



## Inventing Mental Health First Aid: The Problem of Psychocentrism

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**ABSTRACT** *This article provides a sociopolitical critique of contemporary Mental Health First Aid (MHFA) discourses. The concept of psychocentrism, adopted as an analytical tool, critiques the problematic nature of MHFA premises and practices that automate, expedite, enforce, and normalize the global movement to psychiatrize human distress. Contesting MHFA's international image as a benevolent, individual crisis intervention model, this essay discusses MHFA as a technique of neoliberal governance, moral surveillance, and social control, responsible for reinvigorating the psychiatric profession while dividing and demoting the populace.*

**KEYWORDS** mental health; mental health literacy; mental health first aid; psychocentrism; neoliberalism; critical psychiatry; psychiatrization

More than one decade of evaluative scholarly literature acknowledges the international Mental Health First Aid (MHFA) movement as an extraordinary humanitarian success (Hadiaczky, Hokby, Mkrтчian, Carli, & Wasserman, 2015; Kitchener & Jorm, 2002). MHFA training seminars, central to this global movement, prepare lay citizens to provide immediate MHFA to persons perceived as distressed and presumed to be experiencing “a mental health problem” (Kitchener & Jorm, 2008). As one MHFA website explains:

One in three Canadians will experience a mental health problem at some point in their life. The earlier a problem is detected and treated, the better the outcome. Mental Health First Aid Canada gives people the skills to provide that help that is so important in recovery. MHFA is the help provided to a person developing a mental health problem or experiencing a mental health crisis. Just as physical first aid is administered to an injured person before medical treatment can be obtained, MHFA is given until appropriate treatment is found or until the crisis is resolved. The MHFA Canada program aims to improve mental health literacy, and provide the skills and knowledge to help people better manage potential or developing mental health problems in themselves, a family member, a friend or a colleague. (Mental Health Commission of Canada, 2015)

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MHFA emerges from the Australian Mental Health Literacy goal of early detection and treatment of mental disorders (Jorm, 2000). MHFA training seminars coach trainees to first recognize human distress as psychiatric pathology, and second, to act on that recognition by providing “The Five Basic Actions of MHFA” (Mental Health Commission of Canada, 2010, section 1, p. 4): (1) assess risk; (2) listen non-judgmentally; (3) give reassurance and information; (4) encourage professional help; and (5) encourage informal support (Kitchener & Jorm, 2002; Mental Health Commission of Canada, 2010, section 1, p. 4). Specifically, Action 3 directs MHFA practitioners to “help the [distressed] person feel hope and optimism and realize that they have a real medical condition and there are effective treatments” (Mental Health Commission of Canada, 2010, section 1, p. 4). MHFA medicalizes and psychiatrizes human distress (Conrad & Schneider, 1980), not only through its third core action which frames distress as a medical phenomenon, but also through MHFA’s use of psychiatric terms and psychiatric frameworks to define, describe, understand, and address human distress (Conrad, 1992, p. 211; 2007; Wright et al., 2007). The objective of the MHFA movement is to prepare members of the public to seamlessly integrate psychiatric discourses and MHFA directives into informal conversational disclosures of distress wherever and whenever such expressions might occur (Kitchener & Jorm, 2008). MHFA is now practiced in remote, rural, and urban locations in more than 20 countries around the world (Byrne, McGowan, & Cousins, 2015; Mental Health Commission of Canada, 2015). Aligned with the “global mental health for all” mission of the World Health Organization (Collins et al., 2011), the MHFA movement continues its steady growth around the globe (Hadiaczky et al., 2015; Jorm & Kitchener, 2011).

White and Pike (2013, p. 240) assert, “The making and marketing of MHL [mental health literacy] programs ought to be scrutinized.” MHFA, perhaps the flagship of international mental health literacy, should be no exception. Despite psychiatry’s longstanding crisis of legitimacy (e.g., Cooper, 1967; Foucault, 2011; Frances, 2013), MHFA intensifies the well-documented psychiatrization of everyday life (Conrad & Schneider, 1980) by training and authorizing citizens worldwide to conduct uninvited, continuous psychiatric assessment and intervention in every formal and informal domain of community life. MHFA advises, “there are effective treatments” (Mental Health Commission of Canada, 2010, section 1, p. 4), however psychiatric diagnosing and drugging is fraught with evidence and allegations of harm (Breggin, 1994, 2014; Moncrieff, 2013, 2014b; Whitaker, 2010). As part of the “relations of ruling” (Smith, 1987, p. 3), MHFA strengthens the social and institutional identification and management (White & Pike, 2013, p. 250) of persons assessed as distressed, deficient, or different (American Psychiatric Association, 2013). Recipients of MHFA assessment and intervention must both occupy and “be occupied by” (Mills, 2014, p. 77) inferiorized terms (Rimke, 2010, p. 99) denoting their mental deficits and pathologies (Mental Health Commission of Canada, 2010). Operating under

