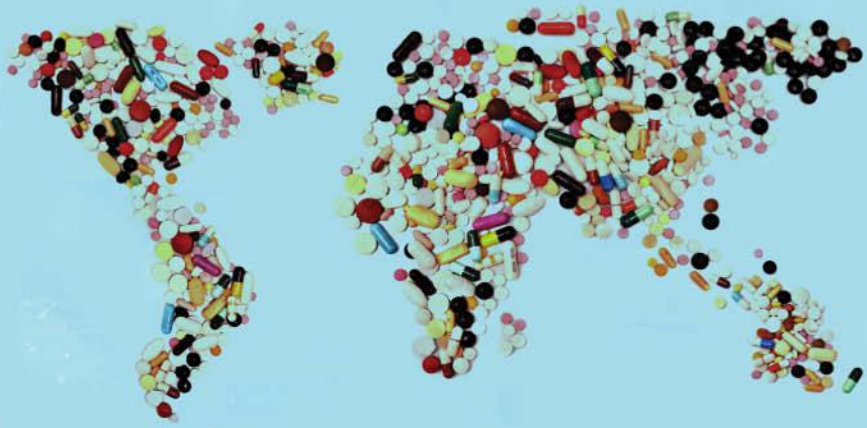
ROUTLEDGE

# DECOLONIZING GLOBAL MENTAL HEALTH

## The psychiatrization of the majority world



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CONCEPTS FOR CRITICAL PSYCHOLOGY | DISCIPLINARY BOUNDARIES RETHOUGHT

# 5 ‘Necessary evils’

## When torture is treatment and violence is normal

> A chapter on violence, on limit figures and emergencies, on psychiatric states of exception, and on violence that we see as normal, necessary, banal and bureaucratic, on violent ‘treatment’.

Throughout this book we have encountered violence in many forms: the brute and benevolent violence of development that acts with impunity, that ‘rescues’ (Chakrabarti and Dhar, 2009); the epistemological violence of biological reductionism (Shiva, 1990); the visual violence of the ‘look’ (Fanon,1967[1986]); and the ‘identity violence’ of colonial and psychiatric discourse (Hook, 2005a:480) – violent interpellations, where there is no ‘turn’. And this violence is situated against a wider backdrop of inter/national power imbalances and violence; chronic poverty, persistent malnutrition, war, natural disasters, the erosion of state welfare, employment that is precarious, disposeable and often dangerous, and the violent displacement of peoples (amongst many other forms of violence). We have also witnessed a further violence – how the distress produced by and embedded within multiple forms of violence is re-configured by psychiatry as an ‘illness’ located within the brain – for which there is a ‘treatment’ (and one that is often chemical). And Kleinman says:

> Turn now to the lives of people with mental illness in poor societies. Appalling, dreadful, inhumane—the worst of words pile on each other to name the horrors of being shunned, isolated, and deprived of the most basic of human rights. But this is not a crisis of the day; it has been the reality of people with mental illness for the four decades that I have been involved in global health and probably for centuries before that (Kleinman, 2009:603).

The quote above, and the picture of a young black girl chained to a tree on the front page of the article Grand Challenges in Global Mental Health that

calls to 'scale up' access to psychiatry globally (Collins et al., 2011), suggests that human rights violations of those who are distressed are more prevalent in the global South. When, in fact,

> Mental health service delivery has involved rights violations across the globe (e.g. use of seclusion, restraint, high dose medication) (Shukla et al., 2012:292).

For Rosenthal and Ahern (2012:13), throughout the world people with disabilities are subjected to mistreatment due to neglect and lack of care, but to compound this, for many, the 'pain and suffering is a direct consequence of treatment practices whose stated purpose is to provide treatment, care, or protection'. Here, '[r]ather than being recognized as torture or other cruel, inhuman or degrading treatment or punishment, these are compounded by remaining invisible or being justified' (Rosenthal and Ahern, 2012:3), often as 'essential' treatment. Many investigative reports into mental health care worldwide evoke a strange intertwining between treatment and torture,[1] often marked by the impunity enabled under the guise of 'treatment'.

