MADNESS AND JUSTICE

Abstract

This paper makes the case for 'social justice' in relation to the conceptions of 'madness' that currently operate in mental health practice. The argument proceeds in eight steps which challenge dominant views of 'madness' in the discipline of psychology. Each of these eight steps is linked to the question of social justice. The first step concerns the irresolvable differences between 'models' of madness, with a focus here on four mainstream models; the psychiatric medical model, psychoanalytic conceptions of 'psychosis', systemic interventions into family systems and cognitive-behavioral therapy approaches. The second step concerns the differences internal to each of these models. In the third step I identify a fifth 'model' which is usually occluded in psychological debate, the model madness elaborates of itself. The paper then turns to the social conditions that structure different models of madness. Step four of the argument is to emphasize the way that models of madness are embedded in structures of power, and point five steps back to the historical separation of reason from unreason as condition of possibility for 'madness' as such to be configured as object of psychology. Step six is concerned with the 'madness' of contemporary social reality, and step seven with the way that this socially-structured madness informs clinical practice. The eighth step is to draw attention to already-existing alternative social practices; social justice in action organized by and for the mental health system user and survivor movements.

Keywords

Madness, Psychosis, Social Justice, Foucault, Marxism

Introduction: Difference between models of 'madness'

Different approaches to 'madness' sometimes lead to conflicts between academic psychologists, and between professionals involved in mental health services. The different ways of understanding it, which are sometimes configured in psychology textbooks as competing 'models' of madness, also sometimes lead to conflict between professionals and their clients, and even between those who are given a variety of diagnostic labels and accept or refuse to accept what they have been told about themselves. These conflicts are sometimes despite or perhaps because we do not really know what 'it' is.

This paper takes the term 'madness' as a shorthand to cover the variety of ways that academics, professionals and users of mental health services debate how mental health and distress should be understood, and it explores consequences of the *difference* of perspective for social justice. The term 'madness' is useful because it spans a number of different approaches, and for all of the problems of playing into stereotypical images of the 'mad' (which I address in the course of this paper), it is precisely because it is a colloquial term that it can function as a more inclusive and accessible reference point for debates that are connected with social action. The term 'psychosis', for example, which is favored as a/the term by many professionals today around which they can discuss the value of different treatment modalities already sounds to me, at least, a little more definite, sure of what we are getting at, and I don't think we can be so sure (Bentall, 2004). The term

'madness' is disturbing to some practitioners, and to some users of mental health services, but is claimed and even celebrated by others (Curtis et al., 2000).

My starting point is that a minimal point of agreement between researchers and practitioners within different 'models' is that there are huge differences between ways of understanding madness, between different approaches to, or 'models' of madness. That difference of approach is one reason why it is good to have multiple perspectives on it, but I am not so sure that practitioners of the medical model, cognitive-behavioral therapy (CBT), systemic approaches and psychoanalysis (to name four main approaches taken today) agree that their different perspectives are even perspectives on the same thing. Perhaps all that can be agreed upon as a first step is that there are big, perhaps irresolvable differences between the perspectives.

Those differences are grounded in the distinctive ontology and epistemology of our own particular favorite approach, and differences over ontology and epistemology have massive consequences for social policy, treatment and social justice. Ontology is about the nature of being itself, what we understand the things in the world to be, and here what we understand the human being, the human subject to be. Different ontologies carry fundamentally different notions of what human beings are. Epistemology refers to the nature of knowledge, how we think we can develop knowledge about those things that our ontology gives us a model for. Not only are there differences over the nature of things concerning 'madness', but over how we can come to know what they are, what the criteria for creating knowledge of them are .

It makes a big difference, for example, if we think that the nature of the human being as biological organism is the stuff we should be targeting, if that is our ontology, for then we will be developing our knowledge through drug trials. This particular process of knowledge production is an epistemology, a way of getting knowledge about what madness is as a chemical imbalance – deficit, excess, perhaps – that is entirely independent of what someone labeled mad thinks about it. The knowledge of the mad about who they are, their own expertise, is completely irrelevant to what academic or professional psychologists think they can know about the things in the world that matter to us if we are working in a medical model. A CBT perspective also rests on a particular view of the beings that matter to it, individual thinking beings albeit with some perceptual or mental processing faults that can be corrected. The procedures we use to understand what works and what does not work as education or training to help people manage their behavior are things we will come to understand through a certain kind of knowledge, knowledge of cognitive modeling and processes that are usually independent of what the practitioner thinks about them. The procedures work or they do not work, and they can be evaluated scientifically. It is a perspective which presupposes the nature of its object and the nature of knowledge about that object, ontology and epistemology (Loewenthal and House, 2010).

