

Pastoral Power Beyond Psychology's Marginalization

Resisting the Discourses of the Psy-Complex

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Introduction

During my seminary training I worked at one of the oldest psychiatric hospitals in the nation in an urban context and visited “chronic” patients who had been in the hospital for decades. Working at this large institution exposed me to the practice of confinement that is unique to mental hospitals. I noted the racial stratification of psychiatry, with white doctors organizing treatment and African Americans cleaning the rooms. I noticed how staff rarely talked to patients.

In a separate experience I worked at another psychiatric hospital/addiction treatment unit in a suburban context where patients stayed a few days or weeks. At this small institution, with more resources, the predominantly white staff seemed to offer in-depth education and therapeutic programming.

These two hospitals, about 17 miles apart, were two different worlds that resemble our divided nation. Indeed, in this book I argue that psychiatric treatment is one of the chief mirrors through which we can explore the true values of our times, namely, who is seen as worthy, who is understood, who is cherished, and who is abandoned. In these two different hospitals “patients” were being treated in different ways. Thus, mental illness becomes an interpretive frame through which to understand our society.¹ The difference in social setting and activities reflected important messages given about class, race, and identity in America.

This book is about the psychological impact of social class in an age of massive income inequity, rising unemployment, and soaring debt. Also, it is a book about how this psychological impact from the social world is inadequately interpreted when people are understood through an exclusively biomedical framework, as in much of modern American psychiatry. I argue that understanding the mental distress impact of the new economy can lead to greater solidarity with psychologically affected persons by redistributing necessary resources to them and also

recognizing their voice. Redistribution is about making sure that persons have what is necessary to survive; recognition is about making sure their voices are heard.

Books about mental illness in pastoral care and counseling tend to favor the psychiatric frame, often accepting biomedical diagnostics without critiquing the power of psychiatry. Indeed, ministers and pastoral caregivers often feel ill-equipped to care for persons with mental difficulties so they refer them to other “experts” with similar class and educational backgrounds to themselves. Current approaches to mental illness in the pastoral counseling literature thus implicitly foster the diagnostic frame of psychiatry by reinforcing its categories, perhaps encouraging churches to be more hospitable to the mentally ill while leaving the framework of mental illness largely intact. At the same time, any redistribution that is offered by churches and ministers is often done under the rubric of charity, seen as a one-time gift for uplift. Since mental illness is often bound up with economic injustice, it is our responsibility to prevent it, and not just treat it.

I write as a white Presbyterian minister who teaches pastoral care at a Catholic school of theology. While growing up in Bangkok, Thailand, and then in Anderson, Indiana, I saw two sides of globalization in a neoliberal era. As an adolescent in Indiana, I saw my friends diagnosed with mental illness when their families were disintegrating. All around us rose the spectral ruins of automobile manufacturers, abandoned and covering the landscape in vast acres, a dystopic nightmare. Much of the social suffering I saw around me in the Rust Belt community where I was raised was related to vast unemployment and economic inequity. There was a palpable feeling of public despair, which was sometimes attributed to the psychologies of presumably mentally ill individuals. In my professional life as a board-certified chaplain in mental health institutions, counselor, and minister, I have been increasingly moved by the fact that we misinterpret much of the social suffering of our time with our given categories for mental illness. My own journey from working-class roots to professional identity has been a complex one. While now a beneficiary of middle class status and prestige, a privilege that comes through being an academic and a professional, I still sometimes feel estranged from both the middle class and my working-class roots.² These are the issues that undergird the book, whose argument attempts to address the economic suffering that underlies this despair in a complex fashion, interpreting the distress not as a sign of something unbalanced in one’s brain, rooted in one’s genes, but rather rooted in the stress and trauma of working-class experience.

Social Class and Mental Distress

An exclusively biomedical approach to mental illness is missing something significant since much of what people are suffering from today could be described as economic oppression. Today people are working in worse conditions than ever before, often with less pay and fewer rights. They face frequent unemployment and carry heavy debts simply to survive. All of these factors have direct psychological effects that are not described clearly by dominant medical frameworks for mental illness.

Emerging research indicates that class dynamics directly contributes to mental distress. Mounting evidence shows links between mental turmoil and one's position in a less-privileged social class.³ Persons in working-class positions are more likely to experience mental distress than managers, as are persons who feel that their labor has been exploited.⁴ Some of the most pressing effects of the current economic crisis—income inequity, unemployment, debt, and home foreclosure—have distinctive impacts on psychological well-being.