The point of departure for this chapter, then, lies in mapping how certain tropes, the 'child-like', the 'chemically imbalanced brain', the 'poor country' and the 'emergency', function as limit figures that reconfigure normative recognition of violence, enabling sometimes harmful interventions to be understood as 'essential treatment' and called for increased access to, globally. This brings into focus some important questions for GMH: what is conceptualized as being in need of 'treatment', what counts as being 'treatment', and what kinds of equality are the MGMH calling for between people of the global South and North? This is important because the frameworks that configure recognition of violence also work to frame what can be understood as suffering, and those who can be seen to have been violated.

## Locked cells, cold floors, open drains

In a report from Mental Disability Rights International (MDRI) about psychiatric hospitals in Argentina, patients told the investigators that the staff beat and rape them; the 'mentally ill' are kept in

> dark, tiny isolation cells … no natural light or ventilation. They were so overheated that the nearly naked detainees were drenched in sweat. There were no toilets and the men had to urinate and defecate in small plastic jugs on the floor. The cells were filthy and infested with cockroaches (MDRI, 2007:v).

In some hospitals the average length of stay is 10 years, and many acknowledged that the majority of these people are 'social patients' – those whose continued hospitalization is due to socio-economic factors, lack of welfare and social support in the community, and not mental health issues (MDRI, 2007). And so, said the governor of the province of Buenos Aires (cited in the report), 'they're not crazy, they're poor and alone, which is a good way to make someone crazy' (MDRI, 2007:ii). Reports from a hospital in Accra, Ghana, found that people sometimes stay in asylums for decades, the cells are locked, the toilets (of which there are few) have no doors, many abandoned children stay in the asylum and are heavily medicated, the women are often naked with their heads shaved (MindFreedom Ghana et al., 2011), and many people sleep on bare floors and urinate into open canals in the floor (Selby, 2011). Human rights abuses in psychiatric hospitals in India are also sometimes exposed, as is evident in a report by the National Human Rights Commission of India (1999), cited by the WHO (2003b:23), which 'investigated the 37 public mental hospitals in India housing nearly 18 000 patients' and found 'gross human rights violations occurring in these institutions'.

The WHO Atlas Survey found that 65% of psychiatric beds globally are in mental hospitals 'where conditions are extremely unsatisfactory', and furthermore 'violations in psychiatric institutions are rife … many psychiatric institutions have inadequate, degrading and even harmful care and treatment practices' (WHO, 2003b:5). Often hospitals in South Asia become dumping grounds for 'chronic' patients, and are places where ECT and drugs come to be relied upon (Higginbotham and Marsella, 1988). During my fieldwork in India I was told many stories, sometimes whispered, 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; 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.

## Cage, camera, drugs; cages as treatment

> There was a relatively young man with severe mental retardation in the cage. We asked the staff how much time he spent in the cage. The answer was all day, except for half an hour when a staffer works with him. And I asked them, 'why do you keep this person in the cage?' And the answer was 'for his own protection'. (Gabor Gambos, cited in Robert F. Kennedy Center for Justice and Human Rights, 2000).

To be caged for your own 'protection' – the discourse of protection is a powerful mechanism here, invoking constructions of the distressed and

disabled as dangerous, and so it is both society and themselves that need protecting. But perhaps we shouldn't be surprised about the violence that occurs in the name of 'protection', for protection was one of the justifications for the 'unprecedented' violence of the colonial encounter (Hook, 2005a). Thus, caged beds continue to be used in many countries, such as the Czech Republic, where, according to the European Network of (Ex-)Users and Survivors of Psychiatry (ENUSP) (2012), they are seen as an 'acceptable "treatment" for psychiatric patients, who are often also heavily medicated, tied to beds and kept in solitary confinement'. In 2012, ENUSP reported a suicide of a woman in a caged bed, where despite the fact that there was a security camera above the cage, no one intervened. Another woman was found dead in a cage in a hospital in Prague – she had been caged continuously for two months; she died after choking on her own faeces. The Court of Appeal ruled 'that the hospital didn't owe the woman's mother an apology for her daughter's treatment' (ENUSP, 2012). ENUSP are not the only ones to be concerned about the sense of impunity that surrounds these violations, which occur despite the fact that the Czech Republic has ratified many UN human rights treaties.

