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WHY WE MUST TALK ABOUT DE-MEDICALIZATION

María Isabel Cantón

Introduction
I understand de-medicalization as the process of discontinuing psychiatric drugs that were prescribed to treat a theoretical ‘disorder’, and also, as a perspective, one that recognizes diverse manifestations of psychic and emotional pain as natural to the human experience.

There are many reasons why people choose to go through de-medicalization processes. Some might find the drugs’ effects too taxing on their quality of life after some time, some cannot afford them and it might not be possible for them to get the drugs for free through the public health system of their countries, others might not have wanted to take them in the first place and certain life events may require one to be drug-free for better safety, e.g. pregnancy, medical procedures, etc. Regardless of the reasons why one might choose to de-medicalize, de-medicalization has to be taken seriously by ‘mental health’ professionals, so they are in a better position to assist their ‘patient/client’ when they choose to de-medicalize, after all, they are the ones who prescribe these drugs to people in the first place, it should be their responsibility to assist discontinuation processes. But I also believe that certain things will not change until the mad community reaches a critical mass, and we are closer now than we have ever been to this.

Our lived experience in processes of medicalization and de-medicalization contains valuable knowledge that might serve other persons to be able to make better informed choices about their health in the future.

Starting conversations in our communities about de-medicalization might feel unnerving because of the huge stigma that exists around the topic. Mad people (users, survivors of psychiatry, persons with psychosocial disability) are a collective already heavily stigmatized, and when talking de-medicalization we put ourselves in opposition to a behemoth with immense influence in public opinion.

The Pharmaceutical Industrial Complex dedicates billions of dollars to produce media, advertise to the public and medical journals, fund clinical trials for their own drugs and present biased results, ghost write, miseducate medical professionals (PharmedOut, 2018), fund national ‘mental health’ and medical associations, lobbying legislation (Open Secrets. Center for Responsive Politics, 2020), and many a time, bury or gag emerging evidence against their products or narratives. There is a tremendous ethical problem when societies allow private corporations, whose main purpose is shareholder wealth maximization, to have such an...
influence in fundamental human rights arenas, such as health. How can any person trust that psychiatric drugs are ‘safe and effective’ when pharmaceutical influence is so pervasive?

My personal perspective and experience with medicalization

Every person has a different history, set of beliefs, circumstances and biology. I consider this diversity of experiences and views to be one of the most enriching qualities we can offer each other as human beings. Regardless of my very radical position in relation to psychiatry and the pharmaceutical industrial complex, I believe that when it comes to deciding to take psychiatric drugs, informed choice should always be respected and honored.

I consider it important to share my personal experience because by doing so, it is easier to understand why I hold this perspective and positioning regarding ‘mental health’ and the de-medicalization of human suffering, but more importantly, because I believe many aspects of our experiences as humans are universal and I know that sharing what I have lived through, provides a great opportunity of reaching and connecting with other humans, which for me, is one of the most important things in life.

I was born in the middle of a civil war in El Salvador and lived there until I was eight years old, but I identify 100% as being Nicaraguan, the country that birthed both my parents and where I have spent most of my life. Nicaragua, which is often referred to as the ‘second poorest country in the western hemisphere’ has taught me that wealth resides in many and more important planes than just the material/economic. I write this as a white-passing mestiza woman, who grew up and has lived her life in much privilege. Privilege that was afforded in part because I grew up with all my material needs covered and had access to some of the best education available, which is a huge advantage over the majority of my country-humans.

It is precisely because of all the privileges I have enjoyed (white passing, upper middle class, able bodied, cis-gendered, access to great education) that I consider ‘mental health’ to be above anything else, a social justice issue. If it were not because of these privileges coupled with the fact that I grew up with a psychiatrized father, de-medicalization might have not been an option for me.

I am not sure how much importance one can attribute to personality traits when speaking about de-medicalization. My intuition tells me that being able to consider de-medicalization has way more to do with external factors and experiences than any particular internal ‘toolbox’ a person is born with.

Before being in touch with the ‘mental health’ apparatus, I had always been critical of western orthodox medicine and its reductionist views. I have always been suspicious of the ‘fix it with a pill’ approach, and by choice and privilege, I have always elected the route of tweaking my lifestyle and routines to find sustainable improvements, before I would consider more invasive approaches.