Briefly put, a systemic approach usually relies on ontology of structured relationships, and that is what matters to that approach. The knowledge it develops of those systems and how to intervene in them is the kind of epistemology in which the observer is part of the equation, part of the system, part of the knowledge. Finally, and with respect to the fourth of the approaches that will be considered in this paper, psychoanalysis rests on an ontology of a human subject divided, torn between what they desire and what they can get, between the unconscious and what they are directly aware of. That perspective means that the knowledge we could have of madness cannot be complete, but is infused with our

desire to know, to understand, and also, psychoanalysts would argue, suffused with our desire not to understand, not to know.

There are, of course, some links between these different approaches, and attempts to stitch over the differences between them. Those links are often what enable academics and practitioners with different perspectives to come together from time to time and try to map out some common ground. Some psychoanalysts, for example, are still very much tied to the medical model, while some are trying to make links with CBT. Some systemic practitioners look to psychoanalysis, to what they call the 'intra-psychic' as an account of what is going on inside individual members of social systems, and others link with cognitive-behavioral accounts of systems. But eventually we notice that there is a deadlock in these meetings of different approaches, a failure to agree.

The connection between the perspectives was where this paper could have begun, and that would have been a more ostensibly consensual and constructive place to start (Fozooni, 2010). The concern of psychologists who wish to bring a social justice dimension into their work is quite understandably often geared to what proponents of different approaches have in common as a starting point, and with how it might be possible to build an inclusive general approach in which we could all work. But social justice for the mad, for those who are described by psychologists of different kinds, requires a more abrasive approach. The *difference* between perspectives is where we have got to start and then we have to learn to live with that.

A consequence of this starting point is that social justice is predicated not on a harmonious shared vision of what problems in the world are, or how distress at the level of the individual should be understood and treated. Rather, we attend to conflict between academic and professional perspectives, and we work those differences in order to open up a space for those who are subject to psychology to speak about what is being done to them (Chamberlin, 1990). A premise of social justice from the standpoint of those who are speaking for themselves is that we do not require them to speak the same language as us as a condition for being heard, and that we acknowledge that there is no common language for describing 'madness' inside psychology. Psychology as such is internally contradictory, molded to different political-economic conditions, and recognition of this makes resistance to psychology possible in the form of 'critical psychology' and by allied approaches that would not choose to adopt that term because it too is internally contradictory (Parker, 2007).

Difference within the models of 'madness'

The second point I want to make intensifies this argument, takes it further, and is that there are big irreconcilable differences inside each of the models. This second step in the argument might seem to make things worse in some ways, and it does make things worse for the academics and practitioner psychologists. The fact that there are irreconcilable differences within each of the models is actually good for the rival approaches; advocates of one model can then sit back and watch their colleagues tear themselves apart without having to do the work themselves.

In the case of psychoanalysis, there are a multitude of perspectives, and very little agreement between adherents of different traditions attempting to comprehend and treat what is usually termed 'psychosis'. At a most basic level, again at the level of assumptions about ontology and epistemology, there is a huge gulf between the Kleinian psychoanalysts,

for example, who see ‘splitting’ and ‘projection’ as evidence that every human subject is a bit mad, has something psychotic as part of them (Young, 1994), and Lacanian psychoanalysts who argue that there is a specific clinical structure, ‘psychotic structure’ that makes this kind of subject quite different from a neurotic (Lacan, 1981/1993). Within the Lacanian camp there is a further division, between those who will argue that psychotics do not have an unconscious as such, and then this means that if there is no unconscious there is no subject (Fink, 1997). This position is in stark contrast with those who will say that this is still a subject who lives their relation to the unconscious as one of the ‘faces of the normal structure’, as Lacan (1961-1962, p. 11) puts it.