the marketing smokescreen of emergency first aid, MHFA exercises naming rights over the emotions, experiences, identities, and knowledges of distressed persons (Liegghio, 2013). MHFA translates struggle and discontent into psychiatric pathology as though human suffering is a *terra nullius* available for psychiatric acquisition. MHFA contributes to psychiatric imperialism while providing neoliberal governance (Rimke, 2000, p. 71) and “uninterrupted social and moral surveillance” (Foucault, 2011, p. 118, 1994, pp. 107-123), functioning as a mechanism for social control – *therapeutic* social control (Conrad, 1992, p. 216; Conrad & Schneider, 1980, pp. 178-179). Just as MHFA augments psychiatric reach throughout the populace, MHFA simultaneously adds to the individualization and depoliticization of distress, dispelling perhaps more than ever the possibility of meaningful and just social reform (Mills, 2014). MHFA is thus more than a crisis intervention model, and more than a mental health literacy campaign.

To provide a critical examination of MHFA, the paper adopts and applies the sociological concept of psychocentrism, which critiques the dominant model of pathological individualism produced by the hegemony of the psy complex in Western society (Rimke, 2010; Rimke & Brock, 2012). Applied to MHFA discourse, psychocentrism provides a way of understanding how the MHFA literacy campaign automates, accelerates, enforces, and normalizes the global psychiatrization of human distress. Application of the concept of psychocentrism both elicits and analyzes a series of linguistic techniques and practices used to legitimize and naturalize the MHFA movement, a critique that until now has not been forthcoming. The notion of psychocentrism opens a space to understand distress as an appropriate response to the loss and pain implicit in human experiences; it also makes room for understanding distress as an “action guiding” (Shotton, 2010, p. 140) necessity for human survival. Moreover, the concept of psychocentrism highlights distress as a collective matter, an issue of social injustice requiring social remedies and reform rather than individual “mental illness” requiring personalized and private psychiatric treatment above all else (Rimke & Hunt, 2002).

### **Inventing Mental Health First Aid: The Problem of Psychocentrism**

Social scientist Heidi Rimke coined the term psychocentrism to study and critique the dominant Western rationality that all human problems result from individual pathologies rather than deficits in society. Psychocentrism is defined as the governing premise of neoliberal, advanced capitalist populations (Rimke, 2012, p. 32). The effect of psychocentrism is a growing range of “psy” technologies and assemblages that de-politicize, pathologize, individualize, and police the social fragmentation, inequality, and suffering neoliberal policies produce (Esposito & Perez, 2014; Moncrieff, 2014a). Generated through the psy complex, psychocentric sensibilities divide

populations into the morally loaded categories of normal and abnormal, healthy and ill, good and bad (Rimke & Brock, 2012, p. 198), classifications that determine important matters such as identity, survival, and “life chances” (Goffman, 1963, p. 5). Normalizing neoliberal ideals such as individual autonomy, freedom of choice, and personal accountability, psychocentrism holds the individual responsible for both successes and failures while diminishing the responsibility of authorities (Rimke, 2010). Indeed, the “compulsory ontology of pathology” (Marsh, 2010, p. 31) characterizes the industrialized West. Our largest, most powerful institutions intricately depend on the ever-expanding psychiatric classification of individuals (Rimke & Brock, 2012; Rose, 2013).

MHFA research programs, training seminars, interventions, and communities of practice, produce, consume, and disseminate psychocentrism. Rooted in psychiatry, MHFA trains citizens to pathologize human suffering rather than critique the consequences of unjust social structures and power relations. Rimke (2010) provides six basic characteristics of psychocentrism: reductionism, determinism, essentialism, presentism or ahistoricism, naturalism, and ethnocentrism. The following sub-sections critically examine each characteristic as a pivotal discursive force (Gergen, 1999; Marsh, 2010; Potter, 1996) for naturalizing and normalizing MHFA’s global psychiatrization of distress.<sup>1</sup>

### *Reductionism*

MHFA ensures psychiatrization of distress through its practice of *reductionism* (Rimke, 2010, p. 97). Collapsing the social, political, cultural, and economic complexity of human distress into one single aspect – the flawed mental interiority of the individual (Rimke, 2003) – MHFA exonerates contextual, socio-political factors while maximizing attention to individual pathology. Although MHFA lists traumatic experiences (Mental Health Commission of Canada, 2010, section 5, p. 8), as well as “losses,” “setbacks,” and “tragedies” (Mental Health Commission of Canada, 2010, section 3, p. 1) as contributors to “mental illness,” MHFA training seminars coach trainees to see distressed persons as people who “have a real medical condition” (Mental Health Commission of Canada, 2010, section 1, p. 4). MHFA thus reduces the diverse breadth and particularity of human struggle to the uniform, decontextualized psy discourse.

