'Not suitable for psychotherapy' - How working class people get working class mental health care.

Some People

RITA ANN HIGGINS

Some people know what it’s like,

to be a called a cunt in front of their children
to be short for the rent
to be short for the light
to be short for school books
to wait in Community Welfare waiting-rooms full of smoke
to wait two years to have a tooth looked at
to wait another two years to have a tooth out (the same tooth)
to be half strangled by your varicose veins, but you’re
198th on the list
to talk into a banana on a jobsearch scheme
to talk into a banana in a jobsearch dream
to be out of work
to be out of money
to be out of fashion
to be out of friends
to be in for the Vincent de Paul man
to be in space for the milk man
(sorry, mammy isn’t in today she’s gone to Mars for the weekend)
to be in Puerto Rico this week for the blanket man
to be in Puerto Rico next week for the blanket man
to be dead for the coal man
(sorry, mammy passed away in her sleep, overdose of coal in the teapot)
to be in hospital unconscious for the rent man
(St Jude’s ward 4th floor)
to be second-hand
to be second-class
to be no class
to be looked down on
to be walked on
to be pissed on
to be shat on

and other people don’t.
'The moment when a feeling enters the body is political'
Adrienne Rich

From both these quotes, it may seem obvious to us that the material circumstances of someone’s life, and perhaps even more specifically the Class system, will inevitably effect someone’s mental state.
Here’s a quick review of some of the data and evidence available to support this conclusion.

The World Health Organization (WHO) has long made the connection between mental distress and social class clear. ‘Studies over the last 20 years indicate a close interaction between factors associated with poverty and mental ill health’. WHO, 2012

- Common mental disorders are about **twice as frequent among the poor** as among the rich.
- People experiencing **hunger** or **facing debts** are more likely to suffer from common mental disorders.
- Common mental disorders are also more prevalent for people living in **poor and over crowded housing**.
In relation to severe mental disorders, and schizophrenia specifically, data shows that:

- People with the lowest socio-economic status (SES) have **8 times more relative risk for schizophrenia** than those of the highest SES;

- Lack of employment drives people deeper into poverty and people are unable to pay for the treatment that they need. In other cases a great deal of money is spent on ineffective and inappropriate mental health care, so they fail to get better

- Supportive community networks help to protect against the adverse effects of illness and poverty. But for people with mental disorders, stigma and discrimination often led to social exclusion (WHO)

MIND – UK Mental Health Research and Campaign:

‘Research shows that disadvantaged communities in the UK have much higher rates of mental distress and suicide than less economically and socially disadvantaged communities. People living on incomes below the average wage are twice as likely to develop mental ill health as people on average and higher
incomes. Many people in debt receive treatment from their GPs for stress, anxiety and depression. Depression, anxiety and suicidal thoughts are part of the territory of debt and poverty’.

‘it is important that mental health services recognize that poverty engenders feelings of powerlessness and insecurity, and compounds stigma and discrimination in mental distress’. (Mental Health and Social Exclusion Unit)

It seems that the evidence-base for the link between mental distress and material circumstances is clear. So why is there so much resistance to recognizing this link in the mental health system? The dangerous result of the refusal to recognize the link, means that the people without financial resources receive inadequate, often ineffective, often physically harmful ‘mental health care’ that all too frequently infringes their human rights. And this relates more to the UK than elsewhere – and I will explain this further. How has this happened?

Some people know how it feels to be second class, no class, looked down on, shat on – other people don’t. But in the UK at least, the argument that exploitation, poverty and oppression lead to mental distress, has not been won.
In the UK, there has long been a political struggle over the aetiology and hence the necessary treatment for mental distress.
And the consequences of this for the millions of people in the UK mental health system, can be catastrophic, leaving many people unable to access the treatment they need, unable to recover, deteriorating as a result of inappropriate and invasive physical treatments, leaving them less able to function and often more likely to harm themselves.

In the UK NHS, as in many other countries in the world, a medical model of psychiatry has taken over the treatment of mental distress. This model posits that mental distress – across its range of forms from depression, so-called personality disorders, bipolar or manic depression, schizophrenia – are genetically inherited medical illnesses, caused by biochemical or brain dysfunction. Treatment therefore takes the form of medication, and other physical interventions including ECT and operations on the brain, so-called psychosurgery (modern versions of lobotomy).
As you may know, genetic theories are also now being applied to eating difficulties including anorexia, OCD and other anxiety disorders.