Inside the systemic tradition there have been big debates about what it means that someone in a family has been made into the ‘identified’ patient, the one who is ill, but who is made to carry the disorder of the family system as if it is inside them (Selvini-Palazzoli et al., 1980). And out of those debates, the narrative therapy approach would ask how it is that certain kinds of families are themselves treated as problems within wider sets of discourses (White, 1989). Here there is an opening to a fully social, discursive approach to what pathology is, how it is created, and who is made to carry the can for it (Parker, 1999). Then again you have a counter-trend that argues that still there is this narrative operating at a cognitive-behavioral level, inside the individual. There is then a connection with CBT, but that connection again itself begs the question about what CBT really is, and to what extent the practitioner reflexively uses the approach to include the impact of shared faulty thinking about the nature of ‘illness’ and health, or whether they do want to keep the treatment in the tracks of a journey from disorder to what is now called ‘recovery’ (Walsh et al., 2008).

Inside the medical tradition, what looks to be quite closed and certain from the outside, is a field of debate, of dispute. This dispute ranges from the underlying ground rules about how pathology should be categorized to disputes over what is happening inside those who are given treatment. Most psychiatrists working in the medical model, for example, use the American Psychiatric Association’s DSM – Diagnostic and Statistical Manual of Mental Disorders – as their bible, but this DSM has not only undergone revision after revision, changing the framework in which it operates, but it is based in one particular psychiatric tradition, that of German psychiatry.

The committee structure of the DSM teams that are drawing up edition number five is already evident in the tick-box approach used now, and this also makes it comfortable for some (not all) CBT practitioners, those kinds of psychologist who are now working in those committees. But even back in its origins, there was a conception of knowledge in the DSM, an epistemology, which specified that those involved should build their understanding of the categories (and who fits into them) by way of observation and accumulation of specific kinds of symptom (Spiegel, 2005). That approach within psychiatry is significantly different from the French tradition which works with a notion of ‘structure’ that is approached in a quite different way. A different notion of ontology, of the way that structure constitutes different kinds of being means that these medics bypass the immediate symptoms to grasp the underlying nature of the subject they meet in the clinic (Vanheule, 2012).

When we turn to the question of treatment, we notice an enormous shift in the conception of what is happening when someone is given medication. Up until the 1960s it was commonly understood among doctors, psychiatrists, that the drugs each had their own effects, that they changed the physiology of the person. This is a ‘drug-centered’ view of what happens (Healy, 2002). The impact of the pharmaceutical companies since the 1960s has changed the terms of description of what happens, has shifted psychiatric discourse so

that now the drugs are supposed to be targeting underlying disease states, correcting imbalances and so on. This is now a 'disease-centered' approach to distress that creates and reinforces an ontology of illness, of the 'illness' as what exists and what should be dealt with (Healy, 2004).

If we shift the discourse back to talk about what the altered states are that the drugs produce, then we are also led to make use of the accounts of those who experience them (Moncrieff, 2009). Otherwise, there is no need to listen to those accounts, they are beside the point. So, even within the medical approach, there is an argument about the democratizing of the approach, to open it to bring the expertise of those who are given the medication, to weigh up what the drugs do. Some adherents of these different approaches are quite flexible, some are trained in more than one model, and some manage the relation between the competing models, and the bickering inside them, well enough. But all too often there is a closing of ranks against outsiders, against those from other perspectives, which seals over the differences in it. But, to emphasize, as the second point, those differences are there *inside* the models, and they are irresolvable.

There are consequences for those attempting to promote a social justice agenda for those who are treated as 'outsiders' to these debates, those to whom the diagnostic labels are applied as if there is agreement between the professionals in mental health teams. Social justice for the mad does not presuppose that there should be a choice for one particular treatment modality over others, but that the diversity of perspectives should be made as transparent as possible (Cresswell & Spandler, 2009). The internal divisions among academic psychologists and practitioners should be seen as an opportunity for those who are usually silent in the debates to be able to participate openly. Only then do we have the possibility of making those who are given the labels partners in a dialogue with those who design the diagnostic systems. The 'critical psychiatry' movement that anticipated 'critical psychology' was a lesson in dispute among the professionals as a sign of health, of the possibilities of mental health for everyone else (Ingleby, 1981).