A study of the mental health literacy of citizens in an economically strained, rural area of Maharashtra, India, provides a specific example of reductionism (Kermode, Bowen, Arole, Joag, & Jorm, 2009). The study

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<sup>1</sup> As articulated in her introduction to this special issue, Rimke has further developed the notion of psychocentrism to include four additional characteristics: victim-blaming, double standards, positivism and pathological individualism. My analysis here does not consider these additional characteristics.

evaluates Indian participant responses to vignettes portraying Indian citizen distress (Kermode et al., p. 477). MHFA researchers rejected the participants' understandings of distress as "stress" (p. 478). Instead, the MHFA researchers regarded the vignettes' depiction of distress as "the presence of a mental disorder" (p. 479). The Indian participants suggested that distressed persons needed "love and affection" (p. 478), "family as a source of help" (p. 482), and "financial support," (p. 478) coherent with "local views regarding the causes of mental distress, which are largely thought to be social and economic" (pp. 479-480). In contrast, the MHFA proponents reduced Indian distress to mental pathology that requires healthcare and "selective referral to professional psychiatric services" (p. 482) along with "appropriately administered psychotropic medication" (p. 480). Significantly, the Indian study participants understood their distress as a debilitating and life-threatening relational and economic matter, whereas the MHFA experts reduced the complexity of Indian distress to symptoms of mental pathology.

Another MHFA study involving 176 participants (Massey, Brooks, Burrow, & Sutherland, 2010, p. 9) further illustrates how MHFA utilizes reductionism to automate and normalize psychiatrization of human distress. Set within a Canadian university campus, this study evaluates the effectiveness of MHFA training seminars to increase staff knowledge about mental health (Massey et al., 2010). The term "mental health" directly frames distress as a mental phenomenon, a health subject interchangeable with "general mental health conditions (e.g., depression, anxiety, inability to concentrate...)" (p. 12). The study also aims to "enhance sensitivity" (p. 9) and "raise confidence" (p. 9) in staff response to distressed students. Study participants are shown vignettes featuring emotional turmoil, and each vignette is "written to satisfy the diagnostic criteria for [a] particular illness..." (p. 11), demonstrating MHFA's automatic conflation of distress with psychiatric illness. Analyzing their data, the investigators conclude the following:

...that the [MHFA] trained group of participants was more certain of when they were in contact with a person with a mental health condition than the untrained group and, in fact, recognized more individuals as experiencing a mental health condition. (Massey et al., 2010, p. 16)

This study downplays the role of contextual factors producing student distress, such as continual evaluation, or financial strain. MHFA proponents, pleased with their study findings, recommended MHFA training for all Canadian university staff (Massey et al., 2010, p. 22).

Certain versions of MHFA are less reductive than others, however, MHFA never strays from its psychiatric disciplinary underpinnings (Kitchener & Jorm, 2002). According to Hart, Jorm, Kanowski, Kelly, and Langlands, (2009, para. 6), "The AMHFA [*Aboriginal* MHFA] course differs from the general MHFA course in recognizing the historical, cultural and political forces that have affected Aboriginal mental health." Indeed, AMHFA

recognizes sociopolitical forces but ultimately maintains its foundational psychopolitical understanding of Aboriginal suffering. The MHFA training seminar for Aboriginal and Torres Strait Islander people reduces Aboriginal distress to mental pathology (Hart et al., 2009), instead of presenting Aboriginal distress as an inevitable human response to colonization, ecological devastation and genocide (Barta, 2008). Instead of questioning MHFA psychiatrization of Aboriginal distress, the MHFA seminar for Aboriginal and Torres Strait Islanders merely advises trainees to recognize “symptoms of mental illness within their Aboriginal cultural context;” the same MHFA training seminar teaches citizens to “be aware of relevant cultural factors in mental illness” (Hart et al., 2009, conclusion, para. 2). Critical analysis of the MHFA scholarship thus suggests MHFA founders Jorm and Kitchener (2011) permit superficial and strategic adaptation of MHFA course training, as “this tailoring to various national needs has contributed to the acceptability of the MHFA Program in diverse countries” (Jorm & Kitchener, 2011, p. 809). However, Jorm and Kitchener (2011, p. 809) require “fidelity to the course curriculum,” ensuring psychiatry’s dominance over alternative understandings of distress.

