chapters - through a discussion of farmer suicides in India, with a particular focus on the responses to these suicides by the Indian Government and within Global Mental Health literature and advocacy. I aim to draw upon farmer suicides in India as a lens through which to situate the question of what function the conceptualisation of distress as 'illness' serves, and to illuminate what political rationales may be at work in this mobilization. However, farmer suicides in India are more than a conceptual lens - they are a matter of life and death, and thus to draw upon them, to look through them as a lens also implies an ethical responsibility in rethinking how these suicides might be responded to and from what registers this might be possible. While questioning the role of a solely psychological or psychiatric register for understanding suicide, this chapter does not argue for the complete abandonment of this register for a solely structural or economic lens, or for a collapse of the biological and psychological with the economic.

Vidarbha is an area in Eastern Maharashtra, known for the cultivation of cotton, soybean and as a 'suicide district' of India, where from June to September of 2008, there was a suicide every 8 hours (Perspectives, 2009:1).<sup>47</sup> In 2007, more than 4000 farmers committed suicide in the state of Maharashtra (Das, 2011:23). The suicide rate

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<sup>47</sup> I passed through Vidarbha, in central India, on my way to the Indian Association of Women's Studies (IAWS) 13<sup>th</sup> National Conference, in Wardha. My time spent there is tinged with a bitter taste after the local police burst into the room of my hostel and questioned me about my taking part in a protest (see Mills, 2011).

for farmers, in 2004, in Maharashtra was nearly 4 times the national average than for non-farmers; 53 in every 100,000 farmers committed suicide, and in affected areas this was nearly 10 times more (Perspectives, 2009). Vidarbha is not the only 'suicide district' for farmers; there have been over 200,000 farmer suicides since 1997, in India (Lerner, 2010). And farmer suicides are not phenomena specific to India, there are estimates of 300,000 deaths due to self-poisoning with pesticides a year, in the Asia-Pacific region alone (Patel et al, 2007).

The rise in farmer suicides has largely been framed within India and globally as a public health concern because of the resulting premature mortality of men (and some women) that are of working age and thus loss of productivity calculated within an economic register (Das, 2011). Research into farmer suicides in India has led to debates as to what the suicides signify, particularly what the suicides are a 'symptom' of? While the Indian Government tends to conceptualise and respond to farmer suicides through an individual (often psychological and genetic) framework, others call for understandings of farmer suicides to be grounded in a historical analysis of agricultural reforms in India, attending to the current 'agrarian crisis'.

### **Agrarian Crisis**

Until the 1970s, in India, cultivation of many crops relied on indigenous varieties of seed, with little cost to farmers as these seeds were not bought from the outside market. After 1970, with the advent of the Green Revolution, hybrid varieties of seeds were produced, which from the 1980s began to be released onto the market by private seed companies, pushing up market costs of seeds (Perspectives, 2009). In the 'suicide district' of Vidarbha, the cultivation of cotton and soybean has become completely dependent on purchased inputs, meaning that in order to sow seeds farmers must have access to cash or credit, usually borrowed from private money lenders. This reliance on credit puts farmers in a precarious position, as they become particularly vulnerable to crop failure or to price fluctuation of crops in the world market. Until 2003, in Maharashtra, the price of cotton was determined by the State Government. However, since the scrapping of the Monopoly Procurement Scheme the price of cotton is determined by the international cotton market, while at the same time the USA highly subsidises its own cotton production. Therefore currently for farmers there is no

guarantee that their profits will cover cultivation costs (which are also increasing with the introduction of genetically modified crops), thus leading to increasing risks that farmers' will default on loans (Perspectives, 2009). This indebtedness to private money lenders was found by Mishra (2007) to be the main reason given for suicide, with 87% of farmer suicides being linked to debts.

While Das (2011:23) also summarises the findings of research into the reasons behind farmer suicides as pointing to factors such as indebtedness, economic downfall, crop failure, family conflict and addiction, much of this research tends to attribute 'the reasons for suicide to socio-behavioural practices of farmers' (Das, 2011:29). This fails to fully acknowledge the role of the wider agrarian crisis (for example, how volatile economic markets may lead to substance abuse or family conflict, which may then lead to suicide). Government sponsored studies into the causes of the suicides have also tended to be limited to individual-level factors (Das, 2011). Thus the psychology of farmers has been the site of much Government intervention and relief efforts.

Often 'statements have been made suggesting that the victims needed psychological counselling', and the State government of Maharashtra responded by providing 'psychological healing sessions' for farmers (Perspectives, 2009:4). Simultaneously, psychiatry has also provided a platform for intervention, with the former Chief Minister of Andhra Pradesh (Mr Naidu), sending teams of psychiatrists to visit farmers in an attempt to prevent them from committing suicide (Sharma, 2004). Understanding and responding to farmer suicides through a psychological and psychiatric register, what might be called the psychiatrization of farmer suicides, also interweaves with a simultaneous medicalisation, or more specifically, a geneticisation. A glimpse of this emerged when, in 2007, the Indian Government responded to a sudden increase in farmer suicides through launching a study to 'probe the genetic link to the spate of farmers' suicides in Vidarbha'...exploring if there is a 'genetic factor which makes people in a particular community more prone to suicidal tendency' (Arya, 2007 -online).

Thus the Indian Government interprets and intervenes in farmer suicides through the lens of psychiatry and genetics, despite research that suggests that those farmers who committed suicide did so due to chronic stress and not because of pre-existing mental

illnesses (Prasad et al, 2006). It's interesting to note that the Indian Government chose to examine farmer suicides through a genetic register, and respond with psychological and psychiatric interventions. Such Government responses framed through a bio-genetic matrix have been criticised by some as ignoring the systemic nature of the suicides (Perspectives, 2009:4), working to depoliticise farmer suicides, and foreclose critical analysis of the policy context in which the suicides take place. This arguably makes certain lives not worth living, and then reduces analysis of the contributors to this solely to the individual body and mind – a double constitution of bare life.

### **'Why I am giving up my life'**

It seems to be the farmers themselves, in the act of suicide, who call for a political reading of their actions. In fact, '[a]n increasing number of suicide notes today directly address the Prime Minister...taking the form of a public statement accusing the state of betrayal' (Perspectives, 2009:2). One note from a young male farmer said; '[t]he cotton price has fallen to Rs. 1,990 a quintal. We cannot manage with that. Which is why I am giving up my life' (Perspectives, 2009:2). The research team from Perspectives (2009:17), who collected these stories, thus call for recognition that,

[s]uicides by farmers of Vidarbha are not individual acts of desperation but part of a systemic problem located in a much larger socio-economic-political context. It cannot be and should not be reduced to a phenomenon confined to the individual self.

In highlighting the role of the agrarian crisis in farmer suicides, the Perspectives (2009:1) team calls for a conceptualisation of this as 'homicide, not suicide'. Such a polemic is an attempt to create a framework away from individualised causes to highlight the role of the State in making farmers' lives unliveable; illustrating that economic reforms can be literally and figuratively crippling (Loomba, 1998) - they can kill. Thus death itself can be political.

For Hook, the most powerful form of resistance to the oppressive brutality of colonial existence occurred when the oppressed confronted, and brought themselves into a 'living proximity' to death (2012: 33). This proximity to death interlaces with Biko's

'political ethics of death', that is 'the acceptance of death as a constant condition of one's political existence' (Hook, 2012: 32). For Biko (1978:152), '[y]ou are either alive or you are dead, and when you are dead, you don't care anyway. And your method of death can itself be a politicizing thing'. This would suggest placing suicide on a psychopolitical, rather than a psychiatric or psychological, register.

But what does this recognition of the role of the political in farmer suicides do to our understanding of suicide more generally. Rather than demarcate farmer suicides as inherently political, assuming suicide more generally is in the realm of 'mental illness', perhaps this could enable a reading of other suicides as responses to social inequalities and economic reforms in different contexts. This is important when we consider that, '[e]very year, about 800 000 people commit suicide, 86% of whom are in low-income and middle-income countries, and more than half of whom are aged between 15 and 44 years' (Prince et al, 2007:2).

### **The 'Hidden Cause' - From rural India to 19<sup>th</sup> Century France**

According to Hacking (2007:294), the mobilisation of biological and genetic frameworks to understand suicide began in the 1830s, where the brains of those who had committed suicide were dissected to find the 'hidden cause'. Here the counting of suicides, the rendering of suicides into statistics was linked to a search for the 'cause' of suicides within the brain, thus promoting a deterministic 'organic solution to the problem of suicide' (Hacking, 1990:71).

Hacking (1990:65) documents how Esquirol (1838) (who became the French suicide expert) was determined that suicide was 'one of the most important subjects of clinical medicine'. Esquirol tried to establish that a) madness is a matter for physicians and physical medicine, b) suicide is a type of madness, and therefore c) suicide is a matter for physical medicine. Following this logic, doctors (and not priests) should have the job of judging, controlling and preventing suicides; not an insignificant conclusion in a context of large imperial expansion of medicine, and its professions (Hacking, 1990). Hacking (1990:69) goes on to expand Esquirol's syllogism;

a) madness is medical. b) suicide is madness. So, c) suicide is medical. But, d) all disease is organic. So, e) madness is associated with organic defects. So, f) suicide is associated with organic defects.

Exploring the historical conditions of possibility for the medicalisation of suicide and its links to imperial medical expansion may be significant in light of current attempts to analyse farmer suicides through the lens of Global Mental Health, currently dominated by psychiatry. Analysis through a Global Mental Health framework enables particular psychiatric 'solutions' to be made visible to the 'problem' of farmer suicides globally. Within the Global Mental Health literature these 'solutions' tend to centre on the 'effectiveness of reduction of access to pesticides; improvement of medical care for pesticide poisoning in low-income or middle-income countries'; on improvement of treatment for depression; and access to anti-depressants (Patel et al, 2007:50).

Similarly, the World Health Report (2001:xvii) states that suicide prevention should involve 'reducing access to poisons and firearms, and detoxifying domestic gas and car exhausts'. The assumption at work here is that 'mental disorder' is a contributor to suicide, and therefore suicides can be reduced through psychiatric interventions, and through practical interventions, such as limiting access to pesticides and increasing access to anti-depressants. However, Global Mental Health literature does not attribute farmer suicides entirely to 'mental disorder'. For example, Patel (2007:14) acknowledges that '[u]nrestrained economic reforms, which lead to the loss of employment of vulnerable populations in societies with no social welfare net, amount to no less than sanctioning their starvation and the only escape route available to many is suicide'.

Suicide here is an 'escape route', an escape from economic reforms and from poverty. But if this is one of the only means of escape, what might Patel et al's (2007) suggestion of limiting farmer's access to pesticides as a form of suicide prevention mean for farmers? One farmer, interviewed by the Perspectives fact-finding team, illustrated this when he said 'this bottle of pesticide will always be an option' (Perspectives, 2009: back cover). What does it mean to limit access to one of the means that people use to commit suicide as a form of prevention? There is a suggestion here that when people

commit suicide by swallowing pesticides that they do so at a whim, or because they have pesticide close to hand. This suggests that such suicides stem from a sudden decision, a moment of madness, instead of prolonged desperation or oppression. However, there's a further irony here that prevents a romanticised reading of suicide as escape from poverty.

### **Rescue Missions and Benevolent Outsiders**

In India's Green Revolution pesticides were 'aggressively promoted, with huge subsidies being doled out to keep the fertiliser companies afloat' (Sharma, 2004 - online). The result has been devastation to the sustainability of agriculture, 'made flesh' through an increase in farmer suicides (Sharma, 2004). Therefore, pesticides, swallowed as one of the means for escaping poverty, are also part of the reason that an escape is required in the first place. Furthermore, as access to pesticides is also determined by the world market, even this form of suicide becomes dependent on the same economic market and rationale that made life unliveable for many farmers in the first place (for example, in the opening of India's cotton market to the world market). Here, life and death are dependent on and made possible through the working of the global capitalist market.

This is further complicated by the fact that 'the same breed of scientists and policy makers [who promoted pesticides in the first Green Revolution] are now being asked to provide a solution to the prevailing agrarian crisis' (Sharma, 2004 -online). Unsurprisingly perhaps these experts thus push for the increased role of biotechnology and agribusiness in intervening in the agrarian crisis - interventions framed by the same neoliberal rationales that many argue led to the crisis initially. This is also evident in Chakrabarti and Dhar's (2009) analysis of the logic of development discourse employed by Governments and capitalist enterprises to destroy forms of life lived in countries of the global South (a destruction echoing that of colonialism) and then paradoxically, send in 'rescue missions' of NGOs and international agencies to 'help' the dispossessed through acts of resettlement and compensation.

Therefore '[e]ven as it smashes and shatters life within world of the third, the hegemonic (with its organs) strives hard to emerge as the benevolent outsider' – thus



making it so the people of the global South must be grateful for compensation, never losing faith in the rule of the hegemonic (Chakrabarti and Dhar, 2009:186). As the dispossessed splinter out to the border of the camp of global capital, they provide cheap, disposable labour – helping to ‘secure the hub of (global) capital – a hub whose very coming into being has been made possible through the dismantling of *their* forms of life’ (Chakrabarti and Dhar, 2009:186).

Here development discourse can be seen to draw upon two related yet seemingly opposing frameworks; ‘growth through capitalism-induced industrialization that is aggressive and ruthless and poverty management that is, as if, benevolent’ (Chakrabarti and Dhar, 2009:41). In the case of farmer suicides, psychiatry and Global Mental Health advocacy, it seems that the distress and unliveable lives caused by economic and agricultural reforms (pushed by a capitalist agenda that benefits many HICS and multinational businesses) is evoked as being offset by benevolent psychiatric and pharmacological interventions, or more often, there is a failure to recognise any connection between them at all. This is despite the fact that such interventions (particularly in the case of the pharmaceutical industry) are often implicated within the same neoliberal logic as that which contributed to the distress - that which made life unliveable - in the first place. Thus the psychiatric and pharmacological interventions implicit within much Global Mental Health advocacy may be one example of such ‘rescue missions’ , coming to the rescue as the benevolent outsider while simultaneously drawing upon and securing the hub of global capital, the rationale of Neoliberalism. This illuminates yet again the symbolic violence of developmental discourse (child, national, economic and global development) and the material violence made possible through it (as discussed in Chapters 3 and 4, and later in the thesis).

For Chakrabarti and Dhar (2009), this violence is affected on those in the global South along two axis; brute violence and benevolent violence. Brute violence is the violence marked by the logic of development, of dislocation from place as well as from local forms of life, ways of living and understanding the world. This brute violence acts with impunity (and often as we saw in the last chapter is not recognised as being violent at all). Then there is violence that is benevolent, that works through the ‘image of a destitute figure waiting to be rescued’ (Chakrabarti and Dhar, 2009:96). This destitute

figure, 'the wandering destitute' (Shraddha Foundation), is a common image within NGO literature in India and a common justification for the psychiatric interventions carried out by many NGOs, particularly with those who are homeless and distressed (see chapters 6, 7 and 8 for a detailed exploration of this). This takes further the analysis of violent 'treatment' enabled through the tropes of the 'mentally ill child' or the 'poor country', to mobilise a reading of psychiatric interventions as constituting forms of benevolent violence, akin to the humanitarian violence documented in the previous chapter, the 'necessary evil' of ECT (Delhi Psychiatric Society, 2002). This speaks to a continued colonialism, the creation of new dependencies – where to die or to continue living both depend on the fluctuations of the world market, and on the often imported expertise of psychiatry and pharmaceuticals.

### **Psychopharmaceutical Imperialism**

For Tsao (2009:1), 'blinkerered conceptions of psychic suffering acquire especially ironic undertones in regions subject to the depredations of the IMF and World Bank'. These ironic undertones also haunt the Movement for Global Mental Health's call upon multilateral agencies such as the World Bank to increase funding into mental health interventions in LAMICS (Lancet Global Mental Health Group, 2007). This is apparent when Horton (2007:806) says,

WHO is not the only institution with a responsibility to strengthen mental health services. The World Bank, country donors (such as the USA, UK, and European Union), foundations...research funding bodies...and professional associations all share a duty to make mental health a central theme of their strategies and financial flows. For the most part, these organisations have done far too little, if anything at all.

But what are the ethics of making this call when it is reforms by the World Bank that may contribute to distress and lead to suicide in the first place? This is, for Tsao (2009), a form of 'psychopharmaceutical imperialism', or what might be seen as the medicalisation or psychiatrization of economic suffering. This is illustrated by Tsao (2009), through the process by which hunger in the drought wrecked villages of 1960s Brazil became so normalised that it was no longer a sign of nutritional deprivation but a

mental pathology, 'delirio de fome' or hunger madness, to be managed by tranquilizers and sleeping pills imported from the United States. Thus 'delirio de fome' became a 'national codeword for mental instability rather than a symptom of socioeconomic inequality' (Tsao, 2009:1). This, as Parker (1997:27) notes, 'constructs a place for people to experience their economic distress as a *psychological* problem and to look into themselves as if *they* were the cause of social ills'. Thus locating the source of distress within the brain or within genes, 'psychiatry and epidemiology can be used as a tool to mute important issues that underlie social suffering' (Aggarwal, 2008:27). It may also, as Tsao (2009:2) points out, be useful in creating a market for pharmaceuticals;

In India, where over a decade of structural adjustment has led to both widespread collapse of agricultural markets and soaring suicide rates, antidepressant sales are so reliable that marketing managers for best-selling brands no longer bother to advertise them.

Many critics conceptualize this as the medicalization of suffering that works to decontextualize suffering from its socio-economic context. For Lakoff (2005:151), such critiques are rendered redundant in contexts such as Argentina, where psychodynamic explanations of distress are dominant and the link between Depression and the socio-political was assumed to such an extent that 'social accounts of suffering served not as a *critique* of the role of pharmaceutical marketing but as its *basis*'.

Lakoff cites an example of this by documenting how the drug company Gador developed its marketing campaign for anxiolytics and anti-depressants in Argentina. Aware of the dominance of psychodynamic and social explanations for the origins of distress in Argentina, Gador's 'lock and key' images of neurotransmitters and Depression, so popular in America, were redundant. Instead, aware that the public and the medical community are conscious of the deleterious effects of globalisation, Gador's marketing campaign depicted globalisation as a cause of anxiety, and the company's 'pharmaceuticals as a means to alleviate social suffering' (Lakoff, 2005:151). Here there is an assumption that while Depression and anxiety may be caused by globalization they can still be intervened with at a biochemical level. Within this framework, social contributors to distress are acknowledged and are assumed to be in

part responsible for increased sales of pharmaceuticals, because these social conditions lead to mental illness.

However, increased sales could perhaps be attributed to increased pharmaceutical marketing of drugs, or to a change in marketing strategy, that comes to incorporate economic reform as a cause of mental disorder, as in Argentina. Thus a change in emphasis of pharmaceutical marketing that links economic reform or national financial crisis to increases in mental illness, mediates the frameworks through which it is possible to understand distress. This slightly alters Parker's (1997:27) assertion that capitalism creates a space where people understand economic distress as psychological and 'look into themselves as if *they* were the cause of social ills'. In this reframing, people are actually encouraged to look to economic and political systems, and poverty, not themselves, as the cause of mental illness. Yet despite this, the site of intervention and transformation remains the individual's brain, often through psychopharmaceuticals. While this example may be relatively specific to Argentina, it is a useful reminder that medicalisation as a critique can be taken on and reworked by psychiatry and the pharmaceutical industry. And furthermore that the rationale of the pharmaceutical industry, what Lakoff (2005) terms 'pharmaceutical reason', can take diverse and multiple forms in different social contexts, and even in contexts that emphasise the economic and political causes of distress.

### **Poverty and Mental Illness**

In fact, within Global Mental Health literature and research from within transcultural psychiatry, the link between poverty and mental illness is often emphasised. In an article titled 'Poverty and Common Mental Disorders in Developing Countries', Patel and Kleinman (2003) point out the stress on farmers caused by indebtedness to moneylenders and suggest a key aspect of primary prevention of mental disorders could be the establishment of radical community banks and microcredit schemes. They go onto argue that just as,

clinicians must treat tuberculosis even if they cannot get rid of the overcrowding, so, too, must we challenge the despair of clinicians who

argue that if their patients are poor they must be depressed and there is little they can do about it (Patel and Kleinman, 2003:612).

Again this acknowledges the link between poverty and both physical illness and Depression, alluding to the social determinants of both illnesses, yet in doing so it sets up a comparison between Depression and TB as if they are analogous as physical illnesses. This suggests that despite both having social contributors or causes, they can both be intervened with at an individual level through medications (which of course they both can, but with vastly different histories, critiques and implications). It also implies that attributing causes of Depression to social ills leads to an attitude of despair and nihilism, while interventions at the individual level imply action and positivity. Yet the clinician's despair might alternatively be read as signifying the futility of a clinical framework when understanding and intervening in socially determined distress.

It is in their suggestions for secondary prevention of common mental disorders however that Patel and Kleinman (2003:612) emphasise 'the efficacy and cost-effectiveness of psychological and pharmacological interventions...in developing countries'. It seems that although the social determinants of mental illness are discussed widely in Global Mental Health literature, they are articulated through the assumption that poverty (and economic reforms) can lead to mental illness. Here the framing of this response to poverty as being 'mental illness' makes it possible to work on the individual (brain), while still openly acknowledging the role of social inequalities.

Thus according to some, the World Health Report (2001) frames social problems, such as poverty and violence, as concerns for psychiatry, as psychiatric problems (Desjarlais et al, 1995). This may be because, as Furedi (2004:27) notes, it seems that 'society is much more comfortable dealing with poverty as a mental health problem rather than a social issue'. This is a psychologism that Fanon rallied against, for 'the poor are plagued by poverty...blacks by exploitation [and psychology and psychiatry often deal] with all of these estranging afflictions as if they were...mere states of mind' (Adams, 1970:811).

The 'solutions' to farmer suicides put forward by Patel et al (2007) within a Global Mental Health framework, such as limiting access to pesticides and increasing access to

anti-depressants, work as strategies that centre on managing populations who have been constructed as 'at risk'. In fact the very analysis of farmer suicides creates a population of people identified as potential suicide victims, pre-emptively 'making up' particular kinds of people (Hacking, 2007). The calculation of certain populations as being 'at risk' of committing suicide is partly based, then, on an analysis of the social environment in which these people live, for example, that they are farmers who have small holdings and live in areas affected by agricultural reform, and so epidemiological data would suggest that they are at risk of committing suicide. Here the very constitution of certain groups as being 'at risk' is saturated with an analysis of the socio-economic environment.

However, despite this implicit acknowledgement of the role played by economic and agricultural reforms in contributing to farmer suicides, many of the interventions put forward do not operate at this societal level (other than brief and often vague comments in the conclusions of some journal papers that call for advocacy in changing society – see Patel, 2007). Interventions tend to focus on the individual, and often on the brain, and while analysis centres on the economic costs and burdens of mental illness, the potential economic contributors to mental distress are often overlooked.

However, there are some exceptions to this, for within Global Mental Health advocacy there are glimpses of other ways of responding to and intervening in suicide. In the mhGAP launch video (WHO, 2008), Dr Lakshmi Vijayakumar, founder of SNEHA, an NGO in Chennai, explains that many students, in the state of Tamil Nadu, commit suicide each year due to exam failure. Dr Vijayakumar goes on to explain how SNEHA called upon the Government of Tamil Nadu to take action, to which they have responded by making 'a new rule in which a student who has failed in the 12<sup>th</sup> exam, can write the failed subject within one month after the results, so that he doesn't lose a year.' This is conceptualised as one example of 'low cost suicide prevention programmes, currently being initiated in other parts of India and elsewhere' (WHO, mhGAP launch video, 2008). In calling for structural change at a Government level, this intervention stands in contrast to interventions into suicide prevention that centre on increasing access to psychiatric drugs. It is an example of intervening with distress at a structural level.

## **Social Determinants and Inoculation**

While biological explanations of 'mental illness' are relatively dominant, the acknowledgement of social determinants by predominantly biomedical organisations, such as the WHO, may also work to divert criticism about biological determinism or about interventions that tend to focus on individuals. The elusion to individual-oriented social determinants also enables the neoliberal rationale that frames those social determinants of health to remain unquestioned. I want to interrupt with a field note.

On the second day of the Global Mental Health course, at the Institute of Psychiatry,<sup>48</sup> after breakfast pastries, Vikram Patel began his session by talking about the WHO study into social determinants on health, particularly mental health, explaining it was unusual for the WHO, a usually biomedically focused UN agency, to do research that located inequalities in health in the way societies are organised. He explained that the thinking behind examining the 'gap' in healthcare, between those who need it and those who receive it, was based on the assumption that if we lived in a just world then everyone would have the same health outcomes; as there is no biomedical reason as to why this should not be so, health must be determined by social differences. He went onto explain that all experiences of mental illness involve a biochemical element mediated through a neurological pathway, but these biological determinants are influenced by culture.

Culture as an influence on biology – this seems to be the framework in which 'social determinants' of health are understood. The fact that the WHO's focus on social determinants of health came after the 1990s 'Decade of the Brain' seems telling here. This process may also be understood as one of inoculation. For Barthes (1973:42), inoculation is a process whereby the Established Order is criticised, only to be recuperated at the final moment;

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<sup>48</sup> Global Mental Health Summer School (one week course) at the Health Service and Population Research Department of The Institute of Psychiatry, London (22<sup>nd</sup>-26<sup>th</sup> August 2011).

One inoculates the public with a contingent evil to prevent or cure an essential one. To rebel against the inhumanity of the Established Order and its values, according to this way of thinking, is an illness which is common, natural, forgivable; one must not collide with it head-on; but rather exorcize it like a possession; the patient is made to give a representation of his illness, he is made familiar with the very appearance of his revolt, and this revolt disappears all the more surely since, once at a distance and the object of a gaze the Established Order is no longer anything but a Manichaeian compound and therefore inevitable, one which wins on both counts and is therefore beneficial.

In the analysis of the social determinants of mental health then, is the 'essential evil', made inevitable and beneficial through inoculation, that of a neoliberal, free market rationale? Tracing the doubled interlacing movement of neoliberal reforms as being both problem and solution (i.e. contributor to agrarian crisis and 'solution' to the crisis), we might wonder if this is the 'winning on both counts' that Barthes is alluding to. But to whom is the rationale of neoliberalism the most beneficial?

Barthes (1973) may also help to explain Raphael's (2006) assertion that despite the vast amount of evidence on materialist social determinants of health, there is little action at this level to improve health. Perhaps this is because, through the process of inoculation, 'any piece of evidence undermining a particular social system can be rendered safe for it. Inoculations break the link between evidence and action' (Robinson, 2004 – online). Thus, mention of social determinants of mental health, such as economic reforms, in Global Mental Health literature seems to enable a discursive existence of mental health as affected by the social, while delimiting a discourse of structural or systemic change or transformation.

For Das (2011), this marks an individual-oriented materialistic approach to social determinants of health, problematic because the lesser the focus is on structural deficiencies and state institutions, the more likely that the political message will be a conservative one, attributing inequities and suicides (and sometimes even poverty) to personal attributes, and biological or psychological inferiority. Thus while socio-cultural issues are acknowledged, they are often used as a way to increase compliance to



psychiatric approaches (Higginbotham and Marsella, 1988). And according to Raphael (2006), while recognition of the social determinants of health has become common, the further acknowledgment that such social determinants are determined themselves by the political and economic forces that shape the organisation of societies and resource distribution is rare. Raphael (2006) goes on to attribute this as due to an individualist approach to health, consistent with neoliberal governance and a free market rationale which fosters the very social inequalities that may lead to poor mental health in the first place. It is interesting to be aware then of the mechanisms by which agrarian (and economic) crisis come to be rearticulated and reconfigured as individual crisis, as mental illness.

Thus it seems possible to trace a double movement here, whereby the distress caused by a neoliberal rationale of reforms and inequality is mediated through a bio-psychiatric lens as 'illness', opening up interventions that are individual and often pharmaceutical, and that are thus part of the same neoliberal rationality as that which may have caused distress initially. This seems to work, like Fanon's (1967:13) 'double process' - as sociopolitical and economic conditions of inequality and alienation become internalised, as they are made flesh – a process of 'epidermalisation'. Furthermore, many critics point out that 'farmers' suicide is symptomatic of a larger crisis in the agricultural sector in India' that of agricultural trade liberalization and the influence of the World Trade Organisation (WTO) (Das, 2011:23).

### **Patenting Distress**

Patents in India originated in the 1856 Act, a patent system introduced by the British under colonialism in order to secure the Indian market for British industry, meaning pharmaceuticals were mostly exported from abroad (Gerster, 2000). However, in 1970 this was abolished (Nair, 2008), marking a strategy to 'break away India's dependence on imports for bulk drugs and formulations and provide for the development of a self-reliant indigenous pharmaceutical industry' (Zacharias and Farias, 2002:42). This made medications cheaper and thus more accessible to greater numbers of people (Patel, 2006). This changed when the WTO made its members comply with the Trade-Related Aspects of Intellectual Property Rights (TRIPS). According to an article in Pharmatech (2002), the enforcement of TRIPS and the process of trade liberalisation is a 'boost for

multinational companies' who were previously reluctant to invest in India due to the lack of patent protection for their products (Zacharias and Farias, 2002:48).

Drawing upon this, and calling for HIV/AIDS activism to be used as a model for Global Mental Health, Patel (2006) mobilises the 'moral case' for Global Mental Health, because while '[g]overnments can exempt diseases that are life-threatening or national emergencies' from the TRIPS charter, 'mental illness does not figure as an exemption category.' Thus Patel (2006:1314-5) argues that the

moral case is that the mentally ill have a right to access affordable, evidence-based treatments. Mental illnesses must be excluded from the Trade Related Intellectual Property Rights charter.

Here the conceptualisation of distress as 'mental illness', and as both 'life-threatening' and a 'national emergency' is mobilised to fight against the pharmaceutical industry's practice of patenting, and thus in some ways against the WTO's imposition of specific neoliberal practices. In fact, according to some, the 'WTO and neo-liberalism have become synonymous and inseparable' (Kazmi, 2005 – online). This marks a messy space – for here bio-psychiatry, which for many critics is intricately intertwined with Neoliberalism (Moncrieff, 2008) is being mobilised to work against Neoliberalism (or at least against a specific practice of it).

However, Neoliberalism, understood here as a set of practices that seeks to deregulate markets, privatise services (including the health sector) and 'roll back' the government's role in providing services, mobilising the mechanisms of the free-market into increasing areas of social life, is also messy. Like the exporting of psychiatry to LAMICs, Neoliberal policies have travelled globally through 'packages of reform' (such as Structural Adjustment policies in India) made by multilateral agencies - packages that are forged in one context and then transposed often forcefully onto other contexts, with no attention to socio-political context and history (Laurie and Bondi, 2005). However, Power (2005:209) suggests caution in speaking of the 'unprecedented hegemony of the International Financial Institutions and of neoliberalism being spread

through them to the global South', for in these accounts – 'the messiness, unevenness and hybridity of neoliberal developmentalism' gets lost.

The issue of medications and patents alludes to a troubled relationship between advocates of Global Mental Health, the WHO, and the pharmaceutical industry. Many advocates of Global Mental Health explicitly eschew pharmaceutical company funding,<sup>49</sup> and in some (but not all) cases argue that older, first-generation psychiatric drugs, now out of patent, are just as effective as the newer ones (Mari et al, 2009). In Global Mental Health advocacy the construction of mental illness as a 'national emergency' is being used to remove patents and to fight against the pharmaceutical industry making profits out of distress. However, these moves often only bolster the assumption that mental distress can and should be treated using psychopharmaceuticals.

Furthermore, the last chapter considered how the framing of distress as both individual and national emergency invoked a state of exception in which normative recognitions of violence were altered, enabling violent interventions to be carried out in the name of necessity, violent treatment, violence unrecognised as violence. Yet this state of exception has increasingly become normative, where, for Benjamin (2003:392), 'the state of emergency in which we live is not the exception but the rule'. Furthermore, for Bhabha (1994:59), this 'state of emergency is always a state of *emergence*'.

But what emerges from this state of emergency? Despite the Indian Government's resistance to enforcing TRIPS, due to international pressure from the WTO and its high-income member countries; India signed the General Agreement on Tariffs and Trade (GATT) on April 15<sup>th</sup> 1994, thus making it mandatory to comply with TRIPS. It was framed as impossible for countries, such as India, to be integrated into the world economy without becoming members of the WTO, of which a prerequisite was the enforcement of TRIPS. This meant, according to Gerster (2000 –online), that LAMICS had to 'swallow the TRIPS pill' in order to become part of the world market, with the WTO and TRIPS marking a 're-colonisation of the economically weak countries'

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<sup>49</sup> This was explained at the Course in Global Mental Health, that I attended in London, August 2011.

(Gerster, 2000). The analogy here between pills and colonialism is worth attending to more closely, in part, because some critics argue that the pharmaceutical industry acts as a colonising force as it expands into new markets. But how does psychiatry travel and expand? Who emerges in the space of its expansion? What sort of person is made possible?

## Chapter Six

### **Educating, Marketing, Mongering; Making Mental Health a Reality for All**

*A chapter on the 'making up' of psychiatric 'subject peoples', on eliciting, fostering and promoting, on the blurry boundaries between educating and marketing, on different types of literacy – mental health, colonial, and emotional, on the global mongering of disease, on 'native madness,' and on whether mental illness exists.*

## **'Making up' psychiatric subject peoples**

[T]he most potent weapon in the hands of the oppressor is the mind of the oppressed (Biko, 1978:92).

The Movement for Global Mental Health calls 'to make mental health for all a reality' (Patel, et al, 2011:90). Over the next two chapters, I want to focus on three of these words; 'make', 'all' and 'reality'. To 'make' mental health a reality hints at the potential 'made-up-ness' of psychiatric diagnostic categories, for example, made up by the pharmaceutical industry for profits, disorders made up for drugs, 'disease mongering'. It alludes to how psychiatry and Global Mental Health, to draw upon Hacking (2006), work to 'make up' people, to make possible particular ways of being a person; neurochemical selfhoods (Rose, 2003), pharmaceutical citizens (Ecks, 2005), and 'pharmaceutical personalities' (Martin, 2007).

'Making' mental health a reality also hints at a force (discussed in the next chapter), to 'make' someone do something – a force that seems interlaced with psychiatric and colonial subject formation. This is to begin to map how Global Mental Health may operate as a 'rationality' – making up a kind of 'intellectual machinery' or apparatus for rendering reality thinkable in such a way that it is amenable to political programming (Rose, 1996:54).

To make mental health a reality for '*all*' suggests the global spread of psychiatric ways of being a person, how we all come to understand ourselves within this register. For Nikolas Rose (2006:481), this is a process of psychiatrization,

[i]n shaping our ethical regimes, our relations to ourselves, our judgements of the kinds of persons we want to be, and the lives we want to lead, psychiatry, like the rest of medicine is fully engaged in making us the kinds of people who we have become.

But many people in LAMICS have not (yet) become psychiatrized peoples – something which the translation of diagnostic and classificatory tools in order for them to travel

across geographical borders - a 'diagnostic creep' (Rose, 2006:478), may change. Here Global Mental Health and psychiatrization might be read as meeting two of Bhabha's conditions for colonial discourse; a) 'the creation of a space for a "subject peoples" through the production of knowledges', and, b) through 'marking out a "subject nation"'...operating as a form of governmentality that 'appropriates, directs and dominates its various spheres of activity' (Bhabha, 1983:23).

This creation, this 'making up' of subject peoples, seems to involve them being brought within a psychiatric system of representation – which marks the 'reality' that mental health is being made for all. Like colonial discourse, psychiatry and Global Mental Health, seem to form 'a system of representation, a regime of truth, that is structurally similar to Realism' (Bhabha, 1983:23), in fact doubly so, as it is dominated by psychiatric systems of knowing the difference between reality and unreality, between sanity and insanity. But by what mechanisms does psychiatry travel? What sort of 'subject peoples' occupy the space of Global Mental Health? This chapter will chart one specific global strategy for producing psychiatric subjects – mental health literacy campaigns. It will then go onto to read these alongside colonial practises of literacy promotion.

### **A 'Mental Health Literate Society'**

A key part of the Movement for Global Mental Health's 'scale up' of psychiatric interventions has been to raise awareness and increase knowledge about mental illness and its treatment, in LAMICS. One of the ten recommendations for achieving this, in the World Health Report (2001:xii), is to 'educate the public',

Public education and awareness campaigns on mental health should be launched in all countries. The main goal is to reduce barriers to treatment and care by increasing awareness of the frequency of mental disorders, their treatability, the recovery process and the human rights of people with mental disorders...Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical healthcare closer to each other.

Global Mental Health advocacy and the WHO thus point to the evidence that many LAMICS have ‘poor mental health literacy’, meaning a lack of ‘knowledge and beliefs about mental disorders which aid their recognition, management or prevention’ (Jorm, 2000:399&396), or as lacking ‘the ability to correctly identify mental illness in oneself or one’s peers’ (Saxena et al, 2007:884). In finding that in both HICS and LAMICS ‘[m]any members of the public cannot correctly recognise mental disorders and do not understand the meanings of psychiatric terms’, Jorm (2000:396) points to a need to explore how the public seek information about mental illness, in order to ensure that the information they get is accurate. (However, thinking back to Chapter 2, what one means by accuracy and ‘evidence’ often remains tied to pharmaceutical rationales).

According to Jorm (2000:399), there is a continuum of mental health literacy, from professional to lay knowledge; where ‘professionals have expert knowledge which is to a large extent based on scientific evidence and expert consensus’, while the public hold beliefs based on the media, anecdotes and personal experience. Here the public’s negative views about medication are framed as ‘beliefs’, in comparison to professional ‘scientific’ ‘knowledge’ about mental disorders and evidence-based treatments.

Global Mental Health literature frames ‘poor’ mental health literacy and ‘negative beliefs about medication’ (Jorm, 2000:398) as explanations for a diverse range of issues, such as; young people’s avoidance of health care (Saxena et al, 2007); for making people ‘vulnerable to misinformation from unscrupulous providers’ (Saxena et al, 2007:886); for hindering public acceptance of evidence-based mental health care, for people’s failure to seek medical advice, and for ‘lack of compliance with any medication recommended’ (Jorm, 2000:398). Vulnerability here is a lack of scientific information about mental illness.

Mental health literacy campaigns thus equate ‘knowledge’ with acceptance of a bio-medical model of mental illness. For example, a recent campaign by the World Psychiatric Association labelled those who understood Schizophrenia as a ‘debilitating disease’ as being ‘sophisticated’ and ‘knowledgeable’ (Read et al, 2006). Some of the problems with this approach are acknowledged to some extent in the literature, which points to potential limitations in assuming ‘the superiority of expert psychiatric



knowledge over lay beliefs', and also for constructing 'the sufferer's interpretation of his or her condition as less valid' (Jorm, 2000:400). Despite these limitations (mentioned as a brief bullet point in Jorm's [2000] article), Global Mental Health advocacy and the WHO highly promote mental health literacy campaigns, concluding that, 'we need a "mental health literate" society in which basic knowledge and skills are more widely distributed' (Jorm, 2000: 399 & 396). Thus the Movement for Global Mental Health mobilises calls 'to make mental health for all a reality' (Patel, et al, 2011:90).

But what are the formations and contours of a 'mental health literate society'? What kinds of beings occupy such a society? The construction of a 'treatment gap' - 'the gulf between the huge numbers who need treatment and the small minority who actually receive it' (WHO, 2001b:7) - and the gap in 'knowledge' about mental illness between LAMICS and HICS, thus seems to work as a space to enable particular kinds of people to come into being.

Therefore Global Mental Health and mental health literacy campaigns enable new ways of talking and thinking about people in LAMICS, and about distress, marginalisation, social equality and justice in 'biologically colored' language (Rose, 2007:140), marking a shift in human ontology that enables the biomedical reshaping of global citizenship. This shift makes available, 'makes up' (Hacking, 2006) new selves; 'neurochemical selves' (Rose, 2003), and bio-psychiatric activists. In this way, it seems central to attend to how Global Mental Health may operate (within a Foucauldian register), as a 'regime of practices', that elicits, promotes, facilitates, fosters and attributes 'various capacities, qualities, and statuses to particular agents...successful to the extent that these agents come to experience themselves through such capacities' (Dean, 1999:32). These capacities and subjectivities thus tie those who are subjected to specific governmental and socio-economic rationales (Dean, 1999).

I am interested then in tracing how Global Mental Health literacy and psychiatrization could be read as modes or fields of subjectification for the production of particular subjectivities (Coonfield, 2008), and the means by which these subjects are secured and maintained - the 'putting into place of a subject' (Butler, 1997:90-91)- the processes by

which mental health is made a 'reality' for all. This chapter will read psychiatric subject formation alongside colonial subject formation, and pharmaceutical marketing – in order to traverse the terrain of how psychiatric diagnostic systems travel globally and what subjects they make possible, the 'making flesh' of Global Mental Health (Cromby, Newton and Williams, 2011). Thus the tracing of subject formation that forms the focus of this chapter will be interrupted by psychiatry's colonial history in India – the colonial history of psychiatrization.

### **The 'not-yet-citizen patient'**

For Hacking (2006 - online), it is the human sciences and their tools of measurement and classification that 'create kinds of people that in a certain sense did not exist before'. NGOs in India often point to the inhuman lives lived by the 'homeless mentally ill', ignored by a society who behave as though such people don't exist – they then use this to mobilise the call to see such people as 'mentally ill' but also as human, 'the not-yet-citizen patient' (Ecks, 2005:241). However, it could be argued that the mentally ill indeed do not exist, in a psychiatric sense, prior to being 'seen', identified and visually encountered by psychiatry (see chapter 8). Here tools of classification, such as the DSM and ICD, widely translated into many languages, play a key part in bringing into being the mentally ill subject.

According to Ecks (2005:240), in an increasingly pharmacological world, to be marginal, under-developed and vulnerable often 'means to be cut off from the circulation of biomedical substances. The voices of "marginalized" people that are quoted in the World Bank Report all speak of being unfairly deprived of medicines'. Here 'the biomedical promise of an effective pharmacological treatment becomes a promise of "pharmaceutical citizenship"...that works on redefining belonging, personhood, exclusion, rights' (Ecks, 2005:239&241). However, Ecks (2005:240) explores a friction within pharmaceutical citizenship,

between citizen-as-patient who is entitled to medicines because he or she is already a full citizen, and the not-yet-citizen patient, for whom the taking of medicines becomes a practice of becoming a full citizen.

This friction may also mark the distinction between the provision of medications for physical diseases, such as diabetes, and mental illnesses. But by what mechanisms are mental health literate subjects produced in India? I want to begin to explore this by drawing upon a juxtaposition of stories from my fieldwork, interviews with those who work for or who founded mental health NGOs in India, and NGO literature about mental health; websites, books, community resource packs, and pamphlets. Materials that I hoarded on my travels, and posted home by sea, sewn into multi-coloured fabric packages.