Differences between the models and 'madness' itself

I will bring in another model now, a fifth model. As I do this, it should be noticed that like each of the main models I have been talking about – CBT, systemic, psychoanalytic, medical – this 'model' is internally contradictory, and different experts in this fifth model will have different competing views. I am not so concerned with the nature of this model as such but with the differences between the mainstream models and it. 'It', the fifth model, is 'madness itself'. So, the third point I want to make is that it is necessary to treat madness as a *model of itself*, not only because that brings in the voice of those who are labeled into the mix of perspectives I am acknowledging here, but because it enables us to examine how the expert models relate to it. It is itself also a form of expertise. People are experts on their own lives, though they are not always treated as if they are, and it makes a difference if someone who is 'mad' can speak about it or not (Bates, 2006).

The problem is that when they speak about it, when they speak about their experience, they are too often heard from within the framework of a particular model, so everything they say is interpreted, reformulated and slotted into the way the practitioner sees the world, into a worldview, which is what a framework that specifies what ontology and epistemology we should take seriously is-- a worldview. That is usually the way that these different perspectives view madness, when they (the professionals) try to fix it in

place so they can cope with it. Madness cannot win in the face of these strategies. I am not suggesting that madness should win, or intending to romanticize madness and to treat this struggle as if it is a zero-sum game. That is not the issue here. The issue is how each perspective on madness does in practice try to win and the destructive effect of this attempt to win on social justice.

So, on the one hand, madness is characterized both as too disordered, unreasonable, out of control, and, at the same time it is characterized as too certain, excessively rigid, a caricature of reason. The different perspectives on madness are often difficult to grasp by practitioners working in other approaches precisely because of this mixture of flexibility and certainty. Each of the perspectives on madness appear to the other perspectives as quite peculiar, incomprehensible or, even at the same time, fixed in a rigid unassailable view of what madness is (Newnes et al., 1999, 2001). One might say that the 'psychotic discourse' that psychologists try to pin down is actually operating as a discourse that structures the debates among the professionals (Hook & Parker, 2002).

When people who are labeled as mad, 'diagnosed as psychotic' professionals might prefer to say, speak this mixture of flexibility and certainty is itself treated as a problem. For example, when a conference on 'hearing voices' was held in Manchester in 1995, we invited people to come and give papers on their theory of what it means to 'hear voices'. We let some psychiatrists and clinical psychologists and psychotherapists come and talk about their own pet theories. But most of the papers were from people talking about their own experience and their own mad theories about that, making use of telepathy, computer-models, Shamanism and so on (Parker et al., 1995). The conference ended with a huge row between supporters of different spiritualist churches. It was a good argument, more interesting than what you will hear in most academic and professional conferences. The point is that it was an argument which showed us competing models of madness, models as coherent and supple as the ones we read in the textbooks and journals. We learnt that madness has its own model of itself, and the other models find that difficult to come to terms with, but we must come to terms with it.

Social justice is only possible when the expertise of thosewho are theorized about begin to have their own voices heard in all their complexity and contradictoriness. The demand that the 'mad' should speak clearly and unequivocally as a condition for being heard is itself quite unreasonable. As with the dominant 'models' of madness, the internal contradictoriness of the mental health system user and survivor movement is a sign of their incompleteness, of the existence of conceptual and political debate, even of their humanity (Billig, 1987). Social justice requires that we do not set conditions for participation in mental health services that are unequal, that suppose that those who speak about their experience are consistent. Strands of oppositional 'discursive' psychology that are allied to critical psychology have helped us to take seriously what users of services have always insisted, that their strength lies in the diversity of perspectives they bring-- including a dialectically-worked diversity-- to each of the different positions they adopt (McLaughlin, 1996).

The different models of 'madness' need to be able to maintain themselves

The fourth point is about the role of power. Each of the models needs sources of power to legitimate their own worldview. It is not enough to have a good theory. To make the theory stick, to make enough people believe in it, especially when it is riddled with contradictions, especially when there are lots of other competing theories trying their best to do it down,

you need to be able to maintain it and defend it; the 'psy complex' here operates as an apparatus to enclose the identity of those concerned with mental health, and to divide these professionals from their objects of inquiry and treatment (Ingleby, 1985). This is not merely a question of polite debate. With respect to differences of opinion which are about what the world is and how we should understand it, about the nature of being and knowledge, the stakes of the debate are very high, including for professionals attempting to mark out a territory against outsiders and against those who seem to work with outsiders (House and Totton, 2011).