When I became pregnant I found a universe of information that I was not aware of before. By deciding to birth naturally and preparing for it, I learned that in the health system a natural process comes second to hospital policy, risk minimization and your practitioner’s schedule, which did nothing to improve my faith in medical approaches to health. The empowerment that came with succeeding at having a natural birth in a medical setting would serve me well in my de-medicalization process. I found myself more open to consider alternatives because my lived experiences prompted me to not regard doctors as an absolute authority, especially because I had discovered by experience the fact that orthodox medicine is inherently patriarchal.
My first personal encounter with the ‘mental health’ approach to extreme psychic distress happened in 2014, just seven months after the birth of my first child. Even though Nicaragua has universal health care for all, I had a private insurance through my work, which took me to a private hospital instead of the public asylum, so I say confidently that my experience as hellish as it was for me, does not reflect that of the majority of people that go through the public health system.

Private care did not exempt me of the ills that come when confronting the ‘mental health’ apparatus as a mad woman. Due to life circumstances that can be defined as the ‘perfect storm’, I ended up disconnecting from consensual reality one morning in July. My husband, who had not been exposed ever in his life to the type of manifestations I was having, did what every person is conditioned to do in western society, he turned to the medical establishment for help.

‘Help’ turned out to be the most denigrating and horrifying experience of my life. A forced hospital stay where I was physically and chemically restrained in intensive care for one day and injected against my will with no explanation whatsoever. In the proximity of my bed, there was a baby that would start crying desperately and whenever that happened, I would manage to wake up from the stupor the drugs had put me in, with images of my baby being skinned alive over and over again. A whole night spent in absolute panic, where I would call the nurses requesting to see my husband, to see my baby, asking for their help as my breasts were painfully engorged and I feared mastitis, calling them because I needed to pee, and not one of them would engage with me, they were either too busy or afraid, and I was left isolated and ignored.

After four days, I was sent home with a prescription that included an anti-depressive, a neuroleptic/‘anti-psychotic’ and a benzodiazepine. This all happened while I was still nursing my little baby. When he was born I was determined to breastfeed until he was two years old, this was a very important goal in my experience of motherhood, which is why I decided after a week to stop the neuroleptic and the benzodiazepine, I never took the anti-depressive, as I was not depressed.

The perfect storm I was going through before the hospital, only got worse as a result of my stay there so I ended up disconnecting from consensual reality a second time, fortunately my husband decided not to take me to the hospital after seeing how much suffering the first experience brought upon me, and instead recurred to strong sedation at home while requesting guidance from a psychiatrist he managed to call on the phone.

I found myself in an extremely vulnerable position going through this experience while being the mother of a young baby. People around me would make comments that implied I might be a danger to my baby, even though I never said or did anything to harm him or myself. Quickly I realized I had no other choice but to comply with my husband’s demand of going to a psychiatrist and getting on the drugs again if that was the recommendation.

I ended up going to another psychiatrist who prescribed an anti-depressive, a neuroleptic, a benzodiazepine and a mood stabilizer, which I proceeded to ingest as prescribed. Even though I was heavily drugged, I kept having strange ideas and perceptions, which I kept only to myself as I soon realized that the more I shared with the psychiatrist, the more drugs I was prescribed and the more possible labels were brought up in the consultation.

I had never before in my life entered such intense altered states of consciousness so I had no idea what was going on. I felt disempowered and ostracized and ultimately, I had to comply to a narrative that did not resemble in any way, shape or form what I was going through. I surrendered and let my voice be extinguished for a whole year by a stream of pills, mainly because I feared being separated from my baby again.
Coming from a ‘mental illness’ background

I was born and grew up in a family that embraced without question the ‘mental illness’ narrative for human suffering. My father was psychiatristized for 58 years. At 17 years of age he was diagnosed with endogenous depression and put on lithium and anti-depressants, thus starting his torment as a ‘mental health’ patient. After spending two decades on anti-depressants and lithium and receiving several electro-shock ‘treatments’, he had a ‘psychotic episode’ when he was 50 years old. This granted him the ‘manic-depressive’ label and several other drugs added to his regimen.

