Joe Moran

A Hidden History of Unhappiness

In *A Fortunate Man*, his account of the six weeks he spent shadowing the doctor John Sassall in the village of St Briavels in the Forest of Dean in the summer of 1966, John Berger writes that unhappiness is like illness in that 'it too exacerbates a sense of uniqueness'. Many of those who came to Sassall's surgery, as in doctors' surgeries everywhere, were not just ill but incurably lonely, fearful and sad. With an unhappy patient, Berger reflected, the doctor's task was to recognise the person behind the illness. This act of recognition could help to defeat a sense of hopelessness and offer at least 'the chance of being happy'. For the patient to feel recognised, the doctor had to appear to them as a comparable person, an 'ideal brother'. Sassall (a pseudonym) was known in the community as a good doctor because he met this 'deep but unformulated expectation of the sick for a sense of fraternity'. In witnessing their sorrow, he lessened the tendency of human frustration to 'magnify its own dissimilarity and so nourish itself'.[1]

As Berger discovered in Sassall's consulting room, people feel intensely the singularity of their own unhappiness, in a way that drowns out wider explanations. 'With the fatal a-historical basis of our culture', he writes, 'we tend to overlook or ignore the historical content of neurosis or mental illness […] Vulnerability may have its own private causes, but it often reveals concisely what is wounding and damaging on a much larger scale'. Sassall rarely referred a patient to a mental hospital, considering it 'a kind of abandonment'. In the evenings after supper, though, he had hour-long sessions with 'patients he believes he can help through psychotherapy'.[2] His own deep depressions derived in part from his sense of powerlessness in the face of his patients' problems, at a time when GPs were legally responsible for their care, twenty-four hours a day, all year round.

This essay traces a history of how we have understood acute unhappiness in Britain in the sixty years since *A Fortunate Man* was published. I know I am risking vagueness in adopting Berger's deliberately unmedicalised term, 'unhappiness'. I am not trying to conflate ordinary sadness with severe mental distress, still less to enter the complex debates about the efficacy of different therapeutic methods or drug

treatments for depression. My interest here is more in the history of everyday mentalities than in histories of medicine and social care. By examining seemingly disparate phenomena – the running down, closure and reuse of mental hospitals, the rise and fall of 'care in the community', the contemporary discourse of mental health awareness – I want to explore a shift in cultural attitudes in these years. This shift relates to our hidden assumptions about what makes us miserable and how we deal with that, both collectively and individually.

I draw especially on the work of David Smail, a clinical psychologist who also preferred the word 'unhappiness' to more medical terminology, believing that 'ordinary' and 'clinical' distress existed on a continuum. I argue that public understandings of unhappiness have increasingly discounted its historical origins and the material reality of people's lives and have seen it as a personal rather than collective responsibility. In *A Fortunate Man*, Berger was already noticing this shift away from sociological towards individual explanations. Despite this shift, acute unhappiness remained what it had shown itself to be in Sassall's surgery: something both knottily individual and inescapably social.

The slow death of the asylum

In 1961, David Smail began his first placement as a 25-year-old apprentice clinical psychologist at Horton Psychiatric Hospital in Epsom, Surrey. At the time, mental patients occupied forty per cent of all hospital beds in England.[3] Horton was one of the large mental asylums built in the Victorian era, after the Lunacy Act of 1845, for the long-term custodial care of those considered irremediably insane. When opened, they had been seen as enlightened institutions, with expansive grounds for recuperation, including farms and orchards. But since then most had become overwhelmed by the number of admissions and the rapid deterioration of their large and hard-to-maintain buildings. At Horton, Smail became concerned about the rigid hierarchies at these institutions, from the all-powerful Physician Superintendent at the top to the patient at the bottom, and the increasingly invasive treatments, such as electroconvulsive therapy, prefrontal leucotomies and insulin shock therapy. In his first encounters with mental patients, he found that 'even the most severely disturbed didn't appear ill so much as confused and despairing' and that there was 'not one whose life story did not abound with good reasons for their distress'.[4]

In 1964, he moved to another vast Victorian mental hospital, Claybury, near Chigwell in Essex. Claybury, under the leadership of Denis Martin, was a new kind of institution, a 'therapeutic community'.

This idea had developed among army psychiatrists during the Second World War and just after it to treat traumatised soldiers and returned prisoners-of-war. It was pioneered by psychiatrists such as Tom Main at Northfield Military Hospital in Birmingham, Maxwell Jones at Mill Hill Hospital in Middlesex, David Clark at Fulbourn Hospital near Cambridge and Russell Barton at Severalls Hospital near Colchester. The therapeutic community aimed to break the authoritarian structure of the mental hospitals. It saw patients as active and articulate participants in their own recovery and sought more open communication between staff and patients as a way of breaking down hierarchies.

At Claybury, Martin got rid of most of the locked doors, allowed men and women to mingle and initiated meetings about the running of the wards at which patients contributed equally.[5] With his colleague Tom Caine, Smail embraced these methods. They co-wrote a book, *The Treatment of Mental Illness* (1969), which questioned the impression of infallibility that the psychiatric profession presented to the public while making 'irreconcilable claims with equal confidence'. They argued that 'no amount of scientific wishful thinking can obscure the importance of personality and attitudinal factors in the psychotherapeutic relationship'.[6]

Therapeutic communities thrived especially after the 1959 Mental Health Act, which allowed patients to be admitted to psychiatric hospitals on an informal, voluntary basis. Smail became convinced that this was the future for the treatment of mental suffering: asylums that recognised the social roots of distress, without the top-down structures and invasive treatments. By the end of the 1960s, though, the therapeutic community experiment had stalled – overtaken by a general mood that the asylums should be closed rather than their practices reformed. In Adam Boggon's words, this move towards decarceration was the result of a rare alliance of 'therapeutic optimism, cultural skepticism, and fiscal conservatism'.[7]

First, therapeutic optimism. New developments in psychotropic drugs – particularly the introduction of Largactil (chlorpromazine) from the early 1950s and Valium (diazepam) from the early 1960s – held out the possibility that mental patients could live independent lives outside of institutions. Second, cultural scepticism: a view of the mental hospitals as cruel and punitive places. This view gained special traction in the UK through the anti-psychiatry movement led by R. D. Laing, David Cooper and Aaron Esterson, but it spread internationally. In the USA, it was given impetus by two influential books, both published in 1961: Thomas Szasz's *The Myth of Mental Illness* and Erving Goffman's *Asylums*, which revealed the everyday abasements inflicted on inmates of

a Washington asylum. And in Italy, from the early 1960s, Franco Basaglia led a movement in 'democratic psychiatry' under the slogan 'freedom heals'.[8] His reforms took root in other countries, especially Spain, Brazil and Argentina, and led to the Basaglia Law of 1978, which closed all Italy's asylums.[9]

Third, fiscal conservatism. The Victorian asylums were large buildings with astronomical running and maintenance costs. For Enoch Powell, conservative health minister from 1960 to 1963, ideas about decarceration tallied with an ideological commitment to cut state expenditure, increase market efficiency and discourage individual dependency. Addressing the 1961 conference of the National Association for Mental Health (now Mind), at Cane Hill Hospital in Surrey, dominated by a brick service tower, Powell used the architecture of the Victorian asylums as a metaphor for their obsolescence. The asylums had often been built in rural areas without a mains water supply, and these towers provided fresh water and a head of water in the event of fire. 'There they stand', he said, 'isolated, majestic, imperious, brooded over by the gigantic water tower and chimney combined […] the asylums which our forefathers built with such immense solidity – to express the notions of their day'.[10] A year after his 'water towers speech', Powell issued his Hospital Plan, following the provisions of the 1959 Mental Health Act. It provided for the replacement of the mental hospitals by psychiatric wards in general hospitals for acute-care patients and community-based services for non-acute cases.