Research suggests that persons who own a home or a car are less likely to experience mental distress, while chronic unemployment is a leading cause for suicide.⁵ Studies have even demonstrated how impoverishment impacts persons in childhood, producing stress that influences early childhood development and leads to anxiety and depression in adolescence.⁶ Since biomedical models of mental illness systematically exclude all but the most general economic information, these links between economic factors and mental suffering are not theorized effectively.

The paradox is that an exclusively biomedical model of mental illness obscures from us the distinctive causes and sources of suffering that stem from these new economic times. The changes that we have seen in our society in the last 20 to 30 years can be described as neoliberalism, which David Harvey defined as

a theory of political and economic practices that proposes that human well being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade.⁷

It is important to note that neoliberalism is not simply an economic system; it is also a culture that promotes a certain view of the person.⁸ A distinctive aspect of this culture is its tendency to place internal blame for suffering that is rooted in the social realm. At the same time, there is the implicit expectation that everyone should be able to succeed.

As the market increasingly comes to define various aspects of persons' lives,⁹ neoliberalism silences organizing and labor movements, as well as movements for self-definition and intersectional rights.¹⁰

For example, major depression first entered the diagnostic manuals in 1980, just when neoliberal governments told us "there is no society, only individuals [and their families]."¹¹ Bruce Rogers-Vaughn argues that biomedical psychiatry, which broadened the mental illness framework at the same time that it individualized the consumer of mental health, has turned suffering into a market and thus created a culture. This culture has been fostered by direct-to-consumer advertising that has promoted an individualized view of mental distress that is simply meant to be overcome.

Rogers-Vaughn carefully nuances his point, stating that depression is a complex phenomenon, and argues that an exclusively biomedical view of depression as rooted in the brain or the genes obscures the fact that, with rising economic inequity, depression should be considered, in the words of Ann Cvetcovich, a "public feeling."¹² If a greater number of people sense that they do not quite measure up and that they may be failures in an economic world intent on cutthroat competition, and if more opportunities are available to see their suffering as being treatable by medication only, then we are obviously missing much of the tenor of our emotional times. Rather than silencing the voice of depression, Rogers-Vaughn argues that we must listen to it, noting how it reflects on our wider society.

Rogers-Vaughn makes a compelling case that mood disorders are more prevalent in societies with a great deal of inequality. Neoliberalism seeks to maximize profits, and in the process incites persons to measure themselves primarily in economic terms. He argues that depression in persons is a response to the message that their monetary value is the only meaning placed on their lives.¹³ He interprets the rise in antidepressant medication as a stifling of the potential for political resistance against the imposition of an unjust system.¹⁴

What we have on our hands is widespread confusion about what ails us and what we should do about it. Indeed, there seem to be a range of professionals in a variety of disciplines who are happy to individualize a person's mental suffering as a disease and chart its course, applying medicine to the problem. By contrast we need to find ways of listening to the distinctive suffering of our times and enabling persons to respond directly to what causes that suffering.

In this book I argue that social class is an important way to understand the suffering of neoliberalism. On one hand, social class could

just refer to the fact that these changes under neoliberalism were made by persons who were elite and who fostered their own interest by moving companies abroad, eviscerating unions, and keeping wages low. On the other hand, social class is a more complex phenomenon since it involves the relationship between workers and employers. For this book, social class means not simply “collections of families and individuals who have similar levels of, and access to, scarce and valued resources over time”¹⁵ but also *the interdependent antagonism that links workers and owners together over time as owners exploit the surplus labor of workers primarily to further capitalist profit and thereby forcefully exclude many seeming nonproducers*. Note that this definition—which I explore further in chapter 1—includes relationships of production and talks about the core conditions of capitalism. Unfortunately, many of our current ways of describing and managing psychological distress do not grapple with the concrete realities of social class.

The Psy-Complex

Nikolas Rose coined the term the “psy-complex” in his discussion of the development of psychological testing in the United Kingdom during World War I, and his definition indicated that it included various disciplines of psychiatry, psychology, and social work, as well as the institutional settings in which they are deployed.¹⁶ Drawing heavily from Michel Foucault, he argued that the psy-complex helped persons describe various aspects of their lives under the rubric of an overarching theme and that this contributed to the production of a certain kind of identity, an identity as a *psyche*. In this book, I address how the system of mental health diagnosis and treatment exerts a social control over persons that obscures some significant aspects of their suffering.