This image, something I can't stop thinking about, marks the intertwining of the very different modes of surveillance at work within psychiatry, often simultaneously: the cage, the camera and the drugs. It is also a space where medication is strangely entangled with freedom. As Selby (2011) notes in her visit to a psychiatric hospital in Ghana,

> the medication is free, but the atmosphere and most parts of the environment don't look free enough, considering the situation of these inmates, the environment and atmosphere create a kind of cage, coupled with the lack of freedom for these inmates.

I want now to explore how this strange interrelating of treatment and torture is played out in debates about the use of direct-ECT in India.

## '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 paralyses the respiratory muscles, and so the person undergoing ECT is artificially ventilated during the procedure (Andrade et al., 2012).

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-harm and who was thus given 15 sessions of ECT (Chieco, 2009). The fact that the ECT reduced his self-harm was thus seen as a justification to develop this 'therapy' for use on more children with autism. But why is self-harm 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.[2] This is ECT without the use of an anaesthetic – widely practised in India (Agarwal et al., 1992) and in many parts of the world (see MRDI, 2005 for a report on the use of direct-ECT on children and adults in Turkey). 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) argues 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).

Alongside these 'violent, suicidal' and 'treatment unresponsive cases', literature justifies direct-ECT in India because anaesthetists aren't always available and anaesthetic raises the cost of ECT, meaning that direct-ECT is the most 'cost effective' form of psychiatric treatment (Andrade, 2002). 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 anaesthesia 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 (Center for Advocacy in Mental Health [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 legitimize and justify. As the Center for Advocacy in Mental Health, at the Bapu Trust in India, points 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).

Like the 'mentally ill', 'the poor are also assumed to be "underdeveloped" and – momentarily at least –deprived of their capacity to define their own interests' (Rahnema, 1992:163). This enforces a dependency on

outside expertise – the multi-lateral agencies and Goverments that reach a consensus 'on the diagnosis of the disease (underdevelopment and lack of income), as well as its cure (economic and technological development)' (Rahnema, 1992:162). Yet, like the 'treatments' of psychiatric technology, the technocratic and economic problematization of poverty is disembedded from local lived realities and made up of 'dead data of an alien, often ideologically biased, knowledge system' (Rahnema, 1992:171), that further strip the poor from tapping into a pluralism of locally available resources.

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' (Delhi Psychiatric Society, 2002:8). Drawing on a citational matrix of Western (particularly Euro-North 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.


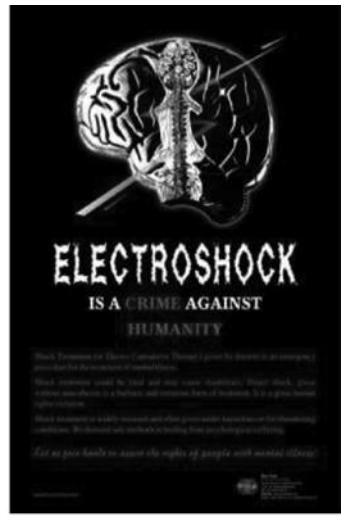


*Figure 5.1* Posters from Bapu Trust's campaign against direct-ECT (see http://www.bapucamhindia.org/) reproduced here with their kind permission.

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 (2001, 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, direct-ECT could be read, as it is within Bapu Trust's campaign to abolish it in India, as a 'crime against humanity'.

Here it would seem that the evocation of the 'poor country', and that of the 'violent', 'suicidal' and 'treatment unresponsive' individual, work alongside each other to change our normative recognition of violence, and to legitimize 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). Here the construction of 'violent' and 'irrational' individuals work as powerful devices in changing direct-ECT from a method of torture into what the Delhi Psychiatric Society justifies 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 in 2007 on the 'Myths and facts of Electro Convulsive Therapy (ECT) or shock treatment in psychiatric care'. 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 and MindFreedom, 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 summarize here).[3]

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 and MindFreedom, 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 and MindFreedom, 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 and MindFreedom, 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, directed by Dr Macheswalla, 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 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). 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 four 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.