The mental hospitals did not close as quickly as Powell had hoped, and nothing as definitive as the Basaglia Law came into force in the UK. However, these institutions did come progressively to be seen as unsuitable for long-term care. Between 1954 and 1994, the number of psychiatric beds in England fell from 152,000 to 43,000. Admissions, though, increased dramatically; the stays were much shorter, and voluntary referrals declined. The focus shifted to stabilising patients who had been sectioned under the Mental Health Act and then releasing them.[11]

By the 1980s, the Victorian mental hospitals were clearly coming to the end of their life. One consultant psychiatrist who began working at the Towers Hospital near Leicester in 1986 recalled 'an asylum that was closing down, ward by ward, corridor by corridor. Suddenly you couldn't go a certain way because a wall of breeze blocks had gone up overnight'.[12] The historian Barbara Taylor entered Friern Hospital in Barnet as a patient in July 1988. The reception desk was 'a mahogany cubbyhole with a broken ivory bell', which reinforced her impression that the building was 'a bloody museum' and that 'someone should be selling tickets'. When her friend, the historian Raphael Samuel, visited

her there, he suggested, perhaps tactlessly, that the history of the asylum should be her next subject: 'Barbara, darling! Colney Hatch! Don't you know about it? You must read about it, write about it! […] What a privilege for you, as a historian, to be present at the demise of one of the last great Victorian institutions!'[13]

The decaying wards of Friern, Taylor writes, 'faithfully mirrored the gothic inner landscapes of madness'.[14] They became popular with photographers and film companies, who were especially drawn to the hospital's six miles of corridors, including one over a third of a mile long. Scenes for *Britannia Hospital* (1982), in which Lindsay Anderson framed an outrageously mismanaged hospital as a metaphor for British decline, were filmed there, as was the black comedy *The Madness Museum* (1986). Roger Luckhurst argues that, because their architects had favoured Victorian Gothic, it was easy for the asylums to merge in the collective imagination with 'ruined castles, haunted houses and mad doctors intent on monstrous experiments'.[15] This added to the general sense that they belonged to a shameful past.

The rise of magical voluntarism

Working in psychiatric hospitals in Nottingham throughout the 1970s and 1980s, David Smail saw a more individualised approach to mental distress take hold. He considered this a subtle form of victim-blaming, one that played on the natural human tendency to feel responsible for our own feelings, even to feel that we have authored or invented them. By attributing unhappiness to neurotic or faulty thinking, this new psychotherapeutic model offered a 'sanitized technology of conduct' which ignored the unequal power relations we deal with from birth.[16] Smail coined the term 'magical voluntarism' to describe this newly pervasive belief that, through our own efforts, we can stop a cruel world causing us suffering.[17]

The transformation of British society in the Thatcher era convinced Smail of the social origins of unhappiness.[18] As the 1980s wore on, he found himself treating more and more people afflicted by a deep, nameless misery that they blamed on their own failings but that he felt could be better explained by the rise of a more competitive, unequal society. One new feature of this society was that the imperatives of the free market were seen as valueless and self-evident, while being evoked as ethical demands. The call to be efficient, productive and cost-effective came to be asserted with what Smail called 'a strangely puzzling ferocity'.[19] Growing disparities of wealth and power had heightened the tendency for the rich and powerful to mistake their own advantages for virtues

and to believe that those without money or power needed to work harder and be more responsible. In a 1987 interview for *Woman's Own*, Margaret Thatcher had famously said: 'Who is society? There is no such thing! There are individual men and women and there are families'.[20] Smail felt that this view found 'an unacknowledged echo in almost all approaches to therapy'.[21] With magical voluntarism, the miserable had to accustom themselves to the system that was immiserating them.

These years led to a huge growth in mental health advocacy rooted in magical voluntarism. Psychotherapeutic language spilled out from clinical practice into daily life. The therapy and counselling professions boomed, no longer limited to treating individual neuroses but moving into areas such as grief, relationship counselling and work mediation.[22] Magical voluntarism found its most popular expression in the success in the UK of self-help books by American authors such as Louise Hay, M. Scott Peck and Susan Jeffers, which populated the new 'mind-body-spirit' sections of bookshops. They offered individualised solutions to unhappiness, typically urging readers not to blame outside forces for their problems but to take control of their own destinies. 'When you blame any outside force for any of your experience of life', wrote Jeffers in an influential example of this genre, 'you are literally giving away all your power and thus creating pain, paralysis and depression'.[23]

For Smail, magical voluntarism was defined by the faith it placed in the transformative value of 'insight'. The original meaning of the word *insight* is 'internal sight'. It retains some of that sense of penetrating beneath the surface of things, seeing with the eyes of the mind. In modern medicine, *insight* refers to the patient's awareness that they are ill and must submit to treatment. In magical voluntarism, it referred to a person's ability to understand the reasons for their maladaptive behaviour. In both cases, the fog of self-delusion lifted when a person learned to comply with expert opinion and accommodate to reality.[24]

The assumption behind this therapeutic understanding of 'insight' was that unhappy people were unlikely to be insightful about their own unhappiness unless they were prompted into enlightenment by others. Smail believed that, as participant-observers with long experience in the field, unhappy people should trust their own hunches about their feelings instead of using someone else's expertise to haul them into 'insight'. While not infallible, our own subjectivity was the best available means we had of accurately reading reality.[25] We should see emotional pain as a deeply felt, embodied reality likely to be felt by others – the appropriate response to a world that gives us good grounds to feel hurt.