### **Mental Health Camps – BasicNeeds**

I contacted Mr Mani Kalliath, the programme director for BasicNeeds in Bangalore, after having read an article about him in an issue of *Tehelka* (a popular independent Indian magazine) that had been dedicated to mental illness.<sup>50</sup> He sounded like an interesting character, and from our first email exchanges, where he told me he'd never heard of 'such a name as China', he didn't disappoint. Many of the NGOs I visited in India were relatively small; often set up and funded by Indian people. However, BasicNeeds is different. It was set up in 1999, in India, by a British man, Chris Underhill, and now works on mental health issues internationally.

I arrived at the BasicNeeds Bangalore office, after an unusually easy bus ride (had I finally mastered the immense and yet terrifying Bangalore bus system?), and the office was cool, and quiet. Mani asked me to introduce myself, asking me if I was a user / survivor – the terminology of which he said he wasn't sure about. Bhargavi Davar, founder of the Bapu Trust, had asked me a similar question when inviting me to a meeting of psychiatric survivors. In both instances I mumbled something about not really having 'survived' the system, not in the way many people have, but that 'yes, I had taken medication for a while a few years ago, when I was deeply unhappy'. Bhargavi had stopped me; 'that's enough to count as a survivor here, China', she'd said, 'we don't worry about that stuff in India'. 'That stuff' – the comparisons of survival, the

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<sup>50</sup> See *Tehelka Magazine* (2010). 7(19), May 15<sup>th</sup>. [online] [http://www.tehelka.com/story\\_main44.asp?filename=Ne150510coverstory.asp](http://www.tehelka.com/story_main44.asp?filename=Ne150510coverstory.asp) (Accessed, January 27<sup>th</sup> 2011).

hierarchies of surviving, what I had heard someone call 'survivor cannibalism', was something I had experienced first hand in the UK (Mills, 2010).

But back to Mani – who sat quietly while I meandered through my life history for minutes that felt like hours. I wondered how his life story related to his work at BasicNeeds – Mani had been depressed for many years, and had gone through intensive therapy in his recovery. His speciality was in public and community health, and he had always wondered how a development agency could work around a medical problem such as mental illness - then he came across BasicNeeds. A booklet produced by BasicNeeds (undated:15), that Mani gave me when I left, explains that,

BasicNeeds India realised that the model had to take into account two important aspects: one that a scientific knowledge base of mental illness does not exist in the minds of rural people. It is difficult for them to understand that just as for physical illness medicines are available to cure mental illness too. Secondly, knowledge regarding mental illness is overwhelmingly dominated by the local knowledge of faith-healing. This needed to be respected while disseminating information about medical support for mental illness. A scientific approach was to be promoted.

A key strategy in the promotion of this scientific approach to mental illness by BasicNeeds has been through the development of mental health camps (also used by Iswar Sankalpa). While there had been eye camps and dental camps to provide treatment for people in rural areas of India, mental health camps were not common. Before the camps could begin, BasicNeeds worked with partners, often organisations and field staff that worked in the arena of disability, 'to identify and locate people needing treatment' (BasicNeeds, undated:18). Camps are held in rural areas because district hospitals are often far away in urban areas, and the medications may be unaffordable, thus camps 'ensure that every person with a mental illness receives treatment' (BasicNeeds, undated:20).



A BasicNeeds Mental Health camp in Sri Lanka.<sup>51</sup>

The BasicNeeds website further explains that,

In the areas where we work, particularly in rural areas, easily accessible mental health services simply do not exist. To change this, we hold regular mental health camps where mentally ill people can access treatment and other services. At a mental health camp, mentally ill people and their carers from the surrounding area all come together to be seen by a visiting psychiatrist. The psychiatrist diagnoses them or checks their progress and then prescribes the next instalment of medication. Mentally ill people can then go to a medication dispensary, which is part of the camp, to get their medication. After they have been seen by the psychiatrist, they can also take part in other activities that are taking place, for example, group therapy sessions, occupational therapy sessions, consultation meetings or advocacy groups.

This enables people with mental illness to return to work and take part in activities that show the community that 'people with mental illness can be treated, that mental illness is treatable like any other illness' (BasicNeeds, undated:23). From its beginnings in India (funded by donors in the UK), BasicNeeds now works in seven countries, and has reached over 54,076 people with mental illnesses (BasicNeeds, undated:1). According to their Annual Report, in 2009, BasicNeeds made 26, 590 home visits, and

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<sup>51</sup> Picture from the Basic Needs Website  
[http://www.basicneeds.org/slideshows/mental\\_health\\_camp\\_slideshow7.htm](http://www.basicneeds.org/slideshows/mental_health_camp_slideshow7.htm)  
(Accessed 22.3.2012)

held 1,889 mental health clinics, with 40% of those accessing treatment being new participants (BasicNeeds, 2009:3).

### **Mental Health and Development**

Alongside running camps, BasicNeeds began a community based programme in Karnataka, India, to link mental health and development, and increase awareness of mental health in a small community. Previously those with mental illness in this community had gone to a local psychiatric hospital, which was over a hundred years old. BasicNeeds took small groups of people to the hospital for treatment, while encouraging them to live at home, enabling a 'community approach to institutional care' (BasicNeeds, undated:25-26), and eventually leading to the closure of the psychiatric ward.

BasicNeeds have thus developed a 'Model for Mental Health and Development', an approach that aims to deal with the issue of mental health in the context of development (BasicNeeds, 2008). This approach aims to tackle poverty as well as mental illness; aiming to create sustainable livelihood programmes to help people to start earning a living after being given access to community-based treatment. Their approach 'is holistic and explicitly links mental health and development', working simultaneously on health and socio-economic issues, 'much beyond treatment and cure' (BasicNeeds, 2009:2).

BasicNeeds forms part of a push by the Movement for Global Mental Health, of which it is an active member, to frame mental health within an international development agenda. Here mental illness is seen as an international emergency, one that 'international development virtually ignores', meaning 'mental health is the invisible problem in international development' (Chambers, 2010). For Chris Underhill, the founder of BasicNeeds,

mental health is not just a medical concern – but "part of a larger development related problem". Mental illness adversely affects people's ability to work, creates a potential carer burden on their families and generally leads to greater poverty (Chris Underhill, cited in Chambers, 2010).

Drawing upon prevalence rates of 450 million people worldwide suffering at any one time from mental disorders, The WHO Ministerial Round Tables (2001b:6), also pushed for a recognition of the link between mental health and development, saying that ‘mental health is not only essential for individual well-being, but also essential for enhancing human development including economic growth and poverty reduction’, and thus, ‘there is no development without health and no health without mental health’.

Thus mental health is increasingly being tied to international development in a variety of ways. For example, it is framed as key to the development of self, community and nation state; as directly affecting progress towards several Millennium Development Goals (though mental health is not explicitly acknowledged within the MDGs) (Prince et al, 2007); and as a means for young people to ‘fulfil their potential and contribute fully to the development of their communities’ (Patel et al, 2007:1302). This takes us back to Chapters 3 and 4, and the need to critically analyse development discourse (child/economic/ international) and to attend to how the tying together of development and mental health (and psychiatry) may presume the global applicability of psychiatric frameworks for understanding distress.

### **‘Into the heart of the [global] community’**

The interweaving of international development with mental health, through mental health literacy and camps, works, according to the BasicNeeds website, to,

bring issues of mental health into the heart of the community – they aren’t locked up in a psychiatric hospital anymore. Mental health camps bring mental illness into the open and show people that mental illnesses are just like any other disease and are nothing to be feared. They are an important tool in the battle against stigma.<sup>52</sup>

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<sup>52</sup> Basic Needs website  
[http://www.basicneeds.org/html/what\\_mental\\_health\\_camps.htm](http://www.basicneeds.org/html/what_mental_health_camps.htm) (Accessed 3.3.2011)

This suggests, that through mental health literacy campaigns, both those with mental health problems, and the mental health problems themselves, are unlocked from inside the confines of psychiatric hospitals and brought into communities - they are made a 'reality' for all. In a similar movement, then, mental health problems themselves (as a category of personhood, a way to be a person) are somewhat 'unlocked' or enabled to travel from countries of the global North to the global South.

As an outcome of the WHO (2001:7) Round Tables it was decided that the 'WHO has a critical role to play in turning this knowledge into reality'. Thus mental health became a priority programme that set the stage for 'global mental health action through a combination of special events' (such as, World Mental Health Day) that 'aim to raise awareness of the nature and scope of mental problems ... and disseminate the evidence and science related to prevention and care' (WHO, 2001b:7). All this has been key in 'mobilizing interest and commitment for global and national action to redress the mental health status of populations around the world' (WHO, 2001b:7).

Raising global mental health awareness has been employed as a key strategy to increase national and international policymaking and funding of mental health, and to draw attention to inequities in mental health status between countries. As part of this, calls to 'scale up' psychiatric services in LAMICS, of which mental health literacy campaigns form a key part, operate as a site to release psychiatry from within the walls of the asylum, to take it out into the community, across global borders, to 'make mental health for all a reality'. However, does this reading of making mental health a reality as a process of 'making up', imply that mental illness did not exist in LAMICS prior to the Movement for Global Mental Health and WHO intervention?

### **Poor People do not suffer from Mental Illness**

Much of the Global Mental Health literature attempts to oppose the idea that mental illness simply does not exist in the global South. This is evident in a booklet published by BasicNeeds (undated:1);

There is a commonly held view that very poor people do not suffer from mental illness. This view is founded on the assumption that somehow mental illness



are generally a disease of affluence and that poor people would not have time to be depressed. In fact of course people living in severe poverty are not protected from the plight of mental illness.

The critique of the assumption that mental illness does not exist in LAMICS was often repeated at the course I attended in Global Mental Health, at the Institute of Psychiatry (in August 2011). It made me wonder where the assumption in Global Mental Health of a commonly held view that mental illness does not exist in 'poor' countries had come from. This took me to colonial Java, a divergence I want to follow now.

### **'Ethnic psychosis of Occidental society'**

Emil Kraepelin 'the designer of modern psychiatric nosology', the 'father of Schizophrenia', made his first trip to Southeast Asia, in 1904, a trip that led to the founding of a new discipline - comparative psychiatry (Jilek, 1995:231). Kraepelin wanted to examine 'whether certain forms of insanity that provide the main content of our [European] institutions, occur in like manner and frequency as among us also under entirely different conditions of living and among entirely different ethnicities' (Jilek, 1995:233).

Spending three weeks in a hospital in (colonial) Java, Kraepelin found that the severe deterioration that affected Europeans was not present in Indonesians with mental illness, concluding, along with many prominent psychiatrists of the time, that Western civilisation had a negative effect on mental health (Jilek, 1995:235). This was based on the assumption that those in poorer countries lived simple, contented lives, and were thus less plagued by mental illness, and that it was the 'progress inherent to Western civilization [that] was apt to produce mental derangement' (Ernst, 1999:165).

Other psychiatrists also assumed a link between civilisation and mental illness, as documented by Jilek (1999:235); Georget, in 1820, suggested a link between industrial development, modern civilisation and nervous disorders; Esquirol (1830) saw the progress of civilisation as responsible for increased numbers of people with mental illness; and Buschan (1906) suggested that brain volume increases as a civilisation progresses, making the 'civilised' more intelligent but more vulnerable to mental

illness. Similarly, Tuke (1858) and Maudsley (1867, 1879), looked to civilisation as the cause of insanity, assuming that non-Europeans were immune to mental illness (Fernando, 1988).

Thus, 'the rarity of major mental disorders among "primitive" peoples was a widely held notion in 19th century psychiatric thinking' (Jilek, 1999:235-236). This led to Schizophrenia, seen as absent among 'primitive' peoples, to be defined as the 'ethnic psychosis of Occidental society' (Devereux, 1980:235). Kraepelin observed that in Java patients were rarely depressed in comparison to those he had worked with in Germany, and he perceived these cross-cultural differences 'in terms of genetic and physical factors rather than culture' (Fernando, 1988:59). However, despite his work marking the 'starting point for modern pharmaco-psychology and subsequently pharmaco-psychiatry', and psychiatric epidemiology (deVries et al, 2008:1), there was a social dimension to Kraepelin's work. For example, on a trip to America, Kraepelin noted that the native Americans, having been exposed to disease and deprived of their previous ways of existing had 'sunk into fatalistic apathy' (Kraepelin, 1925, cited in Jilek, 1995:232).

There is an explicit acknowledgement here of the social factors involved in mental illness, particularly in the dispossession of certain forms of life through development and 'modern civilisation' as leading to mental disorder. While retaining an assumption of the superiority (in intelligence and society) of the West, this resonates strangely with calls from Global Mental Health, and NGOs such as BasicNeeds, who seek to explicitly frame mental illness as a development issue. These calls assume that mental illness impedes development (for example preventing the realisation of the Millennium Development Goals), and that lack of development contributes to mental illness, assuming that with development mental health will improve. Conversely, assumptions from colonial psychiatry see mental illness as coming about from development, as a direct product of being 'civilised'.

Findings from the International Pilot Study of Schizophrenia (IPSS) (1967), and DOSMED (1978), complicate this further, as they have 'consistently found persons clinically diagnosed with schizophrenia and related disorders in the industrialized West (chiefly

Europe and the United States) to have less favourable outcomes than their counterparts in “developing” countries’ (Hopper and Wanderling, 2000:836). In considering these findings, many, like Warner (1994), have concluded that it may be easier for those who have experienced distress to integrate back into, and find meaningful roles in, non-industrialised societies, and thus socio-cultural factors influence outcome of so-called Schizophrenia far more than treatment options. Actually, Hopper and Wanderling (2000) point out that if Hong Kong was subtracted from the International Study of Schizophrenia (ISoS) ‘developing’ country cohort, then the other sites were all in India, suggesting that perhaps Indian responses to distress have something to tell us about better outcomes.

The current ‘scale up’ of ‘Western’ psychiatry and the transcultural diagnostic systems that Kraepelin’s work led to the development of for psychiatric epidemiology, thus constitute the ‘conditions of possibility’ for the globalisation of bio-psychiatry. This could be read as colonising or dispossessing indigenous ways of knowing distress and forms of life (see discussion of psychiatrization shortly) – a dispossession perhaps akin to that which Kraepelin himself saw as constituting the ‘apathy’ of the Native Americans (in 1924).

Murphy’s (1961) concern that mental illness was linked to the ‘rapid Westernizing of non-Western peoples’ (cited in Jilek, 1999:236) also enables a strange reading of the implications of psychiatrizing people in LAMICs through ‘Western’ psychiatric frameworks; such as through mental health literacy. Here again is a double movement; the globalisation and westernisation (of agriculture, economies etc) that may cause distress, followed by the mediation of that distress through ‘western’ bio-psychiatric systems of classification: a second ‘westernisation’. This is reminiscent of Lakoff’s (2005) ethnographic observations of psychiatry in Argentina, and the WHO and Global Mental Health’s use of psychiatry, with its explicit acknowledgement of the social determinants of mental illness, while still promoting pharmaco-psychiatric interventions that work on the individual brain. The inoculation of the social determinants of mental distress.

## **Native Madness**

Colonial psychiatry in India, beset by assumptions that the 'natives' were too 'primitive' to experience mental illness, then encountered a dilemma: madness among the 'natives'. Colonial doctors thus struggled to reconcile 'with the colonial precept of Western superiority while providing evidence to support the widely held view that allegedly uncivilized people ought by definition to be less prone to mental problems' (Ernst, 1999:166). This colonial encounter with 'native' madness thus brought into being the 'native insane' (Ernst, 1999:164) as a category of personhood, while simultaneously troubling assumptions of the uncivilised barbarity of natives that were used in part to justify continued colonisation.

Importantly, however, this colonial dilemma of the uncivilised becoming mad was resolved with the medicalisation of madness through psychiatry, during the second half of the 19<sup>th</sup> Century, when social and colonial problems came to be 'construed in the allegedly impartial technical idioms of medical science' (Ernst, 1999:166). This German-British biological approach to psychiatry thus assumed the universality of mental illness globally (resonating with the sublation discussed in Chapter 2).

Interestingly, the argument that the hyper-capitalism and consumerism, that make up life in many HICS leads to mental illness or emotional distress, has remained a key critique of bio-psychiatry, and one fiercely rejected by the WHO.

Mental disorders are not the exclusive preserve of any special group; they are truly universal. ...The notion that mental disorders are problems of industrialized and relatively richer parts of the world is simply wrong. The belief that rural communities, relatively unaffected by the fast pace of modern life, have no mental disorders is also incorrect (WHO, 2001a:22).

For Oliver James (2007), mental illness is a different kind of disease, an 'Affluenza' that spreads like a virus through (usually high-income) countries where people's self definitions revolve around money and consumption. On the course in Global Mental Health that I attended, James' book was criticised as working to deny the 'reality' and

'existence' of mental illness for the populations of LAMICS (perhaps another act of in-coluation).

Here it seems that the work of Global Mental Health advocacy to map the prevalence (and the existence) of mental illness in LAMICs, attempts to work against, and yet simultaneously mobilises, colonial assumptions of Western superiority of mind. It is haunted by, in its very refutation of, a colonial assumption that mental illness is linked to 'modern civilisation' and Western superiority. And yet such advocacy often invokes the assumption of the superiority of 'Western' knowledge through promoting 'scientific' bio-psychiatric approaches to mental distress over indigenous healing systems.

It seems, then, that 'western' bio-psychiatry is interwoven from its very beginnings with both cross-cultural comparisons (from colonial settings) and assumptions of the social aspects of mental illness, and thus that Schizophrenia may be always already interlaced with colonialism. Global Mental Health thus seemingly remains caught in a distinctly colonial dilemma, which it attempts to negotiate through recourse to increasingly bio-psychiatric terminology, a similar strategy employed by colonial psychiatrists.

### **Does 'it' exist?**

Did mental illness always exist in LAMICs prior to 'Western' influences? Do the populations of LAMICs experience the same mental illnesses as in the 'West'? These questions, while important, sometimes seem to lead to a dead end, closing off discussion. Hacking's elaboration of the process of 'making up' people thus seems to be useful here. For Hacking (2006), 'making up' is the bringing into being specific ways of being a person that may have not been possible before. In adapting his discussion of the 'making up' of multiple personality disorder, for Global Mental Health / psychiatric subject formation, we could say that, either:

- A) Prior to colonialism and recent (global) mental health and WHO literacy campaigns, there were no mental illnesses in India.

Or

B) Prior to colonialism and recent (global) mental health and WHO literacy campaigns, 'Western' bio-psychiatric categories of 'mental illness' (for example as caused by biochemicals) were not an available way to be a person, people did not experience themselves or their family members in this way.

This is helpful because it enables a different understanding of claims that in many LAMICS mental illness does not / or did not until recently, exist. This is not to deny that people who were distressed, who heard voices, who self-injured, and so on, did not exist. However, such people may not have been conceptualised within bio-psychiatric classificatory systems as being mentally ill, and as thus requiring psychological or psychiatric intervention.

### **Colonial Psychiatry and Psychiatrization – a 'civilising mission'**

Therefore, psychiatrization in India is not solely a recent phenomenon, it has a history, a colonial history, which it is worth taking a moment to briefly explore. According to Ernst (1997:154), by the end of the 18<sup>th</sup> Century, the East India Company and other British institutions in India took as their model the 'valuable improvements in the treatment of Lunatics which have been introduced into European asylums', and built India's first asylums. In tracing the historical conditions of possibility for psychiatry and for asylums in India, Ernst (1997) charts how the management of asylums often replicated social stratifications, authoritarian and paternalistic systems congruent with the reality of colonialism.

Provision of asylums was tied to debates around the social responsibility of the colonial state, and how it should treat its citizens – the citizens and subjects it was bringing into being through often medical and educational mechanisms of subject formation. Here 'psychiatric confinement as social control was an important component in the preservation and delineation of the contours and composition of colonial society' (Ernst, 1997:175). Thus, the interweaving of medicine and education provide a surface of emergence for mental health literacy.

In fact, both Western education and medicine were constructed as justifications and benefits of colonisation, the 'excuse' of colonialism (Lyautey, cited in MacDonald,

1950). Thus British asylums in India were for a time seen as ‘citadels of European progress—symbolic strongholds of Western reason standing up against the maddening abyss of Eastern irrationality’ (Ernst, 1997:172). Psychiatry and medicine thus formed key tools of Empire, not only as a means of social control through the institutionalisation of those who were deviant, but because they acted as sites to perpetuate the,

colonial myth that Western medicine and psychiatry were practically and clinically efficient and effective and that the benefits of European medical practice could, and did, therefore outweigh and excuse the hardships and social problems concomitant on colonial domination (Ernst, 1997:172).

Medicine and education therefore acted as sites to justify colonial domination, to legitimise colonisation in the name of progress, and as rational scientific knowledge that would decrease the suffering of the ‘natives’. Thus,

Western medicine and its emergent offshoot, psychiatry, lent themselves especially well to purposes of ideological legitimisation. The attempt to impose a Western healing system and to discredit indigenous ones as uncivilized and superstitious became perceived of, and construed as, a noble part of the civilizing mission and as an expression of humanitarian concern (Ernst, 1997:169).

That mental health literacy resonates with colonialism is explicitly acknowledged by Summerfield (2008:992), in his discussion of research that constructs non-Western populations as having,

“limited knowledge of mental disorders”, their lack of “mental health literacy”, or the need to “teach” health workers and the people they serve about mental health. Here Western psychobiological discourse is setting out to instruct, regulate, and modernise, presenting as definitive the contemporary Western way of being a person. It is unclear why this should be good for mental health in Africa or Asia. This is medical imperialism, similar to the marginalisation of

indigenous knowledge systems in the colonial era, and is generally to the disadvantage of local populations.

Summerfield's concerns also resonate with Kirmayer's experience of the marketing of anti-depressants (and thus of Depression) in Japan.

What I was witnessing was a multinational corporation working hard to redefine narratives about mental health...[t]hese changes have far-reaching effects, informing the cultural conceptions of personhood and how people conduct their everyday lives. And this is happening on a global scale. These companies are upending long-held cultural beliefs about the meaning of illness and healing (Kirmayer, cited in Watters, 2010:198).

Reading mental health literacy and pharmaceutical marketing alongside the 'civilising mission' of colonialism in India, there are echoes, particularly in the conversion of those of 'heathen faiths' to Christianity (Bhabha, 1994:124). While mental health literacy promotion may seek to convert those who make use of traditional or religious healing to biomedical understandings, colonial company rule in India required a system of subject formation, to instil 'a sense of personal identity as we know it' (Grant, 1792, cited in Bhabha, 1994:124). This has links to pharmaceutical advertising techniques, which often market psychiatric medications through mobilising the desire 'to be yourself' – an exploitable and marketable desire. In fact increasingly drugs such as Ritalin (for ADHD) do not promise a false self, or even a new self, they mobilise the desire to get 'yourself' back again, 'it is through the drug that the self is restored to itself' (Rose, 2007: 214).

For Butchart (1999:66), missionary medicine, as a technology of benevolent conquest', emerged to convert the soul through clinical medicine, meaning that 'the caring hands of the doctor displaced the spectre of the gallows', epitomising a move from sovereignty to disciplinary forms of power during colonisation. And in parts of Africa, it was through the establishment of the Bantu clinic that the technology of social medicine aimed to make every African 'health conscious and health minded' through health propaganda in native schools (Butchart, 1999:66).



In fact, schools in colonial societies, as sites for the launch of mass literacy campaigns in the late 19th Century, operated as key sites for the technical transformation of individuals and societies and as technologies of discipline central to normalising colonial rule (Tarar, 2010). Thus colonial education in India served as a mechanism of social control, justified on an ethnocentric privileging of 'literacy' over the presumed 'orality' of the colonised (Tarar, 2010), calling for an exploration of the politico-economic rationales that different forms of literacy may be mobilised to serve.

### **Colonial Literacy**

That schools were central sites of colonial normalisation is interesting considering that Global Mental Health and the WHO increasingly target schools as key sites for mental health promotion and intervention for children and young people. This is evident in the following statements from the WHO (2001b),

With the spread of universal education, schools are becoming the most appropriate venue for health related interventions for children. Primary care workers need to be based in schools and to be equipped with skills to identify emotional and behavioural problems in children, and to treat and manage them (p25)...Special mention needs to be made of the potential of staffing schools with mental health workers who have basic skills in detecting and treating developmental and emotional disorders in children (p17)... [who] should also be able to identify vulnerable children and to employ preventive strategies (p33).

Thus within Global Mental Health, children and young people are constructed as vulnerable to mental illness, with schools seen as the best sites for both intervention and prevention. Schools are to operate, thus, as sites to pre-empt mental illness through being sensitive to vulnerability, and able to respond using preventative techniques. However, schools will do so by being staffed with mental health workers, and thus psychiatric knowledge is needed within schools to enable them to carry out interventions. The construction of children as vulnerable resonates with colonial constructions of the colonised as 'child-like' (see chapter 4) often made to justify colonisation in the guise of protection. In colonial India, English manners were taught

to construct 'an appropriate form of colonial subjectivity' ...'an empty form' of imitation of English manners, inducing the subjects to remain under colonial 'protection' (Grant, 1792, cited in Bhabha, 1994:124). Is it then possible to read mental health literacy as a system that teaches people of the global South to understand and frame their distress through a psychiatric or psychological register that then justifies psychiatric expertise and protection from the global North?

### **Emotional Literacy**

In fact, increasingly schools are also becoming key sites for mental health intervention in the UK, with the rise of another kind of literacy – 'emotional literacy'. Burman (2008) calls for analysis of the political agendas served by this turn to the emotions, and the available frameworks for writing and experiencing emotions that are in symbolic and cultural circulation. Similarly, Ayo (2011) points to the need to attend to the interconnections between health promotion more generally and the socio-political and economic modes of governance embedded within health discourse. For Ayo (2011:1), it is particularly the 'logic of neoliberalism [that is] deployed to shape health promotion', with neoliberalism coming to shape what Western societies understand as health.

Since the mid-1980s, Ayo (2011) charts how there has been an increase in policy that focuses on health promotion: a growth in healthism. For Ayo (2011:2), this healthism works alongside neoliberalism to promote self-regulating, individualised practises over more social interventions, reinforcing 'the idea of the entrepreneurial responsible citizen, at the same time as state's increasingly take less responsibility for citizen's health'. This raises concerns, then, for Global Mental Health and the WHO's deployment of mental health literacy and their simultaneous increased focus on the social determinants of mental health. A key focus of Global Mental Health advocacy is to push Governments and international agencies to recognise the 'burden' of mental illness, and thus to fund increasing numbers of mental health interventions. However, it seems that mental health literacy can be mobilised to promote individualised regulation that enable Governments to take decreasing responsibility for citizen's health.

A further problem here is that variations in emotional response and experiences of distress across and within countries thus become suppressed. Difference is denied in favour of conformity, and emotional responses become standardised – hinting at why Burman (2008) sees emotional literacy as a key example of a ‘technology of the self’ (Rose, 1985). This mapping of emotions on a global political scale, as a form of capital, thus works to ‘re-centre masculine and imperial privilege’ (Burman, 2008:15).

### **Colonising Global Mental Health**

Diverging into the colonial enables a reading of how mental health literacy and the work of some NGOs in India may operate through a colonial relation. For some critics of psychiatry and Global Mental Health this relation is explicit. For Read (2005:597), this is a colonisation of the bio-psycho-social model (into the ‘bio-bio-bio’), where ‘psycho education’ is a euphemism ‘promulgating the illness ideology to individuals and families’. For Thomas et al (2005:24),

The World Health Organisation’s mental health Global Action Plan (mhGAP) (World Health Organisation, 2002) is a global strategy to make governments more aware of mental health problems, and to get them to spend more money on psychiatric services. This is a mental health promotion strategy aimed at educating and persuading hundreds of millions of people across the planet about their mental health, but it articulates a very limited view of how we are to understand ‘mental health’.

We need to attend to the ways that mental health literacy may work to create particular (arguably psychiatric and neoliberal) subjectivities and ways of being a person on a global scale. This not only points to how Global Mental Health’s promotion of mental health literacy may (perhaps unintentionally) serve to establish global markets for the pharmaceutical industry. It hints at how mental health literacy may work more intrinsically as a mechanism to implant the logic of bio-psychiatry and neoliberalism deep into the minds of subjects, to create neoliberal subjectivities. Thus it may work as a means to allow ‘global capital and its circuits to prise open territories hitherto outside the purview of the modern industrial economy’ (Chakrabarti and Dhar,

2009:179) - to prise open (and simultaneously constitute) minds through the use of psycho-pharmaceuticals.

Thus bio-psychiatry (like the creation of Special Economic Zones on indigenous land) could be read as 'a (capitalist) "colony" deep inside the South' (Chakrabarti and Dhar, 2009:183). For Dhareshwar (2010:51), 'colonialism...is deep because it immediately brings up the question of what constitutes a form of life and what conditions are needed for its continued existence and flourishing'. In fact, as psychiatric drugs enter the body, they may well be one of the deepest forms of colonisation.

This resonates with Biko's (1978:92) assertion that 'the most potent weapon in the hands of the oppressor is the mind of the oppressed', and perhaps increasingly the brains of the oppressed. Thus it is possible to trace how this educating / marketing complex, 'helps generalize the concept of the modern West from a geographical and temporal entity to a psychological category. The West is now everywhere, within the West and outside; in structures and in minds' (Chakrabarti and Dhar, 2009:176). And indeed Western psychiatry is (almost) everywhere, within and outside of the walls of the asylum, within and outside of the West.

This was apparent to Higginbotham and Marsella (even in 1988) when they found that psychiatric treatment in many of the capital cities of Southeast Asia was relatively uniform, and spoke the same language of psychiatry as in the 'West', despite huge cultural and linguistic differences. They attributed this to older colonial forces and current mechanisms for the diffusion of psychiatry from the 'West' – mainly, mental health education, consultation, and the fact that many of the psychiatrists in national decision making positions had often been educated in the West (just as many psychiatrists now leave India to work in HICS, such as the UK – the 'brain drain') (Higginbotham and Marsella, 1988).

Bhargavi Davar spoke to me a little about this 'brain drain'. She said, '[i]n India there are only 3000 psychiatrists, as of now. Because new trained psychiatrists leave the country and they go to the UK (Bhargavi laughs, infectiously)...Take the rest of them, take the other 3000.' I giggled, and said, 'but a lot of NGOs frame that as being a

problem – the low number of psychiatrists, lack of access to meds, where do you stand’? And Bhargavi replied,

I don’t know, because earlier I used to be happy that these guys are going away, but do you know what they’re doing? The few of them who are left behind, they’re training lay people to give prescribed medicines. And that’s really risky...and they’re training private practises to deliver shock treatment. Private practitioners are delivering shock treatment by the dozens. Shock treatment is huge in the last decade after a large recruitment by the NHS and Australia, and a huge number of asylums, where people are just put away. I don’t think these are nice options. I would prefer that the psychiatrists came back. Because there’s no one to take their place when they go, because they don’t share power with clinical psychologists or other professionals. Middle-class people can access yoga teachers and mediation but the poor and the ‘severely disturbed’ get pushed into forced treatment...and they don’t get out, they’re there forever.<sup>53</sup>

Perhaps, then, there are multiple colonisations at work; of the bio-psycho-social by the ‘bio’; of distress, and its indigenous and cultural idioms by psychiatry; and of psychiatry by the pharmaceutical industry. For Loren Mosher, ‘[p]sychiatry has been almost completely bought out by the drug companies’ (cited in Redler, 2004).

### **Tick Tock, pharmaceutical clock**

Taking this seriously, it might be useful here to briefly explore those campaigns that proponents of mental health literacy, such as Jorm (2000), point to as being successful in HICS, and the political and corporate rationales these may align with. For example, America’s National Depression Screening Day (1991) aimed to ‘call public attention to depression; to educate the public about symptoms and treatments and to identify individuals who may be unaware they are clinically depressed’ (Jorm, 2000:399). Such campaigns ‘showed small but significant changes in the percentage of the public who believe that antidepressants are effective and who would be willing to seek professional help...the results are certainly encouraging’ (Jorm, 2000:399). But

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<sup>53</sup> Interview with Bhargavi Davar, in Pune, February 2011.

encouraging for whom? This is a question worth asking when we consider that the National Depression Screening Day was funded by a grant from Eli Lilly (the company that manufactures Prozac) (Citizens Commission on Human Rights International, undated).

This highlights the point made by Ecks (2005:241) that within pharmaceutical citizenship, 'the role of civic education is replaced by medical marketing.' For Jorm (2000:397), the public's ability to 'use correct psychiatric label[s]' and their knowledge of symptomology is key because '[d]etection of a mental disorder is greater if the patient presents his or her symptoms as reflecting a psychological problem and explicitly raises the problem with the GP'. Thus mental health literacy works to enable people to identify their distress as being psychological, and to present their experiences as psychological 'symptoms', to a doctor.

Identifying one's distress as psychological or psychiatric 'symptoms' also appears to be a key goal of direct-to-consumer advertising in America (legal since 1997), with research suggesting that 'patients who request particular brands of drugs after seeing advertisements are nearly nine times more likely to get what they ask for than those who simply seek a doctor's advice' (Rubin, 2004:379). Rubin (2004:380) goes on to highlight this as a process of 'merchandising madness';

The range of psychotropic pharmaceutical merchandise is breathtaking. It is not uncommon to find friends and colleagues drinking from a Zoloft mug, writing with a Seroquel pen, squeezing a Paxil sponge ball-brain, relaxing to a Prozac waterfall, eating popcorn and Pop-Tarts in Resperdal packaging, wiping away tears with Librium tissues, or telling time from a Geodon clock.

It was under the ticking of a pharmaceutical company clock (Shine pharmaceuticals), in the noisy Iswar Sankalpa office (an NGO in Kolkata), that Sarabani Das Roy (the founder of the organisation) explained that the charity have 'never had to buy any [psychiatric] medication. It's only general medicines that we have to buy'. When asked why, she replied with a wry smile that this is because pharmaceutical companies donate psychiatric medications for free. She felt this was because the managerial board of the

organisation is made up of psychiatrists, thus free donations of psychiatric medicines was a marketing strategy. She talked of psychiatrists she knew having had their marriages and funerals paid for by pharmaceutical companies. The clock ticked.

This begs the question of why pharmaceutical companies would freely donate psychiatric medications but not medications for other, physical illnesses. It suggests that pharmaceutical companies are attempting to create a market for psychiatric medications in LAMICS, and may draw upon NGOs as distributory channels, both for medications and for biomedical and bio-psychiatric knowledge constructs that in part originate from HICS. The Banyan's provision of 'free medication for life', and the work of the Shraddha Foundation, both posting envelopes full of psychiatric medications all over India, is an example of these channels (see the following chapter).

### **Global 'Disease Mongering'**

This potentially opens mental health literacy campaigns to the same critiques made against pharmaceutical advertising, that they are methods of disease mongering,<sup>54</sup> 'widening the boundaries of treatable illness in order to expand markets for those who sell and deliver treatments' (Moynihan, Heath and Henry, 2002:886). Might Global Mental Health literacy campaigns thus perform disease mongering on a global scale? Does mental health literacy, like pharmaceutical marketing, market the disease as much as the medication? There is a huge financial incentive here for the pharmaceutical industry because India, 'with a population of over a billion is a largely 'untapped market' for psychiatric drugs (Equity Master, 2004).

However, executives from the pharmaceutical company Novartis told the World Bank (in reference to making available a cancer therapy) that they viewed India as a market of just 50 million people, meaning they did not plan to sell their drugs to the other 95% of the Indian population, many of them poor (Shah, 2006:116). It would thus seem that not everyone is destined to be a pharmaceutical citizen. However, those who may never be the consumer of the product, who may never become a subject through

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<sup>54</sup> See PLoS Medicine's April 2006 series of articles on 'disease mongering' <http://www.ploscollections.org/article/browse/issue.action?issue=info%3Adoi%2F10.1371%2Fissue.pcol.v07.i02> (Accessed August, 15th 2010).

medication, were not outside this process. Some of them became the test subjects in a booming clinical trials industry, aggressively promoted by the Indian Government (Srinivisan, 2009), and often justified on the grounds of helping those who are 'medicine deprived' (Shah, 2006:36).

Reading global markets in mental health alongside WHO warnings 'that many countries will be unable to cope with a predicted boom in mental illness over the next decade' (BBC, 2001), further complicates matters. Healy (2004:2) suggests that since the discovery and marketing of anti-depressant drugs, there has been a thousand-fold increase in the number of people thought to be affected by Depression. Similarly, Kleinman (1999 - online) stated that '[i]n developing countries, there was a problem with under-recognition of depression, but in the West there was a danger of over-diagnosis'. This brings into being an anxious space. While it seems obvious that increased recognition brings increased diagnosis, the mechanisms at work here are difficult to discern. This could mean either that with increased knowledge there is better recognition of mental illness; or that as 'mental illness' becomes a part of the cultural imaginary, an increasingly available way to be a person, then increasing numbers of people come to see themselves, or be seen by others, as mentally ill.

This also troubles the use of a critique originating in a space of 'excess' (over-prescription) onto a site of under access (where often access to life-saving medicines may not be available). Furthermore, this calls for consideration of whether advocates of Global Mental Health, such as Jorm (2000), should, when bearing in mind the financial incentive for the pharmaceutical industry in marketing disorders, call for pharmaceutical industry funded education campaigns to be used as models to promote global mental health literacy. Can mental health problems be recognized (whether as an illness or not) without simultaneously creating new markets for pharmaceuticals?

Having traced the ways in which Global Mental Health literacy works, like colonial discourse, as a 'knowledge' base that creates a space for a "subject peoples" (Bhabha, 1983:23), psychiatric citizens, to come into being, this chapter leaves many questions to be answered. How does this 'reality' of Global Mental Health function as a field of subjectification? By what other means and techniques might psychiatric subjects be



formed? And how do the channels that distribute Global Mental Health knowledge, such as NGOs, bring into being particular realities and subjects? For 'making up' through mental health literacy campaigns may not be the only way of formulating the bringing into being of psychiatrized subjects.



## Chapter Seven

### **The Turn / The Look: Interpellating the Mad Colonial Subject**

*A chapter on abrading, objectifying, crushing, on psychiatrization, on hailing and recruiting, recruiting them all, a way of forming subjects that almost always gets its (wo)man, about a look, and a turn, a doubling, the formulas and figures of interpellation – from behind, from above, face to face, about a psychiatrist squatting down on the street.*

*Who will occupy the space of Global Mental Health, and how will ‘they’ come into being?*

### **'It recruits them all'**

'[T]o make mental health for all a reality' (Patel, et al, 2011:90) – the last chapter explored what this reality might be, what political rationales it might align with and how this may be read as a process of 'making up' people (Hacking, 2006). In this chapter, I want to turn, through the interpellating 'turn', to the 'on the ground' mechanisms of bringing psychiatric 'subject peoples' into being, in India. To enable a conceptual reading of these mechanisms, I will draw upon two different formulas of interpellation – Althusser's hail - 'Hey, You', and Fanon's 'Look, a Negro'. Having juxtaposed psychiatric and colonial subject formation, these two formulas offer different readings of how subjects are 'made up', often violently, and how they may 'all' come into being.

In the last chapter, mental health literacy was read alongside colonial literacy and pharmaceutical marketing to illuminate the process by which particular subjects are brought into being to occupy the 'reality' of mental health. In fact, pharmaceutical marketing hints at some useful conceptual tools with which to grapple with the formation of psychiatric subjects - how they are 'called upon', called into being. Saatchi and Saatchi, the advertising company that designed the advertising campaign for Astra Zeneca's anti-psychotic, Seroquel XR (2010) (discussed in more detail in the following chapter) suggest one formulation for bringing subjects into being. In an interview, representatives from the company explained that,

Bipolar depression is a new term for the consumer audience, so the campaign had to be as much about education as it was about medication. The ad team did a stunning job setting a tone and mood that made viewers turn to the TV and say "That's me, that's what I feel like, and now it has it's [sic] name" (Saatchi and Saatchi, 2010).

This 'turn' to the TV, 'that's me', this naming of oneself through a psychiatric classification (its name), is reminiscent of Althusser's (1971) 'turn', where subjects come into being through being hailed by an ideology, similar to the banal, everyday act of a police officer hailing a person in the street – 'Hey, you there!'

If we suppose that the imagined theoretical scene takes place in the street, the interpellated individual turns around. By this simple 180-degree physical conversion, he becomes a subject. Why? Because he has recognized that the interpellation is “indeed” addressed to him, and that “it is indeed he” who has been interpellated (and not another)...ideology “acts” or “functions” in such a way that it recruits subjects amongst individuals (it recruits them all), or “transforms” individuals into subjects (it transforms them all) by this very precise operation that we call interpellation (Althusser, 1971:174).

Interpellation, through a turn, recruits subjects, ‘it recruits them all’, just as mental health is made a reality ‘for all’ (Patel, et al, 2011:90), and just as Schizophrenia can affect ‘everyone, everywhere’ (WHO, 2001:x). Mental health literacy, alongside other psychiatric interventions, thus seems to recruit particular subjectivities, hailing people in specifically psychiatric ways. That this interpellation is banal, occurring on the street also resonates with the psychiatric interventions of many NGOs in India, who through the diagnosis of some homeless people as ‘mentally ill’ on the streets, highlight a key mechanism for the interpellation of psychiatric subjects.

There is a saying at Iswar Sankalpa (a mental health NGO in Kolkata), widely repeated with a sense of pride – that their work is ‘psychiatry without the cables and cobwebs’. Sarbani (the co-founder of the organisation) explained to me that this refers to their work on the streets, where psychiatrists squat down next to those who are homeless and distressed, and diagnose them with mental illness. Here the streets of India are the site, the field, of psychiatric subjectification. And there are other mechanisms at work, other ways of forming subjects ‘on the ground’.

### **The ‘Destitute Mentally Ill’ - The Banyan**

The Banyan was one of the first organisations that I contacted in India, and the first one I visited, the day after I arrived in Chennai. The Banyan works with the ‘destitute mentally ill’ in Chennai; ‘rescuing’ homeless women from Chennai’s streets and bringing them into their ‘transit centre’ for psychiatric and psychological treatment and rehabilitation. I visited this ‘transit centre’ in January 2011.

After an onion uttapam and then another, followed by a rickshaw journey mostly in the wrong direction, I arrived at the Banyan's 'transit care centre' – Addaikalam (see picture below). However, on entering it seemed to me that for some of the women housed there it would be a long and possibly not very transitory stay. After a little bureaucracy, I waited in the reception area, welcomed by many of the women who live there amid hand shaking, cheek pinching, and a chorus of 'have you had your lunch'? What did you have'? Then Sonia [name changed], a residential social worker, took us on a tour. Straight up a narrow staircase to the third floor, to 'Acute Ward A'. There were rooms we couldn't see into. About a dozen women stood in one room, behind bars, the gate was locked. Some of the women reached their hands through the bars to shake my hand. One lady asked me, 'Do you remember me?' I had never visited before.

Sonia said they had to be locked in. I asked her if all the women were taking medications. She said they had to. She explained that all the women housed there are referred either by the police or by family, and all the women are destitute. They are almost all medicated, and continue to be so if they return to their families. They are sometimes brought back in if they stop taking their medication. The third floor also housed isolation rooms – locked. We met a lady in one of these rooms, she sang to me in Tamil.

