Downloaded from mh.bmj.com on 2 December 2008

Mental health in an age of celebrity: the courage to care

P Barker and P Buchanan-Barker

Med. Humanit. 2008;34;110-114
doi:10.1136/jme.2008.000539

Updated information and services can be found at:
http://mh.bmj.com/cgi/content/full/34/2/110

These include:

References This article cites 8 articles, 1 of which can be accessed free at:
http://mh.bmj.com/cgi/content/full/34/2/110#BIBL

1 online articles that cite this article can be accessed at:
http://mh.bmj.com/cgi/content/full/34/2/110#otherarticles

Rapid responses You can respond to this article at:
http://mh.bmj.com/cgi/eletter-submit/34/2/110

Email alerting service Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Topic collections Articles on similar topics can be found in the following collections

Psychology and medicine (8 articles)

Notes

To order reprints of this article go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to *Medical Humanities* go to:
http://journals.bmj.com/subscriptions/

Downloaded from mh.bmj.com on 2 December 2008

Mental health in an age of celebrity: the courage to care

P Barker,[1] P Buchanan-Barker[2]

[1] Faculty of Medicine, Dentistry and Nursing, University of Dundee, Dundee, UK; [2] Clan Unity International, Fife, UK

Correspondence to: Professor P J Barker, 90 West Road, Newport on Tay, Fife DD6 8HP, UK; phil.j.barker@btinternet.com

Accepted 8 July 2008

ABSTRACT

Modern psychiatry, which once focused only on the containment and "cure" of madness, has evolved into a mental health industry, where almost every aspect of human life, may be cast as a "mental disorder". In Western countries, a narcissistic appetite for self-improvement and "well-being" has evolved over the past 50 years, mirroring the emergence of the celebrity culture. These developments appear linked to a fading of interest in the traditional concept of human caring, leading to a further marginalisation of people with serious "mental health problems" and to increased use of authoritarian forms of control and containment. In this paper, the idea of vocation in the field of mental health is explored. What *exactly* are we called to do as *people*—whether as professionals, friends or fellow travellers—when someone experiences a significant problem in human living?

Today's world is commonly described as "post-modern" or, as Fukayama claimed, somehow beyond the "end of history".[1] However, given the role of story and story-telling in the construction of our sense of self, can we ever be "post" the past, detaching ourselves from our histories, whether personal, social, institutional or philosophical?

In England, the psychiatrists Bracken and Thomas developed the idea of "postpsychiatry", which they described as "a way of challenging current thinking" which aimed "to provoke a serious discussion about the theoretical underpinnings of mental health work in the 21st century".[2]

They claimed that postpsychiatry challenged the three "guiding assumptions of modernist psychiatry":

(1) that madness needs to be controlled by professional experts or authorities;

(2) that mental problems are best viewed through a technical idiom (eg, as diagnosis); and

(3) that madness is located inside people: within some individual "internal world".

They described various projects and other loose-knit groups that illustrated alternative ways of making sense of people and their madness. Having been associated with similar projects for almost 20 years, we share most of their concerns.[3] However, ultimately Bracken and Thomas pull their punches. Despite their intelligent discussion of continental philosophy, they appear to be conservatives in radical clothing and are candid about wishing to conserve "psychiatry" (post or otherwise) and what they call minimal therapeutic coercion—if that is not a contradiction in terms. And, despite their references to madness, they also want to conserve the notion of mental illness, casting critics of postpsychiatry such as us—and the original critic of the "myth" of mental illness", Thomas Szasz[4]—as some kind of mental illness deniers. Recently, they wrote, of an earlier paper of ours,[5]

