THE POLITICS OF MENTAL HEALTH BETWEEN COLONIALITY AND HUMAN RIGHTS. A PERSONAL JOURNEY

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1. Operating in the Heart of Darkness

The journey, understood as moving through boundaries, presence in between, intellectual, spiritual and existential transition, has characterized my intellectual, formative and academic path for the last 20 years: poised between science and art, nature and culture, between care and suffering, ease (understood in its ecological and multifaceted forms of well-being) and dis-ease (idiomatic expression of deprivation of subjective well-being), between love and death, between the desire for justice and the deprivation of fundamental human rights.

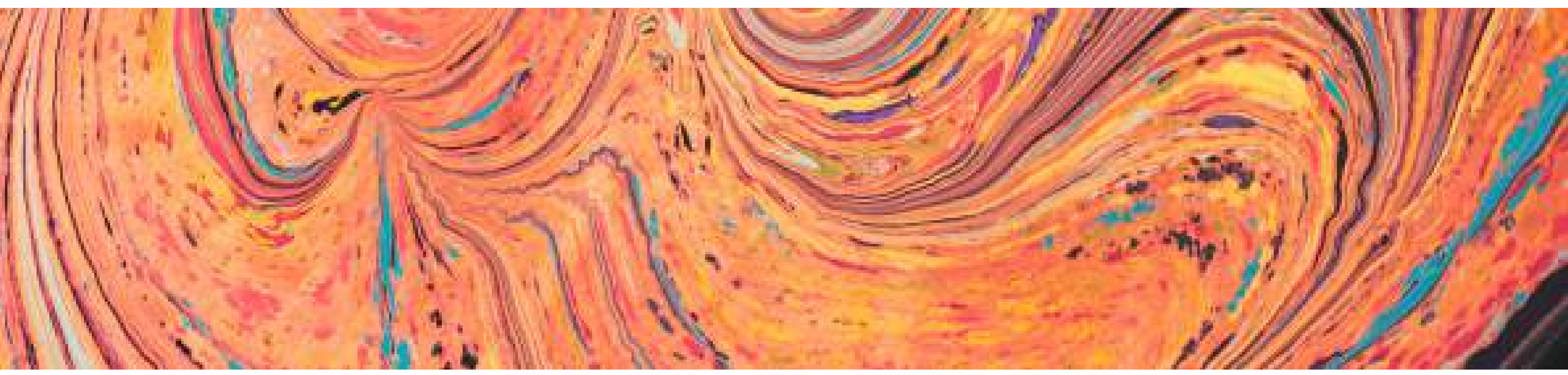
The object of knowledge I have been confronted with since the early days of my academic life has been mental health, as a clinical psychologist in transition - and perhaps still in between psychobiological, cultural, and socio-constructivist models. During this personal journey, often perilous and full of uncertainty, the need arose to identify Northern Lights, anchor points, fathers and theoretical friends who would accompany me in the troubled waters of knowledge, making me a resilient and resistant scholar.

To sum up, there were many fellow travellers.
They continue to be, in fact, those stars of the North that allow nomadic and transhumant thoughts, to maintain direction, and not to get lost in the night of a single narrative and lose the differences in the monological dictatorship of the empirically supported.

In the most recent phase of my journey, I have more clearly outlined a possible goal; perhaps even more a mirage than anything else, the goal that can restore meaning to my life as a researcher and to the scientific work of the last two decades: the search for social justice and the salutogenic (Antonowsky, 1979) redemption, over the oppressors, of the oppressed, of colonized bodies and minds.

The very painful focal point that I have been confronted with (and still am) is the awareness that my training as a clinical psychologist lies at the intersection of having been raised in a Western academic context in the global North, of being a male and white psychologist and therapist. In summary, I found myself maturing intellectually, scientifically, professionally, and humanly on the side of the oppressor. The double realization that civilization and colonization are two sides of the same coin. Borrowing Joseph Conrad's words and translating them, I found myself, unintentionally, operating in the heart of darkness.