The debates resonate at the heart of our competing views of social order and what we want (and what we think other people should want). One only has to step into debates about psychiatry and so-called 'anti-psychiatry' to see that we are in one of those kind of debates with high stakes (Brown, 1981). And then you see that discourse should be thought of not as being like conversation but as like war (Foucault, 2006). For those of us inside our own garrisons, things can seem pretty civilized most of the time, and it is only when we have to do battle with the other models that things can turn nasty. Take, for example, the way the pharmaceutical industry sets the agenda for the development of different categories of mental disorder. Many specific categories are formulated not at all on the basis of what psychiatrists have observed, but what new drugs seem to be able to remove.

Once a drug 'works', the category it comes to define as if it is targeting an already existing disorder has to be lobbied for, it has to be marketed, doctors have to be persuaded to prescribe it, and critics have to be silenced. Millions of dollars are spent by the drug companies as part of this process, and they have succeeded in blocking appointments in universities of people who have argued against them (Healy, 2007). It is a debate conducted with a ruthless strategy like a war.

And if the medical model has its big battalions through sheer financial power, the other models have their own sources of support. Many CBT practitioners are unhappy at the way a cognitive-behavioral quick-fix approach to 'happiness' has been pushed by governments keen to get people off incapacity benefit for long enough to save money, but even so this State agenda has succeeded in giving CBT far more power than it had before (Layard, 2006).

If we turn to psychoanalysis, we know that its institutions have notoriously been adept at protecting their own privilege, using patronage of wealthy clients to support it when it has been under threat. It does not always work, but it has been crucial to the battle to protect the label 'psychoanalyst' in many countries, and then to exert control over what are seen as lesser therapies (Parker & Revelli, 2008). Systemic approaches have also had to maintain and defend themselves and built a following through networks, journals, and links with social work and welfare systems. (Of course, I should acknowledge that 'critical psychology' such as it is also has a little niche now in some academic institutions, and for me to make these arguments I need some kind of support and protection.)

In many countries where there is no system 'survivor' or 'user' movement, those who are labeled by the mainstream models have no voice, or it is a voice that is neutralized and absorbed by whatever system has been generous enough to humor it for its own purposes. In some places now this movement, through the hearing voices groups or asylum support groups does provide spaces, publications for the voices to have an impact, to join battle (Romme & Escher, 1993). There is some power now to these voices, but still pitifully little and hard-won and this movement still needs to be fought for to maintain its right to be heard.

The necessary next step for social justice therefore is for the mental health system user and survivor movement to develop its own collective forms of organization so that it can defend itself against attack, and so that it can defend individuals who are incarcerated and drugged (Fabris, 2011). This organizational dimension also then needs to address the way that forms of power that structure academic and professional practice can also be replicated, as a necessary result of the dominance of those forms of power, inside the user movement itself (Lakeman et al., 2007). The political struggle for social justice that responds to mainstream models of 'madness' also needs to be a political struggle inside the social justice movement so that it may reflect on its activity, allow all voices to be heard and renew itself in the face of new threats (Parker, forthcoming).

The notion of 'madness' itself had to be created and maintained

I want to move on to open up the question of institutional support and power that is given to different perspectives on madness, to my fifth point, because there is a much wider context to the disagreement between different specific models. There are attempts by each approach to set its own ground-rules for the debate, and often the dispute is about the ground-rules themselves. But above and beyond those particular squabbles there are general ground-rules set in place which frame what we think we know about madness (Pilgrim & Rogers, 1993). This frame is reiterated over and over again in the media so that the term 'psychotic', for example, is wrenched out of its specific clinical context and treated as equivalent to 'madness'. Then other words and phrases cluster around this popular representation of the mad so that it is associated not only with being unreasonable but with something dangerous. Headlines that tell us that someone who 'heard voices' was then violent repeat this connection so the readers are led to believe that voices automatically lead to violence, despite the fact that most killings and atrocities in the world are carried out by people who are, to all intents and purposes, quite sane (Blackman & Walkerdine, 2001).