> Barker and Buchanan-Barker argue that postpsychiatry has failed to engage with the problem of the future of psychiatry. They propose that medicine has little or nothing to offer those who experience madness or distress. Other professionals can offer such things as psychological help, practical inputs and human supports. Nurses are now trained to diagnose and prescribe. There is no raison d'être for a "medicine of the mental", for a psychiatry. We are broadly sympathetic to this position and the very concept of "postpsychiatry" implies some sort of endgame for the discourse and practice we now call psychiatry … [However] We also share their sensibility to the oppressive history of psychiatry and have attempted in our writings to expose the limitations of psychiatric theory and the hurt caused by many psychiatric interventions … *No matter how much we are opposed to the oppressive and barbaric practices of psychiatry, the problem of the future of psychiatry will not be answered simply by wishing psychiatry out of existence.*[6] [Italics added]

Is this an illustration of complicity or collusion with the mental health industry? We take a different view.

EVIDENCE-BASED REVOLUTIONARY CHANGE

Two hundred years ago, when modern psychiatry began, the abolition of slavery had not yet begun. Who then would have imagined the possibility of a "post-slavery" society?

One hundred years ago, when Freud began to shape the concept of mind and brain, women had not yet gained the vote. Who then would have imagined a "post-women's-suffrage" society?

In 1960, when Thomas Szasz first laid down his challenge to the orthodox logic of psychiatry, the American civil rights movement had just begun. Who then would have thought that we would now talk so easily of a "post-civil-rights" era?

In 1990, as Ronald Reagan announced funding for the "decade of the brain",[7] the Soviet Union began to implode. Who then would have believed that 15 years later we would talk so casually about "post-communist societies"?

All institutions and their supporting ideologies have a limited lifespan. Nothing lasts. At least in principle, that should include psychiatry. However, institutions are, first and foremost, ideas. And, as Szasz has reminded us, ideas have consequences.[8] The idea that people are "mentally ill" and need a range of "experts" to contain and control such an illness has led to the contemporary consequence of

Downloaded from mh.bmj.com on 2 December 2008

the "mental health" field. If people wish to experience an alternative to psychiatric authority, they must *act*—individually *and* collectively. People need to be *agents* rather than *patients*.

THE PERSISTENCE OF PROBLEMS IN LIVING

The so-called modern world is almost 500 years old. People began to talk about the "future" and its relationships to "today" and "the past" in Shakespeare's time. In that sense, we address ourselves as modernists. Are Bracken and Thomas right in arguing that we can make sense of ourselves *only* by gazing through the philosophical lenses of Foucault or Fanon, Heidegger or Husserl? We think not. However important such writings may be, history tells us that social change is not dependent on the stimulation of the philosopher. Change has been, and will continue to be, shaped by all manner of unlikely forces. History shows how ordinary people can become *extraordinary* agents in changing society. But first those people needed to know their purpose.

We have been arguing for several years that it is time to stop talking about putative forms of mental illness and to talk, instead, about people's "problems in human living". Recalling that ideas have consequences, we believe that by focusing on problems in living we might be better able to consider what might need to be done to help people address and live with them, rather than simply contain, or attempt to control, people with such problems. We were also interested in who might do this helping—and in how many different ways it might be done. However complex the development of an alternative approach to helping people might be, it does not appear to be dependent on understanding the complexities of continental philosophy.

VANCE PACKARD AND THE MYTH OF THE EXPERT

The process of helping people address and resolve their problems in living is complicated by the multiple, often conflicting, demands that society places on psychiatric professionals. This is related to the assumption that complex problems—such as human living—cannot have simple answers, which in turn is linked to the assumption that we always need experts to "fix" our human problems.

Fifty years ago, Vance Packard first described how advertisers manipulated people, fostering desires for certain products, encouraging people to have expectations that these products might change their lives.[9] Ironically, Packard's warning became a behaviour-change manual for many baby-boomers, some of whom shaped the "shopaholic" culture that overshadows us today.[10] Packard showed how people could be manipulated into believing that something more substantial was happening. However, clearly some people need to be manipulated, or find it too difficult to be their own, autonomous agents. Packard would not be surprised by today's celebrity culture, in which people slavishly follow fashions, volunteer to be bullied and humiliated on "reality television" or crave direction, leadership or "life-coaching" by various gurus—of fashion, diet, health or spirituality.