The women usually spend their first few months at Addaikalam in 'Acute ward A', seeing a psychiatrist twice a month. Then they move onto 'Acute ward 2' where the women were not locked in. They were, in Sonia's words, now 'manageable'. In the unlocked rooms the floors were lined with sleeping bodies, some women sat hunched over - looking faraway. The wards changed as we made our way further downstairs. There were less locked doors. There were women making bags and doing embroidery.

On the ground floor, in the geriatric ward, beds were filled with older women and some young ones amongst them who had sneaked in to watch the television. Sonia said that these women had no family – or at least none that

could care for them. Ordinary nursing homes would not take them because of their mental illness. It seemed like some of the women had been, or would be, there for a long time. [Field notes, January 5<sup>th</sup> 2011].



Addaikalam – The Banyan ‘transit centre’

### **‘Power that speaks softly’**

The Banyan buys medication for their patients from pharmaceutical companies, at slightly discounted prices (spending much of their budget on this). As part of their services they offer many low-income families ‘free medication for life’, posting envelopes full of psychiatric medicines all over India.<sup>55</sup> The Banyan also runs an outpatient clinic in the grounds of a local sixth-form college. Vandana Gopikumar, the co-founder of The Banyan, asked me if I would like to come and visit, they were going in a moment and I could get a lift. I said yes, and off we went.

Located in a hot dusty courtyard, in the grounds and in the shadow of the imposing white façade of Loyola Sixth-form college, in Chennai, sits the outpatient clinic of the Banyan. Here people who have been diagnosed by the Banyan as ‘mentally ill’ come for check-ups and to collect medication, with their families. Some families have travelled from miles away, from rural Tamil Nadu, hours on a bumpy bus. I stood in the outdoor square, while the patients formed a circle, where shiny blue and white leaflets were distributed. Someone gave me a copy of one. It was a leaflet from the drug company Pfizer. The leaflet asks people to rate how strongly they experience particular side-effects of one of the

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<sup>55</sup> See The Banyan’s website <http://www.thebanyan.org/>

company's anti-depressant drugs. It was in Tamil and English. Instead of filling in the form individually, everybody formed a circle, with a man in the middle who read out the list of side effects, asking people to move in or out of the circle depending on how strongly they experienced particular effects. Then the circle dispersed; on to a quick meeting with a social worker, and to join the long queue outside the room that dispensed the psychiatric medications. I stood there smiling nervously, the Psychiatrist in charge came to chat, he told me they had wanted to make the out-patient clinic a community resource centre, but he felt it had never really developed beyond being a drug dispensary. I had a quick look at Pfizer's leaflet; it was for Daxid Sertraline (known in the USA as Zoloft), an anti-depressant. The leaflet says; 'Sertraline, power that speaks softly', and 'Pfizer, working together for a healthier world'. I wondered what constitutes Pfizer's idea of a 'healthier world'?

[Field notes, January 5th 2011]

How Pfizer's idea of a 'healthier world' interlaces with the softly spoken power of psychiatric medications, promising forms of 'pharmaceutical citizenship' (Ecks, 2005:239), is something this chapter will return to shortly.

### **The 'Wandering Destitute' - Shraddha Foundation**

The train from Pune to Kargat took around 2-3 hours, it was too crowded to sit, I didn't even need to hold onto the rail because I was so tightly packed. A text message from Dr Bharat Vatwani, the co-founder of the Shraddha Foundation, where I was now heading, asked me if I minded riding 'legs a pillion' on my arrival. I had no idea what 'legs a pillion' meant, so I said I didn't mind and hoped for the best. I had contacted Bharat when I found the website for the Shraddha Foundation in one of my many hours spent researching in often hot, crowded Indian internet cafes (if only I'd brought a laptop!). The website said that Shraddha was founded in 1988, by husband and wife psychiatrists, to care for 'the mentally afflicted destitute wandering aimlessly on the streets of India'. It says; 'Shraddha is a humane experiment...providing treatment, custodial care and rehabilitation to a neglected group of mentally-ill roadside destitute



and reuniting them with their lost families'.<sup>56</sup> I emailed Bharat to explain a little about my research, and asked if I could visit. He emailed back saying I was welcome to visit but;

What I won't allow are the patients being interviewed. Basically these are schizophrenic patients or severely depressed or whatever. Even though technically and legally I have their consent for just about anything, I don't want them to be used in any research material, be it in India or abroad. The whole idea of the institution is to treat them with medicines and a certain degree of dignity, care and compassion and once they become reasonably ok to reunite them with their families, and during the process of reunion bring about awareness about psychiatric illnesses, symptomatology etc in the villages in which the reunions take place. I don't believe it is ethical on my part (and this is a very personal view) to allow them to be used in any research materials. Hope you will understand the sensitiveness of the issue. You may however use any interviews with the staff/ me/ my wife etc since we are all aware of what we are speaking.

I agreed to no interviews with the 'patients' (to which I will refer to those who reside at Shraddha, as this is the word that the staff use), but I felt uncomfortable, and not just because the train was so crowded. The train arrived and I waited at the railway bridge. A psychiatrist on a motorbike arrived, and 'legs a pillion' we drove through beautiful countryside, through the gate of the Shraddha Foundation and straight into the reception. Bharat was busy, so a young male psychiatrist showed me around, chatting while we walked through Shraddha's ample space, enough to include a dairy farm, vegetable and rice cultivation 'by the inmates' (as the psychiatrist called those who reside at Shraddha) and an outdoor prayer unit.

We came to where the 'inmates' live; low bungalows, with a courtyard open to the air in the centre; one for the women, one for the men. They were locked. The person with the key used to be a patient, but couldn't be re-united with their family, so stayed and

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<sup>56</sup> See Shraddha Foundation website:  
<http://www.shraddharehabilitationfoundation.org/innovation-statement.htm>.

worked at Shraddha, letting visitors like me and the psychiatrist in and out, and making sure the patients stayed inside. Many of the patients looked quite heavily medicated, some were walking up and down, and many watched the television. A strong smell of disinfectant mixed with the fresh countryside air.

We left and went to visit the building where the women patients live. An ex-patient unlocked the gate. A lady with a hopeful look in her eye spoke to me urgently in Urdu. I smiled my apology; I could only say 'God be with you' (though I really meant it). The psychiatrist who was my tour guide, explained that the lady speaking Urdu had been found at a railway station, where many people with mental illness are found in India, and brought to Shraddha. Currently the staff member who spoke Urdu was away, so no-one knew what the lady was trying to tell us in Urdu. We left, the gate locked behind us, out into the open countryside, a strange contrast to the locked gates.

After my tour, Bharat and I had lunch, a feast made by some of the women who used to be patients and now worked at Shraddha. Bharat didn't want to be recorded. He explained to me that Shraddha differs from many organisations that work with the mentally ill in India because of their emphasis on reuniting the patients with their families. I told him about my visit to the Banyan, in Chennai, and how I worried that many of the women once 'rescued' from the streets could never leave the institution – unless their family came to collect them. Bharat agreed, he saw the problem with many NGOs being that they 'collected' the mentally ill, and kept them. But the reuniting work they do is hard. He explained that the mentally ill from all over India turn up at railway stations, particularly in Mumbai. Often these people don't know where they have come from, and because of the vast number of languages spoken in India, they are often unable to communicate with anyone on their arrival. Thus Shraddha now employs staff who can speak many languages, and once the 'destitute' person has been treated at the Foundation, they try to help them remember their homes. Sometimes from just a name of a nearby temple or village, they have located that person's family, and after many long journeys on trains and buses all over India, have reunited them. According to Shraddha's 2011 newsletter, they are very successful at this aspect of their work;

We are pleased to inform you that in the year 2011 gone by, we have picked up 332 mentally ill destitutes off the streets, brought them to our center in Karjat, treated them for their mental illness and finally reunited them with their families in different corners of India. This is a six fold increase in the quantum of work compared to the meagre 47 destitutes which we had picked up in the year 2006.<sup>57</sup>

The family may not recognise the person, some have been gone for over twenty years, but the team from Shraddha explain to the family, and the local community that the person is mentally ill, often 'Schizophrenic', and that with medication and care they can be rehabilitated. Thus, according to their website, a key part of Shraddha's mission involves;

Educating the family, neighbouring locals & elders, with organized gatherings involving hand-on question sessions about mental illness; causation, symptomology, treatment amelioration; dispelling myths and misconceptions about Schizophrenia.

This education also extends to others in the community who might encounter mentally ill people on the streets, such as rickshaw drivers. Due to such awareness raising some rickshaw drivers have on occasion brought distressed people from the streets to Shraddha, instead of taking them to the Police. Perhaps unsurprisingly, considering Shraddha was founded by two psychiatrists, the framework for understanding mental illness taught to families and communities is heavily medical. 'Treatment' always involves psychiatric medicines, with the families being taught how and how often to administer these to their 'mentally ill' relative. Like the Banyan, Shraddha posts out envelopes full of psychiatric medications all over India. To enable their mental health education to reach further than small communities, Shraddha have also appeared in the media, including in many Indian newspapers. One article, in the Bombay Times entitled 'Shraddha Foundation brings Schizophrenics back to reality,' explains;

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<sup>57</sup> Newsletter from Shraddha Foundation. [online] <http://www.shraddharehabilitationfoundation.org/newsletter.htm> (Accessed January 12th 2012).

Schizophrenia is a major mental illness which requires immediate and definite medical attention. The patient's thoughts and emotions are disjunct and split off from reality.

SYMPTOMS:

- Gibberish talk
- Smiles, laughs, talks to himself without any reason.
- Prefers remaining unhygienic and unrepresentable in appearance.
- Is suspicious about friends, neighbours (Fernandes, 1998).

What 'reality' is Shraddha bringing 'schizophrenics' back to? Might this be read as making 'schizophrenia' a reality? How does this relate to 'making mental health for all a reality'?

**'Making up' Schizophrenics in Ethiopia**

On day four of the course in Global Mental Health, at the Institute of Psychiatry (London, August 2011), as the rain continued to fall and I noticed with suspicion that the breakfast pastries seemed to be getting smaller each day, a Psychiatrist arrived from Ethiopia to talk to us about Schizophrenia. He had been part of a study that all the psychiatrists in attendance were very excited about, 'one of a kind'. The study aimed to examine the clinical outcome for Schizophrenia in a 'predominantly treatment naïve cohort in a rural community setting in Ethiopia' (Alem et al, 2009:646). 'Treatment naïve' refers to the fact that large populations of people in many LAMICs have not had access or been exposed to psychiatric interventions and medications. This lack of access to medications that are widely available in HICs, this 'naivety', is in part conceptualised by the pharmaceutical industry as an 'untapped' or 'emergent' market to sell drugs to, and as potential subjects for clinical trials (as noted earlier).

The study in Ethiopia came about as a means to further investigate the findings from the WHO's DOSMED (1978), which found overall more favourable outcomes for people with a Schizophrenia diagnosis in 'developing countries'. While the researchers in the Ethiopia study see the DOSMED study as one of the 'best designed' outcome studies of its kind, they point to a number of methodological limitations important to the

interpretation of the findings. The key problem for them is that ‘despite the application of well-defined operational criteria, broad diagnostic classes were incorporated together to represent schizophrenia’, and many would not have been classed as having schizophrenia under the ICD (Ninth revision), or using more narrowly defined classifications (Alem et al, 2009:647).

The reliability of psychiatric diagnoses has long haunted psychiatry; the DSM-III being an attempt to control this by employing ‘descriptive diagnosis’ where a check-list is used to define illness through the symptoms present (Greenberg, 2011). However, this questioning of the DOSMED study on the grounds that many of those who had better outcomes in developing countries may not have actually had Schizophrenia reminds me of a discussion in one of the workshops I facilitated at an NGO in India. After discussing the stories of recovery of people who heard voices and /or had a label of Schizophrenia (in the UK), one participant was keen to establish whether those who had recovered *really* had had Schizophrenia. This points to how the portrayal of Schizophrenia as ‘serious’ and ‘debilitating’ within Global Mental Health literature (see chapter two) may work to prevent those with a favourable outcome, or who recover, from ever being seen as having had Schizophrenia in the first place.

Back to the study in Ethiopia, where, before the clinical outcomes of Schizophrenia could be assessed, the researchers needed to identify those in the community who had Schizophrenia. This is the part of the study that inspired so many admiring sighs from the psychiatrists in the room where our lecture took place. This process of identification involved an initial screening that targeted ‘the entire adult population of the 44 subdistricts...estimated to be 83,282 [people]’ (Alem et al, 2009:647). The screening involved door-to-door surveys and the administering of the affective and psychoses modules of the Composite International Diagnostic Interview (CIDI) (version 2.1). This was administered to 68,378 people; 82.1% of the total population of the district. The ability to screen such large numbers of people was aided by the location of the study in a district that housed a Demographic Surveillance Site (DSS) that monitors health statistics. The study used these statistics to standardise their findings against. This hints not only at the role of statistics in a biopolitical production of life, but at a link

between diagnostic tools, medication and surveillance (a link that will be further elaborated upon shortly).

The Composite International Diagnostic Interview (CIDI) is a diagnostic tool specifically designed to be used in cross-cultural research and to be administered by lay people. According to the WHO (2004),

The CIDI is a comprehensive, fully-structured interview designed to be used by trained lay interviewers for the assessment of mental disorders according to the definitions and criteria of ICD-10 and DSM-IV. It is intended for use in epidemiological and cross-cultural studies as well as for clinical and research purposes.

The CIDI allows the investigator to:

- Measure the prevalence of mental disorders
- Measure the severity of these disorders
- Determine the burden of these disorders
- Assess service use
- Assess the use of medications in treating these disorders
- Assess who is treated, who remains untreated, and what are the barriers to treatment.

Thus the CIDI, alongside other tools such as the ICD and DSM, work as instruments of psychiatric technology that elicit 'symptoms' of mental illness, bring into being particular people 'with mental illness', and conceptualise these people as in need of treatment. The use of diagnostic tools in epidemiological and cross-cultural studies has been useful in displaying the variation in prevalence of mental illnesses across cultures, and as in the WHO's DOSMED studies, in pointing to variation in outcomes of mental illness for people in different parts of the world. Such tools have also been key in beginning to map the relation between poverty and mental illness, and the social determinants of mental health more generally.

However, according to Sedgwick (1982:24), psychiatric epidemiology 'achieves this social insight by regarding the contours of the boxes into which its numerations fall as

uncontroversial, objective boundaries, analogous to the physical disease categories'. Epidemiology was, after all, originally the study of epidemics of infectious disease, and while it has now become possible to speak of epidemics of mental illness, for example, the 'depression epidemic' (BBC, 1999), it bears the implicit assumption that mental illnesses are comparable to diseases caused by bacilli (Sedgwick, 1982). Similarly, statistical techniques of classification, such as the CIDI, rely on a numerical taxonomy devised originally for sorting microbes according to objective characteristics (Sedgwick, 1982). This enables an understanding as to why individualised techniques of treatment, such as anti-depressants, seem so easily to co-exist alongside recognition of the social determinants of mental illness.

In fact, diagnostic tools and statistical technology have been key to the growth of transnational psychiatry and Global Mental Health, as it is assumed that they enable the standardized diagnosis of diverse populations for comparison, and that diagnostic categories and therefore 'mental illness' are transferable across cultures. This is despite the fact that 'both the concepts under investigation and the standardized means for measuring them were created and imposed by Western researchers onto nonWestern cultures' (Higginbotham and Marsella, 1988:556). Despite this, these tools, that for Summerfield (2008:992) 'are Western cultural documents par excellence', are employed on a global scale through the WHO World Mental Health Survey initiative and the WHO Mental Health Atlas 2011 project, and provide the 'conditions of possibility' for a 'treatment 'gap' to come into being; a field of visibility for the 'treatment gap' to be seen.

Such tools also, according to Lakoff (2005), enable the re-biologisation of psychiatry, apparent in the number of languages that the DSM has been translated into, and the wide distribution of the DSM by pharmaceutical companies in LAMICS. According to Rose (2006:478), such 'diagnostic tools elicit signs that are taken as evidence of pathologies that would previously have been invisible', and are then conceptualised as in need of treating, enabling a 'diagnostic creep', often 'elicited by the technology itself'. Perhaps here we should heed Fanon's cry ([1967]1986a:231), that the '[t]he tool never possess the man [sic]'.

This prevalence data of the 'global burden' of mental illnesses, and the diagnostic and statistical tools it emerges from, are used to mobilise increased recognition and resources from Governments (nationally and internationally) to address mental health. However, this points to a somewhat troubled relationship between advocates of Global Mental Health, the WHO, and the pharmaceutical industry. As previously mentioned, many advocates of Global Mental Health explicitly eschew pharmaceutical company funding;<sup>58</sup> in some cases argue that older drugs, now out of patent are just as effective as the newer ones (Mari et al, 2009); and argue for psychiatric drugs to be exempted from patents under Intellectual Property (Patel, 2006) (discussed in Chapter 5).

Yet through mental health literacy campaigns people are 'educated' to locate distress in their brain chemistry, potentially securing markets for the sale of psychiatric drugs in countries of the global South. Taking criticisms of global 'disease mongering' seriously then, it becomes possible to see how the very tools for measuring mental illnesses across populations, as 'epidemics', may also be part of spreading that epidemic, enabling disorders to cross geographical borders. This suggests that mobilisations of psychiatry and 'mental illness' may work both within and against the pharmaceutical industry, often simultaneously.

### **The Flip Chart of Mental Disorders**

A key mechanism for the globalisation of mental illness categories has thus been the training of lay people to administer diagnostic and epidemiological tools, such as the CIDI. This training of lay people and community health workers in areas 'where there is no psychiatrist', has been central to community mental health interventions, marked by Vikram Patel's (2003) mental health care manual of the same name, which is widely used by many NGOs in India. Training in the community is also a key part of the work of BasicNeeds. In their 'facilitator's manual for training community mental health workers in India', BasicNeeds (2009:26) suggest an activity using 'symptoms of mental disorders cards' to 'help participants recognise symptoms associated with mental disorders'. Some of the pictures from these cards are shown below.

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<sup>58</sup> This was explained at the Course in Global Mental Health, that I attended in London, August 2011.





14. Attempting suicide



17. Seeing things not really there



18. Poor judgement

*Pictures of 'symptoms' from BasicNeeds (2009) 'Facilitator's manual for training community mental health workers in India' (pp. 117-119).*

That the training of lay people to administer psychiatric diagnostic checklists is key in recruiting psychiatric subjects, also resonates with the colonial imaginary of developing 'a class of interpreters between us and the millions whom we govern – a class of

persons Indian in blood and colour, but English in tastes, in opinions, in morals and in intellect' (Macaulay 1835, cited in Theodore de Bary, 1958:49). Furthermore, in the study in Ethiopia, 'key informants' were used to aid 'case identification'. This involved using the CIDI with people who were identified as key figures in the community, to identify anyone in the community who may behave like, or have experienced any of, the categories of symptoms and behaviours listed in the assessment tool.

The Shraddha Foundation also uses pictures of 'symptoms' for community mental health education, and 'key informants', to identify people with mental illness within the community. However, instead of using an assessment tool, like the CIDI, Shraddha Foundation uses pictures taken from the WHO-NIMHANS 'ten features of mental disorders' flip chart. (See below).<sup>59</sup>

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<sup>59</sup> The flipchart is available from the Centre for Advocacy in Mental Health website, see [http://bapucamhindia.org/aaina/aaina\\_march06.htm](http://bapucamhindia.org/aaina/aaina_march06.htm)



Behaving in a strange manner



Feeling unusually sad



Unusually Cheerful or boastful



Seeing and hearing things others do not



Abnormally suspicious of others



Having Suicidal Tendencies



Suffering from fits



Becoming moody and withdrawn

*Illustrations taken from the WHO-NIMHANS 'ten features of mental disorders' flip chart.*

These pictures are shown to members of the community, including to rickshaw drivers and shop owners, to teach them how to identify people in the community who may have a mental illness. These people can then inform the Shraddha Foundation if they encounter any such people (who seem to match those in the flip chart), and staff from

Shraddha will arrive in a converted ambulance to assess the person, and decide whether they should take them in to be treated.

In many Indian States the pictures from the NIMHANS/WHO flipchart have been made into posters and are often displayed prominently in hospitals (Bapu Trust, 2006). However, Bapu Trust in Pune is calling for the need to advocate with India's mental health authorities, and the WHO, to push for the withdrawal of these materials. In 2006, Bapu Trust ran a training programme on 'Gender and Mental Health', where a workshop was held to discuss the mental disorders flip chart.<sup>60</sup> The participants at the workshop were concerned with the pictures in the flip chart and, in summary, felt that; the pictures portray all socially unacceptable behaviour as mental illness; the pictures and text may actually increase stigma as they depict mental illness as 'aloof', 'strange', 'abnormal', and 'unusual'; and that there is bias against traditional healing, and a suggestion that going to a 'mantravadi' (healer) is itself a symptom of mental illness. Furthermore, an article in Bapu's advocacy magazine, Aaina, (2006) raised concerns that the use of the flipchart within communities,

may actually lead to witch hunting in communities through the community mental health programs. People who do not have an identity as a "mentally ill person" would be identified and compulsorily brought for treatment to the satellite clinics (Bapu Trust, 2006).

The workshop also raised concerns that the reasons why people might become mentally ill are not discussed in the flipchart and the voices of those with mental illness remain entirely absent. Bapu Trust felt that a strong 'Severe Mental Disorder' perspective is propagated through the flipchart likely to lead to more alienation of those with mental illness from their communities. This is worrying because the flipchart is often the only material available for district mental health programmes.

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<sup>60</sup> This resulted in the publication of a booklet - Center for Advocacy in Mental Health. (2006). Gender and Mental Health. A Report. CAMH, Pune.

However, it is not the use of pictures itself in mental health education that troubles Bapu Trust. In fact the use of pictures seems important in a country like India, where many different languages are spoken. This became apparent to me at the end of a long day in Kolkata, when I arrived to facilitate a workshop about alternative understandings of hearing voices, at Sarbari - Kolkata's first women's night shelter, opened by Iswar Sankalpa. Here's a field note.

Just before we began, as the PowerPoint didn't work, and a new arrival at the shelter began singing Hindi film songs at full volume, Sarbani said to me, 'I hope you've got examples, and it's not all words'... 'you should tell them how they might use drawings'. I panicked, drawings? Really? I'm terrible at drawing. I tried to ignore her.

But later on she persisted - has the Hearing Voices Network got pictures / images of what the voices are like - images of what a voice seems like or how it makes you feel - the characteristics of a punishing voice, a comforting voice? This just reminded me of the WHO/NIMHANS flipchart- the illustrations of Indian people displaying a range of 'symptoms'. I don't want to replicate those - to me those images are a tool to colonise understandings of distress, or in the language of those who use them, to '(re)educate' people about mental illness, and particularly Schizophrenia. They are similar to the translation of the DSM into local languages. This throws me into a confusion over whether alternative approaches may also colonize local understandings; whether I should 'educate' the 'locals' about the Hearing Voices approach; whether I should translate survivor literature or Hearing Voices Network material into local languages, and show pictures of what it's like to hear voices at community 'education' events.

Furthermore, I am beginning to wonder whether colonisation is actually a helpful concept here. For Sarbani and the staff at Iswar Sankalpa there's a sharp reality to this - everyday they meet new people experiencing mental distress, on the streets and railway stations where they carry out their work, people who arrive from all over India and bordering countries; people the staff can't communicate with not only because they are sometimes very distressed but because they speak another language - languages which the staff not only don't

speak but sometimes don't recognize at all. And then there are the stories, told by many but spoken in whispers, of people incarcerated in a mental hospital for decades because no one could speak their language. [Field notes, March 22<sup>nd</sup> 2011].

This raises difficulties in the use of the Hearing Voices Network's approach in certain contexts in India, as it is heavily reliant on shared language and communication. (Although drawing the voices people hear is often a useful coping strategy, particularly for children who hear voices).<sup>61</sup> For Sarbani, this also raises ethical concerns about how to obtain consent from someone who is distressed and on the streets, and who speaks a different language. Sarbani was keen to explore whether consent forms could be in pictorial form. But obtaining consent using pictures seems very different from using pictures of 'symptoms' of mental illness to identify, diagnose and 'rescue' people with a mental illness, on the streets. This going door-to-door and using key informants speaks of an active and powerful recruitment of subjects into psychiatric frameworks of understanding.

### **'Coming to terms with' India**

It thus seems that in order for HICS to 'help' LAMICS, and for Indian NGOs to 'help' poor people, the countries and populations of the global South need to become mental health literate, they need to demand access to medications, to professional expertise, they need to know what mental illness *is* –as the HICS *know it*. Within the literature on Global Mental Health it seems that the way that the HICS *know* mental illness is through a bio-medical register, and thus the globalisation of this understanding discredits or makes invisible traditional or alternative ways of knowing distress globally (the nightmares of many medical anthropologists, and the irony of the globalisation of psychiatry for cross-cultural psychiatry) (Kirmayer, 2006).

More fundamentally, this model is underwritten by specific understandings and prescriptions of what counts as a person, of what it means to be human, and thus operates as a normative project –a project of making the same. This could be read post-colonially as an orientalist project, 'a way of ... coming to terms with the orient in

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<sup>61</sup> See Hearing Voices Network (undated) leaflet on advice for children who hear voices.

terms of occidental categories' (Chakrabarti and Dhar, 2009:26). That is, 'coming to terms' with the populations of LAMICS in terms of bio-medical and psychiatric categories. However, the psychiatrization of India does not only come from the global North or the non-governmental; alongside this process come attempts from the Indian Government and the Supreme Court to enact psychiatrization through law and through force.

### **Psychiatrization through Legislation**

Psychiatrization as a Governmental project in India has become particularly marked since the Erwadi tragedy, in 2001, in Tamil Nadu, where 26 people labelled with 'mental illness' and chained up died when a fire broke out in a privately run hutment that claimed to provide religious healing. As a response to this, the Indian Supreme Court has begun a process of intervention against local and traditional healing sites all over India. This is a process documented by the Bapu Trust,<sup>62</sup> whose collection of Affidavits and documents filed to the Supreme Court provided me with a few days of arduous reading and an enormous amount of photocopying.

As part of this intervention the Supreme Court demanded that the Mental Health Act (1987) be implemented by all State governments, and that all shelters not covered by the Act be closed. Within the Supreme Court directives, and in the State Government's responses to these, raising awareness of mental health issues, particularly in rural areas, has figured as key.

Both the Central and State Governments shall undertake a comprehensive awareness campaign with a special rural focus to educate people as to provisions of law relating to mental health, rights of mentally challenged persons, the fact that chaining of mentally challenged persons is illegal and that mental patients should be sent to doctors and not to religious places such as temples or Dargahs (Supreme Court Order, 5<sup>th</sup> February 2002, in Davar and Lohokare, 2009).

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<sup>62</sup> See the Erwadi Case Study Files, Library and Documentation Center, Center for Advocacy in Mental Health, Pune.

Here the seeking of help from local healing sites is framed as due to a lack of education about mental illness, and alongside advocating that mental patients should be sent to doctors and not dargahs, some States have increased their vigilance over traditional healing sites. The States of Haryana and Tamil Nadu have sent vigilance officers to visit local healing centres to check compliance with the Mental Health Act (1987); many traditional healing sites have been shut down; those with mental health problems have been chased away from some Dargahs; and outside some local healing sites banners have been displayed telling people with mental illness to go to the psychiatric hospital (Davar and Lohokare, 2009). The Government of Andhra Pradesh took this further, saying that,

Mentally ill persons staying in the Dargah without any relatives may be handed over by the Dargah authorities either to the relatives whose addresses they have, or to the local police station, so that appropriate reception order may be obtained for their involuntary admission into the mental hospital (Directorate of Medical Education, 2001, cited in Davar and Lohokare, 2009).

Furthermore, the Union Ministry began to map out those faith healing centres visited by people with mental illnesses (Davar and Lohokare, 2009). This process however does not seem to be new. During colonisation, and particularly towards the late 19<sup>th</sup> Century, Poornima (1995:36&97) charts how Western medicine began a 'process of elbowing out of the indigenous systems of medicine to help western medicine consolidate itself and thereby maintain its hegemony'. Here the construction of Western medicine as modern and rational was set up against indigenous healing systems which 'were condemned for their "irrationality" and "superstition"' (Poomima, 1995:38-9).

Currently the Indian media also invokes traditional healing as 'irrational', as using 'bizarre, inhuman forms of treatment', part of a more general thread of critique of temple and indigenous healing as being pre-modern and thus in need of replacement by treatments that make claims to scientific rationality, such as psychiatry (Siddiqui, Lacroix and Dhar, 2012). Thus, in the second Lancet series on Global Mental Health, Patel et al (2011:1442) say that,



The mhGAP guidelines should become the standard approach for all countries and health sectors; irrational and inappropriate interventions should be discouraged and weeded out.

It is worth noting here how 'irrationality' is mobilised to justify psychiatric interventions within the method of healing, and at an individual level. In fact, in some cases, psychiatric services are called for because they,

would go a long way in preventing society from utilizing services at unlicensed places such as Dargahs, temples, churches and other religious institutions which do not have proper facilities and expertise (Davar and Lohokare, 2009).

Here facilities and expertise mean psychiatry. Often the very act of seeking help from indigenous healing sites seems also to be constructed as a sign of madness, or of lack of knowledge, a criticism that the Bapu Trust (2006) level at the WHO/NIMHANS flipchart of mental disorders (discussed earlier).

### **'An asylum in every district'**

There are further colonial repetitions at work here. After the deaths at the hutments in Erwadi the Supreme Court ordered construction of mental hospitals in Indian States where there were none, and thus many states have set about building new asylums (Davar and Lohokare, 2009). 'An asylum in every district' was an idea put forward by many colonial officers in India, in the 1850s, but one that was never put into force (MacPherson, 1856, cited in Ernst, 1997:171). Even if it had been, doubts have been raised as to whether the Indian population would have made much use of Western psychiatry when they could instead consult a healer from their own culture (Pfleiderer, 1981). However, currently the question of whether Indian people will draw on Western psychiatric services or not is less salient, because of the prescriptive nature of the Supreme Court directives, and in the action taken by certain State governments through forcible removal of those with mental illness from local healing sites to psychiatric hospitals: from dargahs to doctors.

Davar and Lohokare (2009) recount one case in Andhra Pradesh where the Directorate of Medical Education, with police assistance, inspected a local dargah, carrying out psychiatric assessments on those using the dargah's services and diagnosing many people with mental illness and referring them for psychiatric treatment. Legal action was then taken against the dargah, as it violated the Mental Health Act (1987), and a demand was made for the handover of the mentally ill for psychiatric treatment (Davar and Lohokare, 2009). However, as Davar and Lohokare (2009) point out, a dargah is not a mental institution and it is therefore questionable whether it should come under the purview of the Mental Health Act and custodial mental health law. This was expressed in the letter the healers from the dargah wrote back to the Indian Government, saying a dargah is not a mental hospital and there are no 'patients' in it, thus the issue of handing over the patients to the medical authorities does not arise (Davar and Lohokare, 2009).

This statement is key. From a psychiatric and Governmental perspective the issue is over how many people that seek help from dargahs are really afflicted with mental illness and should thus be transferred to psychiatric facilities. However, if there are no patients in a dargah, then might there be no mental illness in a dargah? Do dargahs function as spaces where mental illness may not be an available identity; where being mentally ill is not a way of being a person? Thus traditional healing could be read as a site of resistance to Western bio-psychiatry, in part because it is a space the occident doesn't 'know'. How this might operate as a space from which to look back at the occident, unseen – using terms different from its own - is something I will explore in the final chapter.

The Supreme Court reaction to the tragedy at Erwadi speaks to the force that can be at work within psychiatric subject formation. The language of eliciting and promoting does not seem to fully account for the force at work here, nor does it enable exploration of whether subjects do always come to experience themselves in the terms of subjectification.

**‘We don’t use the word “Depression” but...’**

Back at the Institute of Psychiatry, in London, Vikram Patel told us about his work at the Sangath Centre, in Goa, of which he is the Director. We had been discussing diagnostic tools and checklists in reference to making them more ‘culturally appropriate’. In groups, we examined a checklist for Post Natal depression (The Edinburgh Post Natal Depression Scale - EPDS, 1987) (see appendix 9), in an attempt to find questions that may not apply or translate in an Indian context. I personally didn’t think any of the questions were suitable, but then I don’t like checklists. (In fact, I later used this checklist with some students in a session on critical global mental health. After reading it, one young man who didn’t have children, told me earnestly that he thought he might have Post Natal Depression.)

Back to Vikram’s lecture, where he told us how, at Sangath, the psychiatrists and health workers often don’t use the word ‘Depression’ in front of the women with whom they work, because the word has no cultural currency or meaning in that context. This was framed as being a culturally sensitive practice. However, when the staff discuss their patients, when they produce statistics on prevalence or outcomes, when they write their medical notes and records, when they prescribe anti-depressants – they use the category ‘Depression’. Thus the women at the Sangath centre are ‘depressed’, but they wouldn’t self-identify as such, and may not even be aware that they have been given this diagnosis. Thus, these women are brought into being as ‘depressed’ as a way for others to understand them and intervene upon them, but not as a way for them to understand themselves, or to ‘be’ subjectively.

This raises questions of how the process of being ‘identified’ as mentally ill, of being made up as a person with mental illness, interweaves with identity formation, and with a person’s subjective experience of themselves. How are people brought into being through language, through the systems of classification that categorise and name them, through the act of being named? For Butler (1997:28), subjection is always to ‘be given over from the start to social terms that are never fully one’s own’. In the Bapu Trust oral history archive - ‘Sanchit’ - Chrysann, a survivor of ECT, says; ‘on the top of a

previous paper it was written “paranoid psychosis”. That’s how I knew that probably this is my problem’.<sup>63</sup>

This process of identification and classification seems to mark the mentally ill, and perhaps especially mentally ill women in India, as ‘excessively described and attributed being[s]’ (Riley, 1988:16), who occupy ‘the paralyzing position of being the spoken’ (Gwin,1988:23). In its marked absence of the voices of people with labels of ‘mental illness’, this thesis is to some extent complicit with this paralysis, unlike the work of the Bapu Trust (for example in its collection of survivor stories into an archive, and the use of these to influence Government policy) which recognises survivor testimony as central to mental health advocacy.

Denise Riley’s (1988:96) question: ‘am I that name?’ is useful for thinking about being suddenly and maddeningly ‘caught up unexpectedly’ in the ‘being’ of categories imposed from the outside. For the ‘Depressed’ women at the Sangath centre, this ‘outside’ is multiple, made up of; categories from outside the global South, transposed from the global North; categories from psychiatry, imposed by professionals; categories in English, not local languages. This hints at the potential alienation of understandings one’s distress in foreign terms (discussed shortly).

### **‘Every subject is turned around’**

According to Murray (2009:12), people,

are forced to navigate a complex and overdetermined nexus of resources; they are called upon to conceive of themselves and their lived bodies—healthy or sick or somewhere in between—as genetic bodies, as bodies-at-risk, as bodies-under-surveillance, as bodies that cost the state a certain amount of money, and so on. The patient’s—or client’s—identity emerges from within a tangled web that includes Big Pharma, innumerable government lobbies, government agencies and public policymakers, academia and its research sponsors.

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<sup>63</sup> Chrysann, a survivor of the Indian mental health system, in Sanchit archives, Center for Advocacy in Mental Health, Bapu Trust (undated).

For Dean (1999:32), the success of governmentality in its processes of subject formation is that 'agents come to experience themselves through such capacities', for example as mentally ill, as biochemically impaired. But at Sangath the women do not experience themselves as 'Depressed', as they are never told the category under which they have been 'identified', the name that brings them into being. This seems to trouble interpellation.

For Althusser (1971), subjects come into being through being hailed by an ideology, similar to a police officer hailing a person in the street – 'Hey, you there'. However, if a police officer were to hail a user of Sangath's services, if the police officer shouted, 'Hey you, with Depression', or 'Hey you, Schizophrenic', that person may well not turn, may not respond to being hailed. Yet they may still come into being under this name, they are seemingly thus 'depressed' or 'mentally ill' if they subjectively experience themselves in that way or not, for they are still medicated, and recorded as a statistic of mental illness. This seems more than to refuse to turn, different from asking 'am I that name?', as the very possibility of asking this presumes a subject, an 'I', to whom the interpellating call is addressed.

There is a universality in Althusser's (1971:174) formulation - interpellation 'recruits them all' - reminiscent of Bhargavi Davar's concerns about the Indian Government's use of competency tests,

You have a vision of this beautiful world for people and at the core of it is social control, social control that is universal, that applies to society at large. And people are going to be witch-hunted on the test of competency...it won't be restricted to the severely disturbed because in order to catch the severely disturbed you're going to have to cast the net over the entire Indian population.<sup>64</sup>

'Casting the net over the entire population', resonates with the study in Ethiopia's method of going door-to-door, of every house in the area, to identify those with mental

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<sup>64</sup> Interview with Bhargavi Davar, Pune, February 2011.

illness. Furthermore, for Althusser 'every subject is turned around...subjects are people who have turned around in response to the call to become what has been projected at them; the constitution of the subject is a matter of turning around' (Macherey, 2012:13). But the women at Sangath have not turned around, and neither does Fanon in the quote below. So does interpellation always imply, require, a 'turn'? Do you need to turn to be interpellated? The white child points at Fanon, and says,

"Dirty Nigger!" or simply, "Look, a Negro!" ... I found that I was an object in the midst of other objects...sealed into that crushing objecthood...my body suddenly abraded into non-being (Fanon, 1952/1967:112-113).

And for Riley, one doesn't think,

"Now, humiliatingly, I've become a woman", but rather that you have been positioned antagonistically as a woman-thing, objectified as a distortion (Riley, 1988:97).

'Positioned antagonistically', 'objectified', 'sealed', 'abraded', 'crushed' – this seems to be something different from Dean's (1999) language of eliciting, promoting, facilitating and fostering identities. Pharmaceutical advertising and many mental health literacy campaigns do, often explicitly, work through eliciting specific subjectivities, eliciting a 'turn', be it to a hail from the TV or from a drawing on a flipchart.

However, Fanon's subject is not a turned subject, but a doubled subject (Macherey, 2012), or to be more specific, in Fanon's turn away from himself, he becomes a doubled subject, a subject in two places at once, the two worlds of the oppressed (Fanon, [1952]1967; Bhabha, 1994). This turn away from oneself, like the black child's turn away from her/himself in their total identification with whiteness, marks the ultimate alienation and negation at work in colonialism.

Thus in Fanon and Riley's accounts, and for the women at the Sangath centre, and those 'identified' as mentally ill by Indian NGOs, or as 'Schizophrenic' in the Ethiopian study, there seems to be more of a forcefulness in identity and subject formation; the

spattering of identities that seems to resonate with the formation of psychiatric subjects, the 'stickiness' (Rosenhan, 1973), the for life-ness (Tucker, 2009) of psychiatric diagnoses. Peter Bullimore, a psychiatric survivor and voice hearer, was told by his psychiatrist 'you are a chronic Schizophrenic, you will never ever work again, go away and enjoy your life". To him 'the words were so damning... you may as well have just ripped my heart out'.<sup>65</sup>

An amputation, spattering of black blood, hearts ripped out - this speaks of the psychic violence enacted by colonial and psychiatric systems of interpellation - 'injurious interpellations will constitute identity through injury' (Butler, 1997:104-105). This 'stickiness' of psychiatric identity categories also hints at how psychiatry may work to meet another of Bhabha's conditions of colonial discourse, that of 'fixing' identities (Bhabha, 1983; 1994). Thus not only bringing into being particular subjects but working to secure them, fixing them in a field of subjectification that the next chapter further maps.

### **Identity Violence**

To be understood and to understand oneself in alien terms, through the gaze of the other, points, for Fanon to the ultimate alienation and thus the impossibility of psychiatry in the colonies,

If psychiatry is the medical technique that aims to enable man to no longer be a stranger to his environment, I owe it to myself to affirm that the Arab, permanently an alien in his own country, lives in a state of absolute depersonalization (Fanon, 1967, cited in Bulhan, 1985:249).

This alienation in identity is for Fanon a key part of colonial consciousness, reminding us again of the violence of colonial subject formation. This brings to mind Read et al's (2006:313) research, discussed previously, which points to the alienation at work within

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<sup>65</sup> From an interview with Peter Bullimore as part of a research project, funded by the Research Institute of Health and social Change (RIHSC), at Manchester Metropolitan University (MMU), December 2007-March, 2008.

bio-genetic categories of mental illness, where people whose distress was explained as being caused by biochemicals were treated as 'almost another species', entirely negating their personhood.

For Riley (1987:97), it is these outside reminders that push you into an 'alienist self-recognition', pointing to the identity of 'mental illness' as always 'overdetermined from without' (Bhabha, 1967 [1986]:xiii) – the 'without' taking the form of psychiatric terminologies and frameworks of intelligibility from HICS, and psychiatric categories in English. In the practice of psychiatry in India, the alien terms by which a person labelled as mentally ill is conceptualised are multiple and involve 'multi-level linguistic and cultural translation', translation between Hindi and English, and the translation of local, cultural idioms of distress into 'theoretical concepts of an alien discourse' (Addlakha, 2008:45&132).

This is the 'identity trauma', the 'identity violence' (Hook, 2005:475 & 480) of the colonial and perhaps the psychiatric encounter. A 'nervous condition' (Sartre, 1990:17) that is both political and psychological, for it arises when one's cultural resources have been eradicated (or almost) 'by the cultural imperialism of the colonizer', and when one comes to think of themselves and act on themselves as though they are white - experiencing oneself as 'phobic object' (Hook, 2005:480). This identity violence works at multiple layers, of body, psychology and symbolic, as the subject's relation to each of these layers is traumatically fractured (Hook, 2012:75). Thus, reflected in Fanon's making of himself an object: colonialism dehumanises and objectifies, it is 'colonisation = "thingification"' (Césaire, 1972:21).

However, in Butler's reading of Foucault, 'even the most noxious terms could be owned...the most injurious interpellations' can be the site of 'radical recuperation and resignification' (Butler, 1997:104). Although in occupying the 'discursive site of injury' in order to resist it, such identity politics invoke a 'self-colonizing trajectory', a paradoxical attachment to the injurious term that has called one into being as a social subject, the term that enables one to exist (Butler, 1997:104). And thus one may become attached to the psychiatric terms that bring them into being, even if these terms enact an injury, even if they are violent.



This is reminiscent of Meesha's use of foreign psychiatric terms - 'psychiatric patient' - spoken in English, to refuse that very identity (at the beginning of the thesis). In speaking the identity she refused to take up - in English, Meesha evoked the potential alienation of understanding one's self in foreign terms, in a different language, that of psychiatry, pathology and English. This is the process by which one must occupy, and be occupied by, an injurious term of identity, in order to refuse it (Butler, 1997:104). This alienation of the colonised, for Fanon, (1967[1986]), points to the impossibility of psychiatry in the colonies. Yet if psychiatry provides frameworks of understanding that are alienating (from people's own understandings, or language of distress), colonising and violent, then might psychiatry to some extent be impossible?