Once again, it is my theoretical fathers and friends who come up to help, to populate the stage of the scientific theatre of which I am an actor/figurant, to provide those conceptual tools and those keys of reading, the backpack, which accompanied me and will continue to accompany me on the complex journey in search of meaning in the deeper Brunerian sense (Bruner, 1990).



The first of them is the Italian thinker and psychiatrist Franco Basaglia (1965) and his irreducible desire for the re-humanization of the psychiatric discipline, that of the correctional world of Michelle Michel Foucault (1961). The one who stood against the society of control, of that resocializing control that looks at the psychiatric patient as a body to be dominated, subjugated and isolated within the narrow de-territorialized walls of correctional psychiatry and asylum.

Basaglia (1965) questioned the essentialist and sacrificial discourse of the asylum institution. The need (essentiality) to isolate, for their own safety and that of their social body, the person who is mentally ill.

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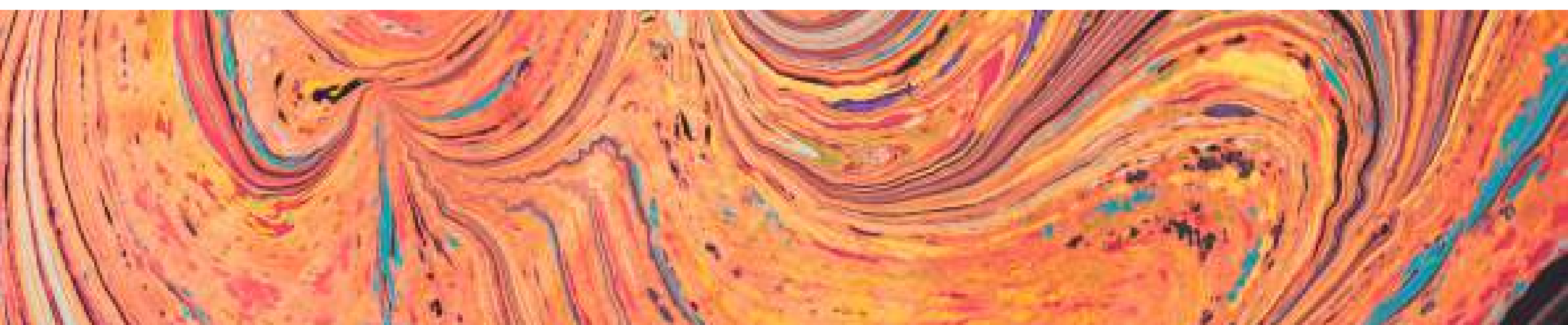
Whether dangerous for themselves or for others, or uncontrollable and intolerable to the community to which they belong, the essentiality of the contention goes hand in hand with the need to sacrifice the dignity of the 'lunatic' and the 'mentally ill'. Thus, they are reduced to captivity, dehumanized, and exposed to exploitation of basic rights so as not to dismay the equilibrium of the patriarchal status quo.

Basaglia (1965, p.1) says, “From the moment they cross the wall of internment, the sick person enters a new dimension of emotional emptiness [...]; they are entered in a space that, originally born to make them harmless and at the same time cure them, appears in practice as a place paradoxically built for the complete annihilation of its individuality, as a place of its total objectification.” If the mental illness is, at its very origin, loss of individuality, freedom, in the asylum the patient finds nothing but the place where they will be definitively lost, made the object of the disease and of the rhythm of internment. The absence of every project, the loss of the future, being constantly at the mercy of others without the slightest personal push, having punctuated and organized their day on times dictated only by organizational needs that – precisely as such – cannot take into account the individual and the particular circumstances of each one: this is the institutionalizing scheme on which the life of asylum is articulated.