Packard might even have understood why, when he was writing in the '50s, there were fewer than 100 forms of "psychiatric disorder", whereas today there are four times that number, and why so many people are keen to have these labels applied to them. Nor would he be surprised by Furedi's observation that in 1980 not a single reference to "self-esteem" was to be found in the British press, but 20 years later there were almost *three and a half thousand*. Such statistics illustrate the development of what Furedi calls the therapy culture.[11] This

> … [reflects] the changing form of subjectivity … [distracting] people from engaging with wider social issues, in favour of an inward turn to the self … [By] normalising the sick role and help-seeking, [it] promotes dependence on professional authority … [discouraging reliance] on intimate and informal relations [thus weakening] the individual's sense of belonging. Worse still, contemporary culture fosters a climate where people really do feel ill, insecure and emotionally damaged … where people "seek solace and affirmation through a diagnosis". (Furedi, 2004,[11] p203)

Although the shallowness of psychiatric diagnosis is well accepted,[12] over the past decade psychiatric nurses and psychologists, worldwide,[13] have all sought the right to apply diagnoses, prescribe psychiatric drugs or gain the "expert" authority to remove a person's freedom under so-called mental health legislation.

THE RISE OF MENTAL HEALTH ACTIVISM

There is, however, little evidence that people want more and more professionals with the power to diagnose, treat and confine them. Indeed, if we are to believe the legion of witnesses from user, consumer, survivor and advocacy groups, people with "mental health problems" want to reclaim some of the age-old universals: voice, identity, meaning, agency and rights.[14] We recognise that some people do want to be drugged, restrained, shocked and even to receive psychosurgery, believing that this will address their problems. Or, Packard might have said, they have been persuaded into believing this. Clearly, people are entitled to ask for any kind of intervention to address their problems, but individual professionals must decide if it is appropriate or ethical for them to deliver this.

It is widely accepted that some kind of consumerism now exists in mental health care in the UK, with "user choice" an integral part of service delivery. However, Newell and Gournay noted:

> It is possible that enthusiasm for rights and the contribution of mental patients has already passed its peak. As Muijen writes: "Whether one likes this or not, the priority in mental health care has fast become the safety of the public rather than the quality of life of "victims of psychiatric oppression" less than a decade ago. The opinions of people clamouring for yet more places in secure units and yet more restrictive care in the community, as reflected by the Mental Health Act, can be seen and heard everywhere."[15]

Coming from an eminent psychiatrist, these words can be interpreted as potentially dangerous talk. Why the "scare quotes"? Is the concept of "victims of psychiatric oppression" in some sense invalid? Is this no more than the "imaginings" of the "oppressed"? Who are the "people clamouring for yet more places in secure units", whose voices can, apparently, be "seen and heard everywhere"?

However intentionally, Dr Muijen, past director of the Sainsbury Centre for Mental Health, inflames an already smouldering situation. He says "whether one likes this or not". We have no hesitation in saying that we do not like this "priority". Indeed, Muijen's dismissive assumption that the debate is somehow *over* is all too typical of the contemporary politics of human caring.

The frenzy—and we use the word advisedly—over the public risk posed by persons with a diagnosis of mental illness has been grossly exaggerated by sections of the media and some politicians.[16] Moreover, the idea that the answer to a perceived mental health "crisis" is to provide more of the same, in the form of psychiatric containment, seems questionable in the extreme. Newnes and colleagues note that

Downloaded from mh.bmj.com on 2 December 2008

> It is as if the eternal truths explored by philosophers, novelists and other artists are of no concern to mental health professionals who continue to absorb a diet of drug company propaganda and government dictats.[17]