### **Psychiatrization as Violent**

Briefly tracing this process of psychiatrization, from times of colonisation to the present, makes visible how psychiatrization works at many levels; from the interpellating call of pharmaceutical advertising, and mental health literacy; to being hailed by and 'made up' as 'mentally ill' through diagnostic tools, administered door-to-door, and on the streets; to being forcibly removed from a traditional healing site and taken to a psychiatric hospital. How the colonial relation may repeat itself within Global Mental Health and psychiatrization, and how in charting resistance to colonisation we might open a space to read resistance to psychiatry, will be explored later. However, having traced some of the mechanisms of psychiatrization it is perhaps worth questioning in what ways this process might be read as troubling.

For LeFrancois (2012), psychiatrization marks a violent state of being objectified through diagnosis, it signifies an act done to a person through unequal power relations, a state akin to the abjection that will frame the main discussion of the next chapter. For Rose (2006), who tends to take a distance from harsh critiques of psychiatry, psychiatrization still remains a cause for concern, as increasing numbers of people come to define themselves as mentally ill (though he does not see this process as entirely negative, as explored in chapter 10). For Rose (2006:481), psychiatric classifications are powerful mechanisms of 'recruitment', of subject formation,

turning them from non-patients to proto-patients, to actual patients. They are powerful mechanisms for retaining individuals within this domain. No walls are now needed to sustain a lifetime career under the psychiatrist.

In fact no walls, no asylums, are required for people to come into being as 'mentally ill', to become psychiatrized, only the squatting down on the streets of a NGO psychiatrist. Perhaps NGOs' practices of psychiatry on the street - the squatting down of the psychiatrist, the administering of check-lists door-to-door, are powerful mechanisms of recruitment and 'fixing' precisely because, like Althusser's interpellation and Fanon's encounter with the white child, they are banal and everyday. Thus subjectivation, in Macherey's (2012:11) reading of Althusser and Fanon,

represents the operation by which one is constituted as a subject for the norms, subject to the call that one answers by bending to the slope of a rationality that quietly goes to work, without being remarked upon, because it has come to penetrate minds and bodies completely, so as to govern them.

Thus the subject bends 'to the slope of a rationality' that is quietly at work in the bending down of a psychiatrist to diagnose a person on the streets with mental illness. That Althusser's interpellation happens on the street, and Fanon's on a train, is not only interesting because it resonates with the work of many mental health NGOs in India, who treat people on the streets and at railway stations, people who have 'wandered' off and boarded trains that take them all over India. It also calls attention to the situation - the site - of interpellation.

### **On the street, on a train - from behind, face to face**

'Hey you, there!' - for Macherey (2012:13) the 'there' 'signals the distance opened up in a space that contains the places to be occupied'. Yet, for Fanon, for the black man, there is only one place to occupy, the place of the black man, for 'every ontology is made unattainable in a colonized and civilized society' ([1952]1967:109-110). In Macherey's (2012:16) reading of Fanon, then, 'being' / ontology 'change in meaning within a colonial framework that requires something other than "normal" ontological analysis, something about not being'. Thus, staged face-to-face, Fanon's encounter

'presupposes a background that teems with the unthought and the unsaid' (Macherey, 2012:17), a colonial background, where the colonised become the background (explored in Chapter 8).

Thus Fanon is brought into being, or a form of not-being, a being where something is lacking, or something is added, face-to-face with the hail that interpellates. For Fanon, as for the psychiatric subjects of NGO interventions in India, there is no Althusserian '180-degree turn' to the psychiatric hail, because it may not come from behind, but from directly in front. This reframes interpellation and 'all' the subjects it recruits, for there is a selection at work (interpellation may recruit them all but they are not all the same sort of subjects), and while one may turn to the hail from behind, a subject must also 'recognize that, "yes, I am a nigger", as he is compelled to do by the gaze that falls on his dark body' (Macherey, 2012:18). For the 'nigger' that he is, 'is spoken to his face, and is sustained in the line of a gaze', fixing him 'in the double sense of taking him for a target and assigning him a place' (Macherey, 2012:15).

Thus what works to differentiate the two formulas of interpellation explored here, 'Hey, you there' and 'Look, a Negro', seems to be the staging of the scene; from behind – where for Althusser the subject comes about through language; or face-to-face, where Fanon's subject is constituted 'in the order of the visible', in plain sight' (Macherey, 2012:15). Meesha's refusal to see herself as a 'psychiatric patient' was also made in the order of the visual, by recourse to the 'look' of those with 'mental illness; their 'wild unbrushed hair', hinting at a visual economy of mental illness; the visual signifiers– the appearance – constantly evoked by NGOs. Alongside the evocation of mental illness within a visual economy, the appearance of the mentally ill, there is a simultaneous construction of the mentally ill in India as 'invisible'; or visibly invisible. It is to the order of the visual (and the invisible) that I now want to 'turn'.



## Chapter Eight

### Oozing Bodies; Visibly Invisible

*A chapter on oozing, defecating, leaking, on the disruption of boundaries, on the pleasure of seeing, and on remaining invisible, on psychiatry's fantasies, and on touch – the touch of medication, the touch of hands, the touch of skin - the 'border that feels'.*

## Looking and Fixing

long, matted hair, uncut and dirty nails and grimy clothing...opens sores, wounds oozing with pus...talking to oneself, laughing or singing wildly, eating from garbage cans, masturbating or defecating in full view of other persons...[these] are signs that social workers on the beat look for (Iswar Sankalpa, 2011:13).

Objectified, sealed, crushed – the previous chapter explored the ‘making up’ of the ‘mentally ill’ in LAMICS – a process marked by a psychiatrization that both elicits and recruits, yet violently. For Bhabha (1994), one of the key facets of colonial discourse is the role of ‘fixity’ in the construction of otherness; a fixity akin to Foucault’s (1977:185) ‘disciplinary individualisation’, the fixing of the individual in writing through the technology of the examination. The ‘fixing’ of the individual as ‘mentally ill’. For Bhabha and Fanon there is something visual at work in this fixing, with ‘looking/hearing/reading as sites of subjectification in colonial discourse’ (Bhabha, 1994:109). These are visual encounters, Fanon’s encounter with the gaze of the White child - ‘Look, a Negro’ - where ‘to exist is to be called into being in relation to an Otherness, its look’ (Bhabha, 1986:xvii). But what is this relation between ‘looking’ and ‘fixing’?

In the last two chapters we traced how, like colonial discourse, psychiatry and Global Mental Health create ‘subject peoples’ - psychiatrized peoples - as a ‘fixed reality...entirely knowable and visible’ (Bhabha, 1983:23). Taking this mapping of Global Mental Health as a colonial discourse and a field of subjectification further, this chapter engages with the ways that surveillance operates through this knowing, this visibility, inciting webs of pleasure/unpleasure: mapping how, like colonial discourse, psychiatry may be an apparatus that ‘turns on the recognition and disavowal’ of difference (Bhabha, 1983:23). How does psychiatry encounter difference? What techniques enable it to ‘see’ difference? I want to turn to the visual, to mechanisms of looking, to psychiatric fields of visibility.

### **Psychiatric fields of visibility – Visual encounters with the ‘mentally ill’**

What struck me from some of the interviews I carried out with founders of mental health NGOs in India, and from the information on the websites of some organisations, was the importance they accorded to ‘seeing’ mental illness. Many of the organisations I visited were founded because of a visual encounter with the ‘mentally ill’. On the Shraddha Foundation website, Bharat Vatwani nostalgically describes him and his wife’s encounter with a homeless person with mental illness, leading them to found the organisation;

One day while sitting in a restaurant, we noticed a young boy who was horribly skinny, dirty, dishevelled and in a really bad shape. We realised that he was a schizophrenic and just while we were watching, he picked up an empty coconut shell next to him, dipped it into the ‘nullah’ flowing nearby and drank the gutter water in a single shot. That was the turning point of our lives. Spontaneously we crossed the road, assisted him to come with us (which given his weak state was very easy for us) and brought him to our nursing home. We nursed him, treated him with appropriate psychiatric medicines and gradually he improved. He turned out to be a BSc graduate whose father was the Superintendent of a Zilla Parishad in Andhra Pradesh. Mental illness could affect the best of the best and reduce a person to pathetically inhuman conditions. And suddenly we realised that there was no organisation dealing with such people (Bharat Vatwani).<sup>66</sup>

Here the diagnosis of Schizophrenia is based on an appearance (dirty, dishevelled) and the ‘realisation’ that he is Schizophrenic is made through watching, at a distance. By pointing out his weak state, Bharat Vatwani seems also to be suggesting that the young boy may have been unable to resist (hinting at how psychiatric interventions on the streets can be powerful mechanisms of interpellation). Vandana Gopikumar, the co-founder of The Banyan, also (according to The Banyan website), encountered the homeless mentally ill when she;

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<sup>66</sup> See Shraddha Foundation website: <http://www.shraddharehabilitationfoundation.org/my-personal-word.html> (Accessed 22 February 2012).

came across a half-naked, mentally ill homeless woman in absolute distress on the road in front of her college. Nobody else seemed even to notice her. With the help of a close friend, Vaishnavi Jayakumar, she tried to find shelter for the woman. Mental health institutions and NGOs were reluctant to admit the woman in desperate need of medical and psychiatric attention. Several more such encounters over the next few months left the idealistic duo disillusioned and the idea was born that they should do something about the problem themselves.

The Banyan started off as a shelter and transit home for homeless women for mental illness who had wandered from their homes across the country and ended up in the streets of Chennai. One of the duo's core beliefs was that the women needed to receive timely treatment and to be rehabilitated in mainstream society. Sixteen years on, The Banyan is now able to reach out to women and men of a variety of levels to support them on their journey to recovery: the duo's beliefs have been vindicated.<sup>67</sup>

Sarbani Das Roy, in a noisy office in Kolkata, told a similar story when she recounted to me her own first 'seeing' of a homeless person with mental health problems, an encounter which led to the founding of Iswar Sankalpa;

Actually it all began one day, when Dr Narayan and myself were walking down the street and there's a big vat over there, you know where people throw rubbish so there was this one man who was eating from the vat and he was picking up rubbish from the vat and eating it and we realised that he was mentally unwell...I just saw a glimpse of a very dire need in the city to address this segment of the population which was remaining untouched by the government and the non government agencies. That was when I decided that, and with Dr Narayan, he said that "I wish we could do something for this person because these are the people who never come to my clinic...and I don't know how to reach them". (Interview with Sarbani Das Roy, Kolkata).

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<sup>67</sup> The Banyan website: <http://www.thebanyan.org/html/history.html> (Accessed 1.3.2012)



The founders of the above organisations thus all story the founding of their organisations through a visual encounter, a 'seeing' of the 'mentally ill'. The accounts rest on the assumption that these homeless 'mentally ill' people exist on the streets, yet are ignored by society; they both exist, and yet do not exist in the eyes of society. Or we could say that a particular way of looking enabled certain people on the streets to be identified as 'mentally ill', bringing them into being as such, without them ever having to step inside a clinic. Butchart (1999:62) explores medical examinations as being one of the conditions of possibility for the bringing into being of the African body during colonisation, for 'it is here, where the doctor examines it, where power has its immediate effects, that the African body is produced as the object and effect of western medicine'.

Thus it may be the squatting down of a psychiatrist to diagnose a distressed person, on the streets of Kolkata, that produces the 'mentally ill' that Iswar Sankalpa aim to work with, as the object and effect of psychiatry. For Global Mental Health, made up of psychiatric and psychological knowledge, the individual's psychology is the main object-effect of its practice, creating 'a surface of purchase for knowledge...as well as something that may be subjectively experienced' (Hook, 2005:230). 'Surface of purchase' seems a useful way of conceptualising this process when we bear in mind the pharmaceutical industry's financial incentives for targeting 'emerging markets' of mental illness in LAMICs. This hints at the key role played by medicine within colonialism, with,

disease and medicine as a site of contact, conflict and possible eventual convergences between western rulers and indigenous peoples...the importance of medicine and disease to the ideological and political framework of empire...and the role of medical agencies and practices in shaping the impact and identity of colonial regimes...the centrality of disease and medicine to any understanding of imperial rule (Arnold, 1988:2).

Medicine thus operated as 'one of the ways in which imperialism sought to "know" the people and establish its authority over them' (Arnold, 1988:17). For Fanon, 'the settler is right when he speaks of knowing "them" well. For it is the settler who has brought

the native into existence and who perpetuates his existence' (1963:28). Perhaps psychiatry and the NGOs who use its techniques also know 'them' – the 'destitute mentally ill', well, for they too may have brought them into existence, 'made' them up.

This 'knowing' then, for example through psychiatric diagnosis, by NGOs and Global Mental Health advocacy in India, could thus be read as a process whereby 'the white man's artifice [comes to be] inscribed on the black man's body' [and mind] (Bhabha, 1994:64). This hints at a process of 'knowing' that brings into being the very subject that is to be 'known'. This 'knowing' however seems to involve more than 'looking'; it seems somehow embodied in the squatting of the psychiatrist, in the handing out and swallowing of medication.

### **Invisible people**

Within NGO literature, it seems that the visual, the way people look, their appearance, is key to 'knowing' people, to the very identification of certain people as mentally ill. Calls to 'see' the mentally ill, who are constructed as being 'invisible', are central to the work of NGOs in India, whose literature on mental health often sets the scene of their work by describing those they work with - the 'mentally ill', in visual terms. As Iswar Sankalpa explain, the mentally ill are those with 'long, matted hair, uncut and dirty nails and grimy clothing' (Iswar Sankalpa, 2011:13). Such people, according to Iswar Sankalpa's website,

are often seen, in various states of mental distress and physical abuse, around railway stations, bus stands, pilgrim centres and on street corners. They are the 'invisible people', separated from and/or abandoned by their families.<sup>68</sup>

The Banyan offer similar descriptions on its website,

Battered, bruised, brutally abused, both physically and sexually, ignored by everybody, eating out of garbage bins and with no place to call home. This was the situation of Chennai's homeless women with mental illness even just a decade ago. They were an invisible minority, and would have stayed invisible

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<sup>68</sup> See Iswar Sankalpa's website <http://www.isankalpa.org/community.html>

had it not been for two young women who put them firmly back on Chennai's social agenda.<sup>69</sup>

Here the 'mentally ill', prior to diagnosis are 'invisible people', an 'invisible minority' – highlighting what, for Bhabha within colonial discourse, is the 'problematic of seeing/being seen' (1994:109). This 'seeing', the pleasure of looking, the 'scopic drive', is related to the surveillance of colonial power (Bhabha, 1994:109). The mentally ill here are simultaneously 'invisible people', who are 'seen' in states of distress, they are 'hidden in full view' (Sen, 2010). There are also hints of surveillance in the above accounts – the role the visual plays for Iswar Sankalpa's 'social workers on the beat', looking out for signs of mental illness on the streets. There is an implication here that intervention works to make visible the 'mentally ill' - a key aim of many NGOs in India, and in the mapping of prevalence of mental illness by the WHO.

### **Visible Invisibility**

In many NGO accounts, to be untouched and unseen by the Government and medical intervention is to be reduced to 'pathetically inhuman conditions' (Shraddha Foundation website). If being 'outside' of a medical gaze is to be a non-person, then we need to explore how medication enables a particular sort of person to come into being – how medication might 'broker subjectivity' (Das, 2003). This calls for an analysis of bio-psychiatry and Global Mental Health as fields of subjectification, as systems of representation, as modes of creating and fixing 'subject peoples' through particular ways of looking and knowing.

Thus the mapping of prevalence and NGO mental health interventions on the streets may work as techniques of interpellation, as mechanisms of recognition that constitute the subject they recognise (a form of misrecognition and of differentiation) (Ahmed, 2000). Thus the hailing shifts not only according to the one who hails (for example, the police officer or social worker), but according to whether the person being hailed is already recognisable as being out of place, for example, as a 'wandering homeless person' (Anderson, 1990:238). This brings to mind Ahmed's (2000: 21-22) analysis of how we come to recognise strangers, those 'out of place'; the differential readings of

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<sup>69</sup> See The Banyan's website <http://www.thebanyan.org/html/history.html>

particular bodies as strange or familiar; the face-to-face encounters that bring the stranger into being 'by recuperating all that is unknowable into a figure that we imagine we might face here now, in the street' - the figure with a 'mental illness'. Like Fanon's interpellation, face-to-face, in the line of the white gaze.

This calls for attention to be paid to how psychiatry employs particular ways of seeing that enable certain groups of people to become visible in their invisibility; to be 'seen' as being 'invisible', a 'paradoxical visual invisibility' (Young, 2005:92). To 'see' someone as invisible implies recognition and recruitment, an interpellation as 'invisible'. This recruitment, done in psychiatric terminology, may work to occlude the different histories of embodiment and labour, and the colonial histories that work to mark some bodies as stranger than others (Ahmed, 2000). Here psychiatry works through an economy of desire, a desire to tell the difference between bodies (strange and familiar, ill and healthy, normal and abnormal) that 'assumes that the difference can be found somewhere on (or in) the bodies of others (on or underneath their skin)' (Ahmed, 1999:91-92). A difference marked not only on the appearance of certain bodies, but inside certain bodies, inside brains. This implies layers of differentiation, knowing and surveillance within psychiatry that work not just through the visual; but through the body – the squatting down of the psychiatrist, the touch of hands in the administering of medications, the effect of the chemicals on the brain as the medication is washed down with a cup of tea (or crushed into the tea, as one psychiatrist at Iswar Sankalpa admitted occasionally happens when people refuse to take medication). For Tiffin and Lawson (1994:3), while,

Imperial relations may have been established initially by guns, guile and disease, but they were maintained in their interpellative phase largely by textuality...Colonialism, then, is a formation of discourse, and as an operation of discourse it interpellates colonial subjects by incorporating them in a system of representation.

Colonialism, representation, textuality and interpellation interweave here to form colonial subjects. However, the privileging of textuality here needs examining. Even if we understand wide-ranging phenomena as 'texts', and understand the symbolic and

societal frames at work in terms of intelligibility, there seems to be a force in the interpellative 'look' that somehow exceeds a solely discursive analysis. For Fanon (1967[1986]:112), pointed at, hailed, through a look, 'Look a Negro',

I subjected myself to an objective examination, I discovered my blackness...[I] made myself an object...What else could it be for me but an amputation, an excision, a haemorrhage that spattered my whole body with black blood.

While interweaving the objective 'fixing', the examination, with the formation of subjectivity, this account also emphasises the body. It points to a force in subject formation that exceeds the boundaries of that body – 'spatters' the body with an identity, the body becomes black, through an excision, a haemorrhage. This exceeding of boundaries, borders, on the site of the body is also present in NGO descriptions of the homeless mentally ill, and in the lived experience of those with this label, on the streets. An analysis of the bodily seems to demand more than a focus solely on the discursive (though visual descriptions are first and foremost text based). Beyond this, they invite consideration of how the physical, the guttural, the body in pain, can be conceptualised as part of subject formation within a project of colonial discourse analysis. Here we need a conceptual framework that will enable an exploration of borders, boundaries, defilement of the 'clean and proper body'; of abjection.

### **Oozing, Masturbating, Defecating**

open sores, wounds oozing with pus... masturbating or defecating in full view of other persons (Isvar Sankalpa, 2011:13).

One of our patients had so many maggots on a ear wound that they came out of her nose...hundreds of them (The Banyan, undated booklet).

Oozing, masturbating, defecating – the 'leaky bodies' of the homeless mentally ill appear continually in NGO literature, and physically on the streets of India. Here the leakiness of 'matter out of place' (Douglas, 1994:50) (defecating in full view, oozing pus) comes to be reinscribed as the body out of place (the homeless mentally ill)

(Ahmed, 2000:39), meaning that a body can be read as out of place, as different, as being mentally ill through its leakiness (just as Bharat Vatwani and his wife diagnosed a man on the streets with Schizophrenia from his dishevelled appearance). This is a leaky visibility, an oozing and defecating that makes the invisible become visible, that enables 'invisible people' to be 'seen'.

Abjection describes 'a powerful visceral reaction' to a reviled object, while the abject is that very object that is repulsive – it is both process and condition (Hook, 2012:68). To be abjected, to be made abject, then, stresses abjection as a process, as a force. For Butler (1990:169), the abject is 'that which has been expelled from the body, discharged as excrement, literally rendered "Other"'. Thus the most powerful and primal abject objects are faeces, blood (oozing, defecating) because they 'challenge the integrity of one's own physical parameters' – once a part of the assumed whole, repulsive when expelled, when separate (Hook, 2012:69). This is central to subject formation, for 'the boundaries of the body are also the first contours of the subject' (Butler, 1990:169). The crossing of these boundaries, then, interlaces with and disturbs the contours of the subject; contours and boundaries which are themselves often arguably 'Western' preoccupations.

In fact, the 'corporeality of disability has figured widely, in the western imaginary at least, as disordered and uncontrollable, both an object of fascination and repulsion', a relation carrying potential disruption to boundaries, to systems of classification (Shildrick and Price, 2006 - online). It invokes ambivalence, the repellent and yet desirable, 'disgusting and irresistible', 'outraging and fascinating' abject object (Holmes et al, 2006:308). Here leaking is framed negatively, and thus 'the encounter between the normative and anomalous body is figured as troubling and dangerous' (Shildrick and Price, 2006 -online).

Here the body that expels may also be read as the social body that discharges and abjects those who are distressed, those who trouble the boundaries of social and symbolic order. For not only do these leaky bodies disturb the borders of the 'clean and proper body', they threaten 'to confront the leakiness of order and other, the liminal, and the borderline that defines what is fully human from what is not' (Jones, 2007:62).

In this way, the leaky bodies of the homeless mentally ill come to be reinscribed as waste, as those who inhabit the border in-between human and non-human, hence calls from NGOs to recognize 'them' as human beings. Thus 'the notion of abjection designates a degraded or cast out status within the terms of sociality', those who occupy 'uninhabitable' and 'unlivable' zones of social life, 'zones populated by those who do not qualify as full subjects of that particular social order' (Butler, 1993:53).

### **Disposability – the outside, inside**

In this way, those constructed as 'outside' not only normality, but 'outside' the market economy, are rendered invisible and disposable. Giroux (2007) describes how the category 'waste' no longer includes simply material goods but also human beings, particularly those rendered redundant in the new global economy; those who are dependent on others for care and those who cannot or will not 'fit' current neoliberal employment structures. These populations, for Bauman (2004:27), constructed as 'outside' the market economy, are reified as disposable, as 'leftovers in the most radical and effective way: we make them invisible by not looking and unthinkable by not thinking'. Making them invisible by not looking evokes NGO's descriptions of the homeless mentally ill as 'invisible people'. Yet this 'not looking' contrasts to the earlier exploration of how psychiatry may employ mechanisms of looking that make people visible as 'invisible', that enable certain people to be seen and recognised as 'mentally ill'. Ways of looking that recognise and thus constitute particular groups as 'outside' or invisible.

Furthermore, Giroux and Bauman's conceptualisation of such people as 'outside' the market doesn't entirely seem to fully grapple with the dual construction of people with mental illness as both an 'economic burden' (in Government and World Bank portrayals), and an 'emergent' or target market for the pharmaceutical industry's marketing of psycho-pharmaceuticals. Neither does it seem to sit easily alongside abjection – for while such (non)people are expelled from the social body as waste, they also constitute, in more Foucauldian terms, an 'outside' that is necessary to maintain and circumscribe the inside.

Seemingly then, in not qualifying as 'full subjects', such people work to circumscribe the domain, the contours, of those who do. That the "unlivable" is required to circumscribe the domain of the subject' (Butler, 1993:3) is useful for thinking not only about people who are homeless and distressed, but for how they may become homeless in the first place. Perhaps there have been other abjections at work before that of living on the streets and eating out of garbage bins. If the production of the Other, within a system of representation, is the very grounds for subject formation, then this also foregrounds political subjectivity; the production of an 'outside' being key to securing global capital.

### **The Image Function**

Chakrabarti and Dhar (2009:186), in their analysis of dislocation, trace how reforms that lead to displacement under the guise of (economic) development cause people to splinter out to the border of the camp of global capital, providing cheap disposable labour that helps to 'secure the hub of (global) capital – a hub whose very coming into being has been made possible through the dismantling of *their* forms of life'. Here the expelling of waste is central to the maintenance of the system that produces it. Do the homeless mentally ill then somehow secure psychiatry? This points to an interlacing relationship between psychiatry and global capitalism, the double movement discussed previously, where the existence of the mentally distressed secure the 'need' for global psychiatric and pharmaceutical intervention, while the very coming into being of that distress often stems from reforms that are part of the same economic rationale as the psychiatric interventions that are now framed as the 'solution'.

More than this, for Brennan (2005:101), the very 'idea of the global periphery...is itself an economic engine'; as the concept of there being an 'outside' to the global market fulfills an 'economic image function'. Capital, in a quest for profit-making, does not seek a world that is equally developed: it requires 'zones of invisibility', sites that are 'underdeveloped' but are not outside the market (Brennan, 2005:117). Here invisibility is required to circumscribe the domain of the visible.

Before I go onto explore how these 'zones of invisibility' and the 'invisible people' who occupy them might open up spaces to look back, unseen, at the global market,



capitalism and psychiatry, I want to examine how NGOs in India grapple with the construction of these 'invisible people' as 'outside' humanity. Does the call by NGOs to recognize those who live unlivable lives as being human work to breach current boundaries of the human, to call into question current frameworks for recognising humanity? If abjection works as an operation of repulsion (Butler, 1993), resulting in avoidance of social contact, what do the calls of NGOs to 'see' abject beings as human, to include them, to 'touch' them, do? This is to begin to grasp the political modes of re-articulating abjection that may be at work within psychiatry and the implications of these for the interventions of NGOs around mental health, and for Global Mental Health advocacy, worldwide.

### **Between bodies: eye-to-eye and skin-to-skin**

When people's human status is called into question, for Butler (2004: 89), this is a sign that we have 'made use of a parochial frame for understanding the human, and failed to expand our conception of human rights to include those whose values may well test the limits of our own'. But what, then, of NGO calls for recognition to 'see' those with mental health problems as 'human'? Does this strategy call to attention such parochial frameworks of intelligibility and exclusionary logics, tearing gaps into assumptions of what and who counts as human? Iswar Sankalpa goes further than 'seeing' the 'mentally ill', it creates spaces for contact between the 'invisible' mentally ill and members of the community through holding mental health camps at charitable clubs in India. Sarbani Das Roy, the co-founder of Iswar Sankalpa, explained;

we had a budget for awareness camps...So what we said was that people have blood donation camps... so we'll ask the club to have a mental health camp in your area...And then we bring the local homeless mentally ill people to that camp. And then we tag these people to the caregivers at the camp....And then there's the diagnosis, then we wash them, we clean them and the club members they take part in that process so then in that way, it's only when a person touches another person and sees that this is not a mad person, it is another human being, then the stigma of mental illness is removed I feel. It's only through touch, that's what I've felt, it's not through any posters, through campaigns, through any intellectual media that I feel the stigma of mental

illness can go, only through touch. You know when you touch a person and you see that this is another human being. (Sarbani Das Roy).

For Sarbani, these camps do more than educate people about biomedical understandings of mental illness, more than mental health literacy promotion, in fact she says that makes little difference, for her these medical encounters are human encounters with the 'other'. They are an opportunity to touch the other, and to be touched by them, and through touch to 'see that this is another human being'. To be 'touched' by somebody, another body, the Other's body (to clean the Other's body), is to recognise how encounters are not just a meeting of bodies but 'between bodies'; how 'eye-to-eye' and skin-to-skin' encounters work to form and deform bodily space and the boundaries of bodily recognition (Ahmed, 2000:39-40). While the skin contains, for Fanon as a 'seal', a border between outside and inside, it simultaneously destabilises itself as a border in the way it registers the touch of others. It is 'a border that feels', enabling a thinking through of how the boundaries between bodies, the skin, is formed only in the possibility of it being traversed, through touch (Ahmed, 2000:45).

Yet while the skin breaches its own boundaries through responding to touch, it seems important to explore how those boundaries, the contours of the body, may come into being through touch. Ahmed (2000:42) examines how bodies come to be marked by difference through the 'techniques and practices of differentiation' that work to mark out the inside and outside of bodily space, that mark bodies as different, that mark certain bodies as stranger than other bodies, as normal or abnormal. More than reading the surface of the body, this is to trace how boundaries are demarcated, how some bodies come into being in relation to other bodies.

While touch may open bodies to other bodies, a tactile encounter that enables bodies to 'see' each other as human (as in Sarbani's account), it may also through that opening, work to differentiate between bodies. This is to examine touch as a 'relation of asymmetry and potential violence' through the different ways that bodies touch other bodies (Ahmed, 2000:48). Here the refusal of touch also works as a mechanism of differentiation in forming bodies.

Touch has particular significance in India, where because of the caste system a whole section of society are excluded from social interactions, constructed as 'untouchable' and 'unseeable', where 'even their shadow, [is] held to be ritually polluting and abhorrent' (Teltumbde, 2010:14). The caste system thus works as a mechanism of control to prevent physical and symbolic contact, constructing whole communities as 'outside'. Interestingly, Vic Finkelstein (1975:34), a key figure in disability studies, drew upon the Constitution of India's (1950) use of the word disability in reference to 'disability arising out of Untouchability' to highlight the social nature of disability, the nature of being disabled and oppressed by society, the foundations of the Social Model of disability.

### **Medication's touch**

How does medication touch a person, and how does the touch of medication relate to visibility? In an increasingly pharmacological world, to be marginal, undeveloped and vulnerable often 'means to be cut off from the circulation of biomedical substances' (Ecks, 2005: 240). However, for Sarbani Das Roy, vulnerability did not solely mean lack of access to psychiatric drugs; for her medication linked to visibility and touch in more sinister ways. She told me about one of the women that Iswar Sankalpa had worked with; she was taking her medicines, 'getting better', had got a job, and then one day died after being gang raped on the street where she slept;

And that day my whole romanticism of community care got a major jolt. I thought that this cannot be the answer for all. And you know I questioned the fact that by making them better on the street, am I sort of making them much more vulnerable? Because they started getting cleaner and they started taking care of themselves, am I making them much more vulnerable? (Sarbani Das Roy).

Might medication make some women more vulnerable? Ahmed (2000:49) draws attention to how some forms of touch (colonial and sexual) have worked to subjugate others through forming the other as a site of vulnerability; touch as 'appropriation, violation and possession.' Here the restitution of a 'clean and proper body' invokes the

disinvestment of the 'object of its contaminating character, it becomes more communicable; it enters the social' (Burman, 2006:201), it becomes touchable. But this 'submission to sociality' (Butler, 1997:197), this visibility in the social space can be dangerous. And if visibility in the social space is dangerous then this implies a safety in invisibility, something I will discuss shortly. For Fanon (1967:112), this submission to sociality is to be made 'palatable', '[t]here is a quest for the Negro, the Negro is a demand, one cannot get along without him, he is needed, but only if he is made palatable'.

There is a need for the Negro, for the other, the other as the 'constitutive outside' to subject formation, the 'abjected outside, which is, after all, "inside" the subject as its own founding repudiation' (Butler, 1993:3). This making 'palatable', in Sarbani's account, seems somehow interlaced with a vulnerability that stems from the danger of recovery, of becoming palatable, that appears to have connections with (sexual) desire. Bhabha (1994) draws upon Lacan's 'scopic drive' to explore the interconnections of looking, seeing, pleasure and desire.

For Hook (2012), this is a 'libidinal economy'; hating and desiring the other; desire of otherness while simultaneously domesticating that other. Here a process of recovery, the disinvestment of the object in terms of mental illness, works to open a person to a play of desires and fantasy, that constitutes the boundaries of and traverses their newly 'clean and proper body'. However, Sarbani warned against solely reading the body of the homeless mentally ill woman as vulnerable and of thus seeing all forms of sexual touch as abuse. She said,

But sometimes I have felt that what I think of as sexual abuse may not be experienced as abuse by the person, it may be the only form of human touch that this person probably will get, or is getting in life and it will be valuable to her. But for women who want to go back and who talk of people who they love and who comes to them at night, I don't think that we need to label everything as sexual abuse and try and you know de-sexualise them and put them into you know put two ribbons on their head and think that they are children. (Sarbani Das Roy).

Sarbani is making the point that just because a woman has been diagnosed as 'mentally ill' does not mean she does not desire to be touched (sexually), or that she cannot make decisions about consenting to this touch. Yet it seems important that, for Sarbani, this 'may be the only form of human touch that this person probably will get'. It seems significant that the only form of touch available here to many ('mentally ill') women is sexual touch. In Sarbani's account, then, to deny such women this touch is to treat them as children, to de-sexualize them through the trope of the child. In fact, from these sexual encounters at railway stations and on the streets of Kolkata, many of the homeless women then become pregnant and have children, some of whom live at Iswar Sankalpa's night shelter. One child still lives there after her mother (a homeless woman with 'mental illness') left, promising she would come back. Sarbani doesn't know what to do with the child, how long should she stay at the shelter before they inform the authorities? Will her mother ever come back?

This realm of the bodily, of touch and how it is registered on and through the body, marks, for Hook (2012) an 'extra discursive' realm, that which seems to elude a solely discursive analysis. A key mechanism for Hook in apprehending this realm is to draw upon abjection. Thus why discursive accounts (and Hook is speaking in reference to racism) are both crucial and inadequate. Crucial because 'symbolic attempts at containment' (Hook, 2006:26) are key responses to abjection, yet discursive approaches seem unable to grasp the 'extra discursive' processes, the conditions of discursive action, that 'escape its codifications and drive the urgency at its attempts at containment' (Hook, 2006:27). Hook (2012:89) warns that if we cannot grasp how the 'extra-discursive', the forces of the body, combine and constitute discourse (racist or otherwise) then we miss the complexity of racism and prejudice, its 'libidinal economy'.

### **Psychiatric Fantasies**

This is useful for thinking about mental health interventions by NGOs because while desires of containment are unspoken, often unacknowledged and themselves invisible, their presence may still be felt at work within psychiatry and Global Mental Health policy. But the 'extra discursive' is always already framed by the symbolic, and yet somehow exceeds the solely discursive, creeping in unacknowledged to the political.

This calls for attention to be paid to the place of fantasy and desire within Global Mental Health advocacy and NGO interventions; for example, fantasies of wholeness, of unified bounded sane subjects to which psychiatry will restore the leaky, oozing bodies of the mentally ill, fantasises of containment and of making palatable, fantasies of being able to tell the difference between sanity and insanity.

This points to a place for psychoanalytical theory in an analysis of the 'libidinal economy' of Global Mental Health; a psycho-political reading that traces the interconnections, the interlacing of desire, fantasy, psychiatry and the political. It also points to a need to examine the 'image function' (Brennan, 2005) of LAMICS for Global Mental Health. If the construction of a periphery; areas of the globe as 'undeveloped'/'developing', works as the 'constitutive outside' (always inside) to the global capitalist market, then what function do such sites serve for Global Mental Health? Might they serve to bolster and reify 'Western' psychiatry?

Thinking about the 'image function', both of LAMICS to psychiatry, and psychiatry to colonialism, is to begin to engage in the effectivity of images, what they 'do'. This marks a shift in intervention, called for by Bhabha (1994:95-96), away from judgements grounded in current political normativity as to whether images are positive or negative, to a displacement through engaging with an image's 'effectivity, its repertoires of power, domination and resistance', an image's 'productive ambivalence'. Such ambivalence is, for Bhabha (1994), a key feature of the psychical landscape of colonialism and also central to a reading of psychic resistance to colonialism and to psychiatry, to which I now want to turn.

Sarbani's account of the dangers of recovery pushes us to think differently about issues of visibility and invisibility as they relate to recovery and vulnerability; a space that defamiliarises the assumed benefit of making people in LAMICS visible to psychological and pharmacological interventions; a space where visibility might be dangerous, and where invisibility might enable camouflage, survival.

### **'Eyes that circulate without being seen'**

One of these 'invisible people' became momentarily visible to me when I accompanied a social worker from Iswar Sankalpa on her daily rounds of Sealdah railway station, in Kolkata. Each day, Pushpa (name changed) travels to the station to find, speak to and give medicines to homeless people with mental health problems, who live within and on the myriad platforms, carriages and spaces alongside the rail tracks. At one point we stopped and Pushpa pointed in front, she said,

“That’s Bharat. We found him a few days ago. He sleeps a lot because of the medicines”. I looked in front, into an empty space. Pushpa called out, “Bharat”. The ground moved, unfolded, and then I could see Bharat, the same colour as the earth. Invisible. Like camouflage. [Field notes, March 19<sup>th</sup> 2011].

NGOs see this invisibility as a key problem to be overcome, while simultaneously, Global Mental Health frames mental illness as the 'invisible problem' within public health and international development. We might, then, understand becoming visible to, or being made visible through, a psychiatric gaze, to be in part a gaze of surveillance –Iswar Sankalpa's 'social workers on the beat'. The potential surveillance at work in NGO's mental health interventions becomes apparent in the different strategies employed by NGOs to ensure medicine compliance, to make sure that once identified and diagnosed people continue to take their medication. A psychiatrist at an NGO, explained to me;

The main problem we face is medicine compliance, which is very important for the patient's well-being... once they start getting better, they leave the place and go to some other place, we may track them or we may not track them. To track them down...there are care givers, who provide them with food or who are entrusted with giving medicines in addition to the social workers and fieldworkers that we have. They most of the time give us the information that the person has left this place and gone there, so go and look there, you might find him or her there. So that building up that caregiver community is very important....We do not force them...but at the same time the person is not willing to take medicines, taking the medicines in a formal fashion...we mix the

medicines with food. And once they start improving they start taking medicines by themselves. So that block, that block that they have regarding medicines ... can be broken and that person feels that he or she is improving after taking medicines, the person starts taking medicines by themselves. (Interview with a Psychiatrist at an NGO).

BasicNeeds employ a similar method when after the camps, field staff make home visits and are;

trained to follow up on people who have dropped out from treatment, those who have side-effects to medication or those who display reluctance to continue with their medicines...All this helps in tracking people needing access to treatment. (BasicNeeds, undated:22).

Here invisibility might be read differently from how it is framed within Global Mental Health advocacy, as a means of survival and resistance, as a secret arts of invisibleness (Jin, 1987: 123-126), that enable people to be less visible to the normative gaze; of the State and of psychiatry. In Sarbani's account, to be invisible may also imply a certain safety on the streets, less vulnerability to touch that appropriates and violates - a secrecy.

### **Secret Arts of Invisibleness**

One day I learnt  
a secret art,  
Invisible-Ness, it was called.  
I think it worked  
as even now, you look  
but never see me.  
(Jin, 1987:123-6).

This account of looking back – unseen - of invisibility, invokes a subject who speaks and is seen, from where it is not, pointing for Bhabha (1994) to the impossibility of



apprehending a subject without the absence or invisibility that constitutes it. The poet, as a migrant woman, can, through such 'secret arts of invisibleness', 'subvert the perverse satisfaction of the racist, masculinist gaze that disavowed her presence, by presenting it with an anxious absence, a counter-gaze that turns the discriminatory look, which denies her cultural and sexual difference, back on itself' (Bhabha, 1994:67). For Bhabha (1994), there is something particularly feminist in this representation of invisibility as a form of subversion, for while during colonialism women were regarded as least resistant, they were 'hidden behind metaphorical veils, they remain[ed] the unknown and unknowable Other' (Shildrick and Price, 1999:390).

Invisible identity is seemingly then neither ontology nor lack, but 'a strategy of ambivalence in the structure of identification that occurs precisely in the elliptical *in-between*, where the shadow of the other falls upon the self' (Bhabha, 1994:85). Although these figures of invisibility - the 'invisible people': the woman's eyes that look but remain unseen, 'emerge with a fixity and finality in the present' they cannot interpellate 'identity as presence', they interrupt the hail of interpellation, they mark an ambivalent identification, a 'double time of iteration' (Bhabha, 1994:76-77). Jones (2007:64) asserts that;

The shape of the culturally abject body always takes the form of "the other," either visible through its marked differences in shape, color, or stability or invisible in its undifferentiated banality.

Or, as in NGO accounts of people with mental illness on the streets, visible in their abjection, yet still invisible. But is there thus a distinction between adapting to one's background; being 'invisible in undifferentiated banality'; and being camouflaged, hidden, concealed?

This enables us to turn to one of the key reasons for employing a (post) colonial discourse analysis of Global Mental Health, in an attempt to highlight how moments of resistance to psychiatry may echo resistance to colonialism. To traverse this 'secret' terrain, I first want to explore resistance at the level of the body and the psyche – particularly practices of invisibility and slyness. The possibilities for reading this secret

resistance within a wider psycho-political register will then be examined. I want now to turn to one key strategy of resistance used by psychiatricized peoples, a resistance that pretends to be something else.

## Chapter Nine

### **Sly Normality: Between Quiescence and Revolt**

*A chapter on fading, being faint, as feint, on making oneself invisible, on camouflage and blending, on a secret terrain of resistance, resistance that is hidden, that leaves few traces and covers its tracks, on pills hidden under tongues, on being sly, and on pretending – pretending to be sane, pretending to be insane, on sly normality – as seduction, symptom and subversion*

## Stories about Pretending

When the great lord passes, the wise peasant bows deeply and silently farts  
(Ethiopian proverb, cited in Scott, 1990:iii).

The circumspect struggle waged daily by subordinate groups is, like infrared rays, beyond the visible end of the spectrum...[the] political terrain that lies between quiescence and revolt (Scott, 1990:183, 199).

My psychiatrist asked if I heard voices. I answered “No” [a lie]. My psychiatrist was glad to hear that: “Otherwise we would have to hospitalise you in a psychiatric institution”, he said (Ronny, in Romme, et al. 2009:27).

I want to tell you two stories; stories about pretending to agree, pretending to be ‘sane’. The first story is about Marie,<sup>70</sup> she told it to me when I interviewed her about her experiences within the psychiatric system.

### **Marie**

Marie heard voices for a long time; they helped her and comforted her while her parents sexually abused her. However, sometimes, as an adult they caused her distress, usually a sign for her that she was getting stressed or a reminder that she should tell someone about the abuse she experienced as a child and kept secret for a long time afterwards. After a particularly distressing experience she found herself sectioned, face to face with a psychiatrist. She found the courage and told him for the first time she had ever told anyone that she was abused as a child. He told her ‘you’re saying that because you’re ill’. She made a decision: she knew that this wasn’t somewhere she’d get well, so she pretended to comply, pretended to agree, nodded her head to whatever the psychiatrist said, in order to get out as fast as she could.<sup>71</sup>

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<sup>70</sup> All names have been changed throughout (unless specified) to ensure anonymity.

<sup>71</sup> Story told to me during a piece of research titled ‘Young People’s Stories about Hearing Voices’ funded by Research Institute of Health and social Change (RIHSC), at Manchester Metropolitan University (MMU), December 2007-March, 2008.

The second story is about George.

### **George**

In the 1950s, George, who was labelled as a 'chronic Schizophrenic', was one of the first people in a psychiatric hospital in America to take part in a clinical trial for chlorpromazine (Thorazine); the first neuroleptic to be used in psychiatry, the drug heralded as marking the beginning of pharmaco-psychiatry.