For Smail, the problem with magical voluntarism was that there is something essentially unteachable about a human being. You cannot simply migrate an insight from one body to another, in a way that overrides the amassed experience of that body's own nerves and senses. Unhappiness is a bodily state, acquired gradually as we work our way through the world. Smail compared becoming unhappy to learning a language. Mastering one's native tongue is not just brain work; it requires the tongue, lips, jaw, throat, vocal cords and lungs to work in unison. Once you have learned to speak a language, though, you cannot be cured of it, any more than you can be 'cured' of unhappiness.[26] 'We disembody people by conceiving of their "psyches" as more or less independent assemblages of conscious and unconscious mental equipment', Smail wrote in 1987. In fact, people's distress arises from 'their embeddedness in a history (which cannot itself be altered) and a set of circumstances (established by networks of social power far beyond their ability to control), and is mediated by experience which has, so to speak, been acquired organically'.[27]

Missing from society's new understanding of avoidable unhappiness, Smail argued, was a crucial element: power. Power was the unspoken constant, the fundamental dynamic of human life, 'the social element in which we exist'. Yet increasingly, to ascribe to someone a desire to acquire or hold on to power was 'to invite the kind of shock, indignation, incredulity or ridicule which is a sure indicator of the functioning of repression'.[28] Smail called power the 'real repressed', in contrast with sex, about which there was more openness than there had ever been.[29] Now, he wrote in 1993, it was 'often more indecent to refer openly to our fundamental appetites for control and domination than it is to our sexual appetite'.[30]

Unhappiness, by its nature, makes us confused as to its causes. Much unhappiness is existential and unavoidable – the normal run of grief, illness, disappointment and loss of heart in a human life. It is hard for us to distinguish between this kind of unavoidable misery and the avoidable miseries that arise out of the way that society is ordered – especially because the way that society is ordered can seem equally unavoidable, as obdurate as granite. The most powerful causes of our unhappiness are likely to be the furthest away from us, and we are least likely to attribute our unhappiness to them. Smail called these influences 'distal powers', because they operated over our power horizon, beyond our field of vision. When power is disavowed, Smail argued, 'the nearly irresistible appeal of proximal explanation' takes over.[31]

The asylum in ruins

The final death knell for the asylum was Sir Roy Griffiths's advisory report for the government, *Community Care: Agenda for Action* (1988), which informed the National Health Service and Community Care Act 1990. Griffiths called for the wholesale closure of asylums in favour of 'care in the community' for the mentally ill, supported by therapy and medication. The responsibility for such community-based care now lay with local authorities. The system would be supported by the NHS's new 'internal market' in which purchasers – in this case, local authorities – bought services from hospitals and health trusts.

Many mentally ill people, especially those without the support of friends and family, fell between the cracks of the available services. There were much publicised cases of 'care in the community' patients attacking members of the public or coming to harm themselves. Two events involving schizophrenic patients, both in December 1992, became notorious: one, Ben Silcock, climbed into an enclosure at London Zoo and was mauled by a lion; the other, Christopher Clunis, murdered Jonathan Zito at Finsbury Park tube station. Ken Worpole and Liz Greenhalgh, surveying public parks in the long hot summer of 1994, found that the parks had become boltholes for the mentally ill, partly because the police moved 'undesirables' there to keep them off the streets and out of the public eye.[32]

'Care in the community' passed into non-clinical language as a general insult, a synonym for the odd or socially awkward. In 1996, the Conservative health secretary Stephen Dorrell dropped the term in favour of 'spectrum of care' to refer to a range of options from detaining people in hospitals to community care.[33] Two years later, the Labour health secretary, Frank Dobson, confirmed the end of 'care in the community'. Psychiatric patients were now being portrayed in the popular press not as victims of a harsh, uncaring system but as potential killers on the loose. 'Evil psychopaths will be locked up' went a typical tabloid headline in response to the policy shift.[34] But the Powellite policy wisdom, that open-ended care bred dependence, remained. The old-fashioned asylums were like 'clapped out old motor coaches', Dobson said, which needed to be replaced with the 'custom-built vehicles' of smaller units staffed by specialist doctors and nurses.[35] The policy of decarceration continued: by 2006, the number of psychiatric beds had fallen to 34,000.[36]

From the mid-1980s onwards, as mental hospitals were slated for closure, people began to think about what should happen to the buildings that housed them. In 1987, Save Britain's Heritage, with the support

of the Victorian Society, launched a campaign to encourage local authorities to make imaginative use of these sites.[37] The community architect John Burrell grew interested in this issue after visiting the now abandoned San Giovanni Hospital in Trieste, where Franco Basaglia, in his role as director, had instructed his patients to knock down its fences and walls. The hospital was now derelict, occupied by squatters and infested by rats. Burrell believed these sites could become self-contained settlements, reducing the need to develop on the Green Belt. He imagined Claybury – built, like many British asylums, on high ground – as the capital of the undifferentiated tracts of suburban housing it surveyed, 'almost like an Italian hilltop town'.[38]

In 1991, Burrell won first prize in an architectural competition, 'Tomorrow's New Communities', organised by the Town and Country Planning Association and the Joseph Rowntree Trust. Burrell's entry saw Claybury as an expansion settlement of 10,000 people, a model that could be rolled out to other redundant asylums. Streets would be extended into the hospital site to break up its monolithic structure. The old airing courts would become small squares and the hospital's main buildings a new civic hub, with the water tower as the symbolic centre.[39] The development would incorporate sheltered housing for former mental patients, embedding the asylum in the community.

Burrell warned that 'the indiscriminate development of these sites as vehicle-oriented shopping or industrial parks or "housing" will be a wasted opportunity'.[40] The opportunity was indeed wasted. Many asylums had been built in rural areas outside of cities (a ring of them surrounded London), but thanks to urban sprawl, they now occupied prime development sites. Their fretted and frescoed interiors, ornamented exteriors, verdant grounds and imposing boundary walls made them ideal for gated communities. In *Notes from a Small Island* (1995), Bill Bryson describes his return to the former Royal Holloway Sanatorium at Egham in Surrey where, in 1973, he had taken a job as an orderly. He found it being converted into a luxury housing development called Virginia Park. He saw 'a glossy brochure full of architects' drawings of happy, slender people strolling around handsome houses, listening to a chamber orchestra in the room where I formerly watched movies in the company of twitching lunatics'.[41]

Friern Hospital closed in 1993, and five years later, it reopened as a luxury housing development, Princess Park Manor, built by Comer Homes. Most of the 550 metres of corridor was subsumed into the new apartments, and the development now had a swimming pool, saunas and a gym. In the years when it was empty or being refurbished, so many former patients had turned up confused at the old site, expecting

to be admitted, that the security guards were briefed to turn them away, 'gently but firmly', with information about local hospital services.[42] The Comer Homes website did not mention the building's former use, apart from recording that Prince Albert laid the foundation stone in 1849 and that 'throughout its distinguished history, Princess Park Manor has had an aura of grandeur about it'.[43] The apartments were popular with city workers (there being a direct line from the nearby tube station to Moorgate), professional footballers and members of boy and girl bands made famous by reality TV programmes, such as One Direction, JLS and Girls Aloud.[44]