In my teens and early twenties I observed in his body and through his manifestations the terrible effects of psychiatric drugs: akathisia, tardive dyskinesia, psoriasis, cognitive decline, violent behavior, insomnia and high blood pressure, to name a few. The psychiatrists who attended him throughout the years in three different countries attributed many of these effects to the ‘natural’ progression of his ‘illness’. My father had three strokes as a result of chronic high blood pressure induced by psychiatric drugs, and spent the last 11 years of his life bed ridden with severe cognitive damage. The last decade of his life brought us the realization that drugs had not done much for him, even though they had provided us, his family, with relative peace of mind when he entered altered states. He died psychiatristized in 2013.

Bearing witness to the harm the drugs caused him granted me the determination to do everything possible to get off the drugs I was prescribed. I count this as one of my many privileges, even though a very sad one.

My journey through de-medicalization

Six months after my hospitalization and when my drug ‘treatment’ had been adjusted in a manner that allowed me to remain awake for most of the day, I started sharing my concerns about the long-term use of the drugs with my husband. By that time I felt safe enough to share more of my real thoughts and feelings with him. He was able to witness how the drugs altered my life, how they affected my ability to mother our son, and I also expressed to him that besides the fear of what prolonged use could bring upon my health, the drugs made me feel dead inside.

The conversation with him lasted for a couple of months, I knew I couldn’t push him, it was a very sensitive issue for him, as he was also traumatized by the disruption that my going through this experience had brought upon our family.

Every time that I tried to convey my feelings regarding my experience and how I felt about the drugs to anyone else around me, I was quickly reminded that I was ‘doing better’ now or was met with silence. So I turned to the internet. I was looking for people who had alternative views on ‘mental illness’, as my experience felt very spiritual and meaningful to me. After searching for content in Spanish and not finding anything, I started to search for content in English and eventually found the group Shades of Awakening on Facebook. In this group I found a community where I felt heard for the first time in almost a year, and by reading the stories of people who had gone through experiences similar to mine, I started to feel hope and with hope I began to regain my self-confidence.

Eventually, my husband agreed to bring up the topic of discontinuation to the psychiatrist, and with his intervention she agreed to start tapering me off the drugs. I give her full credit for advising that I do the taper very slowly, which after hearing and reading many difficult accounts on discontinuation, I can now appreciate.

The drugs had a very strong effect on me, I was sleepy all the time, it was difficult to find real motivation or excitement about anything, I felt stuck. As I was working full time and being
a mother, I did not have the mind or energy to keep a journal of my tapering process, which I now regret. Information about the tapering itself, what percentage of each drug was reduced over what period of time, what manifestations and sensations arose during and after the discontinuation, in sum, all the details of a person’s journey that I now realize might be of great value and support to someone considering discontinuation of psychiatric drugs.

After having lost contact with consensual reality in such an extreme way and being labeled by psychiatry as ‘extremely mentally ill’, even though I leaned towards the opposite path to conventional ‘wisdom’, it was inevitable for me to internalize part of the narrative my proximity was providing for my experience. I was indeed very afraid of having another ‘crisis’ for many reasons. I was terrified of being hospitalized again, deep down I feared that having an altered state of consciousness again would swiftly alter my life circumstances and I would lose the right to mother my child and, I was very apprehensive of the possibility of having to take psychiatric drugs the rest of my life.

Two months after having discontinued all drugs, after a night of very little sleep and into a stressful morning at work, I started experiencing an amplification of perceptions and tingling in my limbs, both of these I was familiar with as they had been present before, each time I entered an altered state of consciousness. I decided to go home midday and took some valerian to sleep, as I was concerned if I didn’t, I would spiral down and lose control. The following day it happened again, this time I lost all hope, as I was questioning if I could live a life without the drugs to keep me ‘grounded’, even though they made me feel zombified. So as the day before, I went home, but instead of going to sleep I called my husband and told him what had been going on, I expressed that I was willing to submit to whatever he deemed appropriate. I told him that if he wanted to call the psychiatrist to call her, and if she said so, I would go on the drugs again.