The second theoretical friend who accompanies me in search of meaning is the radical postcolonial psychiatrist Frantz Fanon (1952). Fanon moves beyond Basaglian anti-psychiatric thinking and clearly defines the lines of demarcation and confrontation between two human species in opposition: oppressed and oppressors. The White psychiatric discipline is thought as a colonial technology in the service of power that takes possession of Indigenous geographical and mental territories to prey on and dominate them, to expropriate, through cultural, physical, and psychological genocide, that wealth to be exported to Western countries. The divide between global North and South, in Fanon’s thought, is not only of an economic and territorial nature, but also psycho-emotional. The global North operates and goes for the economic, political, emotional, and cultural domination of the global South, creating material and psychological subjugation also through the sophisticated technologies of psychiatry:



“the negro, having been rendered inferior, moves from a sense of humiliating insecurity through a strong self-charge that leads them to despair. The attitude of black man towards white, or towards their race, often almost completely duplicates the constellation delirium, often bordering the region in the pathological” (Fanon, 1952, en. ed. 2008, 44).

Finally, to accompany my nights on the journey, the Pedagogy of the Oppressed by Paulo Freire and the urgency of a self-awareness of the oppressed that can lead the damned of the earth (Fanon, 1963, ed. ing., 2007) in the fight against that economic, political, and psycho-emotional subjection to the colonizer. Such a subjection forces the victim to self-devalue and surrender to the oppressor, as well as to the social reproduction of inequalities and colonial, political violence.

Only when the oppressed clearly discover the oppressor and engage in the organized struggle for their liberation, do they also begin to believe in themselves, thus overcoming their 'connivance' with the oppressive regime. This discovery cannot be made on a purely intellectual level, but on an action level; however, it seems essential to us that action should not be limited to pure activism but should be combined with a serious commitment to reflection, in order to become practice (Freire, 1971 p. 51-52).

In my very personal intellectual journey, the despaired radicalism of the Fanonian matrix had to laboriously coexist and find a synthesis with Freire's pedagogy in action, making conflict, the clash - even violent - between contrasting and irreconcilable species a liberating pedagogical and psychological tool. It is the psychology of the liberation (Montero, 2009) of Indigenous South American communities, elaborated and promoted by the Spanish Jesuit priest Martìn-Barò (1983), murdered in San Salvador in 1989, that come with a very difficult, perhaps impossible, synthesis of my nomadic thought. The liberating process must lead to a rupture that has a transformative power of the conditions of iniquity and oppression, as well as to the dissolution of institutions that contribute to the reproduction of such conditions (Montero and Sonn, 2009).

2. Colonial Psychiatry and the PTSD industry.

The cycle of humanitarian intervention, including psychological intervention (IASC, 2007), is based on the fundamental assumption of an objective nature of

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empirical validation, developed in Western academies, mainly in the United States and the United Kingdom. Thus, interventions and their efficiency and effectiveness must be scientifically measured and therefore prove their empirical solidity. Humanitarian psychological aid and reductionist objectivism are combined and build some interesting colonising premises in the world of care in the global South and beyond. It is interesting briefly to discuss these premises and their implications, as well as to use as a case study, the construct of post-traumatic stress disorder (PTSD) among the most commonly used diagnoses to describe the psychiatric suffering of populations affected by extreme traumas such as war, forced migration and systematic violence.

The first consideration, or premise, to dwell on is of an economic nature. A care project to be organized and

implemented must have its own financial and economic sustainability. This sustainability is closely dependent and linked to funding requests and guidelines controlled by large (or small) donors. For the project cycle to come to life, it must be attractive to the donor and therefore comply with the demands and expectations of the funding source. Subsequently, the care project will have to be accountable to its donors and demonstrate that it has fully complied with the guidelines that allow fundability.