MHFA’s practice of reductionism excludes non-psy voices from participation in the production of knowledge regarding human distress (Liegghio, 2013). The practice of reductionism promotes psy literacy while disregarding other literacies and narratives (Costa et al., 2012). In their critique of reductionist mental health discourses, White and Pike suggest:

...a unified, or worse, a *universal* language around mental health and illness may make things appear simpler, more governable, pragmatic, and transferable, but when examined as a state-authorized regulatory practice, MHL [Mental Health Literacy] also has the implied legitimacy to perform the social role of hegemonic training. (White & Pike, 2013, p. 244)

Hegemonic psy training and dogmatic certainty precludes dialogue and justice (Anderson, 1997; Arnkil & Seikkula, 2015). Reductionism encourages MHFA trainees to dispense quick, confident, and standardized formulations (Jensen et al., 2015) instead of supportive relationships based on shared dialogic inquiry, responsiveness, reciprocity, and compassionate collaboration (Anderson, 1997; Shotter, 2012).

### *Determinism*

Demonstrating a second aspect of psychocentrism, MHFA enforces psychiatrization of distress through the discursive practice of *determinism* (Rimke, 2010, p. 97). Through claims that mental illness is like any other illness – like diabetes, cancer, or kidney disease – MHFA discourses ignore the interdisciplinary critique pointing to psychiatry’s absence of bio-marker evidence and objective laboratory tests (Frances, 2013; Rose, 2016). Instead

of acknowledging that in fact, “‘mental illness’ is an illness like *no* other, or indeed better not conceptualized as an illness at all” (Mills, 2014, p. 27, emphasis in original), MHFA utilizes determinism to help construct mental illness as inevitable, random, and socially and politically meaningless (Albee & Joffe, 2004). MHFA founders, Jorm and Kitchener (2011, p. 808) stress the pervasiveness of mental disorder, warning that “contact with people who are affected” is inescapable: “National surveys have shown that mental illnesses are very common, so that it is inevitable that members of the public will more often have contact with people who are affected.” Mental health literacy often uses simplistic numerical language to *inevitabilize* and *scientize* mental illness. The Canadian MHFA training manual for adults who interact with youth (Mental Health Commission of Canada, 2010, section 1, p. 5) claim that “one person in three will experience a mental health problem at some point in their life time.” Elsewhere, MHFA co-founders report, “contact with people developing a mental disorder or in a mental health crisis is almost universal” (Kitchener & Jorm, 2008, p. 60), and that “virtually everyone will either develop a mental disorder or have close contact with someone who does” (Jorm, 2000, p. 396). Determinism persuades the populace that their problems are psychiatric, and therefore their solutions must be also.

Determinism is particularly operative in youth mental health discourses. Reproducing the deterministic conclusion that the first onset of mental illness typically occurs in childhood or adolescence – as though there cannot be any other cause of adolescent distress – MHFA echoes the central messages of other mental health literacy campaigns targeting children, adolescents, youth, young adults, and their caregivers, parents, and educators (Kutcher, Bagnell, & Wei, 2015; McIssac, Read, Veugelers, & Kirk, 2013; The Mental Health Commission of Canada, 2010; Whitley, Smith, & Vaillancourt, 2013). Mental health literacy campaigns, such as *The Jack Project*, *MindWise* campaign, *MindMatters*, and the *School-Based Pathways to Care* (Wei, Kutcher, & Szumilas, 2011), consume, produce, and disseminate deterministic advisements regarding the inevitability of youth mental disorder: “Adolescence is the peak age of onset for mental illness, with half of all people who will ever have a mental illness experiencing their first episode prior to 18 years of age” (Kelly et al., 2011, p. 2). In addition to emphasizing childhood and youth as the beginning of most mental illness, MHFA practices determinism in its assertion that mental illness diagnosis in young persons predicts future mental illness: MHFA proponents frequently warn, “Early onset of mental illness is a significant predictor for future episodes” (Kelly et al., 2011, p. 2). Determinism is embedded in psychiatric diagnostic manuals (DSM) because the best-case scenario in the psychiatric DSM is remission, never cure (American Psychiatric Association, 2013). Additionally, the well-established psychiatric co-morbidity discourse further demonstrates determinism; persons diagnosed with one mental illness are

deemed likely to meet diagnostic criteria for additional psychiatric labels (Hamdi & Iacono, 2014).