Mental health campaigners complained that the developers had glossed over Friern's history. Peter Beresford, of the mental health self-help group Survivors Speak Out, wrote in the magazine *Open Mind* that the building should be turned into a 'museum of madness', which would enable asylum survivors to present their side of the story.[45] In 1997, the mental health activist Pete Shaughnessy launched the Reclaim Bedlam campaign. The Bethlem and Maudsley NHS Trust had organised a series of events celebrating the 750th anniversary of Bethlem Royal Hospital. Reclaim Bedlam protestors picketed the thanksgiving service at St Paul's Cathedral dressed as syringes and stopped the traffic on Tower Bridge by forcing it to open for their boat. In 1999, Shaughnessy and his friends founded Mad Pride and a year later published an anthology, *Mad Pride: A Celebration of Mad Culture*. Such mental health activism centred on the fate of the asylums as a way of thinking about the inadequacies of 'care in the community' and narrowly medicalised approaches to treatment. 'I'm walking around as a product of emotional and physical abuse, broken relationships, no meaningful employment, stressful housing – and I'm taking a tablet for the symptoms', Shaughnessy wrote.[46]

In 2002, Barbara Taylor returned to Friern, now Princess Park, posing as a potential buyer of one of the apartments. Smelling the fresh paint and floor polish, she felt that she and her fellow patients had been 'exorcized', with 'not even the echoes of our voices trapped in the walls'. Two years later, when refurbishing her house, she bought several metres of oak floorboards from an architectural salvage company that turned out to be from Friern.[47] The pattern repeated itself elsewhere. Either refurbished or flattened and rebuilt, the asylums were almost always sold off as high-end housing. Claybury became Repton Park, a gated development with a gym, yoga studio, health spa and a swimming pool dug up out of the old chapel floor.

The historical reversal is almost too clunky a metaphor: the Victorian asylums have become places of retreat and recuperation for the wealthy,

while the mentally distressed must take their chances in 'the community'. Compare this to Italy, where the former asylums have become, as well as housing, open parkland, school and university buildings, mental health services and *Musei della mente*, 'museums of the mind'.[48] The once derelict asylum at Trieste, now Parco di San Giovanni, houses a café and social centre, a radio station, art studios, various cooperatives, offices of the University of Trieste and the largest rose garden in Europe.

In his memoir of mental illness, *The Bullet*, Tom Lee shapes his narrative around Severalls, where both his parents were admitted – his father in 1968 after a breakdown and his mother with a paralysing depression in 1984, when Lee was 9. Closed in 1997, Severalls was left derelict for an unusually long time. When Lee visited the site with his parents in 2014, the once-grand buildings were graffiti-covered, with their windows boarded up and their gutted interiors – piles of broken-up wood and mangled metal – dumped outside. Severalls had the appearance of 'a place abandoned hastily and chaotically, without co-ordination, like some once thriving civilisation abruptly and mysteriously vacated, or a shipwreck decaying on the seabed'.[49] The treatment Lee received for his own breakdown, in 2008, followed a by-now familiar, ad hoc pattern: a visit to his GP, an antidepressant prescription, a single meeting with a psychiatrist and a short course of counselling. Lee recovered, but mainly through the support of friends and family, an understanding employer and a friend's illicit supply of Ativan.

'It is tempting', Lee writes, 'to see the persistence of the asylums in their material form as somehow symbolic, ghosts in the landscape, the social fabric and the private and public imagination'. In the absence of a serious public accounting of their history, 'the urge to memorialise the hospital has found expression elsewhere'.[50] Like many derelict asylums, Severalls attracted ghost hunters and amateur naturalists interested in the bird and mammal life that had occupied the abandoned buildings. Self-styled 'urban explorers' and 'place hackers' broke into the buildings and took pictures of the trashed wards and offices.[51] Severalls was finally bulldozed in 2016 to become Kingswood Heath, 'a stunning collection of 1, 2, 3 and 4 bedroom homes set in an exceptional parkland environment, just minutes from the centre of Colchester', according to the banner.[52] The old water tower has been preserved as a period feature.

Perhaps a full public reckoning of that flawed institution, the asylum, has not been made because to do so would be to address the flawed system that replaced it. Diana Gittins, in her oral history of Severalls, found a complex picture. For some, memories of the place were terrifying; others, especially women who had been raped or abused by

partners, found it a refuge. It is, Gittins concludes, 'just as foolish to romanticise Severalls' past as it is to demonise it'.[53] Taylor, whose own feelings about Friern were conflicted, wonders if history will be kinder to the asylums than we are now. For all their problems, she argues, they gave shelter, comradeship and support for those like her who needed 'a safe place to be, a "stone mother" to hold me for as long as I required it'. They thus fulfilled needs 'that the present system pretends do not exist, offering in their stead individualist pieties and self-help prescriptions that are a mockery of people's sufferings'.[54]

Shit Life Syndrome

In the early 2010s, GPs began seeing an increasing number of patients with a complex mix of health, social and emotional problems created in the new era of austerity. The use of antidepressants had been rising in the UK since the mid-1990s, but the years after the 2007–2008 financial crash saw a particularly steep increase.[55] Frustrated at being expected to solve these problems with ten-minute consultations, prescriptions and sick notes, some doctors gave their patients' condition an unofficial name: SLS, or Shit Life Syndrome.[56]

In a 2011 article, the cultural theorist Mark Fisher defined the new approach to collective unhappiness as 'the privatisation of stress'. He saw it as part of a general trend towards privatisation aimed at 'an almost total destruction of the concept of the public – the very thing upon which psychic well-being fundamentally depends'.[57] Fisher drew on David Smail's work, particularly his concept of 'magical voluntarism', in this and other essays.[58] Writing in the same year, William Davies argued that unhappiness was now 'the critical negative externality of contemporary capitalism'.[59] In economics, a negative externality is a cost, such as pollution or noise, suffered not just by whoever is carrying out that activity but by third parties. For Davies, unrestrained financialised capitalism manufactured unhappiness as this kind of externality and then expected people to rid themselves of it by investing in self-care or seeking care from those close to them.

This crisis of care affected young people intensely. The Millennium Cohort Study, with an original sample of nearly 19,000 babies, followed the lives of Britons born between September 2000 and January 2002. As this cohort reached their teens, the study revealed their extremely poor mental health, especially among girls and those from poorer families. According to one briefing paper produced by the Centre for Longitudinal Studies at UCL, at the age of 17, 24% of the cohort reported self-harming

in the past twelve months. Ten per cent of girls and four per cent of boys had self-harmed with suicidal intent.[60]

In one sense, this was surprising. This cohort had been born into a long period of economic growth. They had benefitted from the New Labour policies of Sure Start and smaller primary school classes – introduced in part because earlier UK birth cohort studies had shown that educational gaps emerged early on. They were generally taller, physically healthier, better educated and more technically savvy than previous generations. But the period since their birth had also seen a steep growth in income disparity and economic insecurity. Many of them had been raised in households hit after the financial crash with sudden precarity – a home repossession, or redundancy, or parents gnawed with worry about debt. From the age of 7 onwards, they had been subjected to a battery of testing, measurement and ranking at school. Now they had waning confidence that jumping through these educational hoops would make their future better, and those of student age were having to subsidise their studies with emotionally depleting work in the zero-hours economy.