No one had paid George any attention for years. Now doctors, attendants and nurses all talked to him and watched eagerly to see what effect the drug would have. His condition improved rapidly. After only two weeks of the drug treatment he was moved to a ward for less disturbed patients where he took part in a number of activities. Soon he was doing so well that he was promoted again. By this time he had lively relationships with the other patients and many members of the hospital staff. He began to spend several hours a day with paints and clays, using them to express the rich fantasy life that had previously interested no one. His doctors marvelled. Attendants praised his skill. George was released from the hospital thirty-eight days after his first dose of Thorazine. While he was signing out he remembered that he had left something behind, went back to his room, and returned with an old sock. The puzzled attendant who asked to see it found thirty-eight Thorazine pills carefully stashed inside the sock. Why, then, had George suddenly come to life? (Dallett, 1988:15).

Pretending to agree, pretending you don't hear voices, pretending to be 'normal', pills hidden under tongues and inside socks. Psychiatry is haunted by such pretending, by a hidden territory of survival and resistance, like the 'infrapolitics' of disguise and deception employed by colonised peoples while they may outwardly appear, in power laden situations, to willingly consent (Scott, 1990). While often not read as political, such 'keeping secrets and telling lies' (Siebers, 2004:1), marks a 'veiled resistance', a troubled 'political terrain that lies between quiescence and revolt' (Scott, 1990:197&199). This is a space where official constructions of 'good adjustment',

maintenance and recovery may work to mask 'phantom acceptance' and 'phantom normalcy' (Smith, 2006:122).

This chapter is about finding ways to read these stories and strategies of pretending, to see if we can fleetingly glimpse how pretending might disturb our understanding of what it means to be 'normal', how pretending might be subversive. This connects to a wider project of tracing how the colonial relation is mobilised within psychiatric treatment in order to think through how the violence of colonialism may enable a re-thinking of contemporary forms of psychiatric violence, particularly the construction of certain forms of violence as 'natural', 'necessary', and 'normal' - violence in the name of 'treatment'. Using post-colonial theory here enables an exploration of how strategies of resistance to colonialism may be read alongside, and used to illuminate, resistance to psychiatry – resistance that may be secret, sly, covered up. At first I wondered if this pretending is a strategy that has links to 'passing', 'passing' off as normal.

### **Passing**

'Passing' marks the crossing of lines, of identities, of boundaries. It was first referred to in America, in the 19<sup>th</sup> Century, in posters offering rewards for runaway slaves who were attempting to 'pass' as white, and thus as 'free' (Sollors, 1997). Here 'passing' meant escape and freedom for enslaved peoples, escape from slavery into a world of white privilege. The literature suggests different typologies of 'passing', between 'passing' voluntarily with its links to deception and political subversion, and 'passing' almost by accident (Sollors, 1997).

There are many facets of learning to 'pass'; the places out of bounds, 'where exposure means expulsion', and the 'back places' where concealment isn't necessary (Goffman, 1963:102). This partitioning of the world into forbidden, civil and back places, 'establishes the going price for revealing or concealing and the significance of being known about or not known about' (Goffman, 1963:104). This partitioned world is evident in Scott's (1990:191) account of colonial oppression where the 'subordinate moves back and forth...between two worlds: the world of the master and the offstage

world of subordinates'. It could also be read in the experience of occupying other worlds, hearing voices, dissociating.

For example, this living between two worlds emerged when Oprah Winfrey interviewed a girl called Jani – in a programme titled 'the 7 year old Schizophrenic' (2009). Oprah talked to Jani about some drawings she had done; Jani said the drawings are of a place called Calalini;

Oprah: "Where is Calalini?"

Jani: "I can't tell you."

Oprah: "Why?"

Jani: (whispering) "Because, because Wednesday lives there and she's the worst one"

Oprah: "What is she?"

Jani: "Calalini is on the border of my world and your world".<sup>72</sup>

'On the border of my world and your world' – here the presence of other worlds, of cats that speak and people called Wednesday - was labelled as Childhood Schizophrenia. However, for Donna Williams, an author who self-identifies as having Autism, these other worlds can be ways for people to cope with adverse events, with inequality or trauma.

The more I became aware of the world around me, the more I became afraid . . . I was frightened . . . My world was full of imaginary friends. They were far more magical, reliable, predictable and real than other children . . . Other people did not understand the symbols I used (Williams, 1992, cited in Billington, 2006:3).

This highlights how these other worlds may open up 'creative line[s] of escape' (Reeve, 2007:7), as individuals find inventive and imaginative ways to psychically 'escape' from

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<sup>72</sup> Oprah Winfrey. (2009). 'Oprah Meets a Child Battling with Schizophrenia' (October 2<sup>nd</sup>) [online] <http://www.oprah.com/oprahshow/Oprah-Meets-a-Child-with-Schizophrenia-Video> (Accessed, January 12<sup>th</sup>, 2010).

conditions in which their lives are constructed as unworthy of being lived. Hearing voices (alongside making your mind go blank or filling it with light, retreating to 'other worlds', and being inhabited by other people) may all be such creative lines of psychic escape. In fact, hearing voices is well recognised in the critical mental health community as a coping strategy.

Similarly, Fanon's encounter with the white gaze alludes to the partitioned, partial worlds of the colonized, 'a doubling, dissembling image of being in at least two places at once...a peculiarly colonial condition' (Bhabha, 1986:xvi). To take yourself from your own presence seems to resonate with stories of how some people use dissociation to escape the trauma of their immediate surroundings. This hints at a way of reading these experiences psychopolitically, raising the question of how psychic oppression and trauma are interlaced with the socio-economic.

#### **'I hear a voice and it says "Thud"' – Pretending to be mad**

However, these other worlds, these means of psychic escape, are often concealed. This concealment is evident in another story.

A voice hearer is travelling by train from Sheffield to London. He's taken the advice of people in his support group and pinned a small microphone to the lapel of his jacket. This way, he can talk back to his voices and appear to be speaking into a mobile phone. Soon after the train leaves the station, he, like other passengers, begins an animated conversation. Nearing London, the train goes through a series of tunnels. Everyone else loses telephone contact, but he keeps chatting. When the journey ends at St. Pancras station, a man comes up to him and says, "I'm sorry to intrude, but I couldn't help noticing that your phone kept working when none of ours did. Could I just ask, what Network are you on?" (Hornstein, 2009:49).

Seemingly then sometimes people 'pass' too well, hinting at why 'passing' held both anxiety and fascination for whites in 19<sup>th</sup> Century America, an anxiety that was muted by the assumption that one could 'always tell' - tell the difference (Sollers, 1997:250). While Ronny (quoted at the beginning) pretended not to hear voices to avoid



hospitalisation, for Rosenhan, in the 1970s, the opposite was true. Rosenhan (1973, online), and a group of researchers, pretended to hear voices in order to be hospitalised and by doing so to put psychiatry's assumption that we can 'tell the normal from the abnormal' to the test. Psychiatry didn't do so well.

On telling a psychiatrist that they heard a voice that said 'thud', all the participants were admitted to psychiatric hospitals, all then behaved as they usually would, behaved 'normally', and many couldn't get out for months. It seemed, then, that a sane individual could not be 'distinguished from the insane context in which he is found' (Rosenhan, 1973). In order to be released the participants had to pretend to agree that they had been ill.

In Rosenhan's study (1973), the researchers 'passed' as voice hearers, they 'passed', posed, masqueraded as what they were 'not really'. Thus, a passer is usually considered a counterfeit, a pseudo, a phoney or an impostor (Sollers, 1997). But here the 'not really' that one 'passes' as suggests there is a 'real' identity, a 'firm and immutable identity' from which one is attempting to 'pass' (Sollers, 1997:250). There's a problem here, then, in relation to 'passing' as sane, for if we assume that the person 'passing' really is 'mentally ill' and is secretly 'passing' for what they are not - sane - then this maintains the binary of sanity and insanity.

Thus, passing is about escaping a subordinated identity and accessing the privileges of the hegemonic (Ginsberg, 1996). However, if one is a passer or not, and no matter what strategies a person uses to 'pass', it seems that the identity that one is trying to 'hide' has been structured in relation to normative, ablist frameworks of intelligibility. In this way, 'passing' may 'unquestionably assume the good of securing a place among the cultural structures of normalcy' (Titchkosky, 2001 - online), and arguably leave those structures in place. This is the seduction of 'passing' as normal because it secures a place within normalcy, enabling the passer 'to be' 'normal', to 'fit' with the status quo (Titchkosky, 2001). Thus, while passing may enable both psychical and physical escape, freedom from slavery – is it able to change that system, the normative framework of intelligibility that demands the very normality that one is 'passing'?

In the account of 'passing' on the train from Sheffield, 'passing' is reliant on a prop - it's made possible because of a microphone, a mobile phone 'hands free' set. Many of my friends who hear voices have told me stories about the freedom to talk to their voices made possible through mobile phones. Might medication also be a prop to enable 'passing'? However, this is a prop that aims to eradicate the voices, to enable the person to 'become' normal, to be assimilated. This seems different to me from 'passing' as white, for while both enable the person whose identity is denigrated to assume an appearance that enables them to access the more privileged position, there is a difference. For while the person who hears voices is able to appear 'normal', to blend in using certain props and strategies, these tactics also enable them to hear and speak to the voices that psychiatry and society insist are not really there. To speak to them, slyly. Thus, while 'passing' may at times be sly, pretending seems always to be. Is it possible, then, to read the story of pretending another way, a way that disrupts assumptions of a 'real' identity, and as a strategy that implies something other than assimilating, adapting? We might read pretending, then, through a post-colonial lens, as a form of mimicry.

### **Mimicry: 'Almost the same, but not quite'**

Pretending to be normal, mimicking normality, seems to emerge in the stories of those who have survived the psychiatric system as a tactic, a strategy of deception that enables some freedoms, at a cost. Stories of pretending, of being sly, resonate with Bhabha's (1994:85) framing of mimicry as a key colonial ambivalence, 'the desire for a reformed, recognizable Other, as a subject of difference that is almost the same, but not quite'. Constructed around ambivalence, *'almost the same'*, colonial mimicry must, in order to be effective, continually produce its slippage, produce difference. This makes mimicry one of the most 'elusive and effective strategies of colonial power' (Bhabha, 1994:85). It is effective because colonial discourse, and arguably psychiatry, frame the colonised (and the 'mentally ill') as similar to the colonisers, the so-called sane, but not identical. If they were identical then the ideologies that justify colonialism and psychiatry's interventions could not operate, because these 'ideologies assume that there is structural non-equivalence, a split between superior and inferior which explains why any one group of people can dominate another at all' (Huddart, 2006:40).

However, in its very effectivity, mimicry is elusive because of the introduction of difference, the 'almost the same, but not quite'. This difference between normal and abnormal, sane and insane, is 'the disturbing distance in-between that constitutes the figure of colonial otherness' (Bhabha, 1994:45). In this between space, between difference and the same, a difference is enabled that cannot be contained, a space is opened up for 'something other, a difference that is a little bit uncanny' (Bhabha, 1994:131). It is here that the agency of the colonised emerges.

### **Mottled against a mottled background**

Lacan says that, '[m]imicry reveals something in so far as it is distinct from what might be called an itself that is behind' (Lacan, 1977:99). Being distinct from an 'itself' behind hints at something more than blending in with a background of normative expectations. For Lacan (1977), nothing of what can be understood as adaptation (behaviour to survive) can be found in mimicry. This is because mimicry operates 'strictly in the opposite direction from that which the adaptive result might be presumed to demand' - subverting assimilation (Lacan, 1977:99). Here adaptation to one's background is always bound up with the needs of survival. Therefore to mimic one's background 'is not a question of harmonizing with the background but, against a mottled background, of becoming mottled' (Lacan, 1977:99). Might we infer, then, that while adaptation solely enables survival, mimicry works in the 'opposite direction', as disguise, and as camouflage? Lacan (1977:99) likens this to the kind of camouflage practiced in human warfare and in the animal world, suggesting that, more than survival, mimicry is a practice of deception. This seems different from Bauman's (2004) 'making' certain lives invisible by not looking, and points to how people may make themselves invisible in order to look back, unseen.

Bhabha (1994:86) develops Lacan's mimicry that works in the 'opposite direction', but ambivalently, seeing mimicry as 'at once resemblance and menace'. While Fanon (1963:200) points to the psychiatric problematic of 'curing' a native, a cure which sought to 'make him thoroughly a part of a social background of the colonial type'. For Fanon (1963:201), the colonised, 'the veiled women' of Algeria, 'make up the landscape, the natural background to the human presence of the French'. This opens a

reading of the failure of the colonisers to make the colonised ever fully blend in with the background of colonial reality. For the colonisers, the colonised are merely the background, part of the colonial landscape that enables the coloniser's presence. Yet this background is partially veiled, hinting at a veiled resistance, an unknown. There is an interlacing and yet also a distinction being made here between invisibility and mimicry; a distinction between invisibility as adaptation (blending in) and invisibility as resistance (being mottled, camouflaged).

### **The 'Invisible Man'**

We can explore this distinction through the artwork of Liu Bolin, a Chinese artist known as the 'invisible man', from a series of artworks named 'Hiding in the City', where he spent hours making himself invisible, camouflaged against different backgrounds of Beijing. He explained in an interview that,

Some people call me the invisible man, but for me it's what is not seen in a picture which is really what tells the story...I felt there was no place for me in society [because of not being able to find employment]...I experienced the dark side of society, without social relations, and had a feeling that no one cared about me, I felt myself unnecessary in this world. From that time, my attitude turned from dependence into revolting against the system (Liu Bolin, 2010, cited in MailOnline).

After the Chinese authorities closed down his art studio, Liu's work came, for him, to mark 'a silent protest, the protest against the environment for the survival, the protest against the state' (2010, cited in MailOnline). This 'invisible' protest is thus used to call attention to the social problems caused by China's sudden growth in economy and to the lack of protection from the Chinese Government for artists. Through the use of his own body, making himself invisible, 'disappearing' himself, Liu aimed to create a space of recognition for Chinese artists, and their troubled relationship with their physical environment.<sup>73</sup>

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<sup>73</sup> See wikipedia entry on Liu Bolin [http://en.wikipedia.org/wiki/Liu\\_Bolin](http://en.wikipedia.org/wiki/Liu_Bolin)



*Picture from Liu Bolin's 'Hiding in the City' series*

In the picture above, Liu has been painted to camouflage against a brick wall, you can almost see him, but not quite. Thus, in making himself invisible, it would seem Liu's work moves in the opposite direction to adaptation, working to make him mottled against a mottled background (Lacan, 1977). Liu's work implies an agency, a resistance in being mottled, that works at the level of the body, just as a passer is one 'who uses his skin as "camouflage"' (Sollers, 1997:249). This is an agency hinted at by Foucault (1983:237) when he said '[f]rom the idea that the self is not given to us, I think that there is only one practical consequence, we have to create ourselves as a work of art'. This implies there is some room for a 'virtual level of personal freedom, some potential room for non-normalized forms of self-regulation', that allow some space in how one might 'experiment with, remake, develop, alter the self' (Hook, 2006b:623).

Liu's creation of his body as art marks a move from dependence on, to revolt against, the Government. Does this somehow point to a difference in being (or being made) invisible, such as Liu felt he was socially when he couldn't find employment, to making oneself invisible, invisibility as performative? If so then there is a need to explore in what ways people might make themselves invisible, perform invisibility, and what

implications this might have, particularly for (Global) Mental Health. There are other ways to make oneself invisible, to mimic.

### **Slyness**

One key strategy of mimicry, for Bhabha (1994:141), is sly civility, illustrated in the Ethiopian proverb, '[w]hen the great lord passes, the wise peasant bows deeply and silently farts' (cited in Scott, 1990:iii). Slyness marks a 'turning off' response; it is 'the native refusal to satisfy the colonizer's narrative demand', which,

represents a frustration of that nineteenth-century strategy of surveillance, the *confession*, which seems to dominate the 'calculable' individual by positing the truth that the subject *has* but does not *know* (Bhabha, 1994:141).

We could read psychiatry then as a form of surveillance, a means to convert the 'irrational' into the 'calculable' through diagnosis, which posits the psychiatric truth that what they have, but do not yet know it, is a 'mental illness', a 'biochemical imbalance'. This is a making calculable, or for Fanon, making 'palatable', of difference ([1952]1986:176). Thus, we could read pretending to be normal as a form of sly civility, or sly normality, that disrupts psychiatry's attempts to make people calculable by hiding pills under tongues and inside socks, through pretending you don't hear voices, or that you agree that you're mentally ill. For Bhabha (1994:141), this slyness is more than a refusal of a narrative demand for the 'calculable', it produces a problem for colonial codifications, it generates an uncertainty in its refusal to be intelligible, it 'changes the narratorial demand itself'.

This refusal to be intelligible through appearing to be intelligible seems different from the 'refusal to reproduce hegemonic appearances' discussed by Scott (1990:203). Pretending to be normal - sly normality – works in the opposite direction to this, as it seems to work not through refusal of, but through the very production of the signs of 'normative compliance'. It appears to comply, it mimics normality, it fools the eye. It seems to work, then, like the genre of art known as the 'trompe l'oeil', which imitates 'the depicted object so convincingly that the viewer is momentarily seized by an inability to tell the difference between original and copy, reality and representation'

(MacLure et al., 2010:496). Marie, George, and Rosenhan (1973), also 'fool the eye' by imitating sanity and insanity so convincingly that for a moment it becomes impossible to tell the difference between them, they mock psychiatry's claims to tell the difference, they raise an anxiety that challenges the integrity of a model that can be mimicked and then discarded so easily.

For Bhabha (1994:86–88), this marks an 'area between mimicry and mockery', a space that poses an 'immanent threat to both "normalized" knowledges and disciplinary powers' because it 'quite simply mocks its [psychiatry's, colonialism's] power to be a model, that power which supposedly makes it imitable'. This echoes the strategies of creative self-protection employed by colonised peoples, the

comical imitativeness which indirectly reveals the ridiculousness of the powerful...an uncanny ability to subvert the valued skills or traits which may ensure one's adaptation to the "system" (Nandy, 1983:84).

Stories of imitating, pretending, mimicking, may enable self-protection because they provide camouflage. Thus, mimicry is linked to the visual, to invisibility, faint figures and partial presence. When Marie pretended to agree with her psychiatrist, when Ronny pretended he didn't hear voices, the penetrative psychiatric gaze was dislocated by this pretence, as a space from which to look back, partially unseen. Fanon (1963:251), however, offers a different reading of mimicry, as a 'symptom' of colonisation, a 'nauseating mimicry' employed by colonised Algerians to mimic Europe (discussed later in the chapter).

### **Fading and being feint: Camouflage or Blending?**

But with what conceptual tools can we establish whether being invisible and being sly are acts of resistance through camouflage, strategies solely for survival, symptoms of oppression, or marks of adaptation and blending? Thinking about these issues I encountered an uncanny likeness, an eerie resemblance, between one of Liu's pictures and an advertising campaign for the drug Seroquel XR (2010), an anti-psychotic medication being marketed by Astra Zeneca for Bipolar Depression; on televisions, posters and magazines, direct-to-consumers, all over America. On the following page, is

a picture from Liu Bolin's 'Hiding in the City' series, where he has been painted to camouflage against a background of supermarket shelves.



*Picture from Liu Bolin's 'Hiding in the City' series.<sup>74</sup>*

And here is an advert from the Seroquel XR campaign, of a man seemingly fading into a background of supermarket shelves.



SEROQUEL XR®

*Advert from Saatchi and Saatchi's Seroquel XR campaign.<sup>75</sup>*

<sup>74</sup> Liu Bolin. (2010). Hiding in the City. [online]  
<http://www.magicalurbanism.com/archives/4069> (Accessed, 5.10.2011).

<sup>75</sup> MM&M Awards. (2008). Best Individual Consumer Print Advertisement. [online]  
[http://media.mmm-online.com/documents/16/cat12\\_3918.pdf](http://media.mmm-online.com/documents/16/cat12_3918.pdf) (Accessed 27.9.2011).



Both pictures depict men, in supermarkets, blending into the background, their bodies opaque. While for Liu this is a process of making himself invisible as a political statement, for Saatchi and Saatchi, the advertising company that created the Seroquel XR advertising campaign for Astra Zeneca, this turning opaque is framed as fading, a 'symptom' of a psychiatric disorder – used to market a drug. The creative team from Saatchi and Saatchi (2010), described what they were aiming for in an interview with an industry magazine; Pharmaceutical Executive,

After doing a ton of research, Saatchi & Saatchi realized that people dealing with bipolar depression feel like they are spectators in their own lives. They said they were literally "consumed" by their condition. The S&S team struck upon the notion that people feel as though they are fading into the background. At first, this was just a phrase to inspire them, but it soon became actual content with an ad campaign depicting people melding into the background of their everyday lives. Bipolar depression is a new term for the consumer audience, so the campaign had to be as much about education as it was about medication. The ad team did a stunning job setting a tone and mood that made viewers turn to the TV and say, "That's me, that's what I feel like, and now it has it's [sic] name". When the phrase "bipolar depression" was put in front of patients in testing there was an immediate head nod. "We didn't just want to tell people that depression hurts, and that it hurts others. We wanted consumers to literally feel the fading and see themselves in the ad", says Helayne Spivak, chief creative officer. However, the television ads remain respectful to the patient population. The players in the commercial are simply going through their daily routine as portions of their body turn opaque and blend into whatever is behind them, be it a couch, bus seat, or grocery stand. The result is a powerful segment that resonates with sufferers and regular viewers alike.

Lewis (2010) explains that,

Saatchi & Saatchi Worldwide created very compelling ads that illustrate the insight that bipolar patients feel like they're "fading into the background" during

depressive periods. The images show people in clothing that camouflages them from their environments so that they seemingly partially disappear.

The suggestion here is that Bipolar Depression makes you feel like you're 'fading into the background', and that this fading camouflages people, so that they 'partially disappear'. Here fading, camouflage and partialness are linked, as 'symptoms' of Bipolar Depression. This returns us to Bhabha's (1994:80) concern with how we might begin to conceptualise the 'overlapping space between the fading of identity and its faint inscription'. If being faint implies camouflage, potential resistance, in what ways does fading work? The Seroquel TV ad informs viewers that 'Bipolar depression doesn't have to consume you' (presumably if you consume the drug), ending with the caption, 'don't fade, fight' (Seroquel XR advert, 2010). This implies that to fade is the opposite of fighting; the opposite of fading (becoming visible) is to fight, and in order to become visible one needs to consume medication - Seroquel XR. This sets up a false binary between fading and fighting, as though the two cannot co-exist. And then for Fanon ([1967]1986:100), for the Black man, there is often only one choice - 'turn white or disappear'. This hints at ways of reading the taking of medication as interlacing with turning white - where to disappear is to become part of a colonial background, a background that is mottled, veiled. And how does turning white relate to the 'turn' that interpellates - the turn to the TV?

Bhabha's (1994) reading of partial presence and faintness, the link he implies between the faint figures of identity and the act of being feint (pretending, feigning, faking), hints at an intentionality or agency in being faint, partial, sly, that is perhaps not implied in fading. It also stands in contrast to the potential resistance and subversion implied in invisibility; how in being faint, in fading, a person might fight against the normative gaze of psychiatry or pharmacology through their very denial of fully 'being'; the disruption caused by an absent presence.

Saatchi and Saatchi have been congratulated for their consultation with those who have a label of Bipolar Depression in the making of this advertising campaign. Here 'patient insights of fading' (Lewis, 2010) and descriptions of what it's like to be a

'spectator in their own life' (Saatchi Wellness blog)<sup>76</sup> have informed the making of the advertising campaign. While this brings into focus issues of how 'patient' stories are used, or potentially co-opted, within pharmaceutical advertising, it also begs the question of how we can distinguish between descriptions of feeling like a spectator in one's life, fading, being faint, and disappearing. Is the feeling of fading the same as feeling like a spectator? And yet watching the advert on TV or the internet one is invited to be a spectator (of the advert), to 'literally feel the fading and see themselves in the ad' (Saatchi and Saatchi, 2010).

But is it possible to 'see ourselves' in an advert, in any image, or does this, as Barthes (1989:348) suggests, produce a fundamental misrecognition; the pressing of our noses 'against that "other" image-repertoire with which I narcissistically identify myself'? This misrecognition is also at work, for Bhabha, in colonial identification, hinting that both colonialism and psychiatry operate as 'image repertoires' to press our noses up against. Drawing on Lacan, Bhabha (1994:110) explores the transformation that takes place in the mirror phase enabling sameness and identities to be postulated as problematic because 'the subject finds or recognizes itself through an image which is simultaneously alienating and hence potentially confrontational'. This is reminiscent of the white gaze on the black child, the school books filled with images of whiteness; images that make the black child turn away from himself in his total identification with whiteness (Fanon, [1952]1967). What would it mean then to turn away from oneself in a total identification with normality or sanity? This turn, away from oneself (problematically assuming there is already a self from which one can turn) is, in Fanon's account, to be hailed and interpellated as white, but never fully, only partially - to be almost white, but not quite. And how does the turn away from oneself link to the interpellating hail of the Seroquel XR advert, 'that made viewers turn to the TV and say "That's me, that's what I feel like, and now it has it's [sic] name"' (Saatchi and Saatchi, 2010).

For Bhabha, (1994) partial visibility, faintness, non-being, in its refusal of presence (its refusal 'to be'), interrupts identification and interpellation, working as a strategy of resistance and subversion, disrupting assumptions of the unified bounded subject. For

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<sup>76</sup> Saatchi Wellness blogspot <http://saatchiwellness.blogspot.co.uk/2010/04/dont-fade-fight.html> (Accessed 27.9.2011)

Gross (1990:90), this links to the abject moment, the precariousness of a subject's identity, a reminder that 'the subject may slide back into the impure chaos out of which it was formed'. This is more than an 'undoing of identity'; it is a 'descent into formlessness', the 'body in pieces' (Hook, 2012:75).

A key subversive potential then of partial visibility for Bhabha (1994), is that it interrupts identity formation and interpellation through a disavowal of presence. However, in the Seroquel advert, consumers are being interpellated as potential sufferers of 'bipolar depression' through identifying with fading, 'feel the fading'; aiming to make 'viewers turn to the TV and say "That's me, that's what I feel like, and now it has it's [sic] name"' (Saatchi and Saatchi, 2010). What is at work in 'seeing' oneself in invisibility, in identifying with, and being interpellated through fading, through absence? What seems important here is the pathologisation of the feeling of fading, and the creation of a medication for this, the creation of a market. The Seroquel ad makes this clear in its adverts in Time magazine, which state, '[b]ipolar depression doesn't just affect you. It can consume you.' (Below).

**Bipolar depression doesn't just affect you. It can consume you.**

**SEROQUEL XR is an option proven effective for treating bipolar depression.**

It's easy to feel like you're fading into the background when you're living with bipolar depression. SEROQUEL XR has been proven to work more effectively than other bipolar depression treatments for many people. It's just one pill, once a day. Bipolar depression doesn't have to consume you. Talk to your doctor. Understand your options. And discuss whether SEROQUEL XR is right for you. To learn more, visit [seroquelXR.com](http://seroquelXR.com).

**Important Safety Information About SEROQUEL XR**

Elderly patients with dementia-related psychosis (having had hallucinations or delusions) and memory loss treated with this type of medicine are at an increased risk of death, compared to placebo (sugar pill). SEROQUEL XR is not approved for treating these patients.

Antidepressants have increased the risk of suicidal thoughts and actions in some children, teenagers, and young adults. Families of all ages taking treatment should be watched closely for worsening of depression, suicidal thoughts or actions, unusual changes in behavior, agitation, and irritability. Families and caregivers should watch patients daily and report these symptoms immediately to the physician. SEROQUEL XR is not approved for patients under the age of 18 years.

High blood sugar and diabetes have been reported with SEROQUEL XR and conditions like it. If you have diabetes or risk factors such as obesity or a family history of diabetes, ask your doctor about checking your blood sugar while taking SEROQUEL XR. Immediately report symptoms if you develop symptoms of high blood sugar or diabetes, such as increased thirst or hunger, increased urination, or weakness, contact your doctor. Complications from diabetes can be serious and possibly life-threatening.

Increases in lipoproteins and in LDL (bad cholesterol) and decreases in HDL (good cholesterol) have been reported with SEROQUEL XR. Your doctor should check your cholesterol levels before you start SEROQUEL XR and during therapy.

Weight gain has been reported with SEROQUEL XR. Your doctor should check your weight regularly.

A risk of possible fatal side effect reported with SEROQUEL XR and medicines like it is myocardial infarction (MI) or heart attack. If you have any symptoms of heart attack, such as chest pain or discomfort, sweating, nausea, or lightheadedness, contact your doctor immediately because treatment should be stopped if you have MI.

Another serious side effect reported with SEROQUEL XR and medicines like it is liver problems. Liver problems may be symptoms of the flu, fatigue, or other parts of the body. Do not become pregnant. And the risk of TB is believed to increase as the length of time in patients taking for about 6 weeks, this is much less common. There is no known treatment for TB, but if it ever go away partially or completely if treatment is stopped.

Before starting treatment, tell your doctor if you have high potassium levels or have a history of, or are at risk for, potassium or a low white blood cell (WBC) count. An eye exam for cataracts is recommended at the beginning of treatment and every 6 months thereafter.

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Other risks include feeling dizzy or lightheaded upon standing, or having trouble swallowing. Tell your doctor if you experience any of these.

Suicidal thoughts or actions may occur. Tell your doctor if you have thoughts about death or suicide.

Some antidepressants have been reported with SEROQUEL XR. You should not participate in activities such as driving or operating machinery until you know that you can do so safely. Avoid drinking alcohol while using SEROQUEL XR because SEROQUEL XR increases the effects of alcohol. Avoid becoming intoxicated or intoxicated while using SEROQUEL XR.

Common side effects: The most common side effects are drowsiness, dry mouth, increases in cholesterol and lipoproteins, constipation, upset stomach, dizziness, a sudden drop in blood pressure when rising, weight gain, increased hunger, weakness, increases in blood sugar, difficulty speaking, and dilly willy.

This is not a complete summary of safety information. Please discuss the full prescribing information for prescription SEROQUEL XR with your health care provider.

**Indications**

SEROQUEL XR is a once-daily tablet approved to treat acute depressive episodes in bipolar depression, acute manic or mixed episodes in bipolar disorder, or when added to lithium or divalproex, and long-term maintenance of bipolar disorder when added to lithium or divalproex.

**Prescription and Brief Summary including Revised Warnings and Adverse Events**

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.fda.gov/medwatch](http://www.fda.gov/medwatch) or call 1-800-FDA-1088.

For a free doctor conversation guide, visit [seroquelXR.com](http://seroquelXR.com) or call 1-866-331-3693.

If you're without prescription coverage and can't afford your medication, AstraZeneca may be able to help. For more information, please visit [seroquelXR.com](http://seroquelXR.com).

**Depression symptoms shouldn't have to consume you.**

**SEROQUEL XR**  
quetiapine fumarate  
extended-release tablets

AstraZeneca

Seroquel XR print advert (2010) (featured in Time Magazine).

Seemingly, then, you (the viewer) can consume Seroquel in order to 'fight' the fading, to be restored to yourself. It is worth noting, and perhaps telling, that both images of

invisibility above (Liu Bolin's artwork and the Seroquel XR advert) depict men blending into, or camouflaged against, supermarket shelves: sites of mass consumption.

### **'The difference which will make us ourselves'**

For Barthes (1989), the effectivity of an advert depends on making the product being advertised appear integral to the viewer's identity. In the Seroquel advert, the medication is portrayed as completely integral to the identity of those with bipolar depression, 'it is through the drug that the self is restored to itself' (Rose, 2007:214), so much so that without the drug their very identity 'fades' into the background. On taking the drug the body returns to itself – from the opaque to being fully present. This is a marketing of personalization; the hair dye, the medication, and the shoes - 'the difference which will make us ourselves' (Baudrillard, 1998:87). In fact marketing is a 'practice based on differences' where 'ever more hybrid and differentiated populations present a proliferating number of "target markets" that can each be addressed by specific marketing strategies' (Hardt and Negri, 2000:152).

This calls for an analysis of how markets may employ 'techniques of differentiation', ways of forming different bodies and how these bodies can relate to each other (Ahmed, 2000:42). Diagnostic tools, such as the DSM and ICD, construct ever more differentiated populations and ever more possibilities and ways to be not normal. Thus, 'the possibilities for being normal are theoretically limited and circumscribed and...the possibilities for being not-normal are theoretically limitless' (Fendler, 2001:127-128). Thus, the theoretically limitless potential for abnormality translates into the theoretically limitless potential for markets in abnormality, where '[e]very difference is an opportunity' (Hardt and Negri, 2000:152).

It is in this way that the market 'fixes' its subjects as 'eternally lacking' (Goodley, 2007:322), thus creating the conditions for people to problematise themselves according to particular normative frameworks of recognition; as always in need of (re)working and recovering. Many products are sold as a way to restore the unity of one's being, and it is 'this lost being which is going to reconstitute itself...by force of signs, in the expanded range of differences' in the tiny signs arrayed to create a 'synthetic individuality' (Baudrillard, 1998:88). In this case a chemical individuality, a

'neurochemical selfhood' (Rose, 2003), which seems connected here to wholeness, to the unitary-bounded subject as a figure of autonomy privileged by the neoliberal market economy, which disavows merging (with the background, with others), dependency and inter-dependency.

### **'Getting better'**

This takes us back to Sarbani's dilemma of community care (discussed in Chapter 8) and medicating people on the streets, as potentially making women more vulnerable, more visible to abuse, where merging with the background may provide forms of safety. Medication might reduce people's abilities to make themselves invisible. This implies a safety in the psychic space, expressed explicitly in Sarbani's concern about what 'getting better' might mean for many women:

And it's her pain, I can't take away that pain. And the pain will not vanish with a few anti-depressants. But then I don't, it's not like bringing her back here, putting her on anti-depressants will make her life easier... a personal dilemma sometimes I feel is that you know like many patients are coming here, they're getting better, sometimes I just question myself. When they're getting better sometimes they can't remember their homes or they don't want to go back home because their memory of the home is so bad. And sometimes I wonder whether am I doing good by recovering them...is the state of wellness really producing the sense of well-being. Or is it actually bringing back such more tormenting memories of a life probably which has been extremely traumatic? Especially for the woman, some of the women I feel, once they have got better it's so much more difficult ... think of what they have lost. Whether the world of delusions and hallucinations was much more sort of comforting to them at least. Rather than the reality which is perhaps a lot more suffering. (Sarbani Das Roy).

Sarbani's text is haunted by melancholia; a withdrawal from sociality into an opaque psychic landscape, another world, of 'delusions and hallucinations'. Despite this opacity, for Butler (1997), it is possible to read such experiences as 'nascent political texts' (McRobbie, 2009; 116), as responses to, and ways of working through trauma.

Even in despair there may be signs of a crushed rebellion (Butler, 1997), an ‘illegible rage’, a rebellion we might read as feminist (McRobbie, 2009). But is this ‘crushed rebellion’ somehow contained in the act of naming and categorising distress as ‘mental illness’?

### **Naming, Classifying, Tucking away**

A name, then, is a ‘very common but not very reliable way of fixing identity’ (Goffman, 1967:77). When Fanon asks (1967:113), ‘where am I to be classified? Or, if you prefer, tucked away?’ he is implying a containment of the abject in the act of classification, in naming. Creed (1993; 28-29) conceptualises that the reconstitution of the self, threatened by the horrific image of the other, occurs through the conventional ending of horror narratives ‘in which the monster is “named” and destroyed’. Does this imply that in its very naming the monster is destroyed? That it is destroyed in being named?

But what happens when medication and medical intervention enter the scene of abjection? What role does psychiatry play in producing abject, psychiatrised bodies? For LeFrancois (forthcoming, 2012:12), ‘psychiatrised abjection’ is ‘the process of rendering abject through psychiatric diagnosis; psychiatric abjection is the result of the subjectification/objectification and psychiatrisation that takes place through diagnosis’. LeFrancois (2012:14) makes a key point when she says that psychiatrised peoples, or people with a label of mental illness, are not ‘inherently abject’ but may become abject through the process of diagnosis. How does this ‘making abject’ relate to possibilities for resistance? Is resistance solely a refusal to accept the constitution of ‘abject object’, as Tyler (2009) suggests? Is there a risk of domesticating the abject within this refusal, making them visible? What ‘secret arts of invisibleness’ are possible after psychiatric intervention? Is it possible to be slyly normal after having direct-ECT administered? Chrysan (who’s story makes up part of the oral history archive at The Bapu Trust) says;

The most embarrassing thing was that my memory was effected so badly [but] thankfully I recognised my children. One day when I went out, a friend of mine was coming over to my house and I met her in my building. She said hello to me and I was just blank...how could I forget my own friends...After a few days

you're just drugged and dazed. I don't know what it was. I cannot express it in words (p17-18).<sup>77</sup>

There is a politics here too of memory, of forgetting; about what is worth remembering;

Forgetfulness with ECT is usually mild, shortlasting and confined to events during the ECT course – a time that the patient would anyway be happy to forget about, for who wishes to retain memories of the period when mental illness was acute? (Andrade, 2002:13).

ECT and medication are, then, also psychiatric encounters with abjection. They too produce abjection, the crossing of bodily borders; drooling, memory loss, seizures. This complicates a reading of abjection as potentially disruptive, as a threat to the fantasy of the unified, whole subject. How are we to understand the abjection produced through some forms of psychiatric treatment alongside the claims of psycho-pharmacology and psycho-pharmaceutical marketing to make people whole again, to restore the self to itself through drugs? Here abjection is a 'side-effect' to medications that claim to make us whole again. Is it possible then to read the abjection produced by psychiatry as disruptive?

Perhaps the abjection produced by medication (the drooling, leaking bodies) highlights the failure of psycho-pharmacology to restore people to a unified whole because in the very project of restoring the self to itself through drugs, that very self leaks. This resonates with Shildrick's (2008) exploration of the normalising strategies of the corporeal cut within surgery and how the body's plasticity can work to disturb and queer these strategies. For Shildrick (2008:31), 'the body in Western culture is characteristically cut off, isolated, from its others, established as whole and bounded...[while simultaneously] it is 'increasingly cut open, breached, treated in its parts and reorganized'.

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<sup>77</sup> 'Chrysan's story', in 'Sanchit' – the oral history archives at the Center for Advocacy in Mental Health, The Bapu Trust, Pune, p17-18.



The bounded unitary rational subject of the West is thus secured by the plasticity, adaptability and the 'amenability to reconstruction, of the singular body' (Shildrick, 2008:32). Treatments such as surgery and pharmacological interventions (medication) 'hold out the promise of a reassembled corporeal unity' (Shildrick, 2008:32) and aim to restore a single unified subject. Thus, the very plasticity and adaptability that makes recovery possible, simultaneously opens a space to queer the normative act of recovery. The corporeal cut betrays and disrupts the unitary subject in the very act of reconstituting it, just as the skin that seals and contains that subject through registering touch, acts as a 'border that feels' (Ahmed, 2000:45). This makes possible different readings of, for example, recovery in mental health. Here recovery could be read as a form of resistance, disrupting the psychiatric and societal imaginary of incurable 'mental illness' –a way of sticking two fingers up at the psychiatric system that told people they would never recover.

Yet how do we reconcile this with the implications of recovering as a neoliberal/sane/unitary subject? How do we grapple with the implications of understanding recovery as a process that reifies the unitary rational subject while simultaneously opening up spaces to resist this subjection through the very act of recovering? And similarly then, how can we read the leaking caused by psychiatric medications that aim to restore people to a unitary self, a self which is betrayed through that very leaking? For Hook (2012:85), while, through abjection, the symbolic order may have been challenged, it is not disenabled, in fact, if anything, 'one might wager, it has been strengthened', and thus 'abjection is not revolutionary'.

How does this link to the act of naming? What is destroyed in naming? Perhaps in the act of naming, not the monster but the monstrosity it implied, that which threatened the unified subject, is destroyed through domestication. In naming, the monstrosity is domesticated, the thing that made us turn away, look anywhere but, becomes familiar, it has a name, and the name is 'mental illness', 'an illness like any other';

Certain biochemical changes, it could happen to you or me. Just a sudden biochemical change could make you go there on the streets, could make me go

there on the streets. So it's something that can happen to each one of us.  
(Sarbani Das Roy).

This is a process of rendering familiar the strange, the abject, naming it as a 'mental illness', a 'biochemical imbalance'. While we have explored how this domestication may work, as does colonial discourse, though a process of fixing identity, for Bhabha (1994), this 'fixing' moves between recognition of difference and its simultaneous disavowal. This is a key point for Global Mental Health and NGO interventions for this hints at how making mental illness visible, and creating spaces to 'touch' the other, may lead to recognition of difference, while simultaneously working to disavow that difference. As Burman (2004:295) points out, similar moves are sometimes made in celebrating difference, where 'different' often also means '[t]hose that, within dominant discourses, are marked with other kinds of 'd's, as deviant or deficient'.

Here it would appear that Global Mental Health may work as an apparatus which 'turns on the recognition and disavowal' of difference (Bhabha, 1994:100). Bhabha (1994:100-101) continues, saying that colonial discourse's,

predominant strategic function is the creation of a space for a "subject peoples" through the production of knowledges in terms of which surveillance is exercised and a complex form of pleasure/unpleasure is incited.

The use of psychiatric classificatory systems and psychiatric knowledge could thus be read as creating a psychiatric and pharmaceutical space for 'subject peoples', a process of 'making up' mentally ill subjects (as discussed earlier). Reading Bhabha into Global Mental Health further, through the work of NGOs – in taking psychiatry onto the streets, in 'identifying' and diagnosing mental illness through camps, the work of 'social workers on the beat' (Iswar Sankalpa), in the formation of caregiver communities and in educating families to administer and monitor medication compliance – it is possible to see the surveillance exercised through psychiatric knowledge and interventions. Further, employing the conceptual lens of abjection has enabled a reading of the 'homeless mentally ill' as evoking both pleasure and displeasure; disgust and desire; glimmers of the 'libidinal economy' at work within Global Mental Health (Hook, 2012).

This colonial discourse analysis of the work of Global Mental Health is more than conceptual. If in labelling distress as 'mental illness' and calling for increased visibility and recognition of the 'mentally ill', NGOs are disavowing difference as they simultaneously make it visible, then this needs addressing. Otherwise Global Mental Health and NGOs are recreating abjection, leaving oppressive societal and symbolic structures unchallenged. This returns us to Hook's call to conceptualise the realm of the 'extra-discursive' in 'how the body might operate as a "dormant register", a grounds of rehabilitation whereby latent exclusionary sentiments become *somatically* manifest' (2012:85). While the somatic and affective (what we might call the 'extra-discursive') enable a maintenance, a keeping alive of what is prohibited within discourse – it is the symbolic that provides, makes available. that 'dormant register' initially (Hook, 2012). Hook (2012:107) points to Fanon's insistence that "'pathologies of affect", despite being wired through sexual realms, through unconscious processes, are ultimately derived from inequalities present in wider social structures'.