### *Essentialism*

MHFA automates psychiatrization of distress through *essentialism* (Rimke, 2010, p. 97), a third aspect of psychocentrism. Training members of the public to function as “spotters” (Goffman, 1959, p. 147) of mental illness typifications essentializes others as identifiable kinds of people (Hacking, 2007) with stable “entity characteristics” consisting of “this or that” (McNamee & Hosking, 2012, pp. 25-26), as inferior (Mills, 2014, pp. 75-76; Rimke, 2003) and as “less than ideal” (Gergen, 1994, p. 149). MHFA seminars instruct trainees to match specific psychiatric labels to persons exhibiting various manifestations of distress (Jorm et al., 1997; Wright, Jorm, Harris, & McGorry, 2007). The MHFA training question, “... what, if anything is wrong with Mary/John?” (Jorm et al., 1997), encourages trainees to typify distressed persons according to the classifications provided by the psychiatric DSM nosology (American Psychiatry Association, 2013). While MHFA training does not equip trainees to provide official diagnosis, MHFA training furthers the psychiatrization of distress by promoting psychiatry-based ways of “seeing and saying” (Foucault, 1994, p. xi; Mills, 2014), diagnostic “styles of thought” (Marsh, 2010, p. 31; Rose, 2000), and diagnostic styles of listening (Anderson, 1997, p. 135), thus fostering diagnostic “sensibilities and sensitivities” (Shotter, 2010, p. v). Despite the stark absence of scientific bio-marker evidence for mental illness (Moncrieff, 2013; Rose, 2016), mental illness diagnoses apply not only to the mind but the whole person; psychiatric diagnoses are totalizing, “fully general,” (Gergen, 1994, p. 150), thereby producing a deviant social identity (Goffman, 1963). Oblivious to the social significance of socio-political factors, the DSM classification system dismisses non-psychiatric understandings (American Psychiatric Association, 2013). Ironically, although MHFA adopts deficit-oriented, essentializing, “us-them” categorization – species talk (Hacking, 2007) – MHFA paradoxically calls on citizens to accept defamatory psychiatric classifications and stop the stigma accompanying psychiatric labeling (Chalmers et al., 2014). The logic of MHFA is essentialist as seen in training seminars, research programs, interventions, and scholarly articles.

### *Presentism or Ahistoricism*

MHFA discourses also rely upon *presentism* or *ahistoricism* (Rimke, 2010, p. 97), a fourth aspect of psychocentrism. Bound to psychiatry’s general disregard of historical factors contributing to collective and individual distress (American Psychiatric Association, 2013), MHFA de-contextualizes knowledge, saying little about historical aspects of human distress. The

MHFA Northern Peoples webpage (Mental Health Commission of Canada, 2011) utilizes presentism, for example, by framing Aboriginal despair and substance as a “mental disorder,” specifically, as “mood disorder” and “substance use disorder,” without offering any historical information for Aboriginal distress. This omission is particularly poignant as Canada’s colonial past is far from over (Comack, Deane, Morrissette, & Silver, 2013). Similarly, in India, MHFA proponents practice ahistorism in their construction of human distress as individual mental problems instead of social problems rooted in a lethal dehumanizing history of colonization and genocide. MHFA proponents claim that Indian distress is due to the lack of mental health literacy, lamenting that mental health is “a neglected issue in most developing countries” (Kermode et al., 2009, p. 476).

One particular mental health training program conducted by MHFA proponents in the Bangalore Rural District, Karnataka, India, utilized a vignette describing a character named Ram in order to illustrate what mental illness “looks like.” Describing Ram’s debilitating distress, the vignette’s narrative reports, “He used to regularly help his father work on the farm but for the past 10-15 days he has not been going to work” (Armstrong et al., 2011, p. 4). The vignette describes Ram’s recent isolation, his tendency to talk with himself, his suspicion of others’ malicious behavior, the time he hit his father, his refusal to eat food, and so on (p. 4). The Indian seminar participants were coaxed to “name the problem” (p. 4), and “only ‘depression,’ ‘schizophrenia’ or ‘psychosis’ were considered correct responses” (p. 4). The vignette offers no acknowledgement of the personal or collective historical context of Ram’s distress.

The same problematic representation of Ram was utilized by MHFA proponents at a training seminar in a poverty-stricken rural area of Maharashtra, India (Kermode et al., 2009, p. 477). Once again, the MHFA discourses frame Ram’s distress as psychiatric, unrelated to historical, political, and economic forces producing widespread Indian farmer despair and dis-ease (Kermode et al., 2009). The MHFA study evaluates Indian participant understandings of distress as “limited” (Kermode et al., 2009, p. 479) because “the majority of participants did not consider the problems in either of the [training] vignettes to be a ‘real illness’” (Kermode et al., 2009, p. 479). MHFA’s ahistoricism complements and strengthens the psychiatrization of human distress.