The alternative, talking treatments which directly address the person’s life experience, social context and social relationships, have become restricted to those who can pay for this privately. There remains a small part of the mental health system funded to provide talking treatment, but in the UK (as opposed to the US for example, which has more of a well established tradition of interpersonal psychotherapy) psychotherapy is dominated by a Kleinian model which insists that mental distress arises from innate, inborn difficulties. Kleinian theory, is a branch of psychoanalysis that believes people are born innately aggressive, envious, selfish and full of hate. Mental distress is therefore seen to arise from insufficient impulse control, a lack of being properly ‘civilized, where these aggressive instincts are curbed and sublimated. Additionally, this theory posits that many mentally distressed people are ‘not suitable for psychotherapy’ including people in states of severe distress – schizophrenic, bipolar, OCD, so-called ‘borderline’ states; or people who have English as a second language; or people with learning disabilities; or people who are not ‘psychologically
minded’ i.e. educated in a particular way. Hence psychotherapy becomes a treatment for the wealthy, worried well. The NHS does offer some so called talking treatments of ‘quick fix’ short term (6-12 weeks) emphasising behavioral treatments.

Kleinian theory, is built on the more conservative aspects of Freud’s theory, which could be seen to echo a Darwinian ‘survival of the fittest’ view of human nature as essentially violent, competitive, individualistic and biologically driven. In contrast, Marx – Freud’s immediate antecedent - presents a view of human nature as essentially co-operative and social, and explains how social forces and material reality shape human consciousness and behaviour, including mental distress and internal splits in the forms of alienation, anomie and false consciousness for example.

But in fact there was a more radical side to Freud. Freud also originally introduced the revolutionary idea that mental distress, including its most severe forms, arose directly out of experiences of trauma, loss and abuse in human relationships and that only a co-operative relationship, a talking cure, could therefore heal mental distress.
Another tradition in psychotherapy has grown from Freud’s more radical insights – what we call relational or attachment-based therapy. Building on the work of psychoanalysts such as Winnicott and Fairbairn, John Bowlby (working for the WHO in the wake of WW2) introduced a powerful new model of mental distress, which defined the basic human need as that of attachment to others, and a sense of belonging to the social world. As the impact of mass trauma, loss, dislocation, emigration, and evacuation of children, spread across Europe and other parts of the world, Bowlby argued for a new approach to mental distress which recognized that ‘we need each other’, as our most basic need, and that everyone in mental distress should be approached as a ‘fellow human being in trouble’ whose real life experience, as opposed to genetic determination, had led them to a place of mental pain and isolation which needed to be resolved via relationship, not medication.

Bowlby then went on to be ostracized and excluded from the established psychoanalytic and psychotherapeutic community in Britain. Today, it is still common for his work to be presented as reactionary and marginal.
A branch of psychotherapy as well as trends within social science and anthropology began to develop an understanding of trauma and social exclusion as lying behind mental distress, and consequently a need for social inclusion and relationship as the appropriate healing process for mental distress.

Rita Ann Higgins' poem, I think clearly outlines how someone who knows how it feels to be ‘second class,’ may come to experience mental distress, as a result of feeling worthless, stigmatized, shamed and excluded. This is an argument we are still having to win. Recently, work linking understandings from social anthropology on social exclusion and shame in small scale societies, and the internal experiences of shame based mental distress in larger scale societies, has helped shed light on how working class people experience exploitation, poverty, powerlessness as trauma, by which they are shamed and socially excluded, and which can then lead to mental distress.

The phenomenon of shame was traditionally connected to the discourse in the field of cultural anthropology from Pitt-Rivers onwards. Shame as a form of social cohesion and control, was seen to enforce ‘belonging’ and prevent transgression.
In psychology, the phenomenon of shame came into the spotlight through the appearance of some newly introduced concepts of relationship and trauma, and it is connected to severe forms of mental distress, the so-called shame based syndromes.

The recent literature suggest there is a connection between contemporary psychological concepts of shame in mental distress, and those traditionally used by ethnologists and anthropologists.

Oravecz et al in their paper ‘Social transition, exclusion, shame and humiliation’ argue that: ‘For example the expression, ‘shame on you’, produces the feelings of shame only if the ‘shamed’ person recognizes and accepts the authority of the shaming person. The threat of rejection and possible abandonment seems to be the source of the behavioural change that is caused by shaming’.

In small scale or authoritarian societies, shame can be induced more easily by external authorities, able to maintain control over human behaviour if: The behavioural norms are homogenous
The community is small
The different generations living in the same community don’t experience major social change.

In other settings, such as large scale societies, in order to maintain this control – that people ‘know their place’, whether they belong or are socially excluded – Oravecz et al argue that it is necessary to activate an internal authority. Therefore, shaming if often connected to the process of internalization of social experience, authority, and relationships. (i.e. in large scale, more diverse, more apparently democratic, hegemonous societies). Hence, shame becomes a form of mental distress, an internal psychological experience. Lisa’s earlier paper at this conference, emphasized this phenomenon on the council estate she lives in in Nottingham, St Ann’s ‘We know they look down on us, we’re shit’. The common usage of the recent term ‘CHAVs’ (Council House and Violent) has also illustrated the increasing shaming and contempt for working class people in Britain.