## When harm becomes 'essential'

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).

In fact, far from reacting with horror, '3.5 million children in [North] America take stimulants for ADHD' (Whitaker, 2010:220), and many proponents of GMH argue that '[a] crucial aspect of access to effective treatment for AD/HD is access to the psychostimulants and other pharmacological agents' (Flisher et al., 2010:1 and 5). This is despite that fact that no research on stimulants, the drugs most commonly prescribed to children, has been able to demonstrate long-term gain for children (Timimi, 2005; Breggin, 2001). Furthermore, Timimi (2002) points out that stimulants are highly addictive and research into the long-term effects of stimulant use in children has found; suppressed growth, tics, sudden cardiac death, dullness, anxiety, and psychosis (Breggin, 2001, 2008). These issues also haunt the use of anti-depressants, with Jureidini et al. (2004:882) stating that 'recommending [any antidepressant] as a treatment option, let alone as first line treatment, would be inappropriate'. Yet despite the harm caused by many psychotropic drugs (documented in Chapter 1), the World Health Report (WHO, 2001a:xii) states that

> 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 the 'situations' where professionals and psychosocial interventions may be unavailable are often in the global South, and so, because these

countries are constructed as resource poor, the use of psychotropic drugs as first-line treatment is justified. Here, drugs that have been found to have brain-disabling effects, and thus to increase disability, are re-framed as 'essential' treatment to reduce disability and included on the WHO's Model Lists of Essential Medicines (WHO, 2011a, 2011b) for both children and adults. And while psycho-stimulants, such as methylphenidate, are not yet included as 'essential' in this list, some proponents of GMH state that 'the inclusion of methylphenidate [Ritalin] in national and transnational lists of essential drugs is crucial' (Flisher et al., 2010:5).

Is there something about the label of 'mental illness', then, that changes our affective responses to distress, framing when we will and will not feel horror, and enabling powerful and potentially harmful interventions to be constructed as 'essential treatment'? There seems to be another trope at work alongside the 'poor country' to reconfigure human rights, and to re-articulate potentially violent interventions as 'treatment' and harmful medications as 'essential' – the figure of the 'mentally ill child', and the child-like.

## The child-like – infantilizing the global South

In colonial constructions of non-Europeans (and women more generally), the trope of irrationality and dangerousness, as well as that of the child-like, were key mobilizations, 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).

Here 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'. Thus, while individual children with a label of mental health problems may operate as limit figures within UK law, preventing children from being able to refuse psychiatric treatment (Mills, 2012), it is also worth noting how the trope of the 'child-like' may more generally function to justify governance through a discourse of protection and 'best interests'.

Burman (1994) explores how the image of the 'needy' child (mobilized within much charity fundraising) not only works through being generalized

to all children of the global South but comes to stand as an idiom of 'need' for the whole of the global South – the infantilization 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). This can lead to a double bind for children of the global South, who are not only represented and conceptualized 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'. Here psychiatrization, adultism, sanism, and racism intertwine not in a sum where one is added to the other, but in a knot.

Here, there is seemingly a 'subsidiary homology between childhood and the state of being colonized' (Nandy, 1983:11), and it is this 'colonial conflation of the colonized with the figure of the child' that, for Nieuwenhuys (2009:149), needs to be interrogated to enable a deconstruction of 'childhood as a metaphor for institutionalized violence visited upon humanity in the name of progress'. In this way, the trope of the 'child-like' functions to reframe psychiatric violence – to construct it as normal, necessary and legitimate (Dhar, 2004), a pre-emptive violence (Weizman, 2011) that enables proponents of GMH to justify scaling up access to powerful psychiatric drugs to young children (see Collins et al., 2011; Flisher et al., 2010:2).

And while the child acts as a trope through which the global South is understood, 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). Here India comes to represent the figure of madness, the figure in need of 'treating'.

## 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-Kline] exhort doctors to detect and treat depression on the basis that treatment will reduce risks of suicide', when in fact, it increases the risk of suicide (Healy, 2006:23). 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 a 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).