His reaction was a turning point in my process. He said that none of that was necessary, as he considered I was already doing the things I needed to do to manage myself: taking distance from stress, sleeping, talking about what I was experiencing. With his reaction I realized two things. The first one was how disempowered I had become over my own life in the course of a year, and the second, that he trusted me even when I was incapable of trusting myself. Both of these realizations were important in my healing journey and allowed me to consider other alternatives to managing my diverse psychic manifestations.

Because of all my privileges, I have had time and resources to explore some of my unusual perceptions deeply and as a result, I have been able to find literal and metaphorical meanings in what psychiatrists would have labeled ‘delusions’ and ‘hallucinations’, had I shared with them. My lived experience is one of healing and transformation through psychic pain and extreme distress, yes, but I feel more liberated as a human now than I did before experiencing madness. Since I cannot un-liberate me, I do what I can from my imperfections and limitations, to contribute to create a world where most people can be afforded the chance I had when having gone as mad as I went.

The rest of my empowerment and stamina to keep swimming upstream in the waters of activism, has come from meeting so many people who have been as damaged by psychiatry as I have, or family members of persons who were on psych drugs and their ‘illness’ had not been resolved and now were impaired by the drugs, concerned mothers reluctant to medicate their children, being able to connect with fellow mad activists, etc. I knew then I was not alone, and I felt comfortable publicly sharing my very heretical perspective that psychiatric drugs might not be the best response to human suffering.

Because of this, I have a certain reputation in the minuscule societal group that discusses ‘mental health’ publicly in my country. When around me, I have heard people use phrases as
‘I am pro-science’ or ‘We have to be responsible when we discuss these matters’, which to me only reflects how many layers of the onion still have to be peeled.

**Some of the problems with medicalization of human distress**

Accepting the pathologization of human distress without a critical view in place is outright dangerous for personal well-being and for social justice struggles in our societies.

**Increases oppression of marginalized groups**

People belonging to already marginalized groups (race, gender, sexuality, class) are subject to more medicalization than those not marginalized, which not only increases human rights violations but erases social injustices and inequities perpetuating systemic oppression and therefore causing more human suffering (Human Rights Council, 2020: 11).

**The science is not there**

Having had the privilege of buying and reading some of the books/articles from known whistleblowers in the ‘mental health’ field, I have come to learn that there is no evidence that supports the popular claim that people presenting manifestations deemed ‘mental disorders/illnesses’ have a chemical imbalance on their brains (Moncrieff, 2009: 169) which in its turn makes it sort of a common sense realization that in the lack of a biological marker, psychiatric drugs do not treat illnesses or correct imbalances. So, what do they do?

In Nicaragua, the Diagnostic and Statistics Manual of Mental Disorders (DSM-V) is the guide used to label suffering people with psychiatric diagnosis. What many people still do not know, is that this manual is based on consensus opinions and not on the scientific method. Identifying myself as a radical feminist in construction, it is very hard for me to give credibility to a practice that at one point in time pathologized homosexuality, intended to pathologize domestic violence as ‘Masochistic Personality Disorder’ on its IV edition, and still pathologizes women’s bodies’ natural cycle fluctuation and diversity as ‘Premenstrual Dysphoric Disorder’ (Gøtzsche, 2013: 292).

If one can consider the World Health Organization to provide unbiased literature and data, then what is shown is that medicalization of psychic distress is associated with poorer outcomes in the lives of people that have been labeled and prescribed by psychiatry (Whitaker, 2010: 193).

**Absence of informed consent, let alone choice**

In Nicaragua, the rule of thumb treatment for extreme manifestations of distress is pharmacologic, no other choice is offered for the general population. Although at least on paper, there have been institutional efforts to promote interculturality when approaching particular manifestations of psychic distress of indigenous communities, the case of Grisi Siknis in Miskitu communities is an example of these efforts; but ultimately, the biomedical narratives are regarded as the correct ones and the health authorities have the final word when information about these experiences is presented to the rest of the country (Martínez-Cruz, 2021).

When I was prescribed psychiatric drugs, I did not give informed consent in the emergency room, and neither was I given all the information about the drugs when I was prescribed by two different psychiatrists. I have yet to hear an account of someone in my country having received all the pertinent information from their psychiatrist regarding the drugs they were being prescribed. This becomes especially problematic when the person does not want to take
the drugs in the first place and is coerced or forced to take them. As opposed to other medical specialties the topic of informed consent is approached in a very relaxed manner by psychiatry (Moncrieff, 2009: 213).