This is useful in pointing to the symbolic structure that frames bodily and affective reactions to the abject, those reactions that appear 'natural' or uncontrollable. It also makes clear the political and symbolic structures always already at work within distress, including distress framed as being 'illness'. It gives conceptual understanding as to why findings often show that labels of biochemical imbalances render those who are labeled with mental illness as alien, non-human, resulting in increased public desire for distance (Read et al, 2006).

This calls into being a more general, yet urgent question of how we might recognise difference without disavowing it, without containing it, without domesticating it. Here the risk of psychiatrization is that increasing numbers of experiences come to be understood in psychiatric terms (itself a kind of colonisation of everyday life), and furthermore, in the terms of knowledge systems that are pre-dominantly from the global North. This could be read post-colonially as an orientalist project: a way of 'coming to terms' with the populations of LAMICS in terms of psychiatric categories.

### **The 'median category' - Difference and disavowal**

Once perceived in this way, difference (as threat) can never be unrealized (Hook, 2012), thus there comes into being a compulsion to repeat the containment, the domestication, a compulsion marked by anxiety. We can read this slightly differently if we conceptualise Global Mental Health within a colonial framework, as imposing and projecting a world of specific understandings of health and illness from HICS, onto LAMICS, in their own image. An image that Fanon (1963) calls for the colonized not to reproduce.

This suggests that Global Mental Health can 'see' mental illness in LAMICs through prevalence studies, and intervene in it through various mental health interventions, while domesticating any alternative understandings that may threaten the fantasy of individual wholeness, and of (bio)psychiatry as the hegemonic framework for intervening in distress. Thus, while Global Mental Health calls to make mental illness more visible on the public health agenda, it may simultaneously work to mask it through disavowal of alternative understandings (i.e. the discrediting of alternative systems of indigenous healing) and through assimilating distress in LAMICs into the knowledge of 'Western' psychiatry.

This process of 'coming to terms' with the Orient, and with mental distress, seems to resonate with Said's reading of the 'internally structured archive' of Orientalism – the 'median category' through which colonial and psychiatric encounters seem to take place, where

Something patently foreign and distant acquires, for one reason or another, a status more rather than less familiar...a new median category emerges, a category that allows one to see new things, things seen for the first time, as versions of a previously known thing...a method of controlling what seems to be a threat to the established view of things. The threat is muted...[through accommodation] (Said, 1978[1995]:58-59).

It becomes possible, therefore, to read Global Mental Health as an encounter that takes place through Said's 'median category'; by rendering the strange familiar;

The epistemic (and ostensibly *psychological*) problem of how unprecedented experiences in colonial environments come to be assimilated into previously existing structures of understanding (Hook, 2012:185).

This is a process whereby difference is constantly deferred, the new is a 'duplication of the old', a projection of what one already knows, 'difference is continually assimilated into a version of the onlooker's self, into the terms of his or her own frame of reference' (Hook, 2012:186). Here the gaze of the white child who 'sees' Fanon - 'Look, a Negro' - both recognises and disavows his identity, 'sees' him through a stereotyped, fixed image, through the child's terms of reference. This kind of looking performs 'a masking function', 'a willful not seeing', in order to protect oneself from 'the *threat* this other poses to a world in my own image' (Hook, 2012:186). Thus, for Ahmed (2000:53), one can be 'assimilated as the unassimilable', leading her to further question how are 'differences that threaten the system recuperated? How do ambiguous bodies get read in a way which further supports the enunciative power of those who are telling the difference?' (1999:89).

This resonates with Coetzee's (1998) observations on texts written about the Khoi San (and more generally Western writings about South Africa), which show two features. Firstly, there is a violence to the texts, their use of de-humanising terms. Secondly, and seemingly in contradiction to the first, there is 'an attempt to formulate a "category of sameness", a grid or conceptual scheme through which this other can be fixed, reliably known', which tacitly presumes a common humanity (Hook, 2005:10). Here there is a paradoxical move to exaggerate difference, and yet fix the other as entirely knowable, creating a situation where 'the confrontation with radical difference *threatens to give way to the possibility of identification*, to the perception of similarity or a common humanity' (Hook, 2005:10). But might this very possibility of humanity, of similarity, also be threatening for the coloniser?

### **The 'suspicion of their not being inhuman'**

This is an anxiety, ebbing and flowing, and snagging like the river filled with rocks that Marlow's old steamboat navigates in Joseph Conrad's 'Heart of Darkness';

No, they were not inhuman. Well, you know, that was the worst of it – this suspicion of their not being inhuman. They howled and leaped, and spun, and made horrid faces; but what thrilled you was just the thought of their humanity - like yours...if you were man enough you would admit to yourself that there was in you just the faintest trace of a response to the terrible frankness of that noise, a dim suspicion of there being a meaning in which you...could comprehend. (Conrad, [1902]1973: 51-52).

Here there is a colonial anxiety, where the colonisers must 'confront their post-colonial doubles' (Huddart, 2006:89). Doubles, who, like the abject, hint at another way of being, the 'other Orient', the Occident's double, that which was expelled as it did not fit the needs of colonialism, a space undefined by the West (Nandy, 1983:72-73). For Bhabha (1994:85), such doubles create 'ambivalence in the structure of identification that occurs precisely in the elliptical *in-between*, where the shadow of the other falls upon the self'. Doubles, like that of the abject, remain 'a shadow threatening the integrity of the subject as whole' (Jones, 2007:64); psychiatry's individual subjects, and the subject, the discipline of psychiatry. This is also an anxiety that haunts much work with people constructed as 'mentally ill' or 'psychotic' - an anxiety that there might be meaning in their distress, in their 'irrationality', a meaning that is comprehensible. For Bhabha, dominance is always marked by an assertion of difference, an anxiety of the sameness between coloniser and colonised, where 'sameness is recognised and repudiated' (Huddart, 2006:4).

Could we read the work of Global mental Health and mental health NGOs as recuperating the threatening bodies of the 'homeless mentally ill', as reading and registering difference only to disavow it? How might Global Mental Health link to the perpetual recognition and disavowal of difference within development discourse? (Escobar, 1997:93). Thus, the 'dominant cultural imaginary' wants to 'see' difference, and to interpret it, 'fueled by a desire to tell the difference, to guard against a difference that might otherwise put the identity of one's own position in question', and this conflation and clarification are mobilized under the 'twin anxieties of visibility and

difference' (Garber, 1997:130). For 'how are we to know the other's difference if we cannot see her?' (Ahmed, 2000:91).

Yet this very 'seeing', the appearance of the 'homeless mentally ill' within psychiatry and Global Mental Health, and the appearance of mental health within International Development and on the global public health agenda, is made possible through specific realms of appearance and frameworks of recognition that delimit and foreclose what sort of subject can appear, the sort of body that can be touched, and the ways of seeing and touching that can come into being. Young (2005:79&86) argues that the textuality of law, and I would add psychiatry, has been occupied by a visual order of representation, where 'judgement becomes an aesthetics of appearance', 'a conversion of writing [and statistics] into a specular image'. Thus, psychiatry and the law reconstruct the 'real' of mental illness and disability in the order of vision, 'where judgement is governed by the desire to see' (Young, 2005:93).

### **The ethics of seeing**

What other ways of 'seeing' difference might be available? Can we speak of an ethics of 'seeing' the other? This links to Dhar's (2004:61) discussion of the ethics of the 'survival of the other', 'survival at the cost of the other', the violence of survival; raising the question of whether the other can survive without being assimilated, survive in partial visibility. Or might the partial presence, the camouflaged other, interrupt or subvert the interpellating call itself, changing the frames that seek to assimilate it and render it docile?

This partiality, opacity, does more, for Bhabha (1994:49), than veil resistance, it 'change[s] the very terms of our recognition of the person'. Invisibility dislocates the penetrative psychological or psychiatric gaze, wreaking 'its revenge by circulating, without being seen', initiating the possibility of 'political subversion' (Bhabha, 1994:79). Thus, the 'disembodied eyes' of the subaltern that see but are not seen, disrupt and subvert both the presumed unitary 'I' of the subject, and the surveillant, disciplinary 'eye' of psychiatry. For Kristeva, from the position of the onlooker, within abjection, in the 'in-between', [i]t is no longer I who expel, "I" is expelled' (1982:3-4), for the place of the abject is 'the place where "I" am not' (Creed, 1993:9). It is not 'lack of cleanliness

or health that causes abjection but what disturbs identity, system, order. What does not respect borders, positions, rules. The in-between, the ambiguous...' (Kristeva, 1982:4).

In this vein, Creed (1986:65) makes strange the desire to be 'whole', when she points out that the '[f]ear of losing oneself and one's boundaries is made more acute in a society which values boundaries over continuity and separateness over sameness'. This would suggest that the reading of the blurring of boundaries into the background as being fading, and this fading as being a 'symptom' of an illness, is perhaps indicative of the sort of society 'we' in the 'West' occupy. And furthermore, what about when this bounded, separate way of being a person is transposed onto other cultures, such as India, as part of mental health literacy campaigns?

For the Banyan, 'every individual is truly special for the very fact that they exist - in spite of all of the odds'. Thus, their motto is 'I exist therefore I am' (The Banyan website). However, this very desire 'to be', to 'persist in one's being' is to be submitted to a world of others (Butler, 1997; 28). India itself has lived under terms that are not its own, under colonial rule, and with cultural ambiguities for many years, enabling it, according to Ashis Nandy (1983) to build psychological defences against cultural invasions. For Nandy (1983:107&111), survival invokes a self that is not defined too tightly or 'separated mechanically from the not-self', preventing it from being 'psychologically swamped, co-opted or penetrated'. Here a self not too tightly bounded, a self that merges, that leaks, is a psychological defence against colonialism.

### **Fading as Symptom, but of what?**

Astra Zeneca 'sees' fading as a symptom of Bipolar Depression, the 'symptom' of a psychiatric disorder. This stands in contrast to the potential resistance and subversion implied in being faint, how a person might fight against the normative gaze of psychiatry or pharmacology through their very denial of fully 'being' - the disruption of presence. While fading and mimicry might then be strategies for refusing to be interpellated within the neoliberal market economy, they may also be translated by psychiatry as a symptom of an illness to be marketed, a commodity within the very market economy that fading as a strategy of resistance sought to refuse.



For Fanon, fading may also be a 'symptom', a symptom of colonialism. For Fanon ([1967]1986:113), the objectifying gaze of colonialism, of the 'look', meant his 'body suddenly abraded into non-being'. Pointed at, hailed, through the look of a White child - 'Look, a Negro' - this surveillance, this visuality brings Fanon into being as a subject, as a Black man,

"Look, a Negro!" ...I was an object in the midst of other objects...sealed into that crushing objecthood...my body suddenly abraded into non-being...the glances of the other fixed me there...My body was given back to me sprawled out, distorted...completely dislocated...I took myself far off from my own presence, far indeed, and made myself an object. What else could be for me but an amputation, an excision, a hemorrhage that spattered my whole body with black blood? ... Where am I to be classified? Or, if you prefer, tucked away? (Fanon, [1952]1986:112-113).

Fanon ([1952]1967:109-110) continues,

not only must the black man be black; he must be black in relation to the white man . . . The black man has no ontological resistance in the eyes of the white man... every ontology is made unattainable in a colonized and civilized society.

'Abraded into non-being', sliding back into chaos, a 'descent into formlessness' – a key issue here seems to be the differential meanings these may have for those who are abjected and for the social structures that perform the abjection. For Fanon, to be 'abraded into non-being' was to be objectified in a space where there was no room for resistance 'to be', no distance between the interpellating hail and the subject hailed, no spaces to occupy. In an article by Macherey (2012:16), it is worth noting a slight change in the translation of Fanon's quote above, where the black man must be black not 'in relation to' but 'in the presence [en face du] the white man'. This makes it clearer why the veiled women that made up the background of the French presence in colonial Algeria (Fanon, 1963), may be subversive through their denial of ever being fully present. To be abraded, to be ground down, chafed, hints at a violent process done to one from the 'outside'. Whereas for the colonial society performing that abrading,

Bhabha reads potential subversion in the very act of abjection, a descent that may render not just the bodies of the colonised, but the social body, into pieces.

### **'Nauseating Mimicry'**

Yet for Fanon, mimicry too is a 'symptom' of colonialism, it is 'nauseating' (1963:251). Fanon (1963:252) calls for recognition of the 'mortifying setbacks such an imitation has led us', for, '[w]hen I search for Man in the technique and the style of Europe, I see only a succession of negations of man, and an avalanche of murders'. Thus, the colonised waste their time in imitating Europe,

that same Europe where they were never done talking of Man, and where they never stopped proclaiming that they were only anxious for the welfare of Man: today we know with what sufferings humanity has paid for every one of their triumphs of the mind (Fanon, 1963:251).

Fanon is calling on the colonised to find something different, an alternative that does 'not pay tribute to Europe by creating states, institutions and societies which draw their inspiration from her. Humanity is waiting for something other from us than such an imitation, which would be almost an obscene caricature' (1963:254). Thus, while for Nandy (1983:84), mimicry can be a 'comical imitativeness' that subverts and mocks the powerful, for Fanon (1963) it is an obscene caricature that pays homage to the victors. For Fanon, 'it is no good sending them [the colonisers] back a reflection, even an ideal reflection, of their society and their thought with which from time to time they feel immeasurably sickened' (1963:255). Sickening, nauseating, what is this nausea of which Fanon writes?

### **Nauseous ontology**

I occupied space. I moved towards the other...and the evanescent other, hostile but not opaque, transparent, not there, disappeared. Nausea. (Fanon, [1952]1986:112).

In Sartre's novel 'Nausea' (1938), the main character, Roquentin, is a 'nauséaste: a man overcome by revulsion, permanently beyond himself', what he sees in the mirror

is his own image, evidently; 'but the image no longer functions as an image. It fails to present him to himself' (Trotter, 1999:32). He is like the absent presence of the colonised, of the slyly normal, that refuse interpellation through the denial of presence, but also like them, his 'wrenching self-estrangement later develops into a nauseous Ontology' (Trotter, 1999:32).

Both Fanon and Sartre evoke the violence of the gaze, the look of the other that 'solidifies and alienates, decentralizes and decomposes, strips bare and destroys', that 'at once enables and disables identity' (Trotter, 1999:37). Akin to Fanon's abrading, his non-being, nausea signifies the melting of the 'veneer' and shape of identity, the nauseous essence of being (Sartre, 1943) in which 'to exist is to get stuck' (Trotter, 1999:32). Living under colonialism, means, then, for Fanon, an inability to embody moral values, where, '[t]o live means to keep on existing' (1963:249). And yet to exist, 'the desire to survive, "to be", is a pervasively exploitable desire' (Butler, 1997:7).

However, Trotter (1999:35) reads Sartre's nausea, not as emptiness, but rather as something that fills, 'something opaque and weighty' that gives substance, as the values of society fade, something that comes in being 'against the background of a complete alteration of the world' (Sartre, [1962]2004:58). Therefore in images of fading, perhaps it is society that is changing its shade, its consistency, and not the fading of the person. Fanon (1967:19) recounts when students returned to the Antilles from France (the coloniser's country), 'literally full of themselves', as if something had been added to fill their previous lack.

Yet nausea prevents Fanon laughing at the white man, it pushes him 'too close to see, too close to imitate, too close to mock' (Trotter, 1999:31). Thus, Fanon rejected the application of Sartre's nauseous ontology onto the experience of black and colonised peoples, 'because the white man is not only the Other, but also the master, whether real or imaginary' (Fanon, [1952]1967:138, fn24).

This is apparent in Fanon's evocation of 'black skin, white masks', which for Bhabha (1986:xvi) (in the foreword to the 1986 edition of the book), 'evokes a peculiarly colonial condition', 'a doubling, dissembling image of being in at least two places at

once'. However in Loomba's (1998) reading of Fanon, the black person adopts white masks to enable survival and thus 'black skin/white masks reflects the miserable schizophrenia of the colonised's identity' (Loomba, 1998:124). Here Schizophrenia is deployed as a figure to describe the colonial condition. However it also opens up a reversal, the possibility of reading the colonisation at work within the diagnostic category of Schizophrenia.

### **The psychopathology of Colonialism**

In Fanon's sociodiagnostics (Fanon, 1967), it is colonialism itself that is psychopathological, 'a disease that distorts human relations and renders everyone within it "sick"' (Loomba, 1998:122), hinting at the possibilities of a psychopolitical reading of how psychiatry renders increasing numbers of people as sick, the current 'epidemic' in 'mental illness' (Whitaker, 2010). Fanon (1963:245) gives the example of how, during colonisation, 'the lay-out of the cerebral structures of the North African', were seen as responsible for their supposed laziness, inaptitude and impulsivity. Here laziness and violence became framed as 'a reaction which is neurologically understandable and written into the nature of things, of the thing which is biologically organised' (Fanon, 1963:245). Thus, the Africans were constructed as blindly obeying nature, and biology, and therefore in need of taming, meaning that 'discipline, training, mastering and today pacifying are the words most frequently used by the colonialists in occupied territories' (Fanon, 1963:245). This hints at a taming achieved through understanding the reason for particular actions as being biological – a depoliticisation also apparent in psychiatric diagnoses.

However, for Fanon (1963: 239), these signs usually interpreted as caused by faulty brain structures and biochemicals may be symbols of resistance, for example, to him, laziness marks 'the conscious sabotage of the colonial machine' by the colonised. He continues,

The Algerian's criminality, his impulsivity, and the violence of his murders are therefore not the consequences of the organization of his nervous system or of the characterial originality, but the direct product of the colonial situation (Fanon, 1963:250).

Here what psychiatry calls 'mental illness' is read as a product of the colonial situation, of inequality and alienation. Furthermore, in its translations of this distress into psychiatric diagnostic categories, psychiatry also alienates, colonises and depoliticises. This seems to similarly be at work in the construction by many NGOs of those who are homeless and distressed as 'wandering destitutes' (Shraddha Foundation), resonating with the benevolent violence of development discourse, a violence that works through the 'image of a destitute figure waiting to be rescued' (Chakrabarti and Dhar, 2009:96).

Furthermore, the designation of the homeless in India, as the 'wandering mentally ill', overlooks questions of what counts as 'wandering'? And who decides? In fact, 'wandering behaviour' is now in the ICD, as constituting a 'symptom' of Autism. This denies recognition of the meaning behind people's attempts to escape from oppressive situations and abuse through labelling it as 'wandering' (Graby, 2011) - what one member of staff from an NGO told me was an outcome of psychosis, 'people wander off because they are psychotic'.

### **Sly Normalization**

Thus, while some people may practice sly normality, techniques of normalization operate slyly and invisibly too. Pharmaceutical companies often do not make adverse and harmful effects of drugs found in clinical trials public and they ghost write articles in psychiatric journals to market their products (Healy, 2006; Moncrieff, 2003). I have heard many stories about the effects of taking psychiatric medications; of drooling, of forgetting things, of not being able to recognise the faces of friends. What happens then when medication enters the performance of sly normality? How 'sly' can you be when, as Pete Bullimore told me he had felt while in a psychiatric hospital, you are so heavily medicated that you're like a 'zombie', when you can't think anymore and find it exhausting to speak. And what about if small doses of medication enable people to be sly, help them to pretend in order to escape the psychiatric gaze and then stop taking the medication given to them by psychiatrists? Like Meesha, at the Banyan, who takes medication 'to be cured of the Banyan'. Or does medication work to make people visible, to prevent slyness? Is it possible to be 'sly' in psycho-pharmaceutical spaces?

### **'Expected to seem normal'**

Invisibility, camouflage, and mimicry - the psychological defences of the colonised (including the psychiatrically colonised) - may undermine psychiatry's attempts at diagnosis and treatment, showing the incomplete character of any civilising or normalising project to fully produce a docile body or mind. Yet this resistance seems unable to rearticulate the terms of subject formation, for to 'thwart the injunction to produce a docile body is not the same as dismantling the injunction or changing the terms of subject constitution' (Butler, 1997: 88). It also may do little to get you released from a psychiatric facility. Therefore such secret strategies and tactics can take their toll on people emotionally, meaning that practising 'sly normality' can be hard work.

I find that having psychosis is horrible, but unless I'm acting strangely no one knows and I'm expected to seem normal. I hear very distressing voices all the time and occasionally get weird delusions and see things in a way that other people say are not real. I've been admitted to hospital and sectioned several times because of it. (Byrne, 2007:690).

Here the expectation to seem normal grates against the performance of being slyly normal – how can we tell the difference? In order to be slyly normal one must always be aware of dominant models of normality and know themselves to be disqualified from them, people must know what 'normal' is to be able to 'do' it, slyly. Thus, for Marie to 'pass' as sane, or as recovered, to be slyly normal – she is required to know what the norm is, know that she doesn't fit that norm and that in order to escape the psychiatric gaze she must learn to emulate that norm. It is that emulation, for Fanon ([1967]1986:38), just as when 'a Senegalese learns Creole in order to pass as an Antilles native: I call this alienation'. An alienation also perhaps at work when Meesha speaks the refusal of her identity in two different foreign languages - psychiatry and English.

While 'passing' as normal may help secure a place of privilege within the hegemonic, for Titchkosky (2001 -online), everything about those whose disabilities or differences are 'invisible' 'can be made to signify normalcy' and furthermore these 'invisible disabilities' are 'made invisible by the structures and assumptions of normalcy'. To make visible these 'invisible disabilities', to 'come out' as disabled, one must then often

navigate normative practices of 'seeing' disability, where one may easily be seduced by normal understandings of disability as lack, for example in naming one's difference through a diagnosis (Titchkosky, 2001).

Sly normality as a hidden transcript, an infra-political strategy of resistance (Scott, 1990), thus leads us into a new terrain; one that is partial, secret, almost invisible, but not quite. But with what tools can we recognise and 'see' sly normality? If mimicry and slyness provide camouflage, invisibility, born of an awareness of unequal power relations, what are the ethics of 'seeing' it? If we 'see' it, does this not diminish its subversive potential, the partial visibility central to it as a strategy of resistance? Or is it in the breaking of the illusion that subversion may lie?

For example, Rosenhan's (1973) experiment would be less subversive if we did not know about it, if the concealment was never made publicly visible. In fact, when Rosenhan's (1973) study was made public, it led to a second experiment where one psychiatric hospital challenged Rosenhan to send some 'pseudo' patients to the hospital, betting that it would be able to tell them apart from the 'real' insane. The hospital identified 41 potential 'pseudo' patients supposedly sent by Rosenhan: in fact Rosenhan sent none (Rosenhan, 1973).

While this experiment made a mockery, through mimicry, of psychiatry's techniques of differentiation and diagnosis, its ways of telling the difference, it also made psychiatry even more determined to tell the difference between sanity and insanity, leading to a change in how diagnosis was given, and thus a supposed tightening of diagnostic categories, as part of the development of the DSM III (Ronson, 2011). In response, then, to these techniques for telling the difference, can sly normality provide more than a means of partialness, of camouflage, of potential resistance within a bodily and psychic register, can it also lead to more wide scale political resistance?

### **'Infrapolitical shadows'**

Much writing on resistance of oppressed groups assumes that within such groups there is a desire to speak back to the dominant, a build up of pressure from living under unequal conditions. However, critics differ in whether they think that this desire is

satisfied and thus pacified in the 'hidden transcripts' of the oppressed, the 'backstage talk', the 'offstage discourse of the powerless', or whether these strategies are a substitute for more 'real' political resistance (Scott, 1990:184). Some feel these tactics may quell or cool off the desire to resist, and so act as a 'relief valve' to preserve the status quo (Scott, 1990:191).

However, for Scott (1990) this debate presents an abstract situation that assumes one dominant side and one powerless, when in fact subordination is rooted in material practices connected to appropriation. Thus, veiled resistance is enacted through a 'host of down-to-earth, low-profile stratagems designed to minimize appropriation', acts such as pilfering, feigned ignorance, shirking, careless labour, secret trade, foot dragging, and poaching – small acts which carried out on a large scale can have widespread economic effects (Scott, 1990:188).

If we read psychiatrization (the understanding of ever increasing experiences in psychiatric terms) as a form of colonial appropriation; appropriation of the psychic means of resistance and of personal, political and indigenous / alternative understandings of distress; then we might see sly normality as a strategy to minimise psychiatric appropriation and thus psychiatrization. In Scott's terms, far from 'letting off steam' to retain the status quo, such hidden transcripts are 'a condition of practical resistance rather than a substitute for it' (1990:191). They form the 'infrapolitical shadow' that lurks behind every act of open resistance (Scott, 1990:184), a shadow which enables resistance to be sustained in situations where open confrontation is not possible. This speaks to a further need, then, to understand the conditions under which veiled resistance might speak its name and also when open resistance might become veiled (Scott, 1990).

Scott (1990) explores how the disguised hidden transcript can in theory provide the conditions to develop a shared critique of power. Such a critique could (and historically has) lead to the development of networks of solidarity through collectively defined common experiences and strategies of resistance to social inequality and coercive psychiatric treatment. Scott (1990:20) urges us to attend to these offstage political acts of disguise, to enable us to 'map a realm of possible dissent'. A map of the 'lies, secrets,



silences and deflections ... routes taken by voices or messages not granted full legitimacy in order not to be altogether lost' (Johnson, 1978:31).

But with what tools might we map this secret terrain of resistance (and should we map it at all)? In Rosenhan's (1973) study, the 'pseudopatients' didn't take the medication they were given, they hid them in their pockets or in the toilet,

The pseudopatients were not alone in this. Although I have no precise records on how many patients rejected their medications, the pseudopatients frequently found the medications of other patients in the toilet before they deposited their own. (Rosenhan, 1973 – online).

The staff didn't notice, as long as the patients were cooperative. How can we know if pretending to be normal is sly, and whether sly normality resists psychiatry within its own limits, remaining a 'homage to the victors'? (Nandy, 1983:12). How can we encounter sly normality, without; capitalising on it, without assimilating it, and when we do encounter it how do we know if it is not recuperating the norm, how do we know if it's subversive? We will never know the number of pills hidden under tongues and inside socks. This is sly normality as ambivalence, as seduction, as 'symptom of oppression', and as subversion.



## Chapter Ten

### **Decolonising Global Mental Health: mapping dissent / (en)countering epistemicide**

*A Chapter on repetitions and on mapping alternatives, on anxiety and repetitions (successful and failed), on Fanon and the psychopathology of colonialism, on Nandy and a language that makes no-sense, a chapter to end on.*

## **The Shudders - the messy spaces**

This thesis is coming to an end. It has sought, taking myriad unexpected turns and surprising encounters, to trace how Global Mental Health, WHO policy, and NGO interventions in India, might be read as forms of psychiatrization that mobilise a colonial relation - as forms of colonial discourse. It has done this in a hybrid layering of interviews, field notes, policy, websites, and conceptual resources, juxtaposed (perhaps a little irreverently), to avoid telling a linear story. For this is not the only way of telling the story.

This thesis, then, has been an encounter with the messiness of Global Mental Health. Each chapter has caused a 'shudder' (Losinsky and Collinson, 1999:3) in the epistemologies and evidence bases of Global Mental Health. The first part of the thesis explored psychiatry's alternative evidence base, including user/survivor critiques of psychiatry, as a different space from which to re-conceptualise, to re-encounter Global Mental Health. Then the research took a different turn to explore the mechanisms (both on the ground and conceptually) of psychiatric subject formation, reading this alongside colonial subject formation, the potential force of interpellation. It evoked the strange figures and formations of Fanon and Althusser's subjects - turned and doubled. Some of the shudders that have come about, the problematisations that have emerged from each chapter, are listed below (because even though I don't like check-lists, I do rather like lists).

- What are the implications of locating mental illness within the brain for how Global Mental Health, the WHO and psychiatry might ethically respond to distress globally?
- What register might be used to speak about distress globally? Is the (economic) language of burden and debilitation the only way?
- How does psychiatry (and the psy-disciplines more generally) mediate the distress caused by neoliberal reforms and policies, and what interventions does this make possible?
- What role should psychiatry play in mediating distress caused by poverty and socio-economic inequality?

- How does this mediation frame the ethical terrain for response, and the psychopolitical demands that can be made visible? (For example, demands for increased access to medications, but also for non-medical spaces of healing).
- Attending to the alternative evidence base discussed in this thesis, we may be led to wonder whether lack of access to certain ‘treatments’ may in fact be more desirable. This raises difficult issues around global access to healthcare and medical treatments, particularly around disparities and inequalities between countries. What ethical frameworks can we draw upon to think through some of these difficult issues?
- What are the ethical implications of ‘treating’ or ‘fixing’ people if we conceptualize their experience psychopolitically - not as a pathology or mental illness but as an emotional protest to social inequality, or as survival strategies and resistance to traumatic conditions?
- How can we speak of urgency, emergency and ‘burden’ without invoking the state of emergency, the changing of normative judgements?
- How can we conceptualise urgency without drawing upon a language of burden?
- If Global Mental Health in part seeks to address the distress caused by economic reforms, pushed by multilateral agencies, such as the World Bank, should these agencies be called on to fund psychiatric interventions? How could global mental health work be ethically resourced and funded?
- If Global Mental Health mobilises forms of colonial power, can we use post-colonial theory to read resistance to the medicalising and psychiatrizing of distress on a personal and global level?
- How can we trace the intertwining of psychic and socio-political resistance? Can psychic resistance lead to social subversion?
- How do psychiatry’s encounters with alternative understandings of distress and healing begin to fracture and change its own frameworks of recognition?

- How can difference be recognised without being disavowed, or capitalised on within a global mental health market place?
- How do we see and recognise difference without recuperating it, finally to assimilate it as unassimilable, to come to terms with it, to make it palatable?
- How might we, and should we, 'see' invisible forms of resistance? Or does this co-opt it and commodify it within a mental health marketplace?

Having formulated these questions, many of which remain as questions, I want to explore how this research may enable some alternative and creative means through which these shudders can be encountered and re-thought. Key to this task, then, is to constantly question what the implications of this research might be for those who experience mental distress (whose voices have remained largely absent in this thesis), for NGOs working in India, and for (global) mental health policy. The first issue, then, in tracing Global Mental Health as a mechanism for enabling psychiatrization, is to ask if psychiatrization itself is troubling and, if so, why?

### **Global Mental Health as colonial discourse**

Rose (2006: 481), asks,

Why does the extension of medicine trouble us for some problems and not others? Why is it preferable to place some aspects of life under one description—as a problem of living for example—rather than another—as a condition that can be alleviated by drugs.

For Rose (2008:8), the biological reductionism of much psychiatry may sometimes be the grounds for optimism, as to 'deem an aspect of human life biological today is to suggest that it can be transformed though technology'. In the reception of the Schizophrenia Awareness Association (SAA) in Pune, the founder, Amrit Bakhshy, told me that he hoped that society would one day change but 'in the meantime we'll wait for a new wonder drug'.<sup>78</sup> Such wishes, expressed by many carer and patient groups,

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<sup>78</sup> *Amrit Bakhshy, interview at Schizophrenia Awareness Association, Pune, 12.2.2011.*

signify a political economy of hope within mental health advocacy, where these groups become interweaved in the governance of mental health; and in their attempts to shape the health of specific populations, often working alongside psychiatry, seem to perform distinctly biopolitical dimensions (Novas, 2006).

Bhargavi Davar talked to me about the link between psychiatry and caregiver organisations, pointing out that caregiver groups often call for distress to be conceptualised as an illness so that parents can continue to act in their children's 'best interests'. She felt that many carers had concerns that 'giving treatment choice means that tomorrow this person [the person experiencing distress] is going to stand up and start challenging your power...challenging family is a big topic in India'. However, this political economy of psychiatrized hope is not specific to carer groups, for Dr Gro Harlem Brundtland, Director General of the WHO,

The message we can bring to the world is one of optimism. Effective treatments are there. Prevention and early detection can drastically reduce the burden. And hence the social and human suffering. (WHO, 2001b:13).

In a very different way, findings from the WHO DOSMED (1973) studies also provide an economy of hope for some within the user/survivor movement. I often hear this research mentioned at psychiatric user/survivor conferences and meetings, people mention it to point out that there are other ways to respond to distress, ways other than psychiatry, and some of these other ways may actually be more useful.

Nikolas Rose has often distanced himself from critics of the psychiatrization and medicalization of distress. However, in an article about 'disorders on the borders' (evoking the ever expanding borders of abnormality and the crossing of psychiatric diagnostic categories across geographical borders), Rose (2008) outlines a number of reasons why there may be grounds for concern about psychiatrization. This is particularly due to the interlacing of competing rationales and incentives behind the expansion and extension of diagnostic categories; the calls for recognition of prevalence of untreated conditions; the mobilisation of concepts of risk and early intervention; and the large scale use of psychiatric drugs. All this, for Rose (2008:481),

serves to lower the threshold at which individuals are defined, and define themselves, as suitable cases for treatment. It increases the numbers of those who enter upon a 'moral career' as a person suffering from a treatable condition, and reduces the age at which many enter upon this career. These are powerful mechanisms for recruiting individuals, turning them from non-patients to proto-patients, to actual patients. They are powerful mechanisms for retaining individuals within this domain. No walls are now needed to sustain a lifetime career under the psychiatrist.

In India, psychiatrists squat down on the streets to diagnose homeless people, 'psychiatry without cables and cobwebs' (Iswar Sankalpa); while the Supreme Court orders the building of more psychiatric hospitals - one in every State. No walls are needed to become a psychiatric subject, in India, and yet more walls are built. Opening up increasing areas of life to be transformed through specific technologies is not always a positive move. Rubin (2004:373) points out that here the physician's role becomes that of 'a technician primed to dispense pills according to scripted cultural stereotypes', resulting in a decontextualisation that overlooks the social contexts of people's lives, 'reducing the complexities of living to predictable, manageable, and ultimately medically treatable symptoms'.

Such decontextualisation was very apparent in the Indian Government's employment of a technical pharmaceutical approach to farmer suicides (discussed in Chapter 5), which led to the wider distribution of anti-depressants and the launch of a study into the genetic causes of suicide, enabling socio-economic contributors to be overlooked. As this thesis has charted throughout, this technical agenda also happens to have a large financial incentive for the pharmaceutical industry.

In employing a colonial discourse analysis of Global Mental Health, this research has also traced other areas of concern regarding psychiatrization. The violent means by which Global Mental Health, and psychiatry more generally, hail and recruit subjects, 'fixing' them to a diagnosis. This thesis has traced multiple readings of psychiatrization as being violent – the material violence of surgery, medication and ECT; the hegemonic



violence of being rendered illegitimate and irrational; the epistemic or symbolic violence of representation and of non-representation; the 'primary violence' of living under terms that are not one's own (Butler, 1997:28); and a subtle violence of delimiting our very desires for what people should be like, and for how they understand themselves - the normative judgments written into the chemicals of psychiatric medication.

For LeFrancois (2012:12, forthcoming), 'psychiatrization as something that is done to a person, an othering based on the norms, borders, systems, social order and rules of living within society', is a violent process akin to an 'inside out' abjection. It is a force that 'intends to annihilate but instead renders into an othered state that remains visible in its grotesqueness; a visible warning of the importance of social norms and the fate of those who deviate' (LeFrancois, 2012:11, forthcoming). The visibly 'invisible' figures of the 'homeless mentally ill' on the streets of India - oozing, defecating and masturbating - could also be read as such a visible warning, a warning about what society thinks madness means and what happens to those who are mad.

For Bhabha (1983; 1994), colonial discourse produces particular ways of knowing that act as a space to bring into being a category of 'subject peoples' who are 'fixed' within a system of representation that operates in a similar way to Realism. In this way the colonised become visible, surveillance operates amid a play of pleasure and unpleasure, and in this visibility difference is recognised and simultaneously disavowed.

### **The 'subject peoples' of Global Mental Health**

Global Mental Health and the WHO (and psychiatry more generally) produce particular ways of knowing, specific knowledges about mental distress – usually as 'biochemical', as a 'brain disorder'. These ways of knowing come to be fixed as the truth, functioning as a system of representation, as a space for the formation of 'subject peoples' – people with mental illness. These subjects are, then, produced 'as a fixed reality' (Bhabha, 1983:23), that constitutes, in part, the 'identity violence' (Hook, 2005:480) of colonial and psychiatric discourse; the 'stickiness' (Rosenhan, 1973), the for life-ness (Tucker, 2009) of psychiatric diagnoses – 'you may as well have just ripped my heart

out', said Pete.<sup>79</sup> This knowing that produces the subjects it fixes, posits 'the truth that the subject *has* but does not *know*' (Bhabha, 1994:141) – a 'mental illness'. This 'fixed' subject, 'which is at once an 'other' and yet entirely knowable and visible' (Bhabha, 1983:23), identified and diagnosed on the streets of India by mental health NGOs, by 'social workers on the beat' (Iswar Sankalpa), marks the oozing, leaking bodies of the visibly 'invisible'.

The 'knowledge' produced by Global Mental Health, the 'scientific evidence base' (Patel, et al, 2006:1312), is that distress is a 'mental illness', a 'neuropsychiatric disorder', it is 'chronic and very disabling' (Patel, et al, 2007:48 –in reference to Schizophrenia), it has a 'physical basis in the brain... can affect everyone, everywhere...[and] can be treated effectively' (WHO, 2001a:x). These ways of knowing thus work as 'powerful mechanisms for recruiting individuals' and for retaining them (Rose, 2008:481), they recruit 'them all' (Althusser, 1971:173), they constitute the 'mental health' that is to be made a 'reality' for all (Patel, et al, 2011:90), for 'everyone, everywhere' (WHO, 2001a:x). But what 'subject peoples' does this knowledge thus bring into being?

Here are some of the subjects this research has encountered;

- 1) The figure of the 'wandering destitute', the 'invisible people', waiting to be seen, to be identified by an NGO, diagnosed by a Psychiatrist, and 'rescued', in a van / or medicated on the streets, and made visible through intervention
- 2) The chronically disabled subject, who has a serious or severe mental illness
- 3) The 'unscientific' rural subject who 'wastes' money on local forms of healing – the subject who has a mental illness but does not know it
- 4) The subject who has a diagnosis of a mental illness but does not know it (like the women at Sangath)

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<sup>79</sup> From an interview with Peter Bullimore as part of a research project, funded by the Research Institute of Health and social Change (RIHSC), at Manchester Metropolitan University (MMU), December 2007-March, 2008.

- 5) The subject of abuse, of violence – abuse from within both psychiatric institutions and traditional healing sites.
- 6) The subject who is mental health literate – who can identify mental disorders, who ‘knows’ that they should consult a doctor, and that mental illnesses have a physical basis in the brain
- 7) The subject who is sly, who uses the terms of psychiatry in pretence, as a feint, in an attempt to escape from the psychiatric gaze.

Then there are the subjects who use the terms of psychiatry, alien terms, to refuse their subject position. Those who draw on psychiatry slyly – who mimic psychiatrization and yet remain psychiatrized, bound to psychiatry through mimicry, through refusal. Subjects recognised and fixed through alien terms - subjects like Meesha and Marie. This research, then, takes Global Mental Health further than Bhabha’s (1983) conditions of colonial discourse, for it has begun to trace some of the effects of living within and through these conditions, a Fanonian reading of alienation, occlusion and violence.

### **Difference and disavowal**

A further facet of colonial discourse is that it is an apparatus that ‘turns on the recognition and disavowal’ of difference (Bhabha, 1983:23). In this thesis about encounters we have come across a number of ways of encountering mental distress, or difference, on a local and global scale. Yet in these encounters with difference it has been possible to trace mechanisms of a simultaneous process of disavowal, seemingly mobilised through the following formulations; sublation, inoculation, and the ‘median category’. I want to revisit these now.

#### 1) Sublation:

A Hegelian concept whereby two entirely opposed terms are synthesised into a seemingly higher category – which often takes the form of being ‘universal’. This is evident in the synthesis of the emic and etic approaches to cross-cultural psychiatry, and in the formation of the bio-psycho-social. It is evident in the WHO World Health

Report (2001:x), where mental disorders have 'a physical basis in the brain' and 'affect everyone, everywhere'. It is the brain here, the physical basis of mental disorder, that enables mental illness to be constructed as universal.

## 2) Inoculation:

A process whereby the Established Order is criticised, only to be recuperated at the final moment, a process documented by Barthes (1973:42),

One inoculates the public with a contingent evil to prevent or cure an essential one. To rebel against the inhumanity of the Established Order and its values, according to this way of thinking, is an illness which is common, natural, forgivable... the patient is made to give a representation of his illness, he is made familiar with the very appearance of his revolt, and this revolt disappears all the more surely since, once at a distance and the object of a gaze the Established Order is no longer anything but a Manichaeian compound and therefore inevitable, one which wins on both counts and is therefore beneficial.

Thus, we might read mental distress as a crushed rebellion (Butler, 1997) that is rendered by psychiatry into an 'illness', a 'common' illness, an illness that the 'patient', the mentally ill subject, is made to give a representation of, made to understand that their distress is an illness. We have encountered yet another way of reading this, that involves a process of 'coming to terms with'; 'coming to terms with the Orient in terms of Occidental categories' (Chakrabarti and Dhar, 2009:26), coming to terms with distress in terms of biochemical and psychiatric categories, coming to terms with populations of the global South using psychiatric classifications. This points to a third process of recognition and disavowal, Said's 'median category'.

## 3) The 'median category':

a category that allows one to see new things, things seen for the first time, as versions of a previously known thing...a method of controlling what seems to be

a threat to the established view of things. The threat is muted... (Said, 1978[1995]:58-59).

Controlling and muting threats to the established order through familiarising them; seeing new things, strange things, as familiar things; rendering these strange things into familiar terms (psychiatric and Occidental categories); synthesising the strange and the familiar – homogenising and hierarchising - these are some of the mechanisms by which Global Mental Health and the WHO encounter, recognise and yet defer difference. However, conceptually strange it may be to read these alongside each other; sublation, inoculation, synthesis, ‘coming to terms with’, and the ‘median category’ –seem all to be mechanisms for the bringing into being of the universal.

### **Drowning in the universal**

Thus, like colonial discourse, Global Mental Health and WHO policy resemble ‘a form of narrative whereby the productivity and circulation of subjects and signs are bound in a reformed and recognisable totality’ (Bhabha, 1983:23). This is ‘everyone, everywhere’ – every brain, everywhere. Here the ‘physical basis in the brain’ enables mental disorders to be understood as universal, ‘everyone, everywhere’ has a brain. This is different from making the claim that distress, manifest in myriad forms, is universal, because psychiatric frameworks are mediators of that distress, they provide but one way of understanding yet they are framed as being the ‘truth’. This, as we explored in Chapter 2, works to Occidentalize ‘the orient in terms of a “shared telos” and a “shared worldview”’ but where the occident is still somehow more advanced, a step ahead in this developmental telos’ (Chakrabarti and Dhar, 2009:26). Here the Occident is assumed to be a step ahead in scientific research, in access to psychiatric interventions and in mental health literacy.