There is little doubt that large numbers of people experience a wide range of problems in human living, who might benefit from less toxic interventions, such as being heard, being supported, being validated and being helped to be their own agent. Many people tell us that they want someone to care *about* them as a person, not care *for* them as a patient—especially when that so-called care is forced upon them.[18]

THE MYTH OF MENTAL HEALTH NURSING

The foregoing discussion raises the question, who really cares any more, anyway? The most popular answer is that nurses care—that is what nurses do: they do "caring" things, hence the distinction between nursing care and medical treatment. However, this assumption does not appear to be supported by the professional literature. We conducted an online search of the *Journal of Psychiatric and Mental Health Nursing*, a key international journal published in the UK, looking for citations on "care" and "caring". We found over 1400 listed for the decade 1997–2007. However, only a handful of these addressed "caring" specifically, as an interpersonal activity. Most used "care" as an administrative or bureaucratic concept: viz., "care plans", "care records", "care pathways", "forensic care", "crisis care" and so on. Only two or three papers explored, examined or described "caring" as a human activity, rather than as an idea. If nurses are the main professional "carers" in the mental health field, why do they not research and write about "caring"?

In an ongoing study, we have asked mental health nurses to tell us: what *is* "psychiatric and mental health nursing"? How do nurses "do" nursing? Using two-line definitions of medicine, psychology and social work drawn from web dictionaries as a guide, we invited a range of practitioners, leaders, researchers and professors from the UK, Ireland, Canada, Australia, New Zealand and the USA to define and describe their discipline in simple language that could be understood by the layperson. Interestingly, most respondents asked for "more time to think about this". Some needed weeks, others needed months, to frame their answer. One respondent said that such a definition should not be undertaken, as there were "philosophical problems in defining anything". Almost all admitted that these were difficult questions. This led us to wonder how nurses encourage recruitment to their field if they cannot explain, simply, what nursing involves?

Very few of the nurses in our study referred to caring or care except in general terms—such as "nurses give nursing care", which is in the same league as "doctors practise medicine". However, one professor of nursing from the USA said that the field was divided into two "camps". The first saw nursing as "a subservient discipline and an extension of psychiatry's social control mechanism(s), for the policing, containment and correction of already marginalised people", which carried "out a number of defensive, custodial, uncritical and often iatrogenic practices and treatments, based on a false epistemology and misrepresentation of what are, by and large, "human problems of being", rather than so-called "mental illnesses"." The second camp saw it as "a specialty craft that operates primarily by working alongside people with mental health problems; helping individuals and their families find ways of coping with the here and now (and past); helping people discover and ascribe individual meaning to their experiences; and exploring opportunities for recovery, reclamation and personal growth—all through the medium of the therapeutic relationship".

We then wondered if, when people apply to become nurses, they can choose to join either the first or the second of these groups.

Another distinguished nurse leader from the UK believed that mental health nursing covered "a broad and moveable spectrum of roles, responsibilities and practices, defined by the economics, instititutions and policies of the day". As a result, nursing could not be defined.

However, if nursing is simply whatever the economic, institutional and political influences of the day demand, how do we avoid a repeat of the "nursing" that emerged during the Third Reich?[19]

If nurses do not talk much about "ordinary nursing", in academic circles they do chat on the internet, where various chat rooms and discussion lists offer participants a celebrity moment. *Guardian Society* reprinted a section from a blog euphemistically called "mental nurse". No context was offered. Perhaps the editor thought this extract would speak for itself. The piece began:

> In modern nursing, there are two schools of thought. One, there is too much paperwork, preventing quality time to ignore patients.
> Two, there is not enough paperwork, making it difficult to avoid patients. The best time to do paperwork is just when someone is going to need a fair period of attention.