Opposing the tenets of the global mental health movement, Mills (2014, p. 36) articulates historical events as critical factors embedded in contemporary Indian farmers’ distress in Maharashtra, India. She points to the privatization of seed since the 1970’s, describing how new, imported hybrid varieties and more expensive, genetically modified seed replaced low-cost Indigenous seed. Mills (2014, p. 36) states these innovations drove up seed prices, requiring farmers to either present cash “up front” or borrow it, typically from private moneylenders. Reliance on credit and debt began to drastically increase food insecurity and economic and social instability. Within this

historical economic context, suicide rates began to rise; “In 2007, more than 4000 farmers committed suicide in the state of Maharashtra” (Das, 2011, p. 23, cited in Mills, 2014, p. 36). Mills (2014, p. 38) reports that “One note from a young male farmer said: ‘[t]he cotton price has fallen to Rs. 1,999 a quintal. We cannot manage with that. Which is why I am giving up on my life’ (Perspectives, 2009: 2).”

While Mills’ scholarship draws attention to lethal conditions produced by historical global power imbalances and volatile markets, MHFA proponents – considering the same farmer distress in the same region of India – by-pass long-standing historical injustices, and instead renew their commitment to improve the mental health literacy of whole Indian communities, enhance awareness of the need to “access appropriate professional help when someone has a mental health problem,” and promote “knowledge about the effectiveness and affordability of evidence-based psychotropic medications” (Kermode et al., 2009, p. 482).

The MHFA movement also exercises ahistoricism by avoiding acknowledgement of the long history of anti-psychiatry, critical psychiatry, and critical psychology movements interrogating psychiatry (e.g., Fernando, 1988; Foucault, 2011; Goffman, 1961; Linklater, 2014; Merecek & Gavey, 2013; Moncrieff, 2013; Parker, 2014). Erasing psychiatry’s historical legitimation crisis thus also strengthens global psychiatrization of distress.

### *Naturalism*

MHFA promotes the compulsory psychiatrization of distress through its use of *naturalism* (Rimke, 2010, p. 97), a fifth aspect of psychocentrism. Distinguishing itself from literature discussing the social construction of mental illness (Gergen, 1994), MHFA naturalizes mental illness by using biomedical vocabulary such as “chemical” and “brain” (Mental Health Commission of Canada, 2010, section 3, p. 4), “symptoms,” (Jorm, 2000, p. 396) and “scientific evidence” (Jorm 2000, p. 398), thus creating the appearance of an illness “decided by *nature*” (Garfinkel, 1967, p. 124; emphasis in original). Drawing upon the cultural capital of science, MHFA discourses are presented as a privileged knowledge, a specialty of physical medicine where mental illness is viewed as part of the universal “natural facts of life” (Garfinkel, 1967, p. 124), as though epistemological consensus prevails. The “first aid” metaphor helps naturalize MHFA while simultaneously conveying urgent need for MHFA, emphasizing the necessity of the “recognition” of mental pathology (Jorm & Kitchener, 2011).

Additionally, the rhetorical and repetitive use of the term “Five Basic Actions” (Mental Health Commission of Canada, 2010, section 1, p. 4) gives the sense that MHFA intervention is elemental and indispensable, much like the periodic table. The rhetoric conceals the powerful psychiatric discourse implicit in MHFA. The emphasis on five basic actions also masks the complex, problematic, and potentially profound – if not harmful –

consequences and life-long implications of engaging with psychiatric expertise during a time of personal crisis (Frances, 2013; Moncrieff, 2013).

MHFA training seminars prepare trainees to adopt roles involving “close observation” (Lofland, 1967, p. 46) of people – not in the context of professional office spaces – but rather “in their natural settings” (p. 46), where MHFA providers have social access to the details of distressed persons’ lives. MHFA trainings offer vignette examples of people exhibiting human distress. Each vignette offers a close account of information that would be regarded as intimate or confidential in real life; “To be close in these senses implies for the naturalist an observational methodology much after the manner of geologists, scholarly flower and bird watchers...” (p. 47). Classifying what they see up-close, MHFA practitioners appear to practice naturalism “in the tradition of Darwin” (p. 45), thereby persuasively normalizing the psychiatrization of distress as “natural” and “scientific” rather than social and historical.

### *Ethnocentrism*

*Ethnocentrism* (Rimke, 2010, p. 97), the sixth characteristic of psychocentrism, serves to ensure MHFA’s psychiatrization of human distress. MHFA’s utilization of ethnocentrism is evident in its automated mass “roll-out” (Jha, Kitchener, Pradhan, Shyangwa, & Nakarmi, 2012; Kitchener & Jorm, 2008) of MHFA in cultures around the globe. MHFA proponents have modified some versions of MHFA (Kitchener & Jorm, 2008, p. 57) to suit groups deemed culturally and linguistically diverse; however, changes made can be seen as superficial since MHFA always remains faithful to psychiatric culture over any other cultural practices. Rejection or poor uptake of MHFA is usually attributed to a deficiency in the so-called diverse host country. For example, MHFA practitioners discredit Nepalese disinterest in MHFA by explaining, “people are hesitant.... because of ignorance ... Even at places where services are available, people are hesitant to access and benefit from them because of ignorance and stigma of mental illness in Nepalese society” (Jha et al., 2012, p. 258). MHFA proponents explain further: “Local residents do not understand the benefit of seeking mental health service in time” (p. 258). Additionally, and tautologically, MHFA adherents blame “poor mental health literacy” for failed reception of MHFA in Nepal: “It is a known fact that if the public’s mental health literacy is poor, this hinders their acceptance of mental health care” (p. 258).