This resonates with how Hall (1992:277) understands the functioning of the ‘West’; as a tool to think with (‘western’ and ‘non-western’); as a set of images that condenses differences; as a model of comparison used to compare how ‘close’ other countries are to the West, or whether they are ‘catching up; and as a tool to explain difference, hierarchically. Here, as arguably within Global Mental Health, there is a simultaneous move to homogenise - to make the same, and yet to hierarchise - to establish chains of

equivalence around a presumed universal criteria or standard. This approach is evident in the launch of The Lancet's (2011) second series on Global Mental Health;

The mhGAP guidelines should become the standard approach for all countries and health sectors; irrational and inappropriate interventions should be discouraged and weeded out. (Patel, et al, 2011:1442).

This universal standard, then, comes to be that which all countries, and approaches to distress, are compared to, and judged by, with the standard itself determining what can be thought of as 'irrational' or 'inappropriate', and what should be 'weeded out'. In this process, the populations of LAMICs are predetermined to fall short of the norms imposed by a universalising global standard – itself a cultural construction (often of the 'West') (Hook, 2004). It seems obvious that prevalence studies using psychiatric diagnostic criteria, translated from those used in HICs, will find a 'treatment gap' in availability of psychiatric interventions and access to medications between HICs and LAMICs (Ecks and Basu, 2009). Thus, in the homogenising, universalizing move of applying these psychiatric classifications globally; a hierarchy is established, whereby HICs will always appear more advanced, in part because the criteria to be met with comes from these countries.

### **'Failure of Humanity' / Common Humanity**

This takes us to a statement from the 'renewed agenda for Global Mental Health',

First and foremost, the issue of the human rights of people with mental health problems should be placed at the foreground of global health—the abuse of even basic entitlements, such as freedom and the denial of the right to care, constitute a global emergency on a par with the worst human rights scandals in the history of global health, one which has rightly been called a "failure of humanity" (Patel et al, 2011:1441).

Having seen the violent treatment of many people with mental health problems, in India and the UK, it is hard for me to disagree with the idea that within mental healthcare there has been a 'failure of humanity'. However, this research has provided

a range of different lens through which to approach such a statement and the implications faced in making it. For example, the very construction of mental illness as a global emergency, and an individual crisis, is often the means by which human rights abuses come into being. Perhaps the 'global human rights emergency' (BBC, 1999) is not caused by mental distress but created by bio-psychiatric conceptions of mental illness as 'outside' of normality, as alien (Read et al, 2006), and thus outside of human rights legislation.

Furthermore, a 'failure of humanity' can be read differently alongside the appeal made by colonialism to a common humanity, a universal man in the coloniser's image, a universal that 'drowns' Fanon, that homogenises and hierarchises. Here the 'failure of humanity' may be that particular conceptions of 'humanity' (who counts as human, and who decides) work through a process of inclusion to exclude, to encounter difference and disavow it, and thus it is the boundaries of this 'humanity' that seem to fail.

For Fanon, this is 'to drown me in the universal' ([1952]1986:186), and for Nandy (1983:73), colonialism could not be complete without universalizing and appropriating 'the language of defiance of its victims', so that resistance comes to be spoken in the language of the colonisers. Speaking one's resistance in the language of the colonisers takes us back to *The Banyan*, and to Meesha. Meesha spoke her refusal, her refusal to identify with being a 'psychiatric patient', in English, in the terms of psychiatry. A Fanonian reading of Meesha's refusal makes it possible to glimpse the alienation at the heart of psychiatric diagnoses – the 'identity violence' (Hook, 2005:480) of understanding oneself and/or refusing that identity in foreign terms, a process that occludes the integrity of one's experience.

### **'Indissoluble Ties'**

According to Dhareshwar (2010:51), Gandhi understood the norms of law and medicine as working to 'occlude experience', they 'begin to dictate how experience must or ought to stand in relation to "facts", "concepts", and "practices -"' concepts and diagnostic categories, such as those in the DSM and the CIDI. For Dhareshwar (2010:51), 'colonialism is destructive of the very integrity of experience. It is deep because it immediately brings up the question of what constitutes a form of life and

what conditions are needed for its continued existence and flourishing'. Stories from this thesis have suggested that psychiatry too can destroy or occlude experience, and it too is deep because it constitutes what counts as a life worth living, while acting through chemicals on people's brains. In a summary of a paper by Fanon and Lacaton (1955), Bulhan (1985:229) explains that in a situation of oppression such as colonialism,

[t]he dominant group imposes its ethico-legal precepts as it negates the validity and integrity of all that the oppressed uphold. The oppressed on their part adopt a position of passive resistance, an autoprotective shield, which renders impossible any comprehension of their experience from the cultural perspective of the oppressor.

This research has seen this at work, particularly through the psychiatric-legal designation of certain experiences as 'symptoms', constituting the veto clause of 'unsound mind'. This is a process that leads some people, such as Marie and George, to resist slyly, a resistance whose meaningfulness may be impossible to comprehend from the perspective of psychiatry, or in the language of rationality. Thus, while colonization rarely destroys all creativity and resistance, for Gruzinski (1988), 'it does succeed more than often in weaving indissoluble ties between indigenous cultures and the imported ones' (cited in Rahnema, 1988:169). Therefore, while resistance may be sly, so too can be the monopoly of bio-psychiatry as it weaves indissoluble ties between people labelled as mentally ill and medication. Ties that are socially and biologically hard to break.

For Nandy (1998:144), '[o]ne of the most damaging legacies of colonialism', and yet one that attracts little attention, is the,

dominance of the cultural language in which dialogue among nonwestern cultures takes place. Even when we talk to our neighbours, it is mediated by western categories, western assumptions and western frameworks. We have learnt to talk to even our closest neighbours through the West.



In fact, with the use of 'key informants' within epidemiological research into mental illness, and the adoption by many NGOs of community alert systems (whereby people in the community are taught what signs to look for in identifying people who may be mentally ill on the streets), the populations of some LAMICs are increasingly coming to understand and encounter their neighbours through psychiatry. And through this spreading and creeping of psychiatrization and Global Mental Health there comes into being 'an international protectorate whose remit encompasses the supervision of the psychological state of the population [and] entails a far more extensive and intrusive foreign presence than past colonial administrations' (Pupavac, 2002 -online). This further relates to the intricacies of language and consent (and dissent).

### **Consent in alien terms**

One of the key implications that could be drawn from this research, then, is that understandings of distress that invoke 'unsound mind' or categorise people's experiences into 'symptoms' (through often foreign, technical idioms) may need to be abandoned within any mental health projects that work to be equitable or draw upon a human rights framework. This is already underway in campaigns like the Campaign to Abolish Psychiatric Diagnostic Systems such as ICD and DSM (CAPSID), and the Campaign for the Abolition of the Schizophrenia Label (CASL).<sup>80</sup> While such campaigns may be needed on a global scale, this thesis also implies that other challenges may remain, particularly in regards to formulating methods for recognising difference without disavowing it, without pathologising it, and without capitalising on it within a global health marketplace.

This suggests that instead of 'educating' the populations of LAMICs about 'western' psychiatric ways of understanding distress as 'illness', 'making' them mental health literate, there is a need to rethink these very terms, to rethink psychiatry. Gandhi's critique is useful here, for he does not (in Dhareshwar's 2010 reading) mobilise against

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<sup>80</sup> Timimi, S. (2011). No More Psychiatric Labels. See <http://www.criticalpsychiatry.net/?p=527> (Accessed, January 20<sup>th</sup> 2012). And Hammersley, P. and McLaughlin, T. (undated) Campaign for the Abolition of Schizophrenia Label. <http://www.asylumonline.net/resources/campaign-for-the-abolition-of-schizophrenia-label/#.UCjJ26FIQzA> (Accessed, May 12<sup>th</sup> 2012).

modernity, but tries to resist structures that occlude, and create structures that preserve, the integrity of experience. This is useful in reading Global Mental Health and mental health literacy as forms of colonisation, because here we might explore the possibilities of not rejecting all psychiatric or 'western' understandings of mental health outright, but attempting to identify how these may operate to occlude experience, in both the global North and South.

The imposition of these alien terms, structures that occlude experience, is thus an ethical issue. It poses for Summerfield,

an ethical challenge for global mental health: non-Western people can give properly informed consent only if the terms in which they are being represented, which here means candidature for psychiatric caseness, are not alien or irrelevant to their interpretations of the world (Summerfield, 2008:994)

How can Meesha, 'rescued' from the streets and medicated, speaking the identity she has been diagnosed with in an attempt to refuse it, be understood to have consented to the 'treatment' with medications that she receives and takes, when in her understanding to be 'cured' is to be rid of the organisation that gave her that diagnosis and 'rescued' her in the first place? This resonates with Sarbani's persistent concern with how Iswar Sankalpa can obtain informed consent to treatment from people who are very distressed, and often speak an Indian language different to those spoken by the staff. Even though imposed, overdetermined from the 'outside', for Sartre (1963:20) '[t]he status of "native" is a nervous condition introduced and maintained by the settler among colonized people *with their consent*'. While this hints at the social, rather than the biological, production of a 'nervous condition' - Fanon's 'double process' (1967) - it also makes me question by what mechanisms the colonised or the psychiatrized could be said to consent to their 'nervous condition' (particularly if, like the women at Sangath, they never know the terms by which their psychiatrists 'know' and diagnose them).

Consent is central here in multiple ways, for not only does 'meaningful consent impl[y] the possibility of saying "no" and having this refusal respected' (Roberts, 1999:15), but

it also implies having a choice between ways of understanding distress and thus of intervening. This means a choice between 'western' psychiatric interventions and alternative forms of healing, meaning that the promotion of non-medical spaces and 'non-Western' forms of healing should be key to Global Mental Health. This is something called for by a number of survivor-led organisations in LAMICs (and discussed shortly). Yet it is seemingly ignored within Global Mental Health's call to impose universal standards and 'weed out' alternatives (Patel, et al, 2011). Also consent may not only be individual – for as Higginbotham and Marsella (1988) make clear, psychiatry constitutes cultural change and thus community consent should be gained before introducing psychiatric technologies.

As well as occluding experiences (denying the reality or the personal meaning of distress); the globalisation of psychiatry also occludes other ways of knowing - local idioms of distress. Thus, it seems a move away from the 'illness' model of mental health may be an important move for Global Mental Health advocacy, and one being called for by some NGOs in India, such as The Bapu Trust, where Bhargavi told me,

we are saying we don't want to be under the Mental Health Act, we want to be under the Disability Act and under the Ministry of Social Justice and Empowerment, because mental illness is largely a justice issue. There's only a small medical component. But a larger part of our needs are social justice linked. (Bhargavi Davar).

However, currently Global Mental Health is making the opposite move from this, through their calls to see mental illness as an 'illness like any other'. Perhaps a word of caution is also needed here, because while for some organisations the framing of distress within the register of disability is preferable (something also called for by the WHO), it is important to take into account that 'the academic literature of disability studies consistently privileges minority world accounts' meaning that 'disability (in both medical and social model senses) has been framed within a minority worldview' (Priestly, 2001:3). Thus, disability studies is also in need of de-colonising, perhaps even more so if mental health and distress are to be understood within its frameworks (see Grech and Goodley, 2012).

## Psychiatry as 'sick'

For Fanon, it is colonialism itself that is psychopathological, 'a disease that distorts human relations and renders everyone within it "sick"' (Loomba, 1998:122). If psychiatry can be read as colonial, then we might similarly diagnose psychiatry as being psychopathological – rendering increasing numbers of people within it sick - mentally ill. It may be from the psychopathology of psychiatry, then, that Meesha is taking her medicines to be cured. Bhargavi Davar also expressed this concern around the high percentages of diagnoses of Schizophrenia in India, what she worries may be misdiagnosis due to the multiple traumas India has experienced - 'man made traumas, natural traumas, and I wonder how much of that trauma is misdiagnosed as Schizophrenia'.<sup>81</sup>

This invokes strange links between 'natural' and 'man made' traumas, made even stranger by Whitaker's (2010) concern that the 'epidemic' of mental illness seems more to be the result of iatrogenic impairments from psychiatric medications than improved recognition of 'brain disorders' - man made mental illness. As mental illness 'booms' and Depression becomes an 'epidemic', as 'the possibilities for being not-normal are theoretically limitless' (Fendler, 2001:127-128), this reading of Fanon, which Fanon himself may not have agreed with, enables a psychopolitical analysis of how psychiatry renders increasing numbers of people as ill, in an ever expanding market in abnormality.

Fanon is a stark opponent of a colonial psychiatry that locates distress in brain structures, overlooking the socio-historical context in which that distress arises. Employing Fanon's socio-diagnostic psychiatry, one cannot understand psychological problems or distress outside of the conditions of oppression that lead to them, thus distress is the result of a double process; as sociopolitical and economic conditions of inequality and alienation become internalised – a process of 'epidermalisation' (Fanon, 1967:13; Hook, 2004). This is to speak of how inequality may come to play on the body, to be made flesh. It also hints at a psychopolitical reading of the mechanisms by which socio-economic crises (such as the agrarian crisis discussed in Chapter 5) come to be rearticulated and reconfigured as individual crisis, as mental illness.

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<sup>81</sup> Interview with Bhargavi Davar, Pune, February 2011.

This, then, interlaces with another process, whereby distress caused by socio-economic conditions (and often neoliberal economic reforms) comes to be rearticulated as mental illness, treatable using techniques that draw upon similar rationales as those that led to distress initially. Thus, if globalisation or ‘westernisation’ cause mental distress (a current and a colonial concern), then that very distress is currently mediated through ‘western’ psychiatric knowledge, itself spread by globalisation.

While this reading of psychiatry as psychopathological is useful, it makes me anxious that such a reading reifies the terms of ‘psychopathology’ and irrationality, even through its reversal of where this sickness may lie. However, Fanon’s work has been central to the psychopolitical analysis of Global Mental Health attempted in this research. His analysis of distress enables a shift in the site of interventions into distress, a shift in focus to the socio-political, to the social conditions that give rise to distress (Hook, 2004). If it is society that is ‘sick’, then it is ‘society that needs to be replaced’ (Fanon, 1968:53-54). And thus if psychiatry is sick, does psychiatry need to be replaced?

Furthermore, Fanon’s ‘psychopolitics’ make available a set of tools to apprehend how symbolic violence might be almost physically experienced, the violence of a ‘look’, a gaze. This enables a reconceptualisation of what counts as violence and of how psychiatrization might be understood as enacting violence on multiple intersecting layers. This opens up possibilities for recognising and responding to violence that is banal and normalised – the violence of normalisation and the normalisation of violence.

How violence is conceptualised seems connected to another messy space that has emerged within this research – how the mobilisation of ‘emergency’, both individual and national, work to change the frameworks by which we might usually understand violence, to ‘civilise’ violence and make it ‘necessary’. How, therefore, can we understand some situations of oppression, and some people’s distress, as being an ‘emergency’ that requires an immediate response, without invoking a ‘state of emergency’, a state of exception where violence becomes normal? Furthermore this

state of exception has itself become normative. Thus, while the current incitement of mental health into a discourse of global emergency and crisis suggests an abnormal deviation from a normal order, mental illness may also be read as a 'normal' reaction to that (dis)order – as a 'healthy' response to the 'unhealthy' globalisation of Neoliberalism. Yet making the claim that mental health problems, such as Depression, are a 'normal' response to inequitable market relations in the global South, may also be normative, as it glosses over a simultaneous globalisation; that of bio-psychiatric explanations of distress. All of this also raises a further problem of how to conceptualise situations of urgency without calling upon a discourse of burden, and how we might think about inter-dependency within Global Mental Health.

### **Anxiously Repeating**

Meesha's words invoke the alienation at work in psychiatric diagnoses, an alienation that is troubling as psychiatry becomes globalised. Her words also hint at one of the key mechanisms for psychiatry's travels across the globe - NGOs. The work of particular NGOs in India has been a focus of this research, and specifically, how through their interventions they act as key sites in the repetition of psychiatric knowledge and in the distribution of medication, forming the 'vectors "from below" [that] pluralize biological and biomedical truth' (Rose, 2007:142)

In its travels, psychiatry is thus repeated all over the world, in different contexts. This repetition is the mechanism by which the globalisation of psychiatry is made possible. For some, such repetitions are condemned to repeat old patterns, patterns of colonial domination that are only slightly altered. For Lorde (1980:123), this is a process through which, 'the old patterns, no matter how cleverly rearranged to imitate progress, still condemn us to cosmetically altered repetitions of the same old exchanges'. And arguably, here, pharmacologically altered repetitions of colonial relations and dependencies.

However, these repetitions, in diverse contexts, may also be read as opening up a space into which other meanings can creep. These repetitions categorize and 'fix' distressed people in the global South as 'mentally ill', and they 'fix' psychiatry as a framework of intelligibility. This fixity, for Bhabha (1994:94-95), while being a

paradoxical mode of representation, connoting both rigidity and disorder, is a key facet of colonial discourse, marking a 'daemonic repetition', which vacillates between what is always "in place", already known, and something that must be anxiously repeated'.

Bhabha draws upon iteration here; the necessary repeatability of any statement, in different contexts, for it to become meaningful. He situates this analysis within the context of the Foucauldian 'statement'; in order to explore the 'statements' that make up colonial discourse. However, while such repetition works to secure the subject, to fix it, it nevertheless fails to reproduce itself identically; each repetition brings with it the possibility of change in iteration. For, 'any change in the statement's conditions of use and reinvestment, any alteration in its field of experience or verification...can lead to the emergence of a new statement: the difference of the same' (Bhabha, 1994:33).

Thus, as the context of iteration changes, as concepts and knowledge systems are repeated around the world, they 'always mean...the same thing but also something slightly different every single time' (Huddart, 2006:12). In this way, repetition works to secure the subject (the psychiatric subject and the subject of psychiatry), to fix it, while simultaneously introducing subversion, difference in repetition. This difference in repetition means that in the very act of travelling, in the globalisation that makes me and many others anxious, in the repetition of psychiatry and Global Mental Health in the global South, a space is opened up for 'something other, a difference that is a little bit uncanny' (Bhabha, 1994:131). For Young (1990:147),

the familiar, transported to distant parts, becomes uncannily transformed, the imitation subverts the identity of that which is being represented, and the relation of power, if not altogether reversed certainly begins to vacillate.

This was evident in the modifications that psychiatry underwent in colonial India, where 'a colonial twist in a Western blueprint' (Ernst, 1997:169) questioned assumptions of the simple transplantation of Western psychiatry onto the colonies. To read colonial discourse, and Global Mental Health, as part of an address, as enunciative acts, is to attend to the specific moments of these multiple addresses 'that bring with them the possibility of variation, difference, even subversion of the key terms and

values of a discourse' (Hook, 2012:176). Through these multiple iterations, colonial authority, and psychiatry, cannot control all possible meanings, thus opening a space for other meanings to emerge.

We're near the end; it's time for a joke - a joke about pretending to be mad. Zizek likes to tell jokes.

### **The Conscript who pretended to be mad - repeated failures / successful repetitions**

Let me tell you the joke of a conscript who tries to avoid military service by pretending to be mad. His symptom is that he compulsively checks all the pieces of paper he can lay his hands on, constantly repeating: 'That is not it!' He is sent to the military psychiatrist, in whose office he also examines all the papers around, including those in the wastepaper basket, repeating all the time: 'That is not it!' The psychiatrist, finally convinced that he really is mad, gives him a written warrant releasing him from military service. The conscript casts a look at it and says cheerfully 'That is it! The "mad" conscript pretends to look for something, and through his very search, through its repeated failure ("That is not it!"), he produces what he is looking for (Žižek, 1989:160).

Zizek's joke is about pretending to be mad. It's about a form of pretending that is a repeated failure – a repeated failure that is not a failed repetition, but a successful repetition because through the repeat of the failure the conscript gets what he was looking for. Drawing on the conceptual tools of psychopolitics and colonial discourse analysis, we have encountered pretending already in this thesis, and how it may be read as a form of resistance. We have encountered Rosenhan (1973) pretending to be mad, a pretending that is between mimicry and mockery, that poses a threat to normalised knowledges (Bhabha, 1994), mocking psychiatry's power to tell the difference between sanity and insanity. Yet this mockery in part led to the reformulation of the DSM (in the form of DSM III), making psychiatry ever more determined to tell the difference.



Zizek's conscript's pretence is successful, just as, for Nandy (1983:84), mimicry (linked in this research to the feint, pretending) is a 'comical imitativeness' that subverts and mocks the powerful. Yet for Fanon (1963:251), mimicry is 'nauseating', an obscene caricature that pays homage to the victor. Thus, to be 'almost the same, but not quite', is the condition of the colonised that justifies an almost complete homogenisation, but with the 'almost' leaving room for the establishment of hierarchies. Yet to be 'almost' the same also marks the partial presence of colonised peoples, a space to look back from, unseen, to disrupt the gaze of psychiatry. Thus, the repetition of partial presence that is the basis of mimicry 'reverses "in part" the colonial appropriation by now producing a partial vision of the colonizer's presence' (Bhabha, 1994:88).

However, the success of repeated failure does not solely imply resistance, for it also hints at how colonialism remained 'successful' for so long, and that while some attempts at psychiatrization may appear unsuccessful in LAMICs (for example, in people's continued use of traditional healing methods) this may not imply that they will not ultimately be successful in producing psychiatric subjects. Just as psychiatrized peoples may look back slyly unseen, psychiatry too can be sly. This is the 'force of ambivalence' at work in colonial discourse, which while giving colonialism its currency (Bhabha, 1994:66), also ensures its repeatability, constantly oscillating between seemingly contradictory positions (Hook, 2012).

### **From the clinic to the globe**

However, I want to proceed with caution here. For, while Bhabha's repetition (drawn from Freud's 'repetition compulsion') may be a useful conceptual scheme, it doesn't address what gives certain ideas and frameworks of intelligibility their currency to travel. Why do certain significations get 'locked into patterns of repetition', how do they become 'sticky' (Hook, 2012:107 & 150). This links to questions around identity formation and interpellation, where certain identities, such as the label of Schizophrenia, seem to 'stick' 'for life' (Tucker, 2009). But there are further problems to encounter.

Can and should we apply conceptual schemes from psychoanalytical theory, such as 'repetition compulsion' and 'abjection', terms that have been developed in individual,

often clinical settings in the global North, to make sense of global or political phenomena? Perhaps even more troubling, is the question of what it means to draw on such theories to enable a re-reading of Global Mental Health as being a form of colonial discourse, of repetition, when doing so simultaneously repeats psychoanalytical theories in the very way they are being mobilized to critically analyse global repetitions of psychiatry. Thus to draw upon the concept of 'repetition compulsion' to understand Global Mental Health, is to; apply a clinical, individual scheme onto the global; and repeat one register of the psy-complex – the psychoanalytical, in an attempt to analyze the repetition of another – psychiatry.

While this follows part of a psychopolitical project to put psychological concepts to work in understanding political schemes, it also calls for caution. Otherwise we privilege psychoanalytical concepts over psychiatry, as though they too do not enact a colonial relation, as though psychoanalysis or psychology cannot themselves be a form of 'colonialism pursued by other means' (Loomba, 1998:122). This points to how the very conceptual tools we draw upon for analysis are implicated and complicit in the systems we attempt to use them to analyse.

However, framing psychiatrization as a process of repetition is useful as it moves away from claiming that Global Mental Health imposes psychiatric knowledge onto LAMICs as though the populations of countries, such as India, are passive recipients of this process. (Although just because direct force is rarely used does not mean unequal power relations are not at play, as we have seen, for example in pressure from the WTO or the World Bank to impose specific economic reforms and structural-adjustment policies in India). Another key reason for understanding Global Mental Health through the conceptual frame of repetition is that it also enables glimpses of potential resistance to psychiatric understandings, and possibilities for change.

Moreover, Hook (2012), in his realm of the 'extra-discursive' explores the body as the grounds for the rehabilitation and maintenance of what is prohibited in discourse. While Hook is discussing this in reference to the exclusionary logic of racism, what about when the thing prohibited in discourse is not exclusionary, for example, the naturalisation of the capitalist market economy, and the subsequent prohibition of

other, alternative ways of framing and ordering life. If psychiatry comes to be hegemonic in India, and indigenous healing comes to be prohibited in official discourse (a process already under way), might the bodies of the mentally distressed act as the site for the maintenance and rehabilitation of these other ways of knowing health and illness?

### **Psychiatry as colonial, as impossible – what would Fanon say?**

Fanon's work seems key to a project of rethinking Global Mental Health because of his insistence on a historical grounding of theory, an opposite move to the universalizing tendencies of psychiatry. Fanon (1968:14) says, '[m]y observations and my conclusions are valid only for the Antilles', stating the need to contextualise his work, in this case, within French controlled Martinique around the 1930-40s. Yet in putting Fanon to work on Global Mental Health and on interventions in India is to begin in some ways to universalise his ideas, to make them travel to other contexts away from their specific histories. Here we encounter another problem in the reading of psychiatrization as a form of colonial discourse. Both Bhabha and Fanon maintain that 'the colonial environment is like no other', that it is an unprecedented situation marked by extreme asymmetries of power (Hook, 2005:11). What then might they say to parallels being drawn between psychiatry and colonialism?

For Fanon, psychiatry as a therapeutic means of restoring those alienated from their environments was an impossibility in the colonial situation. This was evident in his resignation letter to the psychiatric hospital in colonial Algeria where he worked as Head of Psychiatry,

If psychiatry is the medical technique that aims to enable man to no longer be a stranger to his environment, I owe it to myself to affirm that the Arab, permanently an alien in his own country, lives in a state of absolute depersonalization (Fanon, 1967, cited in Bulhan, 1985:249).

However, on leaving Algeria, Fanon continued to practice psychiatry in Tunisia, suggesting that in his resignation letter and his work, he was not stating the impossibility of psychiatry as an intervention, only that such an intervention was

impossible during times of colonialism. Still, Fanon was critical of many practices of psychiatry, particularly the coercive, punitive practices within many large institutions, which he felt denied real liberty (Bulhan, 1985). For Fanon, mental illness is 'a pathology of liberty', and thus psychiatric intervention had a political role in restoring liberty (Hook, 2004). Therefore, Fanon pioneered a 'psychiatry of liberation' both in Algeria and later in the establishment of day hospitalization in Tunisia (Bulhan, 1985:232), meaning that here liberty for both the colonised and for psychiatric patients were placed alongside each other. Thus, Bulhan rejects the popular idea that Fanon abandoned psychiatry for politics, instead it was 'his ability to connect psychiatry to politics or private troubles to social problems and, having made the connection conceptually, to boldly act that made him a pioneer of radical psychiatry' (1985:240). This is Fanon's psychopolitics.

In his criticism of large institutions and his promotion of the integration of psychiatric care into general hospitals, Fanon would perhaps agree with advocates of Global Mental Health, who like him, push for a community approach to psychiatry in LAMICs. While Fanon was critical of the cultural and racist biases within psychiatry and its extension to North Africa, he was not calling to abandon psychiatry, for him, psychiatry like any therapy should be the meeting of two 'free' people (something that he felt was achieved more through day hospitalization) (Bulhan, 1985). Thus, in Bulhan's reading of Fanon,

[T]he paramount tasks of psychology and psychiatry [should be] to unravel the relation of the psyche to the social structure, to rehabilitate the alienated, and to help transform social structures that thwart human needs (Bulhan, 1985:195).

However, what if psychiatry itself mobilises a colonial relation, alienating people from their own understandings of distress and violently interpellating them into a 'fixed' identity as mentally ill? What if psychiatry is one such social structure that thwarts human needs, and thus needs to be transformed? Issues then also emerge in how to make sense of Fanon's promotion of the use of ECT. Undertaking a colonial discourse analysis of psychiatric interventions, such as ECT, in this research has brought about

tools for understanding how such ‘treatment’ may indeed enact violence. Fanon has been key to this project of rethinking violence, and yet he practiced one of the techniques of this violence. Perhaps here Fanon’s calls for his work to be located socio-historically becomes important to understand how ‘he was rooted in his own time, even as he endeavoured to question and transcend it’ (Bulhan, 1985:245).

### **Buying-in and the ‘minions’ of drug companies**

I feel that Fanon’s work on the psychopathology of colonialism remains central in an examination of psychiatric practices as colonial, even if it reifies the concept of psychopathology and even if Fanon himself may not have viewed psychiatry as psychopathological. Perhaps unwittingly then, Fanon enables a reading of psychiatry as a disease that creeps, whose borders expand, as increasing numbers of experiences, across increasing areas of the globe come to be seen as ‘sick’. Here Fanon’s resignation letter from the psychiatric hospital in Algeria resonates with another letter of resignation, made in 1998 by Loren Mosher to the American Psychiatric Association;

Psychiatry has been almost completely bought out by the drug companies....Psychiatrists have become the minions of drug company promotions... No longer do we seek to understand whole persons in their social contexts – rather we are there to realign our patients’ neurotransmitters (Mosher, cited in, Redler, 2004).

If psychiatrists are increasingly the ‘minions’ of drug companies then this also makes for an uncomfortable reading of the Lancet’s (2011) second series on Global Mental Health’s push to increase the involvement of psychiatric associations in global advocacy.

Scaling up such innovations will require a substantial redefinition of the role of specialist personnel...the strong buy-in of the professional bodies that lead these specialists...we welcome the engagement of the World Psychiatric Association leaders with the challenges posed by the shortage of specialists (Patel et al, 2011:1441).

The explorations of this research provide a set of tools with which to question such statements. For example, should professional bodies associated with the pharmaceutical industry be called upon to engage with Global Mental Health? If psychiatry's role in intervening in distress in LAMICs is questionable, is there a need for more psychiatrists in these countries? This buying-in may also increase LAMICs reliance on 'Western' psychiatric expertise (psychiatrically altered repetitions of colonial dependencies), and may work to prevent creative local ways of working from being formulated, or from being seen. It also emphasises a top-down approach to mental health interventions, one where communities have little say in negotiating shared meanings or sharing local knowledge (Higginbotham and Marsela, 1988).

### **Decolonising Global Mental Health**

Fanon vigorously fought for Algerian Independence and decolonisation, thus to read psychiatry as enacting colonialism, if taken to its full conclusion, would be to denounce psychiatry (but can it be denounced without paying homage to psychiatry?). Or perhaps, if psychiatry and Global Mental Health are colonial, then they may need decolonising. But is it possible to speak of a 'global' mental health or a Critical Global Mental Health without occluding experience and 'drowning' the local in the universal? Grech's (2011:98) outline for a Global Critical Disability Studies is useful here – a project that questions the relevance of models from the global North within both the North and South; a project 'grounded in and conversant with local contexts'; a project whose disciplinary borders are not too tight, borders that leak. To further foreground such a project, it seems useful to draw upon a framework that enables,

an overlap of contradictory states that represents neither their sublation nor their synthesis, a moment of juxtaposition and conflict, that is both anxious and nonetheless productive, generative in its failed resolution (Hook, 2012:162).

Thus, in Bhabha's ambivalence and hybridity, a different space is opened, a space where differences between cultures are not accommodated – a 'third space' (Rutherford, 1990). Here Bhabha (2003:202), reading Fanon, urges us not to encounter colonial violence and counter-violence as two opposing, binary spaces in need of synthesis... '[t]hey are not to be sublated into a higher, third term (there is no universal

man here!) because they must be read from the borderline that marks the passage between them. This splits the difference'. This hints at other ways of conceptualising difference within Global Mental Health. For example, in encountering the 'treatment gap' not as a space to be closed often through applying universal psychiatric criteria, but as a borderline, a place of hybrid understandings, of uncanny echoes of what modernity and psychiatry have made invisible, a space that enables other ways of responding to distress to be encountered, ways that may disrupt psychiatry. This is Bhabha's (1994:4) space 'in-between the designations of identity', the 'interstitial passage between fixed identifications [that] opens up the possibility of a cultural hybridity that entertains difference without an assumed or imposed hierarchy'. Bhabha (in Rutherford, 1990:211 ) continues,

[F]or me the importance of hybridity is not to be able to trace two original moments from which the third emerges, rather hybridity to me is the 'third space' which enables other positions to emerge. This third space displaces the histories that constitute it, and sets up new structures of authority, new political initiatives, which are inadequately understood through received wisdom.

This 'third space', a space in which to decolonise psychiatry and Global mental Health, is more than purely conceptual, for these 'new political initiatives' are already at work in a practical way in India.

### **Mapping Dissent**

For many years, Bapu Trust produced 'Aaina': a mental health advocacy newsletter, to provide information on alternative, and often survivor-led, approaches to mental distress. Its regular features included information on the harmfulness of some psychiatric drugs often not made public; information about survivor activism worldwide; poems and stories from user/survivors; and updates on campaigns in India – for example, Bapu Trust's campaign to abolish direct-ECT.<sup>82</sup> Bapu Trust also have an oral history archive of survivor stories from India, some of which are cited within this

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<sup>82</sup> Past copies of Aaina and many other resources are available on Bapu Trust's website; <http://www.bapucamhindia.org/>

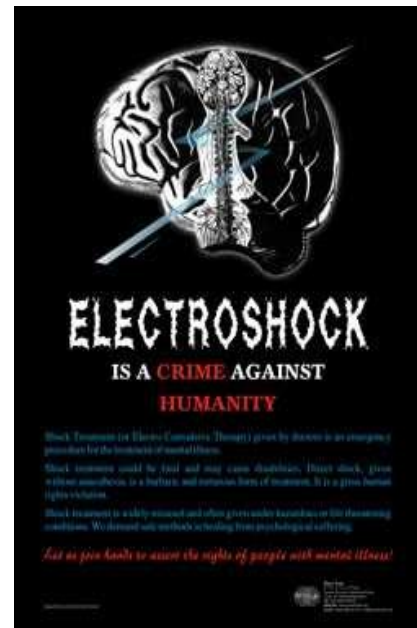
research (also, see Bapu Trust, 2010). In charting hybridity in understanding distress in India, the Bapu Trust are also engaged in documenting spiritual and religious understandings and the interventions of traditional healers (see Davar and Lohokare, 2009; and the Bapu Trust website for videos of traditional healing practices). Furthermore, Bapu Trust explore the methods by which these alternative framings are being discredited, for example, through mental health literacy campaigns, Supreme Court rulings, legislation, and the building of increasing numbers of asylums in India (see Bapu Trust for Research on Mind and Discourse, 2010). As well as research and documentation, Bapu also work with local communities on mental health, below is a picture that I took when I attended one such community meeting.



*A community meeting organised by the Bapu Trust, Pune, January 2011*

The posters about Bapu Trust's campaign against direct-ECT are hanging from pegs in the background of this picture, and are pictured below.





Posters from Bapu Trust's campaign against Direct-ECT (see <http://www.bapucamhindia.org/>)

For Bapu Trust then, it is the 'treatment' that is the crime against humanity – the very humanity that Global Mental Health mobilises many such treatments in the name of (Patel et al, 2011). Such moves work to de-familiarise, opening alternative spaces to engage with psychiatry and psychology's (colonial) doubles. And this work spans further than India – it too is global. This is evident in a new handbook being developed by MindFreedom, 'an independent nonprofit voice for human rights and alternatives in mental health'.<sup>83</sup> According to them, the handbook will encourage 'the emerging voice of people diagnosed with psychiatric and other mental disabilities in poor and developing countries' (MindFreedom, 2011). It will share survivor stories of activism and empowerment, include practical tips for putting rights into action, and will encourage survivors to form organisations and campaigns globally.

### A message from South Africa

Then recently I received a message on Facebook.

Hello

I am from South Africa and work as the coordinator of the Pan African Network of People with Psychosocial [PANUSP] disabilities. I saw that in the latest asylum

<sup>83</sup> See the MindFreedom website <http://www.mindfreedom.org/globalhandbook> (Accessed 3rd March, 2012).

magazine that you wrote about challenging the global mental health care gap - I would so much like to speak to you as this really does impact on us in Africa as you probably know - we are the direct so called 'beneficiaries' of this global encroachment and expansion of the western medical paradigm.

This message was from Annie Robb, my new Facebook friend. In June 2012, (a month ago from the time I am writing this), the WHO launched its 'QualityRights Tool Kit', to address a 'hidden emergency' and to support 'countries to assess and improve quality of care and human rights conditions in mental health and social care facilities' (WHO, 2012). Annie referred me to PANUSP's press statement, made in response to the launch of the Tool Kit (PANUSP, 2012). This statement explains that PANUSP 'as the representative voice of users and survivors of psychiatry and people with psychosocial disabilities on the African Continent' welcomes the WHO's commitment to monitoring the human rights of people with mental health problems (PANUSP, 2012:2). However, the statement goes on to voice concern 'that the Toolkit emphasizes a medical model...approach and does not adequately reflect the ethos of the CRPD [Convention on the Rights of Persons with Disabilities] which has embraced the social model of disability' (PANUSP, 2012:2). They call upon the WHO to

recognize the key role that the pharmaceutical industry has played in the medicalization of mental health issues. Attention must be paid especially in poor countries where "mental health treatments" often serves to mask great social and economic inequalities (PANUSP, 2012:3).

PANUSP make clear that solely monitoring the situation does not improve services, and that all work must be done with the full participation of users and survivors. Furthermore, '[s]ervices and support must be delivered in non-paternalistic and non-patriarchal frameworks with choices available outside of the medical framework' (PANUSP, 2012:2-3). This seems important when we take into account research with children who hear voices, which suggests better outcomes for those who do not frame their experiences within an illness model (Escher et al, 2004). This resonates with Ann Plumb's (1999:463) assertion cited at the beginning (and now at the end) of this thesis,

there is only one way to safeguard our rights and to provide genuinely sound and effective services. This is the pioneering of, provision and resourcing of non-medical sanctuary and support without drug treatment for a person during, and following a crisis, where consent to medical treatment is not given. This is what genuinely new legislation should be about (Plumb, 1999:463).

Davar and Lohokare (2009) also echo this,

If people with an affliction include an element of prayer or penance in a site of their choice as a significant contributor to their being well, should law not protect this as a health care right?

Taking this further, to a South African context, PANUSP (2012:3) make clear that '[c]hoices must be available in the community and this includes the choice not to use western medical "solutions"'. In a speech made on the same day, and included in the press statement, Robinah Nakanwagi Alambuya (2012:7), the Chairperson of PANUSP, said that

no medicines, treatments or sophisticated western medical technology can eradicate human rights violations and restore dignity. The history of psychiatry haunts our present. Our people remain chained and shackled in institutions and by ideas which colonisers brought to our continent and many other parts of the world. Indeed we do remain "objects of treatment and charity" and some of the worst human rights violations do occur in the very institutions that claim to provide mental health care services.

This echoes Bulhan (1985:214),

[t]he tragedy is that, to this day, many in the Third World remain chained and straightjacketed in alien asylums mostly erected by the very Europeans who proclaim their mission as civilizing and humanizing the world.

To call upon people's rights to non-medical interventions into distress serves as a reminder that these alternatives do exist, yet are often eclipsed (or actively demonised) by the dominance of psycho-pharmaceutical approaches. I encountered the dominance of psycho-pharmacology in many of the NGOs I visited in India; in the often vacant stares of those who lived within the institutions. However, it was at Iswar Sankalpa where I saw a relational model of community care that seemed to be very successful, and yet still there the giving up on the idea of medicating those who were diagnosed seemed difficult for the staff. While they told me that the pairing of a 'homeless mentally ill' person with a caregiver in the community enabled the building up of a relationship that was therapeutic and practically useful in terms of often providing employment – still most of those with whom they work continue to be medicated.

### **In a language that makes no sense**

In the work of Bapu Trust, PANUSP and MindFreedom, we can see how counter hegemonic ideas, those of anti- or of critical psychiatry, also travel globally. This is to begin to trace something like Nandy's (1998:147) 'language of dissent which would not make sense - and will not try to make any sense in the capitals of the global knowledge industry'. This making no sense suggests that so-called 'Western' knowledge may not always be desirable for countries of the global South, for whom this knowledge is haunted by other languages - of colonialism and violence. It is a violent language that makes a nonsense of civilising claims. Thus, for Nandy (1983:72-73),

That was why the cry of the victims of colonialism was ultimately the cry to be heard in another language-unknown to the colonizer and to the anti-colonial movements that he had bred and then domesticated.

Thus, 'to speak a language is to take on a world, a culture' (Fanon, 1967:38), which for many means the culture of the coloniser, and for Meesha and many global psychiatric citizens, means a psychiatric culture. For Fanon (1967), language is a tool, a tool by which the black man becomes whiter as he gains mastery of the white man's language. In Tuhiwai Smith's (1999:157) project of 'decolonising methodologies', she recognises that 'naming' is key to retaining control over meaning, and that in "naming the world"

people name their realities', realities that may only be captured in indigenous languages, not in foreign terms.

To speak in a language different to the colonisers was for Thiong'o (1981:xiv) a key step in 'decolonising the mind', where he uses his book of that name to mark a farewell to English as a vehicle for writing. Fanon (1967), writes of a similar expectation of Sartre's (1976), that the black poet will turn against the French language – the colonial language. In fact, '[t]he Negro is not. Any more than the white man' - for Fanon (1967:231) calls on both to 'turn their backs' on the inhuman voices of their ancestors.

The 'turn' against the language of the coloniser, to turn our backs – seems to be a different 'turn' from Althusser's (1971:174) '180 degree turn' that 'almost always' gets its subjects (that recruits them all). And different again from the alienating turn away from oneself, Fanon's turn that doubles. Yet, like both these turns, this 'turn against', has a generative function, like Butler's 'trope' – deviating from customary language, making connections that seem illogical, that defy accepted versions of reality (Butler, 1997:201-202, fn1). Here the 'turn' is generative and productive not only in the formation of subjects, but for a language of resistance, that makes 'no-sense' (Nandy, 1983). This creates a doubled reading of Bhabha's (1983:23) assertion that colonial discourse, and here psychiatry, operate as an apparatus that 'turns on the recognition and disavowal' of difference'. For this 'turn on' could be read as both switching on - hinting at a sudden production, and rotating on – suggesting a productiveness through repetition (the turning of a rotation).

However, for Butler (1997), this productivity only operates when this departure from customary logic is recognised as being a departure, thus it 'presupposes an accepted version of reality for its operation', it is 'an operation of language that both reflects and enacts the generativity it seeks to explain, irreducibly mimetic and performative' (Butler, 1997:201-202, fn 1). This interlaces with 'passing' and 'slyness' as resistance; that one must 'know' what is 'normal' in order to reproduce it, perform it, to pretend; and whether this pretending can ever be subversive if it is not recognised, if it remains faint, if it is not exposed as being a feint.

This is to read psychiatry critically through a psychopolitical lens, one that for Hook (2012:40), is a move beyond solely blame or emphasis on psychic damage, 'towards a strategic consolidation of psychopolitical resources, be those communal (a solidarity of the oppressed) or subjective (a politics of everyday experience)'. India has had hundreds of years of being exposed to the West, incorporating and internalising western systems of knowledge (Nandy, 1983). Here even dissent against the hegemony of Western knowledge may be delimited by the West. However, India, and indeed any project of re-thinking or de-colonising psychiatry, is not forced to reject this knowledge wholesale, in favour of knowledge constructed as 'traditional'. For Derrida (1995:178), it is 'not a question of asking whether the old or new system is harsher or more bearable, because there's a conflict in each between the ways they free and enslave us'.