The writer proceeded to illustrate how nurses might use paperwork to avoid being with patients:

> The theory is that time spent with nursing staff is such a wonderful experience that clients will do anything to repeat it. If they do something loud and messy (slash wrists, kick doors, take a tiny overdose) they will get time from staff. The untaught response to a client… like this is to ignore them. Otherwise they will just do it again when they want something. Ignoring them reduces the reward, leading to a cessation of the disturbing behaviour. Fabulous lack of intervention. Very person-centred.[20]

Some might call this black humour—a way of coping with the demands of caring for "difficult" people. Others would call it postmodern irony. However, other professionals don't seem to feel the same need to publicise their adolescent natures, or, if they do, socially aware journalists do not promote their professional suicide in the quality press.

This led us to the provisional conclusion that mental health nursing is a myth—that is, something that many people believe in, both the professional and the layperson, that gives symbolic meaning to their lives but that cannot be demonstrated in any objective sense.

CELEBRITY CULTURE

These chat-room references remind us that we live in the shadow of the celebrity culture, which has been exploding since Andy Warhol first predicted that everyone would be world-famous for 15 minutes. Christopher Lasch tried to trace its roots, 20 years ago, in *The culture of narcissism*.[21] Anticipating Fukuyama and the postmodernists, Lasch argued that the "cult of narcissism" embraced the idea that things were coming to an end, giving people a rationale for living only in and for the moment.

Lasch anticipated the development of a "therapeutic sensibility", much like Furedi's "therapy culture". Narcissists, he argued, give up the age-old traditions of self-help, becoming

Downloaded from mh.bmj.com on 2 December 2008

dependent on therapists and organisations that will validate their "self-esteem". Anticipating the celebrity age, Lasch noted that in the absence of any sense of psychological peace, meaning or commitment, people experience an inner emptiness, which they try to avoid by living vicariously, through others, or in seeking spiritual masters and other gurus. Lasch commented,

> Because the narcissist has so few inner resources, he looks to others to validate his sense of self. He needs to be admired for his beauty, charm, celebrity, or power—attributes that usually fade with time. (Lasch, 1991,[21] p210)

The mental health field has enjoyed, at least in a limited way, a period of social activism, commonly referred to as Mad Pride,[22 23] which emerged from the era of the Me generation, described by Lasch. This loose-knit movement traced the footsteps of the social revolutions alluded to earlier—the abolition of slavery, the emancipation of women, civil rights and gay rights. However, Lakeman and colleagues[24] wrote that the original concern with social justice that had characterised mental health activism had been eroded. They argued that many of those who previously represented a radical or activist voice in mental health consumerism had been bought off, acquiring celebrity status or becoming corporate entities who demanded

> … large fees for appearances which are often augmented by book, CD and other product sales. They may enjoy a relatively lavish lifestyle being jetted around the world and wined and dined by health professionals at their drug company-sponsored conferences … The more successful celebrities will be those who concur with a medical view of illness rather than seriously challenging prevailing views or practice. The authority of the celebrity often extends well beyond their knowledge, expertise or experience. (Lakeman *et al.*, 2007,[24] p15)

This suggests that the culture of narcissism has insinuated its way into professional and public arenas alike. All the professions are at risk, but nursing appears to have fallen for the narcissistic fiction that the only route to success is through academic prowess, quasi-scientific research, the development of arcane, abstruse theories and fitting in with the political and economic power brokers of the day, whatever the cost to genuine, human caring.[25]

However, if some kind of radical shift in mental health "care" is deemed necessary, it might be politic to ask, to what extent will scientific research, obscure philosophising or boardroom dealing be necessary? None of these played any significant role in the abolition of slavery, the emancipation of women, the raising of feminist consciousness, in civil rights or in the birth of gay pride.

CARITAS AND THE COURAGE TO BE HUMAN

As we noted in our introduction, the "postpsychiatrists" Bracken and Thomas oppose the idea that "madness" invades and colonises some private, personal world. However, it seems axiomatic that if *we* lose our minds (however metaphorically), only *we*, who are "*minding* the store", can know what that loss means. The experience may affect others, and in turn be affected by them, but our personal tragedy, like our personal joy, is ours, individually and alone. This modernist conception of the self serves to remind us that, however much we might access the shared truth of our lives, through conversation and culture, we can never know the experience of others. Ultimately, we are all experts by experience: ultimately we are all alone.