If a person feels better while taking psychiatric drugs and is in full knowledge of its effects documented to date, how it was researched, by whom and for how long, how its effectiveness is determined, and they can also read the raw data and not just the abstract published on the clinical trial results, then and only then would I consider someone empowered to make an informed choice in regards as to how little, how much and for how long they want to take a psychiatric drug it.

**Decontextualization**

The biomedical approach to subjective suffering causes a person’s experience in the world to be decontextualized and reduced to the ‘clinical picture’ they present when they first encounter ‘mental health’ services. All the possible causes for the person’s diverse manifestations, like adverse childhood experiences, traumas, the experience of multiple oppressions, or just a different way of being in the world, are amputated at once and replaced by a supposed malfunction of fancy named neurotransmitters in the brain.

At least at first, people who go to the mental health services to seek help might embrace this theory as the one true cause of their suffering, sometimes with no small measure of relief. The frequent lack of questioning of psychiatric diagnosis and treatments might have multiple factors amongst the Nicaraguan middle to upper class. Some of these factors might include receiving the (dis)information from an authority figure, the medical doctor, not having access to the real science and information that is buried under so much pharmaceutical marketing pitches, and/or a readiness to assume all trends and fads coming from our neighbors from the North as measure of progress and success to ultimately be achieved.

Then, there is the reality of the majority of the population in my country, which might be evenly divided between the group that does not seek help when they are in distress and just ride it out and keep it a secret, due to the social stigma being sky high in a very religious country; and those who are taken by will or by force by their family members to the public health system. For the latter group, the reality of going through the ‘apparatus’ while mad and underserved is exponentially worsened by the dire socio-economic conditions, which in its turn translates into horrible conditions in the asylums, staff who are poorly, if at all trained, no availability of psychiatrists on site at all times, which probably means spending as much time physically restrained as it takes the psychiatrist in charge to show up, lack of consistency as far as prescriptions and doctors are concerned, as people are prescribed what is available from the donations received by whoever is available. This adds another layer of complications to an already terrible scenario.

To exemplify how the ‘illness’ narrative decontextualizes people manifesting distress, I will share an anecdote. Once I was in a radio program promoting the presentation of the documentary ‘Crazywise’ produced by Phil Borges, which provided a great opportunity to open community conversations where ‘mental health’ could be discussed from an alternative perspective. As part of the promotion, I was interviewed and shared part of my personal story. Listeners started calling the show, and they would ask questions and comment about the topic we were discussing. One caller related how his neighbor was ‘psychotic’ and her family had kept her locked in a room for two years. He criticized, and rightly so, the decision of the family members to keep her locked in, and he questioned why they did not take her to seek help, and asked who could intercede for this woman. During the exchange of comments, he mentioned as a side note, that she had become ‘mentally ill’ since her father had raped her a couple years ago.
The biomedical approach robs people of their history, their agency and the possibility to bring healing forth. We are complex beings that are very much affected by our environments. Should not it be expected that the cause of our distress be complex and diverse as well?

De-medicalization challenges

The obstacles that a person might face when undergoing de-medicalization are numerous and systemic in nature.

Capitalism

In the current state of the world, where most societies are living under or moving towards a system that seeks only to perpetuate itself by valuing human beings primarily on the basis of their ability to produce and consume, it is no surprise that the suppressing of pain that might distract humans from the main goal (producers/consumers) is the preferred response. Medicalization of distress might prove to be just a nut and bolt within the engine of capitalism.

How can one process and integrate emerging psychic pain when food, housing, safety, nutrition, rest and leisure time, the possibility of finding and connecting with those who extend love and compassion to our suffering, having access to natural spaces, finding time for physical activity and finding time for community building, are all not accessible to the majorities one is part of?

To pathologize people for having natural responses to insane circumstances and make them feel guilty and faulty for not being happy and successful with the ‘treatment’ provided, is to me, a crime against humanity. And even though I think capitalism has emerged organically through time and space, we now know enough about its destructiveness as societies and individuals to remain complacent, especially those of us who enjoy privileges inaccessible to most.

