MENTAL HEALTH IS A LAWN; DESIRE IS A PRAIRIE

by HERBALISTATLARGE

ABOUT HERBALISTATLARGE

I try to stay fairly private online, but I also think it's important to be honest that I'm just, like, one person. I don't want to pretend to be an organization or claim any authority. I'm just one herbalist, and my opinions are just mine.

That being said: I'm an herbalist specializing in emotional support. I believe very strongly that health education should be freely accessible, and that all people should have full health autonomy. Systemic reform is a long and quite possibly impossible process, but building health skills to share with our communities is something we can all do NOW.

I specialize in emotional support because it is deeply personal to me as a mad person and psychiatric survivor, and because I have been building the knowledge and skills I use in my practice since my early teens. My practice is shaped around a desire model.

Note: I would like to say a huge, loving thank-you to my incredible friends for helping me write this piece. I'm incredibly grateful for the time and effort you've all put in to helping me express what I want to.

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INTRODUCTION

A little over a month ago, I began posting about upcoming changes in my practice, which I've been working on since. As I said in an instagram story, I realized that I've been pretty bad about replacing surface-level words instead of actually challenging underlying concepts; so, I've been taking some time to work on learning to better articulate my philosophy.
In the following essay I am going to try to explain my critique of psychiatry and offer a framework to replace it. You don't have to agree with anything I say to receive herbs, advice or education from me. If I only wanted to work with people that believe the same things as me, I would stick to caring for my network of friends and accomplices. I have a public-facing practice to offer something immediately and materially useful to (broadly speaking) anyone that asks for it. I'm writing this because— while we may or may not be/become friends—my services are a personal gift, and I do not want them to be received as a function of psychiatry.

Most of all, I believe that everyone has an idea about what the future will hold, and everyone is trying to bring that idea to fruition. Ultimately there is nothing in my lifetime that will result in everyone being on the same page about what we all "should" be doing; and we are all relatively powerless on a global scale. What I can do is help the people I can touch, and walk away from those that want to force me to believe things I don't want to believe in. I can't make universal healthcare happen, right now or decades in the future; but I can fight tooth and nail to help heal the people around me for free, and I can share, liberate and generate knowledge to help others do the same.

I'm writing with a very limited scope here—if I was having an easier time writing this it would very quickly become an entire book, not a 3,700-some-odd word essay. I'm asking to you believe at face value that this is what I consider to be true; unfortunately I don't have the capacity to write out an argument containing all the applicable historical evidence and referential sources right now. I hope at some point I do.

PART 1: GROUNDWORK

LOBOTOMISTIC VIOLENCE

I'm going to start by laying out a definition that I think is important to understanding where I'm coming from. I started using this term because I think it marks a useful distinction in how certain people are treated by psychiatry.
Lobotomistic violence is the set of psychiatric "treatments" that intend to make someone "normal" by reducing/inhibiting function in certain parts of their brain. While surgical lobotomies are generally considered outdated and barbaric in mental health culture, the root concept is still very much alive and well. Several antipsychotic drugs have similar effects to surgical lobotomies, and many more otherwise limit brain function in other ways. These drugs can prevent the people they're prescribed to from thinking abstractly or feeling deeply, and often cut them off from meaningful parts of themselves. According to the psychiatric framework there are people who need support, understanding, and accommodation; and people who need their bodyminds* to be physically altered and parts of them literally removed/made nonfunctional. Lobotomistic violence is a "last ditch" effort, when less extreme forms of medication or therapy are considered "ineffective". Sometimes this comes after a long process of trying different treatments— but a lot of people are subjected to lobotomistic violence because they occupy a social position that society sees as a lost cause from the start, like people kidnapped off the street by ambulances in the middle of a psychotic break, or kids in state custody.

*Bodymind is a popular term in mad liberation that refers to the mind and body as a cohesive whole–it invokes the idea that we do not just inhabit our bodies, we ARE our bodies.

DEFINING MENTAL HEALTH

(In this section, I'm using a very charitable interpretation of psychiatry from a scientific standpoint. Even the most advanced neuroscience cannot reliably identify specific mental disorders or their causes—but even if it could, it would still be fundamentally bad, and that's the point I want to make.)

Civilization is an organism and an ecosystem in its own right, with structures to achieve equilibrium and to perpetuate itself. The choices that we make and options we see as available have been formed by thousands of years of accidents and choices that shape patterns of behavior and create social constructs. It is these structures I'm referring to when I talk about control.