This bleak but realistic outlook was the essence of Samuel Beckett's work. Often mistaken for a despairing nihilist, Beckett was a great humorist, if not actually an optimist in the traditional sense. His friend and publisher, John Calder, noted that

> Shaw, an optimist, saw hope of some kind in the future, when man would become God-like. Kafka saw the possibility of something brighter in the future, but no more than that. Proust found his peace in the golden glow of the remembered past, an experience common to most people who live to a comfortable old age. To Beckett, life was the short straw of existence that those of use who are born, are unlucky enough to draw. We live, as Vladimir says in Waiting for Godot, until we die and are forgotten. If there is an answer to life, it must be in *caritas*: the human willingness to share, to comfort, to be a good companion.[26]

Beckett revelled in the absurd fatalism of life, but his work also showed us, however obliquely, how to face and accept the inevitable, and the importance of doing it with dignity (Calder, 2000,[26] p142):

> All of old. Nothing else ever. Ever tried. Ever failed. No matter. Try again. Fail again. Fail better. (Beckett, 1983,[27] p7)

But mostly Beckett reminded us of the futility of hope:

> Where I am, I don't know, I'll never know, in the silence you don't know, you must go on, I can't go on, I'll go on. (Beckett, 1959,[28] p418)

Beckett was a Western Zen master, prodding our awareness that everything is futile, and that we are nothing—reminding us that both we and the world are perfect, in all our imperfections.

In a psychiatric context, Beckett reminds us of Shoma Morita, the Japanese psychiatrist and contemporary of Freud, who died before World War II.[29] Morita belonged to a Japanese society that had changed little in hundreds of years. However, by incorporating ideas from Zen Buddhism in his work, Morita developed a radically different form of therapy, which did not become known in the West until over 40 years after his death.[30] Anticipating today's infatuation with all things "cognitive", Morita said that people thought and felt too much and did not do enough. He saw his role as helping his "students" (the name he gave patients) *learn about themselves*, by living fully their everyday lives. Rather than spending inordinate amounts of time talking about themselves, he would ask them to talk about what needed to be done.

If Sam Beckett's writing was mainly about waiting, then Morita's work was about patience. He waited with his students (patients) until they did what needed to be done. The other parallel is that both Beckett and Morita accepted that there could be no betterment, far less the need for improvement that bedevils our narcissistic, celebrity-obsessed culture. Beckett's stoicism can be interpreted as an offshoot of his family's embrace of Protestantism, in the Church of Ireland. Morita's acceptance also was culture-bound.

According to Ohnuki-Tierney, the traditional Japanese concept of health and illness assumes that there is no such thing as perfect health, since it is not a static state:

> Individuals learn to live with weakness of the body, just as they live their daily lives with the knowledge of ever-present danger and evil. [In this context] the basic premise [of Morita therapy] is that human beings are weak. Therefore the first step for recovery according to this method is to learn to acknowledge one's weaknesses and live with them.[31]

Downloaded from mh.bmj.com on 2 December 2008

Morita experienced anxiety throughout most of his life but accepted this as something like the weather, which came and went. Rather than try to "treat" it, or get rid of it, he lived *with* it—doing what needed to be done. In so doing, he illustrated the importance of "knowing one's purpose". For Morita, living with a purpose was his purpose. Now Morita's ideas are finding a place in palliative care, where people might be helped to find a purpose in dying.[32]

CARING AND COURAGE

Beckett and Morita could hardly be more culturally different—Irish Protestant and Zen Buddhist. Yet they articulated a similar view: that there can be no solutions to the problems of human living, and that this should be a cause for celebration. From this idea we can begin to explore its key consequence—how do we focus on going on, individually and collectively? As animals, we cherish warmth, companionship, belonging and acceptance as actual "lived experiences". As humans, we hanker for these abstract, intangible "things", which we believe bring meaning to our lives. Let the philosophers tie themselves in rhetorical knots over the meaning of life. To both the savage and the enlightened, life just *is*.