Anyone teaching young people in these years could not have failed to note these signs of growing distress in cases of depression, anxiety, insomnia, eating disorders and self-harm. They would also have noted the self-blame of the social victim, a sort of internalised protest in which the mind berates itself instead of remonstrating with reality. I saw in my own students' distress what Arthur Kleinman, Veena Das and Margaret Lock describe as the 'soft knife' of society's incremental mortifications.[61] They were slowly acclimatising themselves to social suffering, gradually assuming what Pierre Bourdieu calls 'the weight of the world' on their shoulders.[62] Bourdieu's notion of the *habitus* as 'embodied history, internalized as second nature and so forgotten as history'[63] was as good an explanation as any for why so many of my students seemed to be suffering similar symptoms while being convinced of the unalterable uniqueness of their own misery.

In an era in which market values were now the pervading undertaste of their lives, my students had more scope to feel shame that they were not living up to these ideals. It must have been the dread of potential shame that led them to procrastinate and not submit work, the most common reason for failing a course. If they convinced themselves that they might have succeeded had they only got their act together, the shame of failure could be diminished. The layperson's understanding of shame is of a dramatically abject and toxic feeling. Psychologists and social theorists tend to see it as a more mundane condition, what Joseph Burgo calls 'the affect of disappointment'. On a basic level, it

alerts us to when we disappoint (or think we have disappointed) our own or others' expectations. This kind of ambient shame is, Burgo argues, bound to be more common in a more unequal society: 'Competition of all kinds inevitably involves shame: when someone emerges as the winner, fulfilling their dreams of victory, others must fall short of their own goals.'[64]

Social media began to be frequently cited, without much supporting evidence, as a cause of collective unhappiness among this generation. Often the assumption was that it served as an unhealthy retreat from 'real life', as if the online world were somehow separate from life and our evolutionary inheritance as social, interpretive animals. A more likely explanation is that social media clarified and distilled our era's already prevailing forms of avoidable misery and then turbo-charged them through its capacity for addictive behaviour and emotional contagion. Long before the birth of social media, David Smail had argued that public space was being transformed: it was now increasingly seen as the aggregated effect of individual self-interest, rather than somewhere that expressed our commitment to others beyond our private desires. The free market, he wrote, tended 'to drag values and feelings out of the private domain and to harness their power as "motivators" to saleable commodities', so that public life became 'inverted into a kind of public privacy, i.e. emptied of public significance and filled instead with objectified personal feelings and needs'.[65] Social media was mostly this kind of public space: an unregulated free market where every private thought could be voiced and that, behind the backs of its users, provided advertisers and other interested parties with monetisable data about them.

Alex Williams, at the beginning of the social media era, noted the rise of a phenomenon he called 'negative solidarity'. This he identified as 'an aggressively enraged sense of injustice, committed to the idea that, because I must endure increasingly austere working conditions […] then everyone else must too'. Negative solidarity operated under 'the invisible, though clearly contradictory and self-refuting, assumption of reflexive impotence'.[66]

Social media timelines became fertile soil for this kind of competitive unhappiness. Moments of national crisis – the Blitz, wartime rationing and postwar austerity – began to be evoked as ways of putting the unhappy present in perspective. Someone might post that they could not afford to eat or heat their home, only for a stranger to remind them that, in the old days, ice stuck our net curtains to the windows and we ate scraps and mouldy vegetables and no one died. In a world where people felt increasingly powerless, hardship was now framed as salutary or purgative. An unfortunate reality was thus simultaneously resented

and collectively enforced. Mark Fisher, who committed suicide in 2017, would have seen it as a symptom of what he called 'capitalist realism' – the pervasive view that, because capitalism is undefeatable, all we can do is privately accommodate ourselves with it.[67]

Managing unhappiness

A few years ago, as a mandatory requirement for the job I hold in a UK university, I completed an online training module on 'bouncebackability'. The word 'bouncebackability' was used without explanation or context, its history expunged. The football manager Iain Dowie had popularised this term in the 2003–2004 season when describing how his Crystal Palace team had gone from near the relegation zone to winning promotion to the Premiership. His clunky nominalisation became the subject of gentle ribbing by the presenters of *Soccer AM*, a Saturday morning football show on Sky TV, who campaigned for the word to be added to the *Oxford English Dictionary*. The Palace fans incorporated it self-mockingly into their stadium chants.[68] Now the word was being used unironically. Its appeal, presumably, was that it sounded more proactive than mere 'resilience' (another favourite word in the new language of mental health), implying the ability not just to survive challenges but to be newly energised by them.

On this online module, along with innocuous advice involving deep breathing, healthy eating and light exercise, I was urged to adopt a 'high power posture' for 'instant access to your feel good factors'. The accompanying illustration was of a besuited woman with her hands on her hips and her legs shoulder-width apart. 'A high power posture literally alters the chemical balance of your body', the text said. 'Within two minutes, the stress chemical cortisol decreases by 25% and testosterone levels increase by 20%'.

The power pose, also dubbed 'the Beyoncé', rose to prominence in 2012, when a Harvard Business School psychologist, Amy Cuddy, presented a TED Talk, 'Your body language may shape who you are', based on a 2010 paper she had co-authored.[69] During the 2015 Conservative Party conference, the cabinet ministers George Osborne and Theresa May were widely mocked for assuming power poses in photographs. That paper's findings about the positive psychological and hormonal effects of power posing have since been widely questioned, including the claim about cortisol and testosterone levels, and its results have not been replicated in other studies.[70] Four years after publication, its lead author, Dana Carney, disowned it.[71] In this online module, though, the

fraught history of the 'power pose' was erased and it was presented as ahistorical fact.

Many employers now have digital wellness platforms for their staff, outsourced to private companies. These platforms sell themselves as 'proactive and integrated workplace wellbeing solutions' or 'user-engaging wellness program delivery and management systems'. The discourse of wellness has penetrated most deeply in jobs like mine, where people spend their days thinking, talking and writing. In such a world, life can feel essentially abstract and frictionless, and mental events are more significant than embodied acts. The modus operandi of these wellness platforms is always the same. First, take the manifestations of human misery: low mood, fatigue and burnout. Then reframe them as performance indicators, warning signs of future absenteeism and lowered productivity. Then imagine mind and body as a dual machine to be tweaked, serviced and fuelled until it performs better. Self-esteem can be 'enhanced'. The brain can be 'rebooted'. Levels of resilience can be 'topped up'.

In the life of a multi-tasking academic, these online modules become just another job to log, another box to tick. The portal on which they appear allows me to collect virtual achievement badges, including 'Early Bird' and 'Night Owl' badges for the super-keen who complete modules before and after normal working hours. This follows the model of wellness programmes in the USA, which, tied to private health insurance programmes, gamify themselves still more, with prizes and bonuses. John Patrick Leary, a professor at Wayne State University in Detroit, found his own university's programme offering 'wellness bucks' in return for meeting lifestyle benchmarks. Quitting smoking earned him a travel mug.[72] The effectiveness of these platforms remains unquantified. Their providers often claim that changing employee 'health behaviours' leads to 'presenteeism savings'. But even by this instrumentalist logic, they are untested. The incuriosity about their efficacy is so pervasive that, in Smail's terms, it can only be a sign of the repression of that universal element of social life: power.