It is in these banal clinical, yet always political calculations of what counts 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 (Arendt, 1963[2006]). Here a statistical, 'normalized, everyday, "rational" and bureaucratized violence' (Burman, 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).

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 (2005a: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 chapter.

In fact, the very reason for this unprecedented violence may be because the colonized were constructed as irrational, and thus not seen to share the same humanity as the colonizers. Here, where proportionality is seen as a rational tool for calculating the necessary collateral damage of war, violence against the irrational comes from within a different economy, where disproportionate power is wielded and justified (Weizman, 2011). This is both a violence that is rendered 'normal' and a violence that is apparent within techniques of normalization.

## 'Outside' rights

So far we have encountered how the 'chemically imbalanced' brain, the child-like, the violent and dangerous, the poor country and the irrational function as limit figures that change normative recognition of violence, that enable violent and potentially disabling interventions to be reconfigured as 'essential treatment' and, in the construction of the brain as universal, provide the grounds for this 'treatment' to travel globally.

But Carr (quoted above) points to another construction of colonized peoples, not only as 'child-like' but also as 'outside society' (1985:50). For Spandler and Calton (2009), psychiatry works to depoliticize distress (specifically experiences such as self-harm and hearing voices) in a similar way, through conceptualizing these experiences as being explicitly *outside* the

realm of human experience and thus outside the parameters of human rights. Here labels of 'irrationality' and 'violence', along with hearing voices and self-harm, 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 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 certain experiences as 'irrational', as 'mental illness', as outside the realm of 'normal' childhood experiences and thus outside the parameters of child rights. As Schrag and Divoky (1981:36) note, 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'.

Thus, as psychiatric treatments and concepts of childhood are globalized 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 'treated' by others in their 'best interests', with or without their consent.

While we may well resist descriptions and prescriptions of a fictitious 'normal' child, made up from statistics that strip children from their contexts (Burman, 2008:176), what happens when the 'treatments' issued to restore this (fictional) normality actually cause children's brains to function in a manner that is 'qualitatively as well as quantitatively different from the normal state' (Hyman and Nestler, 1996:161)? Here, then, the location of children's distress within their so-called chemically imbalanced brain not only denies the potentially personal or social meaningfulness of distress, but also denies the potential psychiatric and psychotropic causes of distress.

In this way, psychiatrized children and adults are subjected to 'treatment' that outside of this psychiatric 'state of exception' would be constituted as legal battery and child abuse (Spandler and Calton, 2009; Agamben, 2005). Here people with mental health problems seem to operate as a limit case to universalist claims of human rights discourse, exposing the limitations of rights-based conceptions that employ 'modalities of exception' (Parr, 2008:175). This seems to be at work for children within UK case law, where unlike with other medical treatment for children, children's refusals of psychiatric interventions are often framed as 'irrational' and as 'part of their illness', and are overridden (Mills, 2012). For some, 'universal' human rights claims – embedded in a narrative from the global North, that prioritises individual rights and overlooks global power imbalances, themselves constitute a continued form of colonialism (Santos, 2008). Furthermore, as

disability, including psychosocial disability (mental distress), enters human rights discourse (for example, through the UNCRPD) and becomes embedded in the language of international bodies, it may marginalize other languages of rights, such as those conceptualized through collective forms of overtly emancipatory struggle (Meekosha and Soldatic, 2011).

## Violent rights

The mobilization of human rights discourse has been central in GMH's calls for more 'humane' conditions in psychiatric facilities in the global South, for example, in making illegal the chaining of people with mental health problems in many countries. 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 stigmatization of such people, despite claims that 'within-brain' explanations reduce stigma. Read et al. (2006:313) found that biological explanations imply that those who experience distress are less human, 'almost another species'; strengthen the stereotype that they are dangerous and unpredictable; lead to desire within the general public for social distance; and provoke harsher treatment from others, in comparison to an explanation that emphasizes the psychological or the social, such as distress as a response to trauma. Angermeyer and Matschinger (2005) also found that stigma increases if causes are attributed to brain disease rather than being psychological, and Waxler (1974) found that psychiatric stigma is almost absent in communities where 'mental illness' is understood as spirit possession.