Lack of alternatives provided in the main discourse

This may vary depending on the country, culture, religion and the different oppressions experienced. In Nicaragua’s particular case, other than the biomedical approach that private and government health institutions and professionals provide, people might turn to their churches when experiencing psychic distress, which is not necessarily a safe step to take.

In 2017, a woman from the Nicaraguan Caribbean coast was tied to a tree and set on fire while having an extreme state of consciousness. The pastor of her church deemed her possessed by demons and persuaded parishioners that prayer would expel the demon, when prayer failed they resorted to fire. The criminals stated that the cause of her possession was alleged adultery, her name was Vilma Trujillo (Baker, 2018).

On top of there being a lack of alternatives, I mostly think there is a lack of freedom to explore whichever alternatives one might wish, as the prevalent narrative even pathologizes a person’s desire to de-medicalize their own suffering. Non-compliance has become an indicator of how ‘ill’ a person is, it is now a ‘symptom’ of ‘mental illness’ that has been labeled anosognosia (NAMI, 2020).

Withdrawal/discontinuation syndrome

The process of discontinuing one psychiatric drug might prove challenging especially when one has taken it over a long period of time, which is usually the case. When discontinuing
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more than one drug, things get more complicated as there might be withdrawal effects that can composite and make the process harder to endure.

In the community of ex-users and survivors of psychiatry, it is very common to hear stories full of struggles when it comes to withdrawal experiences. There are those who quit the drugs cold turkey because they lacked information and support, put themselves through an ordeal because of it but eventually make it to the other side. Discontinuation paradoxically can bring even more psychiatrization, as withdrawal effects are frequently attributed to the person’s original manifestation of distress, for which psychiatry’s response is higher doses, more drugs or a combination of both added to the regimen, almost always causing an inescapable vicious circle (Breggin, 2013: 120–121).

Then there are those people, who even when taking the cautious path of reducing one drug at a time by 10% of the original dose every two–three weeks (Hall 2012: 35) still find themselves struggling for years after first starting to taper.

Psychiatric drugs do create a chemical imbalance in the brain, as the body develops an adaptive response to the drug that causes it to decrease or increase certain neurotransmitters in the brain. When the drug is discontinued, this response no longer finds opposition which brings on what has been labeled withdrawal symptoms. These responses have not been studied in depth and it is unknown if they are reversible in all cases, as well, little is known about how long it can take the body to re-establish its normal operational structure (Moncrieff, 2009).

While tapering psychiatric drugs we swim in the waters of uncertainty. Currently there is no established mechanism by which the persons that have been caused chemical imbalances in their brains for prolonged periods and many times against their will, can hold those responsible accountable for the damage inflicted.

Opposition by prescribers and family members

When I told him that I wanted to come off the drugs that I had been put on, my psychiatrist strongly advised against it. I am inclined to believe that my experience is not the exception, but the rule. Most contemporary psychiatrists have been trained under the biological paradigm and truly believe psychopharmacological treatment is the only avenue to manage manifestations of psychic distress. Many of them might believe that supporting their patient’s desire to discontinue drugs is an act of irresponsibility on their part.

So when undertaking discontinuation this might be the first obstacle to overcome. The option to change prescribers is only available to those who can pay private health services, at least in my country. If a person is not a ‘consumer’, but rather a user of ‘mental health’ services, they will have to taper behind their prescriber’s back, hopefully with the support of family members.

If the person is coerced by their family to follow the psychiatrist’s recommendation, thinking about discontinuing might represent a higher risk, as doing it covertly brings its own set of problems. The fear of a crisis, the fear of being put on higher doses and/or more drugs, the fear of being discovered and potentially having certain rights taken away, e.g. parental rights.

Lack of proper support during the process

I wonder if the majority of current professionals that prescribe, whether they are GP or psychiatrists, really know much about the effects that might appear on the body and the behavior of a person and how much these might last when the drugs are discontinued. Their
frequent reticence to be associated with drug discontinuation processes makes me suspect they might feel limited by their ignorance on the matter.

The families of people experiencing psychic distress might not be willing or able to offer support to the discontinuation process of their family member for lack of resources and knowledge. Many people struggle for years when tapering psychiatric drugs.