In universities, power has always been disavowed to some extent, because academia has long clung to an ideal of collegiality, however imperfectly realised. But now managerialism – the post-Thatcherite migration of business management practices into education and the public sector – has invisibilised power almost entirely, by framing its operations as neutral and irrefutable. Managerialism sets in train uniform processes that claim to be untouched by the self-interested motivations of actual people. In the language of managerialism, the fourth and final stage in addressing a mental health issue, after *awareness*, *reflection*

and *understanding*, is always *management*. There is no end to the things that can be managed in this way: stress, well-being, anxiety, underperformance, expectations, change, anger, difficult emotions, difficult colleagues. Etymologically, *to manage* means to handle, from the Latin *manus*, hand. It comes via the Italian *maneggiare*, to control a horse. If something is being managed, it cannot be got rid of, only softened or assuaged, like a recalcitrant horse. *Adversity* is something we learn to cope better with. *Change* can only be embraced. *Challenges* must be reframed as opportunities to grow. And *power* is only a mysterious inner resource (*power posing*, *willpower*, *empowerment*) on which the sufficiently resilient and insightful can draw.

Students receive very similar advice about mental health to university staff, much of it also coming in online tools from private providers. Smartphone apps guide them through relaxation techniques, meditations, fitness plans and stress-busting tips. Activity trackers tell them if they are moving about enough, sleep trackers monitor their 'sleep hygiene' and 'mood trackers' identify and regulate their feelings. Personalised push notifications nag them throughout the day. *Time to go for a walk! Name four things you can hear right now. Notice your thoughts. Take frequent screen breaks. Keep a gratitude journal. Drink plenty of water*. Our students suffer the same kind of incessant messaging as the citizens of an Eastern European socialist republic might have received in the Cold War – only instead of consciousness-raising slogans (*Keep in revolutionary step! People and the party are undivided!*) they are assailed with nuggets of well-being advice.

In one of the online stress management courses targeted at our students, they are taught that 'stress is a normal and universal experience and not a sign of weakness' and 'how we think about stressful situations can help us to cope with stressful experiences in a better way'. Neither of these insights is untrue or unhelpful, but they repeat the now-standard assumption that the main weapon against stress is the individual's awareness of how it affects them. The ever-present emphasis on defeating 'impostor syndrome' is, similarly, both a fair reflection of student anxieties (many do suffer feelings of fraudulence and inadequacy) and part of this same belief that unhappiness can be cured with 'insight'.

Most such self-evidently true self-help advice – eat healthily, sleep well, make time for friends – fails to factor in that the body has a history, which acts as a constraint on epiphanic transformation. In the words of the psychiatrist Bessel van der Kolk, 'the body keeps the score'.[73] Our bodies betray our unacknowledged histories, the things we try to ignore or disavow. Our muscles, bones and nervous tissue absorb and remember our experiences in ways that cannot just be reasoned or talked away.

Feelings are not erasable, like an unwanted program we can delete because it is slowing up a hard drive. They are a state of being, imprinted on our bodies as they interact with other bodies and the world. Impostor syndrome is not some erroneous self-assessment to be corrected with logic; it is metabolised shame.

A pervasive motif in the discourse of well-being is that it is healthy to remove the stigma attached to poor mental health, to be aware of our negative feelings and share them with others. There is now a crowded mental health calendar promoting this belief: Time to Talk Day, National Stress Awareness Day, Stress Awareness Month, Mental Health Awareness Week, World Mental Health Day. Micha Frazer-Carroll calls this new era of mental health advocacy 'the age of awareness'.[74] Awareness-raising diagnoses the problem as being the inadequate insight of the person in mental distress; once they have been made aware of the problem and shared it with others, all will be well.

As Frazer-Carroll points out, however, those whose mental illness cannot be 'easily realigned with capitalist metrics of exploitability' are excluded from this project of mental health awareness.[75] In the messier real world that exists beyond the blandified collocation of *mental health and well-being*, the police spend an enormous slice of time and resources dealing with mentally ill people; mental illness is rife among prisoners and homeless people; more than 50,000 people are detained each year under the Mental Health Act[76]; Black people are nearly five times as likely to be so detained as White people[77]; and eighty-six per cent of people claiming incapacity and disability benefit report having a mental health condition.[78] These are the morbid symptoms that the discourse of mental health awareness refuses to recognise. Capitalist realism, in Mark Fisher's words, 'insists on treating mental health as if it were a natural fact, like weather'.[79]

Conclusion

In *A Fortunate Woman*, a sort of sequel to Berger's *A Fortunate Man* published in 2022, the writer Polly Morland shadows an unnamed woman doctor working the same patch as John Sassall in the Forest of Dean, in the middle of the Covid pandemic. Those who turn up in her consulting room with physical symptoms are demarcated by age: lots of children and adolescents, a smattering of adults up to early middle age and then lots of people from late middle age upwards. The one constant across all demographics, however, is severe unhappiness: a new mother with post-natal depression, a mechanic whose depression is exacerbated by nerve pain after a work accident, a young woman with

'multiple life stresses', a middle-aged woman whose marriage is on the rocks, an elderly man suffering from chronic loneliness. Many are, in the clinical language, 'first presentations for mental-health symptoms'; some have 'mortal thoughts'. Morland's unnamed doctor had been inspired, aged 17, by reading *A Fortunate Man*, and she tries to be, like Sassall, both 'clinical expert and compassionate witness to people's stories'.[80] This is a challenge in the new world of protocolised care, where consultation time is portioned out in ten-minute increments and there is little space to consider, in Berger's words, 'what is wounding and damaging on a much larger scale'.

Any history should avoid romanticising the past or overcondemning the present. Sassall's pride in being overworked, welcoming night calls and refusing to take time off or seek help for his depressions, now seems problematic. How much this pattern contributed to the worsening of his depressions in the years after the book was published, and his eventual suicide in 1982, will never be known. But his round-the-clock, lone-wolf approach will strike contemporary doctors, working in multidisciplinary teams, as unsustainable. No doubt some good has also come in the intervening years from discussing mental health more, removing the shame attached to depression and encouraging people to seek help. No doubt many find meaning and support in a clinical diagnosis, even if this medicalising language can close off wider social explanations.

Still, what Berger noticed in Sassall's surgery sixty years ago obtains more than ever: the public understanding of mental suffering is ahistorical. Without history, as Barbara Taylor writes, 'there is only noisy silence'. And when history goes, 'so do the people produced by it, whose stories evaporate into a rootless, unbegotten present'.[81] Collective misery does not come out of nowhere. It gestates and is birthed in the embodied circumstances of people's lives, in their courageous but botched efforts to manage in a painfully unfair world.