Similarly, Fernando (2010:39) points to the stigmatizing assumption that schizophrenia 'is a medical condition … associated with dangerousness … and, more than anything else, 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, interventions that are 'outside' human rights. If biochemical explanations of 'mental illness' produce increased stigma, this has strong implications for GMH advocacy which seeks to globalize biochemcial understandings through promoting mental health literacy.

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

> 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. … 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:ix–x).

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 mobilizations 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 from communities who see them as being alien.

## 'Failure of humanity'/Common humanity

The 'renewed agenda for GMH' states that:

> 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., 2011b:1441).

Having seen the violent treatment of many people with mental health problems, worldwide, it is hard to disagree with the idea that within mental healthcare there has been a 'failure of humanity'. However, this book has provided a range of different lenses 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, 2001) 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. In fact, humanitarian 'emergencies', such as after the 2004

earthquake in the Indian Ocean and subsequent Tsunami, may themselves function to enable psychiatric (and often violent) interventions to be exported to countries of the global South (as documented in Watters, 2010).

Furthermore, a 'failure of humanity' can be read differently alongside the appeal made by colonialism to a common humanity, a universal man in the colonizer's image that homogenizes and hierarchizes. Here the 'failure of humanity' may be that particular conceptions of 'humanity' (who counts as human, and who decides) work to encounter difference and disavow it, meaning it is the boundaries of this 'humanity' that seem to fail – which is, for Fanon, to be 'drowned' in the universal (1967[1986]:186).

It seems, therefore, 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 constituting 'unsound mind', GMH 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.

## They pounce, they bash

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). Interestingly, practices such as chaining and beating that sometimes take place at traditional healing sites are often justified by those who work at such sites through 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 Indian healing site), 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 mobilized 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 a mental health NGO in India:

> 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'.[4]

Here it seems that the 'violent' individual/patient works to justify both psychiatric and traditional healing interventions that could both be read as violent. While the WHO recognizes the violence enacted in the name of treatment, 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, and so leading to community care as the 'solution'. 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 makes 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).

Here it does not seem to be psychiatric practices more generally that are being recognized as potentially violent, it is the site of intervention that needs to be moved from large institutions to the community, with psychiatry still remaining the 'solution'. 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).

In those countries where community mental health 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). For Fabris (2011), Community Treatment Orders in Canada enact a bio-incarceration – a 'tranquil prison'. 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 (Cremin, 2007).

While the WHO Regional Office for South-East Asia (2008) promotes the development of community-based treatments that are culturally

appropriate, how this is to be achieved is left unspecified. Fernando and Weerackody (2009:196) point out that

> Developing mental health services in South Asia or other non-western settings is not a simple matter of transferring established strategies and systems commonly used in high-income countries of the west.

And yet, in the WHO South-East Asia document, there are 'signs of the uncritical acceptance of the dominance of biological and pharmaceutical approaches to mental health', evident in the fact that 'the only therapies mentioned as "essential" are "medications" (that is, drugs from pharmaceutical companies' (Fernando and Weerackody, 2009:197). These are the very pills that for Jain and Jadhav (2009) 'swallow' community mental health policy in India, causing multifaceted programmes to become narrowly medication focused. While there is not space here to develop this discussion, 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 community mental health care before it is 'scaled up' to countries of the global South.

## Violence with a civilizing mission

This chapter has traced how the interrelating tropes of the 'irrational' biochemically imbalanced brain, the 'poor country', the 'child-like' and the 'violent patient' operate as limit figures that reconfigure recognition not only of what counts as violence and of what constitutes 'treatment', but of when violent treatment is 'necessary' or 'essential'. In fact, if ECT is constructed as 'necessary' and 'life-saving', as *reducing* violence, then we are prevented from seeing it as violent at all, and are thus unable to recognize those who undergo it as being violated. It seems many violent acts are perpetrated with impunity because they are couched in the language of 'treatment', working 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). The system may also work to obstruct the victims from being seen as, 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'.