In order for civilization to exist as it currently does, the people and things subjected to it must be easily understood, because things that are understood can be controlled. An example my friend used was a small, early agrarian state—a ruler wants to collect tax, with the goal of collecting as much as possible to enrich his position against neighboring states. He cannot collect too much tax, or else the population will either starve, or get angry and refuse to participate in the state; so to maximize what can be taken he has to know how much is produced, and in turn the farmers have to know how much they produce to know what they owe and what they need to meet immediate needs. Civilization needs to reduce complicated questions to knowable categories in order to respond in ways that benefit itself. This legibility occludes true understanding, pares down the messy, beautiful, difficult-to-communicate nature of life into one-dimensional criteria to be accounted for and processed. To see how these criteria are constructed, let's look at an oak tree.

The name "oak tree" refers to a thing that exists, pretty indisputably (at least until you get into existentialism but, uh, let's not go there). However, the name "oak" is something people made up. There are many different perspectives one might understand an oak tree from.

Whatever lens you want to use impacts what characteristics you focus on and how you understand them in relation to the whole. You focus on certain attributes to create a story—if you're using a scientific lens, you might look at DNA and draw connections to other DNA to tell a story about genetic history. Genetic history is also a human construct that only focuses on the pieces that are significant to the stories our culture wants to tell. These stories are what we use to build knowable categories; but a squirrel doesn't give two nuts about the genetic history of an oak tree, and likely has its own stories that are entirely alien to us—because different attributes are significant to its life.

Mental disorders are real in the same way an oak tree is real—and fake in the same way an oak tree is fake.
The experiences that diagnostic labels describe are real, but the way disorders are defined is 100% a social construct that is entirely dependent on what is significant to our culture, scientifically backed or not.

"Health" is defined as bodymind states that are convenient for cultural perpetuation; and illness is bodymind states that are not. What experiences and attributes are constructed as diagnostic categories is dependent on what is valued and relevant to the dominant culture—and more importantly, what is conducive to the reproduction of that culture.

In our modern society, people who do not fit squarely into the mold of a responsible, reproductive citizen are either validated or marginalized. These are both methods of control, pushing people into legible categories to make them more easily understood and influenced by society. Validation might look like a kid who's disruptive in class getting diagnosed with ADHD and working more closely with the school to receive accommodation, whereas marginalization might look like a disruptive kid getting diagnosed with ODD and being treated as if any resistance to an authority figure is a symptom of disease for the rest of their life.

In psychiatry, validation is "positivity". This extends from clinical practice to what I'm going to call "mental health culture", the expansion of psychiatry from a form of medicine to a fixture of culture. I'm going to talk about this more in a minute, but for now the point is: mental health does not identify a list of "problems" that exist in a vacuum. It constructs sicknesses in order to justify control. Which leads us to…

THIS WOULDN'T WORK IF WE DIDN'T CARE ABOUT EACH OTHER

Pretty much everything I have said up to this point describes social mechanisms: how individual actions build on each other and create trends and dynamics as a larger organism. This kind of thinking is helpful to understand how and why things happen on a very large, faceless scale, but becomes messy when we try to apply it to every day life. I think that's part of why conspiracy theories about shadowy puppet masters are so appealing to a lot of people: the world is full of shitty, complicated things and it feels a lot easier to know how to react to them if they were the product of an individual malice we could isolate instead of the chaotic outcome of thousands of years of individual, collective, and environmental actions/events. This is an example of pushing for legibility! 😀 As individuals we are also often guilty of creating legible-yet-false narratives to help us understand things.

Unfortunately, there's no simple malice to blame here. A lot of the ways psychiatry hurts people are made possible by compassion. I try not to make generalizations about the human condition OR evolution-based arguments, but I do believe very deeply that humans are a fundamentally social species and that we are physically predisposed to caring about each other— evidenced in part by how much of the coerced labor necessary for society to function depends on making it hard to even SEE enslaved and low-class people, let alone extend solidarity and care to each other. The history of modern psychiatry (mostly over the past 200 years) and the birth of mental health is a chaotic mash of capitalistic profiteering, attempts to stifle liberatory movements, and individuals who are genuinely trying to take care of other people, all informed by the underlying assumptions about what "mental illness" is that I just described.

Brief digression: I'm always tempted to put "mental health" into quotes, but "mental health" implies a distinction between what I'm referring to and some other legitimate, non-fucked-up mental health that just doesn't exist, so assume whenever I say mental health I'm using a slightly sarcastic tone.