Perhaps our human purpose is no more or less than to provide warmth, companionship and acceptance of our fellow women and men, rather than trying to control, contain or otherwise "fix" them. Today, the pseudo-science of psychiatry is like a hyperactive busybody, trying to find the ultimate, "right" answer to the wrong question, whether through drugs, genetic engineering or talking cures. The question is not how do we control and contain people and their experiences, but rather, how do we care for and about people; how do we help them to live their own autonomous lives, knowing that they are already perfect, just like us, in all their imperfections?

In the spirit of the social revolutions we mentioned earlier, we are awaiting the birth of a caring movement: a velvet revolution that speaks in the voice of ordinary people; the voice of co-operation and collaboration; the voice of compassion and companionship; rather than in arcane, unintelligible, philosophical propositions or in the duplicitous doublethink of concepts such as "therapeutic coercion". That voice has been calling us down the ages: calling us to do whatever needs to be done, to help one another; recognising that, as Beckett and Morita cautioned, ultimately there can be no answers.

Over 25 years ago, in an interview with Jonathan Miller for the BBC, Thomas Szasz concluded,

> I hold all contemporary psychiatric approaches—all "mental health" methods—as basically flawed because they search for solutions along medical-technical lines. But solutions for what? For life! But life is not a problem to be solved. Life is something to be lived, as intelligently, as competently, as well as we can, day in and day out. Life is something we must endure. There is no solution for it. (Miller, 1983,[33] p290)

Szasz was right. There is no solution to life, but there will be a conclusion, if only for us personally. Like Vladimir, we shall soon be forgotten. If we are to be remembered, however briefly, let it be for our shared common decency; let it be for the value we place on our humanity; let it be for our worthless, but priceless, faith in the power of human caring.

The concept of vocation, at least within Western society, has become unfashionable, and often is reserved as a partial descriptor for trades or low-skilled occupations. In these deconstructive times there might be some value in unpacking the original concept of vocation for the contemporary context. What, exactly, are we *called to do*—as persons—when one of our fellow women and men experiences some significant problem in human living? This is a question that needs especially to be answered by all professional disciplines involved in supporting people commonly described as experiencing "mental health problems".

Competing interests: None declared.