Let us briefly shed some light on the most common guidelines allowing access to large funds. The project must be based on data and evidence that prove its usefulness and sustainability, such data must respond to principles of scientificity, replicability, exportability, and generalisability. Hence, the project must

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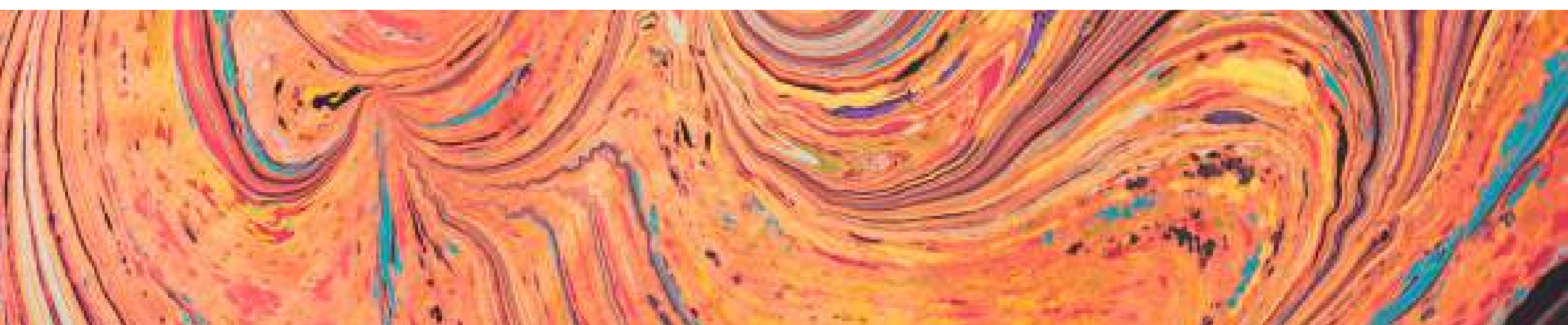
demonstrate that it is based on solid empirical premises using validated tools built in the main Western academic institutions. The grammar of funding most understandable to the wealthiest donors is constructed and scientifically proven in Western and white contexts.

The rules, maps and outcomes are dictated by Western scientific thinking, where the playing field is and remains mostly the global South. Intervention and evaluation tools are designed, tested and cross-validated by those who will later ask to account for how the money is spent, Western institutions belonging to the countries the most responsible for colonial crimes from the 19th to the 21st century (United States, United Kingdom, Europe).

The financial, political, and humanitarian management of care projects remains firmly in the hands of those neoliberal and capitalist countries that for centuries have colonized and expropriated the global South of environmental, economic, and cultural resources, reproducing that relationship of subjugation denounced by Fanon, Freire, and liberation theorists. Science based on empirical evidence, attractiveness of money and power in the name of care, proposes itself as a new device for a sustainable colonization, in which it is the patriarchal and white North that manages instruments and keep the purse strings, while the South chokes, suffers and adapts to the rules of the capitalist game. This is how billions of dollars move annually from the North to the South in the name of intervention and humanitarian psycho-social care, money that will return to the North in the form of training, supervision, evaluation, etc.

A clear example is the so-called 'PTSD industry' which produces enormous profits from the tragedy of mass trauma in oppressed populations everywhere in the world, working on the suppression of symptoms and re-adaptation of victims rather than on removing those premises that maintain the conditions of inequality and subjagation and therefore produce extreme trauma and inflict suffering on civilian populations, who are victims of political and military violence. Derek Summerfield, unpacking the main steps that characterize the history of PTSD diagnosis, goes so far as to set out seven assumptions that expose its deep neoliberal and colonial nature (Summerfield 1999).