Similarly, MHFA proponents argue that Aboriginal resistance to MHFA is due in part to errors made within Aboriginal cultures, specifically, “inadequate measures to reduce the stigma associated with mental illness” (Chalmers et al., 2014, p. 3). MHFA frames Aboriginal peoples as inherently mentally disordered, indicating that “data” shows “inequality” between Aboriginal and non-Aboriginal Australians’ mental health from early ages.

Aboriginal “shame” and “lack of trust” are listed as deficient cultural features impeding the uptake of MHFA (p. 2). Terms such as “genocide” and “colonization” (Barta, 2008) are absent in the report describing “culturally appropriate” MHFA for Aboriginal or Torres Strait Islander adolescents (Chalmers et al., 2014), and instead the report uses vague, de-politicized words, such as “risk factors” (Chalmers et al., 2014, p. 3), “separations in past generations” (p. 3), and “loss of land” (p.3), and claims that “Young Aboriginal Australians are disproportionately exposed to risk factors, such as grief, trauma, loss” (p. 3). Ambiguous “at-risk” and “trauma” discourses conceal why it is that some groups are more exposed to risk than others, thus diminishing the culpability of authorities and dominant settler groups. Similarly, reports of Aboriginal youth suicide and self-harm (Chalmers et al., 2014) without specific identification of the injustices killing and harming youth make a denigrating spectacle of Aboriginal anguish while bolstering the heroism of MHFA (Marsh, 2010). MHFA proponents suggest Aboriginal people understand mental health “within a unique cultural framework that is not necessarily complimentary to the biopsychosocial model of Western medicine” (Chalmers et al., 2014, pp. 2-3), implying a harmonious, “complimentary” relationship between the field of mental health and Western medicine.

MHFA scholarship illustrates Anishinaabe scholar, Rene Linklater’s (2014, p. 20), assertion that Western non-Indigenous psy frameworks pathologize Indigenous peoples’ distress. Eroding Indigenous approaches to distress and well-being that emphasize qualities such as relationships, spirituality, and interdependence (Gergen, 1994, pp. 149-150; Watters, 2010; Baskin, 2011; Hart, 2002), MHFA ethnocentrism psychiatrizes distress, contributing to what Dutro & Bien (2014, p. 26) – drawing on Forter’s (2007) work – call the “mundanely catastrophic marginalization” at the root of the suffering of inferiorized social groups (Rimke, 2003):

There is reason to believe that in their very effort to furnish effective means of alleviating human suffering, mental health professionals simultaneously generate a network of increasing entanglements for the culture at large. Such entanglements are not only self-serving for the professions, they also add exponentially to the sense of human misery. (Gergen, 1994, p. 143)

### **MHFA Psychocentrism as Governance**

In the previous sections, the concept of psychocentrism was utilized as a conceptual tool to analyze MHFA’s international psychiatrization of human distress. Drawing on Rimke’s (2010) conceptualization of psychocentrism, I have discussed the problems of reductionism, determinism, essentialism, presentism or ahistoricism, naturalism, and ethnocentrism as key mechanisms responsible for automating, expediting, and enforcing MHFA’s steady promotion of mental *illness*, “both as medical condition and social identity, as

a disease, like diabetes or heart disease” (White & Pike, 2013, p. 240). More than perpetuating psychiatric imperialism, psychocentrism produced, consumed, and disseminated through MHFA discourses and practices provides a form of neoliberal governance and “uninterrupted social and moral supervision” (Foucault, 2011, p. 118). Considered through a sociopolitical lens, MHFA is an apparatus of neoliberal governance and social control (Conrad, 1992, p. 216; Conrad & Schneider, 1980, pp. 178-179; Moncrieff, 2008). MHFA instructs citizens to notice, manage, and direct emotional distress and disturbance to the attention of psy authorities, thereby implementing a form of governance that cannot be achieved by laws alone (Moncrieff, 2008; Redden, 2000; Rimke, 2003). MHFA practitioners assure distressed citizens that they have real medical conditions and there are effective treatments (Mental Health Commission of Canada, 2010). Psy experts diagnose, stimulate, and sedate the anguish and unrest of the masses as deemed necessary (Moncrieff, 2013), thereby ensuring minimal threat to the inequitable status quo. MHFA reminds citizens of their duties to recognize their neighbours’ distress as psychiatric sickness and turn their neighbours in (Moncrieff, 2008; Redden, 2000).