In chapter 2, I state that the psy-complex includes the tendency to posit internal structures of thought or mind to interpret factors that are inherently social. It often includes a kind of “methodological individualism” along with a preference for organic medical explanations of mental health rooted in the brain or genes of an individual. Persons who work in the psy-complex are, by virtue of their training, often middle class or upper class, although their own class position rarely enters into their official judgments.

Rose emphasizes that the psy-complex constitutes the collaboration of official human sciences with technologies of control and normalization. He did not adequately describe what this control or normalization might be for, or what use it served in society.

CHAPTER 1

Social Class and Mental Illness in a Neoliberal Era

In the Frontline documentary film, interviewer Bill Moyers chronicles the lives of *Two American Families* over a span of two decades in Milwaukee, WI, to explore the impact of the closing of factories and the rise of a low-wage service sector economy.¹ One family, the Stanleys, are African American and each parent had jobs at Briggs and Stratton before the factory closed. Once the factory closed, the father took a seven-dollar-an-hour job finishing basements while the mother worked in real estate. They experimented with opening their own business but had to close it because of a lack of interest. Throughout the film, Moyers expertly narrates the rising income inequity, the dissolution of jobs with living-wage pay and benefits, and the social impact on these families' lives. He notes that all these changes occurred during times of unprecedented growth in the Gross Domestic Product (GDP).

When he returns a decade later to interview the family in 2013, the mother, Jackie Stanley, nearly refuses to be interviewed by Moyers again, stating, "I thought I was a failure. I knew you thought I was a failure 'cause I didn't do it. We went backwards." Due to health problems, she quit her real estate job. Her business came to nothing. She concluded that she had not done enough to make it happen. "I really was ashamed," she told Moyers.²

In the twenty-first century we live in times of tremendous economic resources in the United States, even when rising inequity makes it impossible for people to make ends meet.³ Because there is such an accent on personal initiative, people are likely to blame themselves for their suffering, just as Jackie Stanley did. In these times of crisis, pastoral care and counseling needs to interpret the context of economic suffering

CHAPTER 2

Psychiatric Power and the Limits of Biomedical Diagnosis

In one of the pastoral care classes during my seminary training, we were discussing the possibility that mental illness may not exist, but may simply be the culture's projection of normality on a person, when my professor responded, "Yet, if you see someone with a mental illness, you just know [that they're sick]." This response did not set well with me, but I began to wonder about what kind of world this comment might imply. Did everyone have this power of definition equally? Those who were able to determine mental illness exercise the power of normative judgment.

The assumed power to discern the pathological from the normal—a presumably great power indeed—has repeatedly been shown faulty in both academic studies and popular lore. For example, a team of top UK psychiatrists performed a battery of tests on a group to determine who had mental illness, but scored with only 50 percent accuracy.¹

In "On Being Sane in Insane Places," an article published in the journal *Science* in 1973, Stanford psychologist David L. Rosenhan and seven other ostensibly "normal" participants voluntarily committed themselves to mental hospitals all over the country claiming to hear voices.² None of the staff suspected that these patients were pretending. Seven participants were diagnosed as schizophrenics and one as manic-depressive. Their average hospital stay was 19 days. Only when they accepted their diagnosis and claimed to still be sick but getting better were they discharged as "in remission."³ The patients previously diagnosed with mental illness staying on the wards saw them taking notes about their lives on the ward and understood that these pseudopatients were journalists and not mentally ill.

CHAPTER 3

In Their Own Words: Mental Health Consumers, Survivors, and Ex-Patients

In chapters 1 and 2 of this book, I described the extent to which economic suffering was contributing to mental distress and how biomedical psychiatry alone did not account adequately for the kind of suffering that was so often social in nature. I described some psychiatric critics who challenged the biomedical framework, but in this chapter I argue that we must move beyond expert voices. This chapter explores some representative ways that people who have been involved with the mental health system interpret their distress.

It is necessary to attend to the voices of those most impacted by mental illness diagnoses, including how they name their own experiences, for example, distress, exultation. We might call this a *preferential option for the most silenced stories*. This chapter links themes of self-definition with self-determination. Self-definition is the ability to name one's own experience and to choose what matters most. Self-determination is linked to a host of other macro-factors such as housing, material goods, and social welfare and it provides the basis for self-definition.