The first assumption concerns the notion of the impact



of traumatic events. The tragedies of war are so acute that they cannot lead to ordinary suffering. Instead, they will necessarily result in "traumatization" in the victims. The second assumption foresees in the Western point of view an absolutizing and universalistic interpretation of human responses to acute stress, objectivized and generalized by the dominant scientific paradigms. The third assumption sees the victims of wars and atrocities mainly as in need of specialised and professionalised interventions. Once again, these interventions are attended by a dominant Western matrix. The fourth assumption clears the psychological approaches coming from the global North as the only ones relevant in explaining the effects and intervention on violent conflicts, everywhere. The assumption of vulnerability is the fifth axiom. In fact, mainstream scientific literature clearly identifies human groups and types (e.g. women, children, particular ethnicities) as psychologically more fragile and exposed to the consequences of trauma. The sixth assumption sees the war as predominantly a "psychological emergency". Quick and immediate hit and run interventions can reduce psychological risks. The last assumption excludes indigenous health professionals from the possibility of managing the emergency as they too are traumatized and psychologically in want.

The author concludes that the medicalization of the consequences of war has a victimizing and passivizing effect on the affected populations; it reduces a complex socio-political problem to a predominantly medical/psychiatric issue; it stifles Indigenous differences and competences in recovering from the wounds of war; it reproduces a relationship of subjugation between those who intervene (often also complicit in the management of the war events themselves) and those who suffer the intervention, victims of the conflict as well as of the humanitarian care system.

My personal journey as a clinical psychologist talks about all this. It talks about places preyed on and deprived of freedom by neocolonial greed. It is about power. The power of a privileged minority over masses of oppressed and landless. It speaks of man's violence against another man and the right to resist of the voiceless, "the wretched of the earth", of whom I have been, and still am, a privileged witness.

3. Conclusion

The first conclusive consideration when operating in a context of abnormality is that violence and war concern both mental health and human rights and that the two frameworks are worthy of equal dignity also and above all in the scientific arena. The medicalization of human suffering is a Western perspective that is globalized also because of strong economic, power, control, and surveillance interests. Individual suffering in contexts where what is abnormal, the denial of the most fundamental principles of humanity, becomes normality overlaps with and is part of the social and collective suffering of oppressed populations.

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A second lesson learned in my personal experience suggests how the victims of injustice, war, systematic and political violence do not ask for interventions of a psychological nature.

They demand justice, listening and participation in the process of redemption and liberation. Thus, they are not resilient, they are not passive and resigned actors of an imposed condition. Rather, they are resistant, fighting for the affirmation of their own and others' existence. They have no advantage from the millionaire machine of PTSD and Western treatment, they are exclusively unwitting users of it. Our standardized system of scientific evidence, global and universal, has erased and is erasing, in a sort of cultural genocide, Indigenous and traditional care systems of meaning, alternative to the dominant discourse of science and medicine.

"Whoever produced the disaster cannot and must not be the owner of the repair"

Third, it appears unavoidable, in a subjectivizing process of cure, that the voices of the victims should not only be included but also will generate the guide towards the solution of both individual and collective suffering; above all, it is necessary that such processes will value and assume the perspective of those voices that demand justice and reparation. Whoever produced the disaster cannot and must not be the owner of the repair. In the Fanonian perspective, those who are guilty, those who have failed, must pay for the damage caused and the voice of the victim to become the guide for their own salvation and for the liberation of the humankind. Healing capitalism has shown and shows its true face: colonial and oppressive. Ultimately it did not respond to the deepest needs of the victims and failed.

The choice that today we as cure workers are called to make is an indispensable and not optionable choice, which must involve a paradigmatic revolution and lead to the assumption of a true postcolonial Western perspective. It is summarized in the following question: must the worker (of education as well as of care) be an agent for re-adaptation and re-socialization or for social change? The choice is crucial for the future of the human species endangered by epochal climate changes, conflicts, genocides, man-made disasters and pandemics.

“To love. To be loved. To never forget your own insignificance. To never get used to the unspeakable violence and the vulgar disparity of life around you. To seek joy in the saddest places. To pursue beauty to its lair. To never simplify what is complicated or complicate what is simple. To respect strength, never power. Above all, to watch. To try and understand. To never look away. And never, never to forget.”

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