MHFA continues to reflect its original political and economic birthplace. Jorm and Kitchener developed and launched MHFA in Australia in 2001 (Jorm & Kitchener, 2011). Only one year previous to the emergence of Australian mental health literacy (the ideological springboard for MHFA), thousands of trade union members and others invaded the Australian Parliament protesting the newly elected Coalition Government’s Work Place Relations Bill, widely regarded as an attack against persons living on subsistence incomes (Fairbrother, Svensen, & Teicher, 1997). Led by the Australian Council of Trade Unions, and propelled by Australia’s reeling working class, the mass protest of August 19, 1996, signaled cumulative and widespread anger and fear (Fairbrother et al., 1997; Kuhn, 1993). At this time of economic reform, insecurity, and increasing economic disparity (Fairbrother et al., 1997; Kuhn, 1993), MHFA absorbed social problems with the aim of teaching Australian citizens to *read* outcries of human distress as individual mental health problems requiring on-the-spot, trained-citizen assessment and intervention, followed by expert psychiatric treatment (Kitchener & Jorm, 2002).

The institution of psychiatry emerged at the start of the industrial revolution’s massive reorganization of society according to market-driven premises and human scientific discourses (Moncrieff, 2008, p. 235; Rimke 2003; Rimke & Hunt, 2002). MHFA emerged in the late 1990s (Jorm, 2000) amidst an economic context of extreme national wealth and extremely restrained public expenditure (Hindness, 1998, p. 210), a context described as an Australian version of “economic rationalism” otherwise recognized as “Thatcherism, Reaganomics, and neoliberalism” (Hindness, 1998, p. 210; Pusey, 1991). More than an individual intervention and referral model, and more than a manifestation of psychiatric conquest, MHFA continues to

provide medical social control – *therapeutic* social control – one of the most powerful forms of social control available in modern society (Conrad & Schneider, 1980, pp. 178-179).

## **Conclusion**

This article examined MHFA's production, consumption, and dissemination of psychocentrism as intrinsic to the global psychiatrization of human distress. Emblemizing the inescapable, "compulsory ontology of pathology" articulated by Marsh (2010, p. 31), the force of MHFA psychocentricity extends well beyond the benevolent offer of emergency assistance to distressed individuals. MHFA augments psychiatry's diagnostic powers by commissioning unprecedented, citizen-led, psychiatric assessment and intervention throughout communities worldwide. Recruiting members of the public to participate in psychiatrization, MHFA authorizes new, vague diagnostic practices intended to help distressed persons realize "they have a real medical condition" (Mental Health Commission of Canada, 2010, section 1, p. 4). MHFA invents new psychiatric diagnosticians – *citizen-diagnosticians* – the thousands of international MHFA seminar graduates, each equipped to provide informal psychiatric observation, evaluation, and advice as they see fit. MHFA produces new, more reachable psychiatric patients, presuming and thereby increasing citizen availability to psychiatric contact and life-long patienthood. MHFA transforms and radically extends the psychiatric "office," as MHFA adherents disseminate ongoing, uninvited psychiatric opinion, intervention, and referral into the "everywhere" of community life (Mills, 2014; Rimke & Brock, 2012). With the global implementation of MHFA, no domain of society can be presumed free of psychiatric assessment; trained "eyes ... circulate without being seen" (Mills, 2014, p. 85).

Instead of turning one another into psychiatric subjects according to the mechanistic directives of MHFA, more might be gained from radically addressing the everyday social, economic, political, and historical atrocities debilitating and demeaning persons and communities. More might be gained from adopting a learner stance and "walking alongside" one another, listening and hearing, coming together to mutually determine – through genuine relationship and compassionate dialogic social inquiry – how to best live our brief and sometimes bewildering, excruciating human lives (Anderson, 1997; Arnkil & Seikkula, 2015). As Rimke suggests:

When emotions are taken seriously as a form of human experience and communication, rather than as an expression of abnormality, disorder or uncivil conduct, a practical dialogue about the social effects of the dominant social and political order becomes possible. (Rimke, 2010, p. 105)

The MHFA literacy campaign has spread rapidly since its inception in the early 21<sup>st</sup> century, but the analysis articulated in this essay calls for “other readings and writings of the world,” separate from the psychocentricity and “false generosity” (Lankshear, 1993, pp. 102, 107; Freire, 2014) of the global psychiatric aid industry.

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