The history of the present I have been trying to trace here is one of which I have been part. I recognise myself in Smail's description, written in 1997, of those who came of age in the Thatcher years and have achieved some outward signs of professional success, but for whom 'fulfilled ambition and a kind of biological unease exist side-by-side; realized ideals bring no gratification but only a sense of being cut loose from embodied reality'.[82] I have done my best to assist students in states of distress while dealing with my own life as a high-functioning, low-level depressive, self-medicating on overwork. I have even tried half-heartedly to challenge a managerialist university culture that disavows inequalities of power, a process I have found depleting and isolating – like trying to wrestle with a ghost that no one will admit to being

able to see. Critique, however carefully formulated, is useless in such scenarios. Why should power respond to reason and evidence when it is not even obliged to concede its existence, never mind its history?

The writer Horatio Clare has written about his own short stay as an inpatient in a psychiatric hospital in 2018, after having a breakdown with psychotic delusions. Clare is highly critical of the treatment he received both in the hospital and after being discharged but concedes that being in a quiet, calm ward, relieved from family and work commitments for a couple of weeks, away from the worried faces of family and friends, was 'a boon, and a relief', and gave him the deep rest that he (and they) needed. He envisions a future in which mental hospitals might be reimagined as retreats from the spiritual crush of late capitalism and the madness of the world.[83] We do not have to lament the closure of the asylums to reflect more positively on the flawed ideal they once represented – that mental suffering is a collective responsibility and requires time, space and resources to treat it. And this might allow us to reflect further on the alternative spaces that could serve the functions of asylum, or on how 'care' should happen in 'the community', or on what those words 'care' and 'the community' actually mean.

Without a sense of history, we lose a sense of collectivity, of us as mutually entangled beings caught up in a shared skein of meanings and feelings, experiencing similar sorrows to others and prompted and persuaded by their pain. David Smail called this missing element 'compassionate solidarity'.[84] John Berger, observing John Sassall's interactions with his patients in that surgery in a Forest of Dean village in the summer of 1966, called it 'fraternity'. Neither saw this missing element as a cure-all for distress; neither believed that the human condition could be so easily ameliorated. But both believed that solidarity/fraternity, in its recognition of our mutual dependency on each other, was the most significant and available form of power for people with hardly any power.[85] Our now-default modes of understanding avoidable mental pain fail to acknowledge its histories and so fail to offer a coherent explanation for it. Understanding this history will not make anyone happy. But it might be the first step to unlearning our servitude to a reality we did not sign up for – to begin, as Chekhov put it, to wring the slave out of ourselves, drop by drop.[86]

Notes

1 John Berger and Jean Mohr, *A Fortunate Man: The Story of a Country Doctor* (Edinburgh: Canongate, [1967] 2015), 77, 75, 79.

2 Ibid., 145–6, 114, 126.

3 Anthony Storr, 'Treatment not Protection', *Times Literary Supplement*, 28 September 1962, 7.
4 Quoted in Paul Gordon, 'For David Smail (1938–2014)', *Self & Society*, 42:1–2 (Autumn 2014), 39.
5 Denis Martin, *Adventure in Psychiatry: Social Change in a Mental Hospital* (Oxford: Bruno Cassirer, 1962), 2.
6 T. M. Caine and D. J. Smail, *The Treatment of Mental Illness: Science, Faith and the Therapeutic Personality* (London: University of London Press, 1969), 7, 170.
7 Adam Boggon, 'Swimming in an Asylum', at https://adamboggon.co.uk/adamboggon/swimming-in-an-asylum (accessed 24 September 2025).
8 Tom Burns and John Foot, 'Introduction', in Burns and Foot (eds), *Basaglia's International Legacy: From Asylum to Community* (Oxford: Oxford University Press, 2020), xiii.
9 Tom Burns, 'The United Kingdom's Rejection of Basaglia', in Burns and Foot (eds), *Basaglia's International Legacy*, 189.
10 Simon Jarrett, *A History of Disability in England: From the Medieval Period to the Present Day* (Liverpool: Liverpool University Press, 2023), 150.
11 Sarah Payne, 'Outside the Walls of the Asylum? Psychiatric Treatment in the 1980s and 1990s', in Peter Bartlett and David Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community 1750–2000* (London: The Athlone Press, 1999), 247.
12 Wilson Firth, 'A Psychiatrist's Story', *London Review of Books*, 26, 17 (2 September 2004).
13 Barbara Taylor, *The Lost Asylum: A Memoir of Madness in Our Times* (London: Hamish Hamilton, 2014), 98, 101, x.
14 Ibid., 102.
15 Roger Luckhurst, *Corridors: Passages of Modernity* (London: Reaktion, 2019), 201.
16 David Smail, *The Origins of Unhappiness: A New Understanding of Personal Distress* (London: Karnac Books, [1993] 2015), 1, 26.
17 David Smail, *Power, Interest and Psychology: Elements of a Social Materialist Understanding of Distress* (Ross-on-Wye: PCCS Books, 2005), 7.
18 David Smail, *How to Survive Without Psychotherapy* (London: Routledge, [1996] 2018), 12.
19 David Smail, *Taking Care: An Alternative to Therapy* (London: Routledge, [1987] 2018), 146.
20 Douglas Keay, 'Aids, Education and the Year 2000!', *Woman's Own*, 31 October 1987, 8–10, available at www.margaretthatcher.org/document/106689 (accessed 24 February 2026).
21 Smail, *Power, Interest and Psychology*, 11.
22 Ibid., 9, 13.
23 Susan Jeffers, *Feel the Fear and Do It Anyway* (London: Arrow, 1991), 53–4.
24 Smail, *The Origins of Unhappiness*, 69–70.
25 David Smail, *Illusion and Reality: The Meaning of Anxiety* (London: Karnac Books, [1984] 2015), 150.

26 Ibid., 89–90.
27 David Smail, 'Magical Therapy', *New Society*, 20 February 1987, 14.
28 Smail, *The Origins of Unhappiness*, 26, 25.
29 David Smail, 'Power and the Origins of Unhappiness: Working with Individuals', *Journal of Community and Applied Psychology*, 5:5 (December 1995), 348.
30 Smail, *The Origins of Unhappiness*, 24.
31 Ibid., 37–8, 69.
32 Liz Greenhalgh and Ken Worpole, *Park Life: Urban Parks and Social Renewal: A Report* (London: Demos, 1995), 13.
33 'Dorrell Drops the Term "Care in the Community"', *The Times*, 21 February 1996.
34 Jo Dillon, 'Evil Psychopaths Will be Locked Up', *Daily Mirror*, 9 December 1998.
35 Alice Thomson and Rachel Sylvester, 'Care in the Community is Scrapped', *Daily Telegraph*, 17 January 1998.
36 Joanna Bourke, 'Historical Perspectives on Mental Health and Psychiatry', in George Ikkos and Nick Bouras (eds), *Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960–2010* (Cambridge: Cambridge University Press, 2021), 5.
37 Edward Belch, 'Bedlam in the Housing Market', *Sunday Times*, 12 July 1987.
38 Marjorie Wallace, 'Taking the People to the Patients', *The Times*, 16 December 1986.
39 Ian Martin, 'A Saner Way to New Suburbia', *The Architects' Journal*, 193:8 (20 February 1991), 14.
40 'Mind Games', *The Architects' Journal*, 182:37 (11 September 1985), 44.
41 Bill Bryson, *Notes from a Small Island* (London: Black Swan, 1996), 83.
42 Taylor, *The Last Asylum*, 244.
43 David Brown and Clare McDonald, 'You No Longer Have to be Mad to Live Here', *The Times*, 2 September 2002.
44 Eve Blake, 'Diary: Friern Hospital', *London Review of Books*, 8 May 2003; 'Celebs Have Taken Over the Asylum', *The People*, 21 October 2012.
45 Glenda Cooper, 'You Don't Have to be Mad to Live Here …', *Independent on Sunday*, 10 May 1998.
46 Pete Shaughnessy, 'Into the Deep End', in Ted Curtis, Robert Dellar, Esther Leslie and Ben Watson (eds), *Mad Pride: A Celebration of Mad Culture* (London: Chipmunkapublishing, 2000), 21–2.
47 Taylor, *The Last Asylum*, ix, 243.
48 John Foot, *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care* (London: Verso, 2015), 395.
49 Tom Lee, *The Bullet: A Memoir* (London: Granta, 2024), 17.
50 Ibid., 126, 134.
51 Luckhurst, *Corridors*, 201.
52 Lee, *The Bullet*, 34.