However, with the Convention on the Rights of Persons with Disabilities (CRPD) there is 'growing recognition that pain inflicted in the name of treatment may violate international law' or be a form of torture (Rosenthal

and Ahern, 2012:13). There has been widespread international adoption and ratification of the CRPD, and while many countries that have ratified it still use psychiatric 'treatment', such as cage beds, some change can be glimpsed when we look within the legal system. Prior to the adoption of the CRPD, the European Court of Human Rights (ECtHR) 'was often very deferential to medical justifications for treatment', as is evident in the case of *Herzcegfalvy v. Austria* (1993) where the Court ruled that long-term detention of a man in restraints was not in violation of the European Convention because it constituted a 'medical necessity' (Rosenthal and Ahern, 2012:13). However, more recently such 'treatment' has been recognized as being inhuman or degrading, though it is still not recognized as being torture, and according to Rosenthal and Ahern (2012) the ECtHR remains deferential to any practices constructed as therapeutic. However, it seems central that this strange interlacing of treatment and torture is interrogated, where torture occurs not only in the name of treatment but is justified as an essential necessity to the extent that it is no longer recognized as being torture. As Manfred Nowak stated in 2008, as the United Nations Special Rapporteur on Torture,

> By reframing violence and abuse perpetrated against persons with disabilities as torture or a form of ill-treatment, victims and advocates can be afforded stronger legal protection and redress for violations of human rights (Nowak, 2008).

This means they can also be recognized as being victims of violence in the first place, and thus may work as a platform for human rights and political mobilization. The current campaign for Truth and Reconciliation in Psychiatry is an example of how such mobilization can be used to raise awareness about institutional, often state-sanctioned, violations tolerated or seen as normal, involving acknowledging psychiatry's 'continuing role in human rights violations' (Wallcraft and Shulkes, 2012:13).

Importantly, protections against torture (such as within the CRPD) are absolute, they allow for no exceptions (Rosenthal and Ahern, 2012:14). Thus the CRPD states that a person's liberty cannot be deprived on the basis of a psychiatric diagnosis as this is contrary to international human rights law, and this extends to when the discourse of 'best interests' is used as a justification for psychiatric force (Wallcraft and Shulkes, 2012:14). This is central in a space where constructions of the irrational violent patient and the psychiatric emergency are mobilized to invoke a psychiatric state of exception where violence becomes 'treatment', and where that 'treatment' becomes 'essential'.

## Weapons of treatment

Drawing similarities with Weizman's (2010) exploration of justifications for military attacks, psychiatry's use of ECT (both direct and modified) is 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, a violence invoked against those deemed irrational (the colonized, the 'mentally ill'), and so a violence that does not play by the rules, a disproportionate violence (Weizman, 2011). 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 manoeuvres 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?

And so, now, we are in a strange place, where chains and cages are violent, and yet the medication that replaces them seems also to act like chains. This is a place where violent treatment is not just a 'necessary evil', it is 'essential'. How do we, or what should we, feel in this strange space? Why do we, as Healy (2010) asked earlier, feel horror about recreational drugs being given to children but not psychiatric drugs? Why does the administering of electric shocks to a political prisoner constitute torture, while for a psychiatric patient it is a form of 'treatment' (Frank, 2001)? Under what conditions do we or do we not react with horror?

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 conceptualized as being 'suffering'. Thus, a photo of a child in chains (Collins et al., 2011) and the burnt bodies of those chained in Erwadi evoke a reaction of horror and so are recognized as suffering, while the potential bio-incarceration enabled through psychotropic medications

(Fabris, 2011) becomes harder to see. And so, here, how we see violence interlaces with psychiatric mechanisms of looking and seeing, and with the potential resistance in remaining unseen, invisible.

This enables us to turn to one of the key reasons for employing a (post) colonial discourse analysis of GMH; to enable 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.

## Notes

1 See MDRI's website for a list of resources: www.disabilityrightsintl.org/.
2 The petition also called for changes in the use of physical restraint and single isolation cells in State Mental Hospitals.
3 See MindFreedom website: http://www.mindfreedom.org/kb/mental-health-abuse/electroshock/pune-india.
4 Quote from a participant at a workshop I facilitated at an NGO in South India on 30 April 2011.