This has echoes with Gandhi's endorsement of a 'non-modern Indian reading of the modern West', an attempt to refuse to meet the West's criterion for antagonism (Nandy, 1983:102). In so doing it marks a refusal to meet psychiatry's criterion for what counts as 'sane', and what counts as evidence. This heeds Nandy's (1983:12) warning that dissent to colonialism was often controlled by the colonisers who put forward a way of being anti-colonial that was promoted as 'proper, 'sane' and 'rational', making it possible 'to opt for a non-West which itself is a construction of the West'. Nandy (1983:3) continues,

Particularly strong is the inner resistance to recognizing the ultimate violence which colonialism does to its victims, namely that it creates a culture in which the ruled are constantly tempted to fight their rulers within the psychological limits set by the latter.

Reading psychiatry as enacting a colonial relation, then, we might trace how it works to set the boundaries of what counts as sane, promoting 'sane' and 'rational' ways to be anti-psychiatry, an anti-psychiatry that is a construction of psychiatry. A move to rethink Global Mental Health does not have to be 'anti-psychiatry', for 'the imposed burden to be perfectly non Western' constricts the self just 'as the older burden of being perfectly Western' did...[t]he pressure to be the obverse of the West...in fact

binds him even more irrevocably to the West' (Nandy, 1983:73). This is to think of another India, 'which is neither pre-modern nor anti-modern but only non-modern,' an India that 'is not non-West; it is India' (Nandy, 1983:73-74). And to map other ways of understanding distress that are not anti-psychiatry - they are simply not psychiatry.

For such a project, Fanon urges us to 'work out new concepts' (Fanon, 1963:255). And for Nandy, '[t]he first concept...has to be the victims' construction of the West, a West which would make sense to the non-West in terms of the non-West's experience of suffering' (Nandy, 1983:13). This is to stake out an other space that does not fit the needs of colonialism, capitalism or psychiatry - it is to realise the colonisers' fear that the colonised will discover 'an alternative frame of reference within which the oppressed do not seem weak' (Nandy, 1983:177). PANUSP (2012:8) speak such a language when they say, '[t]here can be no mental health without embracing our expertise. We have always remained the untapped resource in mental health care'.

Yet, the term 'psychiatric survivor' itself is in some ways 'alien' in India, as many people told me in the workshops I facilitated. Furthermore, doesn't a psychiatric user/survivor movement to some extent presume a psychiatric system? Could there be a survivor movement in countries where there is not (yet) a psychiatric system? Bhargavi Davar told me,

when my mum was alive we [India] had about 30 asylums, now we have 300, so you're going to hear a lot about user/survivors from India in the coming years, and about mental asylum traumas.

Thus, with the growing psychiatrization of India, the survivor movement may grow too. This begs the question that if certain forms of oppression are to some extent 'western' then is it possible to draw upon 'western' resistance to this; can resistance be imported and locally reworked? Thus, while remaining sceptical of unthinkingly importing 'western' models onto diverse contexts, we also need tools with which to be sensitive to how psy-disciplines, such as psychiatry, may call upon a nationalist discourse of resistance to colonialism, to defend their own forms of neo-colonial activities from critique.

Thus, the hearing voices approach to distress, while it may be read as ‘white knowledge’, is one such way of ‘knowing otherwise’, a counter-hegemonic framework that does not (always) make sense in the language of psychiatry or neoliberalism. To enable it, and survivor-led and indigenous approaches, to speak back to Global Mental Health and WHO interventions – would be to question their call to ‘scale up’ interventions built on ‘the strong buy-in of the professional bodies’ and specialists (Patel, et al, 2011:1441). In this alternative framework, as voiced by PANUSP, users and survivors would be the main resource.

But then there is Meesha, who doesn’t understand herself as a ‘psychiatric patient’, even though she makes this refusal through those terms, in English. Meesha seems to be stating, alongside Fanon, the impossibility of psychiatry in the colonies, and the colonising, alienating force of psychiatry itself. This is to be overdetermined from within and from without. Here the ‘without’ takes the form of psychiatric terminologies and frameworks of intelligibility from HICs, and psychiatric categories in English, the terms by which people come to understand themselves and to experience themselves from ‘within’, marking a double process of overdetermination. Becoming a stranger to oneself, making oneself an object, speaks of the alienation in identity formation that for Fanon is a key part of colonial consciousness. When Meesha said she took psychiatric medication ‘to be cured of The Banyan’ might she be suggesting that she needs the medication to ‘cure’ her of the alienating conditions of her psychiatric experience? Or perhaps, like speaking the words ‘psychiatric patient’ in English she is implying that she must ‘play’ the psychiatric system in psychiatry’s own terms in order to be released.

Meesha’s words present one of the greatest challenges to Global Mental Health. How can Meesha, and others like her, be understood to consent to treatment when the very mechanism of diagnosis is made in foreign, alien terms? How can distress be thought and perhaps even mapped without transposing alien psychiatric terms globally? When do interventions become part of the ‘problem’ that requires a ‘cure’? Where should the site of intervention and transformation within distress be? Psychiatry’s categorisation of people in foreign, alien terms, and its naming of certain people as ‘irrational’, as



'unsound' of mind seems to point to two key ways in which psychiatry may colonise by occluding experience.

The construction of alternative approaches (like the approaches of The Hearing Voices Network) as a 'luxury', is interesting when we bear in mind that psychiatry's dependence on technological and biomedical approaches to distress over indigenous healing resources, and its adoption of a universal language of 'mental illness' (promulgated by world medical authorities, such as the WHO) came about at a time when psychiatry itself was at risk of being seen internationally as 'an unaffordable luxury', irrelevant to (inter)national development (Higginbotham and Marsella, 1988:556). This serves as a warning, then, at attempts to make alternative approaches available globally, particularly if they attempt to do so by adopting a universal language of distress. Derrida's assertion seems useful here, that 'there is no non-colonial society...the difference is not between colonial and non-colonial structures, but between different sorts of colonial structures' (Derrida, 2001).

The frustration and defensiveness I felt when being told by psychiatrists at the workshops I facilitated that the approach of the Hearing Voices Network was 'white knowledge', was perhaps also tinged with a colonial anxiety. Thus, the Hearing Voices approach may colonise too, just as psychiatry seems to do. This is particularly if it is put forward as 'the' alternative, to replace psychiatric frameworks. However, if read as one of a plurality of non-medical alternatives, the Hearing Voices approach may be still be useful, for while it is to some extent 'white knowledge', in that the approach comes from specific European countries, it is, within these countries, a counter-hegemonic approach. Thus, it may be a form of knowledge that, while produced in the West, is non-Occidentalist, in the sense of it being marginalized knowledge within the West, knowledge that does not always fit the needs of capitalism and colonialism (Santos, 2005). This is knowledge that does not make sense, and makes nonsense, of capitalist, neoliberal and psychiatric systems. It is Nandy's 'cry' in a language unknown to the oppressors.

### **'epistemologies of the South' – epistemologies that shudder**

Thus, evident in the work of Bapu Trust, PANUSP and MindFreedom, the globalization of psychiatry is met with a 'counter-hegemonic globalisation', a set of networks, initiatives and movements that fight against hegemonic globalisation and provide alternatives (Santos, 2005). This also opens a space to imagine counter flows, how 'epistemologies of the South' (Santos, 2004:236) may 'reach into northern territories' and create new spaces (Laurie and Bondi, 2005:7). In calling for access to non-western, non-medical spaces of healing, and in documenting these alternatives (for example, the videos of traditional healing on Bapu Trust's website), some mental health organizations from the global South are already creating this flow, making alternative approaches 'travel' globally. This is important because

[t]he understanding of the world by far exceeds the Western understanding of the world. Northern epistemologies draw abyssal lines between zones of being and zones of non-being, thereby committing epistemicide and wasting social experience in a massive scale. Mapping the lines is as much a search for absent knowledges as it is a search for absent beings. Knowing otherwise is also being otherwise. Knowing and being in a post-abyssal way involves a constant exercise of intercultural translation. (Santos, 2012).

For Higginbotham and Marsella (1988:559&557), 'psychiatry's system of reasoning and classification is intended to replace indigenous conceptions of disorder', bringing about an 'epistemological break' with indigenous and local ways of understanding and responding to distress, leading to 'deleterious...after-shocks' within cultural systems. Here psychiatrization may thus commit 'epistemicide' on multiple registers; as it breaks with indigenous understandings and forms of life, and works to occlude experience, to impose meanings on distress, meanings that are often alien – alienating.

Here, just as asylums are alien, psychiatric epidemiology may also alienate by disavowing or replacing alternative frameworks of healing. Thus, for Higginbotham and Marsella (1988), the introduction of psychiatry into Asian countries, as it discredits alternative healing sources yet provides little to replace them, and as it appropriates many of the resources made available for mental health in poor countries, has actually

resulted in less help for the distressed. This calls for a need for further 'on the ground' ethnographic research into this area, framed specifically around; documenting local understandings of distress and ways of healing; and on the everyday effects, and unintended consequences, of psychiatrization in LAMICs (see Hopper and Wanderling, 2000; and Higginbotham and Marsella, 1988).

As a move, then, against this 'epistemicide' of Global Mental Health this research has engaged with other knowledges, through encountering a series of 'epistemological shudders' (Losinsky and Collinson, 1999:3). This is a different way to encounter the 'marvellous', things out of the ordinary, '[a]n epistemological shudder occurs when a person's preferred representations of their known world prove incapable of immediately making sense of the marvellous' (Losinsky and Collinson, 1999:3-4). It is a way of experiencing and encountering uncertainty.

#### **'excluded-repudiated-foreclosed'**

To reimagine Global Mental Health as a 'third space' (or as Derrida's 'aporia') – is to bring into being a space full of contradictions that rational solutions cannot resolve, highlighting the failure of technical and scientific logic, pushing us over to the ethical (Murray, 2009). This calls for 'an ethic of critique' that is not a new set of sedimented codes to join all the others, but an attention to practice, and to 'those discourses that make our particular practices seem to us to be true or right' (Murray, 2009:12). This is to face 'places of paradox and impasse, and together begin to imagine something new, to forge new metaphors—new ways of speaking and thinking and relating' (Murray, 2009:13). Chakrabarti and Dhar (2009:199) attempt such a project of moving from the hegemonic 'capitalocentric-orientalist development' to the foreclosed of the hegemonic, to retrieve the very thing 'excluded-repudiated-foreclosed' in the discourse of dislocation. This is a turning of the excluded 'into the legitimate territory of ethico-politics' (Zupancic, 2000:3) and 'into the legitimate territory for political subjectivity', marking a 'turning away' from 'prevailing subjectivities incarcerated within the hegemonic to a certain subjectivity premised on the foreclosed' (Chakrabarti and Dhar, 2009:199).

Here, in this project, the 'excluded-repudiated-foreclosed' takes multiple forms, specifically, traditional and indigenous healing practices and user/survivor critiques. These two sites of the foreclosed, of other ways of knowing, have been central to a messy (en)countering of psychiatrization within this thesis. And they seem central in taking forward a project of rethinking Global Mental Health on an ethico-political register, a register not made up of new normative codes, but a 'third space', an ethics that 'lives' (Hunter, 2008).

Thus if there is to be a Global Mental Health, it needs to be a space where absent knowledges and counter-hegemonic alternatives can be sought out, encountered non-hierarchically, enabled to disrupt and grate against each other, with no move to universalize or synthesise. It needs to be encountered in a 'third space', with no universal claim on what counts as knowledge, and instead a concern with what multiple knowledges can be used for, in different places, at different times.

This thesis has begun to trace, to map, psychiatrization as it creeps into domains of experience previously taken to be 'normal', and creeps across geographical borders. This is a creeping that is sometimes forceful, often banal; that may be violent on multiple levels; that recruits and hails, and abrades, and spatters, and doubles. In this creeping, as it repeats, as it travels, it becomes possible to glimpse, in-between each repetition, a gap, a crack, where what is repeated is never quite the same, 'almost the same but not quite'. Here it is worth bearing in mind that my own repetition of statements made by Bhabha, and Bhabha's repetition of statements made by Foucault, out of context, in the layered, hybrid style of this thesis, also introduces potential for new meaning and alternative readings. Thus, repetition is never complete, for it introduces difference.

This 'difference-in-repetition' is a mechanism for keeping previous, past forms of life alive in the present (Huddart, 2006:53), and thus may work as a useful site for de-familiarising taken for granted knowledge systems, such as psychiatry. This suggests that in the very repetitions of psychiatry within LAMICS, a process we could understand as psychiatrization, there are cracks which enable alternative, indigenous ways of knowing to stay alive and present. Thus, the very repetitions that constitute the

globalisation of psychiatry may also be the grounds for its rethinking. This resonates with the disjunction inherent in colonial discourses more generally, that they contain their own undoing, that mimicry is 'at once resemblance and menace'. That,

in "normalizing" the colonial state or subject, the dream of post-Enlightenment civility alienates its own language of liberty and produces another knowledge of its norms (Bhabha, 1994:86).

This is a space 'that could help describe the dominant in terms different than its own' (Achuthan, 2005, as cited in Chakrabarti and Dhar, 2009:5). In reading Global Mental Health alongside colonialism and through Fanon, it seems psychiatry may also alienate its own language of 'care' and human rights. Mosher and Fanon (despite their letters of resignation) both still stake a claim for the role of psychiatry, however it is a role embedded in a social context and not (solely) in the brain - the universal brain that enables psychiatry and pharmacology to travel in the first place. Perhaps both Fanon and Mosher are alluding to the impossibility of psychiatry in times of colonialism; colonisation by the French in Algeria, and colonisation by the pharmaceutical industry in much current psychiatry. Taking this further, then, perhaps psychiatry is impossible in situations of unequal power relations, particularly those where one group has the power to set parameters around what counts as rationality and sanity, and what counts as violence and treatment.

Thus, perhaps a project of decolonising Global Mental Health (and psychiatry) is one of imagining different relationships between medicine and madness, and mapping ways of responding to distress that are not psychiatric. This is a project that Bracken and Thomas (2005) call 'postpsychiatry', of which a key element is to reduce international, professional and individual reliance on psycho-pharmaceuticals, in part to decrease pharmaceutical industry influence on Global Mental Health, and to enable an openness to creative alternatives. This challenge has a sharp reality for those 'on the ground' in the global South because, as Bhargavi Davar told me, 'to challenge institutions is huge it puts your life at risk. The psycho-pharmaceuticals are a very powerful lobby today in the mental health sector... It's quite scary'.

To begin to think of Global Mental Health 'postpsychiatrically', then, would be to put 'ethics before technology', questioning psychiatry's continuous expansion, and searching for more ethical and sustainable ways to respond to distress (Bracken and Thomas, 2005:260). It would be to decentre, deconstruct or de-familiarise psychiatry; to engage in a project that reads psychiatry backwards (as Bhabha reads Fanon); situates psychiatry at the edges (where Nandy locates himself), in the cracks, in the 'in-between'; is haunted by psychiatry's (post-colonial) doubles, is to make visible alternatives to the hegemony of what might be called 'western knowledge systems'.

To 'see' that these alternatives do exist in the present, in the form of 'traditional' knowledge and in counter-hegemonic movements within the global North and South, all form key parts of a repertoire of dissent (Nandy, 1990). To construct and map such a repertoire is to engage with other possible understandings of distress, recognising that Western psychiatry may be just one of many ethno-psychiatries (Summerfield, 2008: 93), and so is not, and perhaps should not be, global.

P.s. As far I know, Meesha is still living at the 'transit centre', medicated, 'upstairs', not a 'psychiatric patient'.

**The End**

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**Appendices:**

**One to Nine**

## Appendix One

### Mental Health Organisations Visited (and their websites)

The Banyan (Chennai) [www.thebanyan.org](http://www.thebanyan.org)

Bapu Trust (Pune) [www.bapucamhindia.org](http://www.bapucamhindia.org)

Schizophrenia Awareness Association (SAA) (Pune) [www.schizophrenia.org.in](http://www.schizophrenia.org.in)

Sahyog Trust (Pune) [www.sahyogtrust.in](http://www.sahyogtrust.in)

Iswar Sankalpa (Kolkata) [www.isankalpa.org](http://www.isankalpa.org)

### Disability Related Organisations Visited (and their websites)

Sadhana Village [www.sadhana-village.org](http://www.sadhana-village.org)

Amar Seva Sangam (Tenkasi District, Tamil Nadu) [www.amarseva.org](http://www.amarseva.org)

### A summary of the time spent with organisations

**Iswar Sankalpa** allowed me to spend two weeks with them; doing interviews, hanging around in the office and chatting with the staff, and meeting the homeless people whom they support. I also spent some time with different workers from Iswar Sankalpa, accompanying them on their rounds as they gave out medication and support to homeless people who had been diagnosed as having a mental illness. This included driving round the streets to meet some of these people, accompanying a social worker visiting Sealdah railway station to give out medications, and meeting the group of women who live in a community at the side of the railway tracks of Sealdah who all receive support from Sankalpa. I also spent some time in the night shelter – meeting the women who stay there, playing with some of the children, and facilitating a workshop.

I spent nearly a month with **Bapu Trust**; mainly buried in the library and archives of the Center for Advocacy in Mental Health (CAMH), in Pune. Here I had access to many publications that may have otherwise been unavailable to me – including copies of Supreme Court affidavits and impleadments. I also had access to Bapu Trust's Sanchit collection – an archive of oral histories about using and surviving the psychiatric system in India. I also attended community meetings organised by Bapu.

At **The Banyan**, I had a number of meetings with those who run the organisation and facilitated two workshops. I spent an afternoon at the Out Patient clinic, with the opportunity of speaking to some of the families who came for treatment, chatting with the psychiatrist who runs the clinic, and watching the activities and the dispensing of medicines. I also spent some time with the women and the staff in Addaikalam - The Banyan's 'transit centre'.

I spent a day at the **Schizophrenia Awareness Association**, chatting with Amrit Bakshy, the founder, and some of the staff. After I facilitated a workshop with a large number of carers and with people who have a mental health diagnosis, I had the opportunity to chat with the families and have a tour of the organisation.

At the **Shraddha Foundation**, I spent a day having a tour of the organisation, and chatting, with a staff psychiatrist, and interviewing Bharat Vatwani. They even gave me half an hour to have a nap after lunch.

I spent a day at **Sadhana Village**, just outside of Pune, meeting those who live there and the volunteers, and sharing a lovely lunch. I also had unrecorded conversations with the founder, Vasant Deshpande, and his daughter.

I spent two weeks at **Amar Seva Sangam**, in rural Tamil Nadu. I worked at Sangam in 2004, and it was lovely to be back. I chatted at length with those who founded and who run the organisation. I spent many days playing with the children and visiting the Special Educational Needs School. I also spent a day with the local village Priest, meeting local women who make money by rolling beedies (Indian cigarettes).

## Appendix Two

Table 1- Interviews conducted in India

Name of Interviewee	Role	Organisation	Location	Type of interview
<b>Bhargavi Davar</b>	Founder	Bapu Trust	Pune	Semi-Structured Interview
<b>Sarbani Das Roy</b>	Co-Founder	Iswar Sankalpa	Kolkata	Semi-Structured Interview
<b>Yusef (pseudonym)</b>	Psychiatrist	Iswar Sankalpa	Kolkata	Semi-Structured Interview
<b>Sonia (pseudonym)</b>	Social Worker	Iswar Sankalpa	Kolkata	Informal Conversation, I accompanied her for a day on her rounds
<b>Kalai (pseudonym)</b>	Social Worker	Iswar Sankalpa	Kolkata	Informal Conversation, I accompanied him as he visited people receiving psychiatric treatment on the streets
<b>Rupa (pseudonym)</b>	Manager of Night Shelter	Iswar Sankalpa	Kolkata	Interview (unrecorded)
<b>Mani Kalliath</b>	Programme Director (South India)	BasicNeeds	Bangalore	Semi-Structured Interview
<b>Amrit Bakhshy</b>	Founder	Schizophrenia Awareness Association (SAA)	Pune	Semi-Structured Interview
<b>Asim Sarode</b>	Founder and Lawyer	Sahyog Trust, and Human Rights and Law Defenders (HRLD)	Pune	Semi-Structured Interview
<b>Bharat Vatwani</b>	Founder, and psychiatrist	Sharddha Foundation	Karjat, Maharashtra	Interview (unrecorded)
<b>Pratik (pseudonym)</b>	Psychiatrist	Shraddha Foundation	Karjat, Maharashtra	Interview (unrecorded), and informal conversation during tour around the organisation
<b>Vandana Gopikumar</b>	Co-founder	The Banyan	Chennai, Tamil Nadu	Semi-Structured Interview
<b>Jyotirmoy Samajder</b>	Psychiatrist	MANAS	Kolkata	Semi-Structured Interview
<b>Sudeshna (pseudonym)</b>	Social Worker	The Banyan	Chennai, Tamil Nadu	Interview (unrecorded) and informal conversation during tour of organisation

<b>Anup (pseudonym)</b>	Psychiatrist	The Banyan	Chennai, Tamil Nadu	Interview (unrecorded)
<b>Sankara Raman</b>	Secretary, and co-founder	Amar Seva Sangam	Ayikudy Village (near Tenkasi), Tamil Nadu	Interview (unrecorded)
<b>Vasant Deshpande</b>	Founder	Sadhana Village	Kolwan Valley, near Pune	Interview (unrecorded)

## Appendix Three

### Semi-Structured Interview Schedule

#### About the founding of the organisation and how it understands mental illness / distress

- Can you tell me about the reasons why the organisation was started and outline the context in which it began?
- What is the mission or the aim of the organisation?
- Ask about particular model used by the organisation.
- Discuss how the model came about, is it linked to personal experience? How has it changed over time?
- How does the organisation understand mental illness / distress?
- What is the organisations' approach with people who might be violent or dangerous?
- (if applicable) what does claiming a survivor identity (for an individual or an organisation) mean in India? What might it help to achieve, or what might it prevent?

#### About the organisation and the policy context

- What role do NGOs play in mental health services / lobbying in India?
- What relationship does the organisation have with other NGOs?
- How is this organisation similar or different to other mental health NGOs?
- What relationship does the organisation have with other community groups and organisations (such as, the police, the railway stations, and charitable organisations)?
- What do you think are some of the key current issues being discussed within mental health in India, and which ones are not being talked about?
- What do you think are some of the main dilemmas with the current mental health system in India?
- How has the organisation tried to participate or intervene in some of these current debates?
- What are some of the dilemmas and problems that the organisation faces in doing mental health work in India?
- What do you think prevents the organisation from achieving its mission?
- What are your / and the organisation's experience of lobbying / doing activism?
- What role do you think the Government should play in mental health in India?

#### About links with the pharmaceutical industry and funding

- What are the organisation's relationships / links with the pharmaceutical industry (if applicable)? (Questions around budget spent on, and any donations received of, medications).
- How were the relationships with pharmaceutical companies established, and built up?
- Ask about how the organisation is funded.



**About resistance and the future**

- Ask about new proposals in mental health legislation and what they might mean for the organisation.
- (if applicable) questions on how to build resistance (for example, to new legislation or pharmaceutical dominance), and about forms of activism and building (international) alliances.
- What are your hopes for the future of the organisation and for mental health in India?

**The Interviews**

The interviews usually lasted between 1 and 2 hours, and were usually carried out in the offices of the various NGOs and organisations.

## Appendix Four

### Informed Consent Form

This form is to ask you for your consent to be interviewed by China Mills, for research that will form part of her PhD. The interview will be informal and will mainly focus on the work of the organisation / project that you work for. It will explore the role of NGOs in mental health provision in India; dilemmas or problems in providing mental health services; and issues around medication and diagnosis. The interview will be recorded, and then transcribed and stored electronically. With your permission, parts of the interview may appear in the PhD thesis, and in conference presentations, and in publications (journals/ books).

Anyone's name mentioned (i.e. people with whom you work etc; and any information that might enable these people to be identified) will be changed or omitted.

Please circle the following regarding your preferences:

I would like to remain anonymous, and I would not like my name to appear in the research.

or

I am happy for my name to appear in the research (including publications).

### And

I would like the name of the organisation I work for to remain anonymous

or

I am happy for the name of the organisation I work for to appear in the research

Participation is voluntary and you can withdraw or say stop at any time.

Please sign your name below if you feel your questions have been answered and you give your consent to being interviewed for this project.

Your name (please print).....

Signature.....

Date.....

Contact details (optional)

.....

Your contact details will not appear anywhere in the research and will not be kept on record after the research has been completed.  
Thank you so much for your time.

## Appendix Five

### Workshops facilitated in India

I facilitated five workshops in India, all around alternative understandings of hearing voices and the implications these have for working with people who are distressed. Two of the workshops were simultaneously translated – one into Marathi, and one into Bengali. All the workshops, including the discussions by the participants, were audio recorded with the permission of those who took part. In addition, the final workshop at the Banyan was video recorded by staff at the Banyan.

**Table 2**

*Where and when the workshops took place*

<b>Where</b>	<b>When</b>	<b>Type</b>	<b>Length</b>
The Banyan and the Banyan Academy of Leadership in Mental Health (BALM), Chennai.	April 30 <sup>th</sup> 2011	Workshop and seminar, with hearing voices simulation, video clips, and activities.	One day – 10am-5pm.
National Institute of Mental Health and Neuroscience (NIMHANS), Bangalore	April 6 <sup>th</sup> 2011	Seminar, with hearing voices simulation.	2 hours
Iswar Sankalpa, Kolkata	March 22 <sup>nd</sup> 2011	Workshop, with simulation. Translated into Bengali	3 hours
Schizophrenia Awareness Association (SAA)	February 12 <sup>th</sup> 2011	Seminar / talk, with people with a Schizophrenia diagnosis and their caregivers. Translated into Marathi.	3 hours
The Banyan	January 10 <sup>th</sup> 2011	Workshop	4 hours

### The Workshops (an outline)

Here is an outline of one of the workshops that I facilitated with The Banyan. Firstly I showed participants an outline of the workshop.

This workshop will explore alternative approaches to understanding the experience of, and working with people who, hear voices, see visions and have unusual beliefs. The workshop will draw upon research by China Mills on the experience of children and young people who hear voices; on the possibilities of understanding and locating distress within people's own frames of reference

and their life history, calling for multiple ways of understanding and responding to distress; and on the concept of the 'survivor' within critical psychiatry. We will explore what it can be like to hear voices; and use stories from people who hear voices to engage with self-help, coping strategies and the possibilities of recovery

The workshop then traced the history of the Hearing Voices Network and alternative approaches to working with people who hear voices; outlined the philosophy of the Hearing Voices approach, the Survivor Movement and the idea of 'experts by experience'; and presented the following key findings.

- Some people who heard voices were able to cope and live well
- Onset of hearing voices is often related to trauma or life events that made the person feel powerless
- The voices are personal and they have a personal message – the person has a relationship with the voices
- Voice hearing itself is not pathological, it is people's ability to cope (linked to the reaction and care from others – such as family and professionals) that may lead to illness.
- Those people who understood their voice hearing as an illness were the least likely to cope well and to recover.

A group exercise to simulate what it is like to hear voices then followed. This is where people work in threes, taking it in turns to be the 'voice' that one of the others is hearing. Often we then tried this in groups to simulate what it can be like to hear multiple voices.

The workshops then moved onto to talking about phases of healing and recovery; young people's experiences of hearing voices; and strategies to support people who hear voices. These strategies included; helping people to develop a relationship with their voices, and discussed how to use the Maastricht interview (See <http://www.hearingvoicesmaastricht.eu/page10.php>). We then talked about coping strategies, keeping a voice diary and talking to the voices.

We then together read some stories and case studies of how voice hearers had learned to cope, and thought of other things that might help.

We discussed self-help groups, including discussions of how these might work for NGOs in India.

I then outlined a whole set of useful resources, and (electricity permitting) we watched a few clips from Rufus May's (2008) Channel 4 documentary.

The workshops were full of time for discussion. Often there were a few hours of recorded discussion from each one. In this discussion time so many different viewpoints were discussed, particularly because the participants were made up of diverse groups of professionals and NGO staff, from psychiatrists to policy makers; social workers to students to carers, and occasionally people with a label of mental illness; and so reflected very different understandings of mental distress and illness. All the workshops took place within the organisations themselves; often with those who the NGOs worked with (people with 'mental illness') in the next room or upstairs. Some of the workshops were translated – into Marathi and Bengali.

The workshops were very flexible – while I had a PowerPoint presentation, hand-outs and video clips – sometimes the electricity didn't work or there was no computer. Sometimes a part of the workshop worked particularly well or didn't work at all. For example, the hearing voices simulation exercise didn't really to work well at The Banyan. The participants seemed to find it very funny and I found it hard to facilitate. While at Iswar Sankalpa it worked very well. Here those who took part wanted to try new things with it, they asked the questions that their social workers usually asked the homeless people with whom they work, while another role played being the 'voice' that that person was hearing. They role-played voice hearing in big groups; with some playing kind voices and others distressing voices. After all this, one of the participants, who had just role played being a voice hearer, said 'the voices [played by some of the other participants] told me not to tell them anything about myself, and I trusted them because the voices would have been with me much of my life and these people who said they're trying to help me are strangers'.

All the workshops were recorded with the permission of those participating, and I transcribed many of them.

## **Appendix Six**

### **Talks in India**

I also had the opportunity to give two talks at Universities and Research Institutes in India (as well as present at two conferences, see section below).

Mills, C. (2011). 'The Violence of Normalization and the Normalization of Violence: Psychiatric 'Treatment' and Sly Normality', at the Center for the Study of Culture and Society (CSCS), Bangalore, India, March 31<sup>st</sup>.

Mills, C. (2011). 'Normal Violence', at Ambedkar University Delhi (AUD), Delhi, India, March 11<sup>th</sup>.

### **Conference Presentations in India**

Mills, China. (2011). Invited discussant at, 'Women: Use, Abuse, Misuse', National Seminar at Bangalore University, Bangalore, India (March 29<sup>th</sup>-31<sup>st</sup>, 2011).

Mills, China. (2011) The Colonization of Children's Distress: Hearing voices as Political Subversion, at: the Indian Association of Women's Studies 13<sup>th</sup> National Conference, 'Resisting Marginalizations, Challenging Hegemonies: Re-visioning Gender Politics', Wardha, India. (21<sup>st</sup>-24<sup>th</sup> January 2011).

## Appendix Seven

The research for this thesis has provided the material for a number of publications over the last three years (2009-2012).

### Publications

#### Books

Mills, C. (commissioned and accepted for 2013). *Globalising Disorders: Psychiatrization in the Global South. Concepts for Critical Psychology: Disciplinary Boundaries Re-thought*. Parker, I. (Series Ed). Routledge, London and New York.

#### Peer-Reviewed Journal Articles

Mills, C (commissioned for 2013). (Title tbc) Paper commissioned for Special Issue of *Children and Society* on 'Psychiatrised Children and their Rights; Global perspectives'. LeFrancois, B. and Coppock, V. (Eds). (impact factor 0.73, 2011)

Kumar, M. and Mills, C. (in press 2012). De-familiarizing Psychology in India. *Annual Review of Critical Psychology, Vol. 10*.

Mills, C. (2012). 'Special "Treatment", Special Rights: Dis/abled Children as Doubly Diminished Identities'. Freeman, M. (ed), *Law and Childhood: Current Legal Issues, Volume 14, pp.862-898. Oxford University Press, Oxford*.

Mills, C. (2011). 'Disrupting 'Disability' and 'Doing' it differently: Professional Talk and Children's Lives'. *Ethnographica: Journal of Culture and Disability (EJCD), K.U.Leuven, Vol. 1, No. 1., pp.12-24*.

<http://soc.kuleuven.be/werkdocumenten/ojs/index.php/eerstejournal/article/view/4/4>

#### Book Chapters

Mills, C. (commissioned 2012). Global mental Health and Critical Disability Studies, in Sapey, Bob., Anderson, Jill. and Spandler, Helen. (Eds). *Distress or Disability*. Palgrave Macmillan.

Mills, C. (in press, 2013). Sly Normality: Between Quiescence and Revolt? In, Burstow, B., Diamond, S. and LeFrancois, B. (Eds) *Psycho-Political Relations: Theorizing Resistance to Psychiatric Violence*. McGill University Press.

Kumar, M. and Mills, C. (forthcoming 2013). Cultural Aspects of Psychoanalysis. Book chapter commissioned by the Indian Council of Social Sciences Research (ICSSR).

#### Articles and Reviews

Mills, C. (2012). Resisting the Movement for Global Mental Health. *Asylum, Vol. 19, No. 1*. (I also co-edited this issue, and organised contributions from colleagues in India).



Mills, C. (2012). Global Mental Health and Critical Disability Studies. Sapey, Bob., Anderson, Jill. And Spandler, Helen. (Eds). *Distress or Disability: Proceedings of a Symposium Held at Lancaster University*. Centre for Disability Research (CeDR) Lancaster University. (E-publication available online at [http://www.lancs.ac.uk/cedr/publications/Anderson\\_Sapey\\_and\\_Spandler\\_eds\\_2012.pdf](http://www.lancs.ac.uk/cedr/publications/Anderson_Sapey_and_Spandler_eds_2012.pdf)).

Mills, C. (2011). Review of the Indian Association of Women's Studies 13<sup>th</sup> National Conference, 'Resisting Marginalizations, Challenging Hegemonies: Re-visioning Gender Politics', Wardha, India. *Psychology of Women Section (POWS) Review*, Vol. 13, No. 2, 28-33.

### **Conference Presentations**

I have also presented parts of this research at 13 conferences and symposia, in different parts of the world, over the last three years.

#### **Invited Keynote**

Mills, C. (2012). Spoof: Faking Normal, Faking Disorder. Invited keynote at the forthcoming conference - *Theorising Normalcy and the Mundane*, University of Chester (June 28-29<sup>th</sup>).

#### **Invited Presentations**

Mills, C. (2012). Globalising Disorder: Crossing Borders through Disorder/s, at the Disability Research Forum, Sheffield Hallam University (Feb 8<sup>th</sup>, 2012).

Mills, C. (2011). Live and Let Die: Possibilities for a Global Critical Disability Studies, at: 'Distress or Disability'. Lancaster University, UK. (15-16<sup>th</sup> November, 2011).

### **Previous Presentations**

#### **2011**

Mills, China. (2011). Globalising Disorders: Bio-psycho-sociality in India, at: Conference of the 5 Continents. The Psychosocial Effects of Globalisation on Mental Health; For an Ecology of Social Links / Congres des 5 Continents. Effets Psychosociaux sur la Sante Mentale; pour un Ecologie du Lien Social. Lyon, France. (19th-22nd October 2011).

Mills, China. (2011). Global Mental Health; Epidemics, Emergencies and International Biosociality, at: Asylum Conference, Manchester Metropolitan University. Manchester, UK. (14-15<sup>th</sup> September, 2011).

Mills, China. (2011). Discussant at, 'Women: Use, Abuse, Misuse', National Seminar at Bangalore University, Bangalore, India (March 29<sup>th</sup>-31<sup>st</sup>, 2011).

Mills, China. (2011) *The Colonization of Children's Distress: Hearing voices as Political Subversion*, at: the Indian Association of Women's Studies 13<sup>th</sup> National Conference, 'Resisting Marginalizations, Challenging Hegemonies: Re-visioning Gender Politics', Wardha, India. (21<sup>st</sup>-24<sup>th</sup> January 2011).

## **2010**

Mills, China. (2010) *Violent 'Treatment': Who counts as a child and what counts as violence?* at: *ESRC Violence and Childhoods*, Manchester Metropolitan University. Manchester, UK. (5<sup>th</sup> Nov, 2010).

Mills, China. (2010) "The Tyranny of the 'Normal' Child" at: *Lancaster Disability Studies Conference*, Lancaster University. Lancaster, UK. (7<sup>th</sup>-9<sup>th</sup> September, 2010).

Mills, China. (2010) "Recovering Governable 'Souls': The 'Economic Tribunal' of Recovery" at: *Qualitative Research on Mental Health conference*, Nottingham University. Nottingham, UK. (25<sup>th</sup>-27<sup>th</sup> August, 2010).

Mills, China. (2010) "'Special' Treatment, 'Special' Rights: Dis/abled Children as Doubly Diminished Identities" at: *Law and Childhood Studies Colloquium*, University College London. London, UK. (5<sup>th</sup> and 6<sup>th</sup> July, 2010).

Mills, China. (2010) "'On the border of your world and my world'... 'Special' Children and Sly Normality" at: *Research Institute for Health & Social Change, Sixth Annual Conference*, Manchester Metropolitan University. Manchester, UK. (1<sup>st</sup> and 2<sup>nd</sup> July, 2010)

Mills, China. (2010) "Monstrous Minds and Irregular Bodies: Contesting the Political Economy of Recovery and Independence" at: *Theorising Normalcy and the Mundane, Critical Disability Studies Conference*, Manchester Metropolitan University. Manchester, UK. (12<sup>th</sup> and 13<sup>th</sup> May 2010).

## **CONFERENCES / SEMINARS ORGANISED**

Child, Youth, Family and Disability Conference, at MMU (23-24 May 2012).

'Iswar Sankalpa: Community Mental Health Care on the Streets of Kolkata'. A talk by Sarbani Das Roy, chaired by China Mills, at The Discourse Unit, MMU (14<sup>th</sup> of March).

Asylum Conference, organised alongside the conference 'Theorising Normalcy and the Mundane', at Manchester Metropolitan University. Manchester, UK. (14-15<sup>th</sup> September, 2011).

(As well as co-organising the conferences, I also chaired many sessions, including one's over Skype).

## **Other Research outputs**

Video Provocation and Live Presentation on 'How psycho-pharmaceutical drugs shape identity', at 'Co-mixed: Playback Identities'; a public engagement event and performance organized by Manchester Beacon and the BBC, at the Contact Theatre, Manchester, UK (December, 2010).

Video available at: <http://www.comixed.org.uk/2010/12/03/china-mills-provocation-on-how-drugs-shape-identity>

## **Appendix Eight**

The Banyan Academy of Leadership in Mental Health (BALM) is organising a training programme on 'Clinical, Psycho-social and Alternative Interventions for Mental Illness' on the 28th, 29th and 30th of April, 2011 at Adaikalam (The Banyan).

This three day intensive course has a package that covers clinical, psychosocial and alternative interventions for mental illness. It is aimed at providing an understanding of the conceptual theoretical and practical clinical challenges in applying clinical and psychosocial interventions, and alternative interventions and follow up care services offered. This course is unique as it will provide participants with a sound technical knowledge, and serve as a refresher course as it also deals with newer and more current practices in mental health.

### **The resource persons are as follows:**

#### **1) Clinical Interventions : Electroconvulsive Therapy**

**Dr. BN Gangadhar** (Professor of Psychiatry, NIMHANS),

**Dr. Muralidharan. K** (Assistant professor of Psychiatry, NIMHANS),

**Dr. C. Naveen Kumar** (Assistant professor of Psychiatry, NIMHANS);

This course is aimed giving participants an overview of the indications and adverse effects of ECT, followed by the protocol for medical evaluation, including Anesthesia, Stimulus and Monitoring.

#### **2) Psychosocial Interventions**

**Dr. Lakshmi Ravikanth** (Counsellor, PhD in Educational Psychology from DAVV school of Excellence, Indore, Certified psychological counsellor from Christian Counselling Centre- Vellore);

The course explores the importance and relevance of psychosocial interventions in improving quality of life. It also focuses on the need for psychosocial interventions and to help functionaries in the field to select the appropriate PSI relevant to individuals/groups in accordance with their needs.

#### **3) Alternative Approach- Hearing Voices Model**

**China Mills** (B.Sc Psychology, and PhD candidate, Manchester Metropolitan University, UK).

This course deals with alternative approaches to understanding the experience of, and

working with people who, hear voices, see visions and have unusual beliefs. We will explore: what it's like to hear voices; the reasons why a label of 'schizophrenia' may not be helpful; and developing coping strategies.

Teaching methods comprise of lectures, discussion and interactive workshops. Participants are expected to read reading materials before the course.

We would welcome participation from Name of University/NGOS. There is a registration fee of Rs.750 for students and Rs.3,000 for others.

To confirm registration and inform us about your participation please contact:

**Kamala Easwaran:** [kamala@thebanyan.org](mailto:kamala@thebanyan.org) , (98402 75085) who is cc to this mail and inform her about the number of participants.

Look forward to your participation.

## Appendix Nine

Attached is a copy of a widely used scale, developed in Scotland, to measure postnatal depression (A common Mental Disorder). In groups, identify one of the following study sites, or create your own, and consider how and whether researchers might be able to assess postnatal CMD in a valid and meaningful way

- 1) A rural community in Southern India
- 2) Recent Bangladeshi immigrants to UK in tight knit community
- 3) A displaced / refugee population in Aceh, Indonesia

The Edinburgh Post Natal Depression Scale (EPDS) - Guidelines for raters

The Edinburgh Postnatal Depression Scale (EPDS) was developed in 1987 to act as a specific measurement tool to identify depression in new mothers. The scale has since been validated, and evidence from a number of research studies has confirmed the tool to be both reliable and sensitive in detecting depression.

Response categories are scored 0,1,2, and 3 according to increased severity of the symptom. Questions 3,5,6,7,8,9,10 are reverse scored (ie, 3,2,1,0)

Individual items are totalled to give an overall score. A score of 12+ indicates the likelihood of depression, but not its severity. The EPDS Score is designed to assist, not replace clinical judgment.

Try to think about

- what the questions might be measuring
- cultural issues in translating the questions
- problems with any questions / what you might ask instead

## Edinburgh Post Natal Depression Scale (EPDS)

(J.L. Cox, J.M. Holden, R. Sagovsky, Department of Psychiatry, University of Edinburgh)

Name:EPDS Score: \_\_\_\_\_

Assessment Date:

Assessor:

As you have recently had a baby, we would like to know how you are feeling. Please underline the answer which comes closest to how you have felt in the past 7 days - Not just how you feel today.

Here is an example, already completed:

I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean "I have felt happy most of the time during the past week".

Please answer the following 10 questions by placing a tick in the appropriate box.

Thank You.

In the past 7 days:

1. I have been able to laugh and see the funny side of things -

As much as I always could

Not quite so much now

Definitely not so much now

Not at all

2. I have looked forward with enjoyment to things -

As much as I ever did

Rather less than I used to

Definitely less than I used to

Hardly at all

3. I have blamed myself unnecessarily when things went wrong -

Yes, most of the time

Yes, some of the time

Not very often

No, never

4. I have been anxious or worried for no good reason -

No, not at all

Hardly ever

Yes, sometimes

Yes, very often

5. I have felt scared or panicky for no good reason -

Yes, quite a lot

Yes, sometimes

No, not much

No, not at all

6. Things have been getting on top of me -

Yes, most of the time I haven't been able to cope at all

Yes, sometimes I haven't been coping as well as usual

No, most of the time I have coped quite well

No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping -

Yes, most of the time

Yes, sometimes

Not very often

No, not at all

8. I have felt sad or miserable -

Yes, most of the time

Yes, quite often

Not very often

No, not at all

9. I have been so unhappy that I have been crying -

Yes, most of the time

Yes, quite often

Only occasionally

No, never

10. The thought of harming myself has occurred to me -

Yes, quite often

Sometimes

Hardly ever

Never