I want to pause here to just refer back to the title of my talk ‘How working class people get working class health care’ which you know comes from Paul Willis’s superb classic ‘How working class kids get working class jobs, because of the
importance Willis places on peer culture and belonging to the group. I mention it here, because this is a crucial factor in the maintenance of shame and mental distress in working class communities. Because the peer culture discourages the sharing of experiences of mental distress, ‘talking too much about feelings’, and can also encourage destructive ways of dealing with feelings of alienation or worthlessness – alcohol, drugs, gangs, dieting, violence – the peer culture itself can serve to maintain a mutual denial of mental pain and an avoidance of seeking the forms of help that could make a difference. (However, it is important to note that self-medicating of mental distress via alcohol, drugs and violence or –acting out-is common amongst all classes and should not be used to demonize the working class. However, considerable shame, stigma or contempt can be attached to going to therapy or counseling in most UK working class communities.

In their paper, Oravecz et al emphasise the importance of linking social exclusion and shame to trauma and mental distress:

‘The process of research into Central and Eastern European social transformation contributed to the realization of some important aspects of social traumatisation. For the
understanding of these aspects, concepts of social exclusion, humiliation and mental pain are very important, as the history of humiliation radically influences the social competency of individuals and groups, the generation of mental pain and consequently, the rise of destructive and self destructive behaviour’.

And if you reflect on this, it can help us to understand why we see so many people from exploited, oppressed, socially excluded groups in the psychiatric system and hospitals seen as being at risk to themselves and self destructive; or in prison seen as being a risk to others. (For example, the homicide rate in the affluent neighborhood, of Hyde Park is 3 per 100,000. In neighboring Washington Park where the residents are poor, it is 26 times higher.

An understanding of material life experience as lying behind mental distress, is a recognition that trauma rather than genetic or biological illness, is at the root of mental health problems. As has been explored above, poverty and social exclusion, are forms of trauma.
Judith Herman – a leading pioneer in the trauma field – defines ‘Disconnection, exclusion from the social world’ as being at the core of trauma. She says:

‘Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love and community. The damage to relational life is not a secondary effect of trauma, as originally thoughts. Traumatic events have primary effects not only on the psychological structures of the self but also on the systems of attachment and meaning that link individual and community’.

As a result, society, the community, is the key to recovery from mental distress:
‘Because traumatic events cause damage to relationships in the survivors social world, social relationships have the power to influence the eventual outcome of trauma. A supportive social response will mitigate the impact of events. Helplessness and isolation are the core experiences of psychological trauma. Empowerment and reconnection are the core experiences of recovery’
Herman argues that survivors on recovering through re-connecting in the relationship with their therapist, can come to recognize a social and political dimension to their personal tragedy and make it a basis for social action......‘Social action offers the survivor a source of power that draws upon her own initiative, energy and resourcefulness but that magnifies these qualities far beyond her own capacities. It offers her an alliance with others based on cooperation and shared purpose’.

And I have experienced in the women’s movement, just as we have seen recently in the Occupy movement, the number of people with MH problems drawn to these campaigns and social justice campaigns generally.

The Bowlby Centre, of which I am part, set up a project called ‘The Blues Project’ which offers twice weekly therapy, for 2 years at very low cost, to people whom would normally be unable to access psychotherapy. The feedback we have had from The Blues Project has been inspiring with many people telling us ‘you saved my life’ and the majority of people undergoing treatment with us (people originally labeled as bipolar, schizophrenic, personality disordered, at risk, dangerous, not suitable for psychotherapy) come out
rebuilding their lives without medication or psychiatric
treatment, ending their isolation and reconnecting with the
community. It has been a privilege to be part of this project.
So I wanted to finish with a vision from the radical tradition in
psychoanalysis:

This is Freud writing back in 1918:
‘It is possible to foresee that at some time or other the
conscience of society will awake and remind it that the poor
man should have just as much right to assistance for his mind
as he now has for the life-saving help offered by surgery, and
that the neuroses threaten public health no less than TB, and
can be left as little as the latter to the impotent care of
individual members of the community. When this happens,
institutions or out-patients clinics will be appointed, so that
men who would otherwise give way to drink, women who have
succumbed under the burden of privations, children for whom
there is no choice but running wild or neurosis, may be made
capable, by analysis, of resistance and of efficient work. Such
treatments will be free. It may be a long time before the State
comes to see these things as urgent. Present conditions may
delay its arrival even longer. Probably these institutions will be
first started by private charity. Sometime or other, however, it may come to this’. (1918)

So, alongside a community focus, to preserve our movements, our activists, and the spirit of opposition, we need to be able to provide effective treatment for mental distress, preferably free or if not at very low cost. We need to make that time soon.