REFERENCES

1. **Fukuyama F.** *The end of history and the last man*. New York: Harper Perennial, 1993.
2. **Bracken P,** Thomas P. *Postpsychiatry: mental health in a postmodern world*. Oxford: Oxford University Press, 2005.
3. **Barker P.** Needs and wants and fairy-tale wishes: A Scottish impression of care in the community. *Architecture et Comportement/Architecture and Behaviour* 1990;**6**:233–44.
4. **Szasz TS.** *The myth of mental illness*. New York: Hoeber-Harper, 1961.
5. **Barker P,** Buchanan-Barker P. Postpsychiatry: bad language, good ideas and getting out of the box. *J Psychiatr Ment Health Nurs* 2006;**13**:619–25.
6. **Thomas P,** Bracken P. Power, freedom and mental health: a postpsychiatry perspective. In: Cohen CI, Timimi S, eds. *Liberatory psychiatry: philosophy, politics and mental health*. Cambridge: Cambridge University Press, 2007.
7. **Compston A.** Decade of the brain. *Brain* 2005;**128**:1741–2.
8. **Szasz TS.** Reply to Engelhardt. In: Schaler JA, ed. *Szasz under fire: the psychiatric abolitionist faces his critics*. Chicago: Open Court, 2004:385.
9. **Packard V.** *The hidden persuaders* (reissue edn). Brooklyn: Ig Publishing, 2007.
10. **Black DW.** A review of compulsive buying disorder. *World Psychiatry* 2007;**6**:14–8.
11. **Furedi F.** *Therapy culture: cultivating vulnerability in an uncertain age*. London: Routledge, 2004.
12. **Kutchins H,** Kirk SA. *Making us crazy: DSM – the psychiatric Bible and the creation of mental disorders*. New York: The Free Press, 1997.
13. **Lakhan SE.** Prescribing privileges for psychologists: a public service or hazard? *Online Journal of Health and Allied Sciences* 2007;**1**:1–11. http://ojhas.org/issue21/2007-1-1.htm (accessed 29 Sep 2008).
14. **Newnes C,** Dunn C, Holmes G, eds. *This is madness: a critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books, 1999.
15. **Newell R,** Gournay K. *Mental health nursing: an evidence-based approach*. Edinburgh: Elsevier, Churchill Livingstone, 2000:24.
16. **Johnson A,** Dobson R. The real truth about murder and Britain's mentally ill. *The Independent* 10 December 2000. http://www.independent.co.uk/news/uk/crime/the-real-truth-about-murder-and-britains-mentally-ill-427852.html (accessed 29 Sep 2008).
17. **Newnes C,** Dunn C, Holmes G, eds. *This is madness too: critical perspectives on mental health services*. Ross-on-Wye: PCCS Books, 2001:5.
18. **Coleman R.** The politics of the illness. In: Barker P, Stevenson C, eds. *The construction of power and authority in psychiatry*. Oxford, Butterworth-Heinemann, 2000.
19. **McFarland-Icke BR.** *Nurses in Nazi Germany: moral choice in history*. Princeton: Princeton University Press, 1999.
20. **Anon**. Reality bytes. *Guardian Society* Wednesday 25 July 2007. http://www.guardian.co.uk/society/2007/jul/25/mentalhealth.socialcare (accessed 3 October 2008).
21. **Lasch C.** *The culture of narcissim: American life in an age of diminishing expectations*. Rev edn. New York: WW Norton and Co., 1991.
22. **Drescher J.** In your face: social activism and mental health. *Journal of Gay & Lesbian Psychotherapy* 2002;**6**:1–8.
23. **Campbell P.** The role of users of psychiatric services in service development—influence not power. *Psychiatr Bull R Coll Psychiatr* 2001;**25**:87–8.
24. **Lakeman R,** McGowan P, Walsh J. Service users, authority, power and protest: a call for renewed activism. *Mental Health Practice* 2007;**11**:12–6.
25. **Hart C.** *Nurses and politics: the impact of power and practice*. London: Palgrave Macmillan, 2003.
26. **Calder J.** *The philosophy of Samuel Beckett*. London: Calder Publications, 2000.
27. **Beckett S.** *Worstward Ho*. London: John Calder, 1983.
28. **Beckett S.** *Beckett trilogy: "Molloy", "Malone dies", "The unnameable"*. London: John Calder, 1959.
29. **Morita S.** *Morita therapy and the true nature of anxiety-based disorders (Shinkeishitsu)*. (Levine P, ed; Kondo A, tr.) New York: State University of New York Press, 1998.
30. **Reynolds D.** Morita psychotherapy. In: Corsini R, ed. *Handbook of innovative psychotherapies*. New York: Wiley, 1981.
31. **Ohnuki-Tierney E.** *Illness and culture in contemporary Japan: an anthropological view*. Cambridge: Cambridge University Press, 1984:72.
32. **Itami J.** A trial psychosomatic treatment for cancer. meaningful life therapy. *Journal of International Society of Life Information Science* 2000;**18**:167–71.
33. **Miller J.** Objections to psychiatry: dialogue with Thomas Szasz. In: Miller J, ed. *States of mind: conversations with psychological investigators*. London: British Broadcasting Corporation, 1983:270–90.