53 Diana Gittins, *Madness in Its Place: Narratives of Severalls Hospital, 1913–1997* (London: Routledge, 1998), 220.

54 Taylor, *The Last Asylum*, 263–4.

55 Becky Mars, Jon Heron, David Kessler, Neil M. Davies, Richard M. Martin, Kyla H. Thomas and David Gunnell, 'Influences on Antidepressant Prescribing Trends in the UK: 1995–2011', *Social Psychiatry and Psychiatric Epidemiology* 52:2 (2017): 193–200; David Batty, 'Antidepressant Use in England Soars', *Guardian*, 30 December 2011.

56 Rosemary Rizq, 'States of Abjection in Managed Care', in John Lees (ed.), *The Future of Psychological Therapy: From Managed Care to Transformational Practice* (London: Routledge, 2016), 70.

57 Mark Fisher, 'The Privatisation of Stress', *Soundings*, 48 (Summer 2011), 131.

58 See Mark Fisher, 'Why Mental Health is a Political Issue', *Guardian*, 16 July 2012, and 'Good for Nothing' at https://theoccupiedtimes.org/?p=12841 (accessed 12 June 2026).

59 William Davies, 'The Political Economy of Unhappiness', *New Left Review*, 71 (September/October 2011), 68.

60 Praveetha Patalay and Emla Fitzsimons, 'Mental Ill-health at Age 17 in the UK', CLS Briefing Paper, Centre for Longitudinal Studies, November 2020, 2.

61 Arthur Kleinman, Veena Das and Margaret Lock, 'Introduction', in Kleinman, Das and Lock (eds), *Social Suffering* (Berkeley, CA: University of California Press, 1997), x.

62 Pierre Bourdieu et al., *The Weight of the World: Social Suffering in Contemporary Society*, trans. Priscilla Parkhurst Ferguson, Susan Emanuel, Joe Johnson and Shoggy T. Waryn (Cambridge: Polity Press, 1999).

63 Pierre Bourdieu, *The Logic of Practice*, trans. Richard Nice (Cambridge: Polity Press, 1990), 56.

64 Joseph Burgo, *Shame: Free Yourself, Find Joy, and Build True Self-esteem* (New York: St Martin's Press, 2018), 23, 36.

65 Smail, *Taking Care*, 129.

66 Alex Williams, 'On Negative Solidarity and Post-Fordist Plasticity', 31 January 2010, at https://splinteringboneashes.blogspot.com/2010/01/negative-solidarity-and-post-fordist.html (accessed 5 November 2025).

67 Mark Fisher, *Capitalist Realism: Is There No Alternative?* (Winchester: Zero Books, 2009).

68 David Hills, 'Said and Done', *Observer*, 3 October 2004; Daniel Finkelstein, 'Dowie Didn't Make It Up: "Bouncebackability" Exists', *The Times*, 4 December 2004.

69 Dana R. Carney, Amy J. C. Cuddy and Andy J. Yap, 'Power Posing: Brief Nonverbal Displays Affect Neuroendocrine Levels and Risk Tolerance', *Psychological Science*, 21:10 (2010), 1363–8.

70 See Marcus Credé, 'A Negative Effect of a Contractive Pose is Not Evidence for the Positive Effect of an Expansive Pose: Comment on Cuddy, Schultz, and Fosse (2018)', *Meta-Psychology*, 3 (2019): 1–5.

71 Dana Carney, 'My Position on "Power Poses"', blog post, 2016, at http://faculty.haas.berkeley.edu/dana_carney/pdf_My%20position%20on%20power%20poses.pdf (accessed 12 March 2026).

72 John Patrick Leary, 'Wellness', in *Keywords: The New Language of Capitalism* (Chicago: Haymarket Books, 2018), 176.

73 Bessel van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (London: Penguin, 2014).

74 Micha Frazer-Carroll, *Mad World: The Politics of Mental Health* (London: Pluto Press, 2023), 37.

75 Ibid., 41.

76 Mental Health Act Statistics, Annual Figures, 2024–5, at Mental Health Act Statistics, Annual Figures, 2024–5 – NHS England Digital (accessed 14 April 2026).

77 Frazer-Carroll, *Mad World*, 59.

78 Eduin Latimer, Sam Ray-Chaudhuri and Tom Waters, *The Role of Changing Health in Rising Health-related Benefit Claims* (London: Institute for Fiscal Studies, March 2025), 12.

79 Mark Fisher, *Capitalist Realism: Is There No Alternative?* (Winchester: Zero Books, 2009), 19.

80 Polly Morland, *A Fortunate Woman: A Country Doctor's Story* (London: Picador, 2022), 101, 139, 175, 56.

81 Taylor, *The Last Asylum*, 17, 262.

82 Smail, *Illusion and Reality*, vii.

83 Horatio Clare, *Your Journey, Your Way: The Recovery Guide to Mental Health* (London: Viking, 2024), 264, 77.

84 Smail, *Power, Interest and Psychology*, v.

85 Smail, *How to Survive Without Psychotherapy*, 213.

86 In a letter to Alexey Suvorin of 7 January 1889, Chekhov urged his friend to write about a young man who 'drop by drop wrings the slave out of himself'. Anton Chekhov, *A Life in Letters*, ed. Rosamund Bartlett, trans. Rosamund Bartlett and Anthony Phillips (London: Penguin, 2004), p. 175.

Author Biography

Joe Moran is a Professor of English at Liverpool John Moores University, UK. His books include *Shrinking Violets: The Secret Life of Shyness* (Profile/Yale UP, 2016/2107), *First You Write a Sentence* (Penguin, 2018) and *If You Should Fail: A Book of Solace* (Penguin, 2020).