The interconnection between the different professional institutions tends to back up popular representations rather than challenge them, and that is mainly because they want to make a claim on state resources or charitable support to do their work and they have to make the case that there is a serious problem. And there is a problem, but broad-brush ways of evoking it for an audience always play into those problematic popular representations. The 'conditions of possibility' – that is, the guiding assumptions that make it possible for us to have debates about how to understand and respond to psychosis – are themselves discursive and practical, and go well beyond what we have control over. We cannot get into the newsrooms and editorial teams that commission shock magazine features that misrepresent what we know about madness, to change those assumptions, those images. Still less can we get back to the historical conditions of possibility that set the terms of the relation between reason and unreason (Foucault, 2009).

We can see that in some other cultures there are more humane and tolerant approaches to distress. This is not to pretend that all is well in these other places, and that there is always wonderful liberal recognition of difference. But neither should we fall in line with the colonial export of psychiatry or the globalization from the West of other models of madness to pretend that there is a prevalence of schizophrenia of a certain percentage there because we have bought the story that there is such a prevalence of it here. Prevalence varies according to political-economic conditions, and the very way that 'madness' is conceptualized varies as well (Warner, 1994). What we can see from cross-

cultural psychiatry at least is that ways of marking the difference between reason and unreason take different forms in different places. That then makes our world a very dangerous place for those who come here, and who are distressed and who then describe what would be considered in their culture to be normal experiences (such as the hearing of voices) to a Western psychiatrist (Maher, 2012).

We are still living with the legacy of a system of what have been described by the historian and philosopher Michel Foucault (1977) as 'dividing practices' that separate those who can speak about experience, who are reasoning about it, from those who are on the other side of a discursive-practical barrier. And this means that you don't have to be in a locked ward of a hospital to have your account treated as evidence of your place on the other side of reason, outside it, as symptom of disease, as faulty reasoning, as the voice of an index patient or of psychotic structure.

This is why it is a necessary aspect of social justice in relation to 'madness' that the relation between what is usually specified as 'mad' positioned as the opposite of 'sane' is itself addressed. The 'deconstructionist' elements of critical psychology tended to assume an activist character precisely because deconstruction operates at the level of underlying conceptual assumptions which structure our place in the world, our subjectivity, and those conceptual assumptions necessarily connect with political questions about who has the right to speak in a social order and who is kept silent. The attempt to 'reconstruct' schizophrenia around psychological rather than psychiatric categories, for example, retained a rationalist and functionalist conception of 'madness', and it served to guarantee the position of a particular kind of professional, the psychologist (Bentall, 1990). An attention to the concealed 'voices' of those subject to psychiatric labels, in contrast, has assumed a 'deconstructive' character that discovers in the 'meanings' of madness a texture of experience that is not amenable to 'reconstruction'; instead, the process of historical excavation situates the meanings in the context of psychiatric power and resistance to it (Hornstein, 2012).

The 'madness' of contemporary social reality

Dividing practices ensure that only if the subject speaks in a certain kind of way about madness will they be assumed to be sane. My sixth point is that this supposed sanity locks us into something that is actually itself quite mad. I have intimated that the models of madness have something mad about them, just as mad as what they try to speak about. I should also say that this quite explicitly sets me against the main traditions in what is sometimes seen as the 'anti-psychiatry' tradition, by which I mean the work of Thomas Szasz (1961). He is seen as an anti-psychiatrist even though he vehemently argues that he is not, and he argues that 'anti-psychiatry' is a mirror-image of psychiatry and is effectively a form of psychiatry (Szasz, 2009). Actually, he is a nice example of a combination of flexibility and certainty that drives his critics up the wall because they cannot quite get a fix on what his position is. It is a bit clearer what he is against rather than what he is for. What Szasz's objection to psychiatric coercion does seem to rely on is a particular version of US American psychoanalytic ethics, the assumption that people should be treated as responsible reasonable subjects who can stand on their own two feet and demand their rights (Szasz, 1965). And this means that anyone who tries to do good for them or make them dependent is betraying that kind of subject. Again there is ontology at work here in this quite particular provincial version of psychoanalysis, an idea about what the human subject is, and an

epistemology, an idea about what our knowledge about that subject should look like (Parker, 2012).