In this chapter, I discuss some of the primary literature in the field of consumer/survivor/ex-patient movements. Rather than the narratives of family members—an important subject in its own right—the narratives of psychiatristized persons are discussed in this chapter. Concepts such as a disease model for mental illness will not be critiqued in this chapter, but neither will it be endorsed.¹ If discourse used in psychiatric spaces emphasize the physician's words about the patient, alternative approaches foreground activist's voices and concerns.

CHAPTER 4

Pastoral Counseling and Social-Class Shame

Robert had been unemployed for some time and his discouragement made it necessary for him to seek a counselor. He came to a pastoral counselor because the counseling center used a sliding scale to make counseling more affordable. When he arrived late for the first appointment, his pastoral counselor Christina did not seem upset, but definitely noticed. He spent most of the first session talking about his discouragement and despair and his sense of life not adding up.

Delving into the conversation a little bit deeper, she discovered that he had lost his job when the factory closed down several years ago, and, after cycling through several jobs, felt chronic discouragement.¹ His marriage had crumbled, in large part because of financial stress, and he had begun drinking heavily in the process. Under all the pressure, his wife left with the children and began another home far away.

Robert kept describing himself as a “failure” and Christina came up empty with what to say. She had been watching programs on nightly news shows about the economy and knew that persons in his position were making less than they actually needed for housing and food by working at service jobs.² She was familiar with the critiques of income inequality.

Robert seemed to be aware of Christina’s class. She noticed that he paid attention to her professional attire and the well-furnished office building where they met. By the end of the conversation she saw that he looked down and away.

Robert emphasized that he did not feel connected to anybody. She had noted that he seemed to be withdrawing even as they spoke and wondered if he would come back for another session. They had worked on some

CHAPTER 5

The Counter-Conducts of Pastoral Power

A pastor welcomes a family into her study, stating that she will be able to meet with them for one or two sessions before she refers them to another counselor. They describe the struggles of being “down in the dumps” ever since the wife was fired from her work unceremoniously. Just at the same time, this family faced their rents skyrocketing. The minister thinks they came in for counseling because she had begun to share economy stories from the pulpit, discussing the effect of the downturn on everyone.

This pastor initially brainstormed getting a local charity to help with this family’s rent, but heard later that week from a dozen other families whose rents were going up. Although the minister had initially approached this as a family counseling issue and had been planning to refer to a couple’s counselor, she began to think that practical financial considerations needed to come first. When the minister began that conversation, it lead to the community organizing efforts to foster affordable housing in their city. Because of the intense public pressure, the landlords relented two months later. With the housing situation sorted out, they went to see the pastor for a follow up: “There’s less stress in our lives now,” they said. “We also have more purpose in our relationship since we have both gotten involved in faith-based advocacy.”

In previous chapters we have explored the extent of mental distress in our times, the limitations of an exclusively biomedical approach to treating it, testimony from mental patients about their experiences of survivorship, as well as pastoral counseling as a way of resisting exclusively medical models of psychiatry and fostering solidarity.

CHAPTER 6

An Integrative Vision for Pastoral Power

At a small church in an inner-city storefront in a community that has undergone massive factory closures, a pastor preaches about unemployment. Afterward, she gathers in a circle with parishioners for prayer, lifting their concerns up for the church to hear and praying together to God. Here is something more than a panacea or the opiate of the people. The minister does not simply sanctify the situation as it is, but focuses on how the community can continue on in the face of adversity. The minister in prayer brings together the chief concerns of the whole person, its soul and its survival, and removes any doubt that this suffering is in any way the fault of these individuals.

In my argument I maintain that pastoral care and counseling must take into account the economic factors that shape people's identities and experiences, rather than simply the interpersonal themes relating to family life that have been the traditional focus of pastoral care. Most forms of oppression are two-dimensional in that they involve both recognition—for example struggles around racial or gender equality—and redistribution.¹ As we have seen in this text, economic oppression itself is frequently multidimensional, in that it involves both the recognition of marginalized identities and the widespread need for redistribution.

Neoliberalism has been explored as a central cultural frame in this book, namely the discourse of private rights and market dominance that has occurred in the last 40 years. It was based in a philosophy of trickle-down economics, the notion that a few wealthy persons could spread universal good to all. This form of implicit faith has been one of the driving ideologies of our time. As we have seen, the good given to a