There are few professionals in general and almost none in public healthcare that have a holistic approach towards health. There is no one professional or public service that can provide detailed guidance in lifestyle changes that promote health: such as changes in nutrition, physical activity, non-pharmacological tools that aid sleep like meditation, breath work, etc.

Information on de-medicalization mostly available only in the English language

Most of the information written by professionals and independent researchers originates in the North and takes time to be translated. This causes Spanish speaking countries to have delayed access to the latest scientific information, especially the psychiatric professionals that work both in private practice and public health care. The textbooks are very expensive and very often have to be acquired abroad, which represents another barrier to people from countries of the Global South.

Value of de-medicalization

By having lived a de-medicalization process after being labeled as ‘extremely mentally ill’ and having met and heard personal accounts of people who like me, have successfully de-medicalized their psychic suffering, I have found some common lessons and learnings.

By not suppressing the manifestations of psychic distress and having a de-medicalized perspective, one has the opportunity to bring to consciousness wounds and traumas that had never been addressed before. Provided one has the proper support, this can be a prime opportunity for healing, integrating and hence, avoiding the cycle of trauma and injustices one has been a victim of.

Living our manifestations of distress fully gives us the opportunity to be able to read our emotional states better, it gives us insight on what triggers us, what our patterns are, through experimentation we can learn which alternative tools help us and which do not. We have the possibility of knowing ourselves better and hopefully accepting ourselves just as we are.

If we begin with the mindset that our pain and suffering are not meaningless, it is more likely that we will be able to find meaning and purpose through it. There is a golden opportunity to get in touch and find out who one really is, to find one’s own voice and growth through self-determination, to become one’s own person, all in relation to the community one lives in. As an admired brother of mine always says: “What you cannot achieve by yourself, you can achieve with a group”.

By being completely in contact with our own suffering, we have the possibility of understanding the suffering of others around us, reconnecting in this way with our own humanity.

Practices that can support de-medicalization processes

Even though the emotional and physical struggles that might appear while de-medicalizing are experienced by the person alone, I believe they can be better processed when shared with a strong network of support, just like any other experience of human suffering.
Peer support groups

Something that can make an enormous difference in a person’s life is to have their pain acknowledged. Safe spaces can be found in peer-led support groups for psychic distress and for people discontinuing psychiatric drugs. I have led and participated in peer support groups after my de-medicalization experience. The most important aspects I have observed for a peer support group to be successful are to have the rules disclosed to everyone in the beginning and have the facilitator reinforce the rules throughout the session if need be. I think the most important rules should be horizontality, respect for the other person’s point of view and narratives around their pain and respect of the speaking times, as the word is power and thus, should always be passed around. By attending a peer support group one can find a network of support inaccessible in mainstream spaces. Peer support groups represent a very tangible tool for de-medicalization in countries of the Global South, where most types of alternative therapies are only available at a price too high for the majorities to be able to afford.

Activism

Activism provides an excellent platform through which we can build meaning and find motivation to face discontinuation struggles. If we have been harmed by psychiatric drugs, activism provides us with the opportunity to put our suffering at someone else’s service by actively sharing our stories, getting involved in our communities and finding a purpose that transcends our individual experiences. If you, the reader, are in Latin America and are a user, ex-user, survivor of psychiatry, mad person or person with psychosocial disability and are in need of a network of peers or just resources in Spanish, look up Redesfera Latinoamericana de la Diversidad Psicosocial through social media, reach out and get involved.

Decolonial perspective

Examining the ‘mental health’ system and its practices from a decolonial perspective served me well, especially when coming from the Global South. Our territories, and us with them, carry colonization pain that has gone unrecognized for generations, and now through globalization, that pain get systematically pathologized and monetized, as institutions of domination that have originated from the very same territories that inflicted such a great wound in the soul of our region (Latin America) are adopted. This collective pain trickles down through families and is manifested individually, sometimes extremely and unusually, like a desperate attempt to free the self and the collective from the insanity of individualism and capitalism. Decolonial perspectives can bring us closer to the wisdom of indigenous peoples, who regard themselves as children of nature and therefore care for it, for they know that her well-being is their good living. Through decolonial reflection one cannot escape the inherent destruction and exploitation that comes along Eurocentric progress.

References


Doing Mad Studies