But what kind of world is this illusion of independence, of the individual subject who must stand up for themselves, buying into? Well, the madness of the markets that is affecting most of us who are being made to pay for the economic crisis is the least of it. Even the idea that we should listen to what the markets say about the measures that are being taken to get us out of the crisis, which is surely as mad as listening to invisible voices, is at the lower end of the spectrum of what I am concerned with here.

We live in a form of reality that we must each assume to be true, as the only way to live, in order to survive. Each day we exchange tokens that we treat as having a certain fixed value, even though we know at some deeper level that they do not, and this money is one of a number of commodities that are themselves bought and sold. Our thoughts and feelings, fantasies and desires are reified, turned into things that are marketable, and what we imagine to be deepest about ourselves we also know can be repackaged and sold back to us (Mandel and Novack, 1970). The enclosure of natural resources at the beginning of capitalism that forced us to sell our labor power so that we would then have to buy back what was once ours, but in distorted reified form now, extends to the enclosure of emotion so that what we perform at work in the service sector becomes a kind of 'deep acting', emotional labor from which others will extract surplus value (Hochschild, 1983).

When Marx (1844) writes about alienation, he identifies four aspects, four ways that our subjectivity is distorted under capitalism. We are, first, alienated from our own creative labor, from our own sensuous engagement with material in the world as we make something of it. We are alienated from that creativity when we sell our labor power to others, and we know that what we are producing is owned by someone else, that they determine what we produce and how we produce it. We are, second, alienated from our relations to others as we compete to sell ourselves, to make ourselves subject to that first form of alienation where we lose what we produce at the very moment we produce it. And that competition requires suspicion and the sense that if the other gains then we lose.

We are, third, alienated from our own nature, from our own bodies, knowing that if we fail to take ourselves to the market-place and sell ourselves at a price lower than our competitors, then we will suffer, perhaps we will starve. And this turns our relation to our body into that of a subject inside a machine who must keep that machine working, and who becomes fearful of it breaking down. Fourth, we are alienated, Marx says, from nature itself, treating it as something to be mastered and exploited, as if it must be treated in much the same way as we have treated ourselves or sold ourselves for others to treat us. This again makes us anxious about nature that cannot be mastered, so we are divided from what we are actually part of and divided at a deeper level from ourselves (Kovel, 2007).

This social reality is mad. To refuse it is mad, but to accept it, which is the condition of being reasonable today, is itself a form of madness. This is the political-economic matrix of reality in which we either adapt or break down or, in some cases, become part of the caring professions to try and rather hopelessly patch things up. The promotion of 'happiness' tied to CBT in the UK is one example of this attempt to patch things up and make individuals take responsibility for their alienation (Layard, 2005). Justice here is for each individual one by one, and it occludes the social dimension (Pilgrim, 2008).

In contrast, those who have been concerned with social justice have shown that the incidence of distress is correlated with inequality, and they have been arguing for a shift of focus from individual 'happiness' to the conditions in which those who have resources relate

to those who do not (Wilkinson & Pickett, 2010). There is a vital connection here with the question of how 'social pain' is constituted at different moments in political economic conditions that suppress possibilities of social justice (Willoughby, 2012).

Shared social assumptions about 'madness' structure clinical practice

Contemporary globalised versions of reality are suffused with images of psychology (De Vos, 2012), and the images of the human subject as vulnerable then structures social work interventions and clinical practice, and even the activities of the social justice movements in the field of mental health (McLaughlin, 2011). This is the seventh point that I want to turn to now.

Szasz's image of the subject is one that other forms of psychoanalysis would be very unhappy with, those forms of psychoanalysis for whom, as Lacanians say, desire is desire of the Other (Vanheule, 2011). Szasz's image of the subject would be diametrically opposed by many systemic practitioners for whom the web of relationships is exactly what makes us human, and dependent on each other. It would jar with a good proportion of those working in the broad cognitive-behavioral tradition who have adopted that framework precisely because it values the collaborative reasoning that makes each individual choice have the weight it does.

And, apart from being stung by his vociferous denunciation of them as modern witch-doctors, even some medical tradition psychiatrists would object that there is a benign side to their discipline where they offer to the patient a kind of responsibility for managing their illness at the same time as they relieve the mad of the burden of being made absolutely morally responsible for what they do when they are under its influence.

Different approaches to madness each have their own very good reasons to be wary of Szasz's version of 'anti-psychiatry' because it seems to be an approach that throws people back to the wolves in the market-place, rather than doing something to help them. The problem is that our own practice is bound up with these wider macro-social issues I've been describing. In fact, those wider cultural and political-economic dividing practices and frames for madness are actually replicated in the micro-social world of the clinic and self-help groups.

CBT that is offered as part of State provision of mental health does risk-- as we have seen in the UK through the 'Increasing Access to Psychological Therapies' programme-- turning the reflexive work of puzzling through how choices are made into an instrumental and quite cynical agenda for moving people off benefits, forcing them into work they find difficult to cope with and exposing them to pressures that will eventually lead them back into the mental health system again (Ferguson, 2008). The economic pressures that are already hitting people in the economy are relayed down to them in a different kind of way by professionals subject to 'targets', administrative tick-box procedures and now cuts in services.

This then means that any sustained engagement with a family structure, let alone support that people might need in tackling community-organizational pressures – the kind of things that a systemic therapist might want to include in their frame of reference when they work with relatives and even with an extended system – is made really difficult. Instead the practitioner has to justify 'short-term' or 'brief' interventions which they hope will not merely put sticking plaster over the problem but which usually amount to little more than that.

In the case of psychoanalysis, provision in the public-sector is subject to the same pressures, including bending to demands to measure how much happier the client is after every session. For those psychoanalysts working 'independently' (as they like to put it), their private practice means that the worried well who can pay for treatment skews the whole of the practice toward catering to the self-indulgent and shunting off what is seen as the really serious pathology to the other practitioners or, worse, to the psychiatrists (in which case all the drug options start to look attractive to the hard-pressed professional). And for service-users, the alternative to complete recovery, in which case they may be left with no support at all, might be to turn themselves into entrepreneurs who become professional users, paid for telling their story again and again, and thus reinforcing an identity tied to the mental health system (Cresswell, 2005).

Conclusions: What is to be done?

Spaces to speak or work creatively away from what is now becoming a dominant therapeutic ideology are necessary for new approaches to develop. Those spaces include the work of the democratic psychiatry movement, which I think is different from 'anti-psychiatry'. It was inspired by the Italian reforms thirty years or so ago that closed the mental hospital in Trieste and set up cooperatives to help people get back into everyday life (Basaglia, 1987). Some activists from France visited and protested, scrawling on the walls that this approach had released the patients only to then put them into the chains of work (Ramon, 1988). Those alternative traditions operated with a different conception of labor (Holland, 2012). Where there is an approach, there is always a critique.

Now 'democratic psychiatry' is a phrase still alive in the work of *Asylum: Magazine of Democratic Psychiatry*, for example, and that ethos is alive in the Hearing Voices Network, the Paranoia Network, Intervoice, the Soteria House groups, Mindfreedom, Mad Pride and so on (McLaughlin, 2003). The more the merrier; this is where the voices in and against madness itself are flourishing, and these alternatives sustain people against the big battalions of medical psychiatry and the other smaller armies of bad professionals, including psychologists (Parker, forthcoming). You could say that one consequence of the argument that I've made is that we should acknowledge these issues and be reflexive in our work, whatever it is. That seems to be a little minimal and could leave things just as they are. Another consequence, a maximum demand, if you like, could be that you have to get together and collectively act now to overthrow capitalism, which seems overly ambitious (but really, to be honest, I think that is quite necessary).

The space between those two options has been worked by those in the user and survivor movement (Spandler, 2006). There was a serious attempt to avoid the worst of each of the two options. By that I mean that reflexive agonizing can be annoying and paralyzing, what smug professionals can sometimes already do quite well as an excuse for doing nothing. And some attempts to overthrow capitalism, and some of the States that pretended to be post-capitalist, have been quite authoritarian, and have had a very bad record on treatment of the mad. There is a danger, for example, that a 'Marxist' rebuttal of psychiatry simply takes the opportunity to instate another closed and fixed notion of reason and unreason that divides the mad from those who are permitted to speak (Robinson, 1997).

Social justice entails operating between those two options, working with those who are on different points of the dimension depending on their own political views, a way of

operating so that the possibility is opened for moving from a quite minimal respect for the experience of madness to tackling the conditions that make it so miserable.

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