Mental illnesses are, by and large, defined and diagnosed based on suffering, and the treatments, by and large, are designed to reduce suffering—or, the assumption that someone is suffering. How that suffering is measured and defined is still dependent on the basic assumption that correctly reproducing culture is good for you and not doing so is bad for you. For example, many diagnostic criteria measure one's ability to work productively, and our society assumes wage labor is the norm for a healthy life. Sometimes, this is obfuscated by so many layers of reformed language and liberal feel-good-ism that many people who would disagree with that assumption when said so plainly (reproducing culture is good for you and not doing it is bad for you) are still deeply invested in mental health culture.

Diagnostic categories pick out certain experiences and characteristics to name as symptoms of a disease—but human brains are not very easy to put into boxes. Who is pathologized—labeled as diseased—is heavily dependent on their class status, and how well their behaviors contribute to the status quo. A lower-class non-Christian is more likely to be labeled as psychotic for describing their spiritual beliefs and experiences; whereas a richer person who talks about "being spoken to by the Holy Ghost" is simply a religious fanatic. We see consistently demographic-based diagnostic biases for disorders that are supposedly an issue with predetermined brain "hardwiring", such as autism and ADHD being diagnosed more in white children, whereas Black children receive ODD diagnoses. By associating abnormality with suffering, and enforcing suffering for the abnormal, attempting to make people normal can represent reduction of suffering and a kindness. This dynamic is even more heavily enforced when people actively choose non-normative lifestyles: someone's body state is not conducive to them living a "normal" life and they don't even WANT to change, that means they are extra unhealthy. Under this logic, (attempting to/)forcing them to change is doing a good thing for them and thus the kindest course of action.

Everyone who advocates for broader mental health services is contributing to psychiatric and lobotomistic violence through kindness. There are plenty of people who think positively of their interactions with psychiatric institutions or mental health culture, AND there are ways to reduce harm when participating in mental health culture/be more honest about the risks involved; but encouraging people to participate in clinical settings is still encouraging people to put themselves in vulnerable, potentially dangerous positions.

MADNESS VS. PATHOLOGY

Anyone can be crazy. I highly recommend trying it. Experiences are individually varied and highly personal—some people see and hear things other people don't, some think in ways that are strange or confusing to others, and so on—but madness is simply refusal to conform to normative categories of mind-state and behavior. It is not bowing to social norms and the embrace of abnormal experiences that get in the way of a middle-class aspirations.

Pathologizing is the process by which madness is constructed as sickness. Pathology includes all the things that are "unapproved" about madness and it increasingly includes things that are only minorly inconvenient to our legibility and our participation. People re-contextualize experiences they never thought twice about as part of a disease, simply because they were given a label. "I never knew that was a BPD thing!"

Mental health culture encourages and facilitates this creep because even though its participants will often nominally criticizing practitioners who enact psychiatric violence, they continue to rely on the frameworks this violence is based on. Mainstream criticism of psych focuses on the idea that individual doctors (and/or institutions) apply psychiatry poorly, but it caries the implicit assumption that if it was only used correctly it would be a benefit. This can look like social/support groups of people identifying with a common or related diagnoses criticizing the way psychiatrists behave while encouraging people to self-diagnose, seek certain medication or therapy, or otherwise enforcing mainstream assumptions about the ontology of mental disorders.

Pathologizing talk surrounds us: "I think you might have ___", "I'm like this because I have ___", etc. It feels very similar to the ways in which certain queer spaces invent and push labels to describe every possible facet of gender or attraction, because well, it is. Both fixations gain traction because we are told that making ourselves legible to the outside world and making those around us legible in the same way will make us feel less lonely or invisible.

Unfortunately, only letting people understand us in terms of our categories instead of on our own, unique terms continues to compound this loneliness. In an effort to make the system "work" we expand what experiences are known, create new labels and try to champion "inclusion", instead of addressing the forces and dynamics surrounding the things that feel lonely, invisible, and difficult to communicate… A list of abbreviations doesn't tell the world who you are, it tells the world how to react to you.

Many people who ascribe to psychiatric frameworks still live in ways that resist legibility. There are also plenty of people who are both mad and mentally ill, who use diagnostic labels but do not seek to conform to standards of "treatment". There are also many people who use these labels to pressure conformity from themselves and those around them. It seems to me like the majority of people who, for example, encourage everyone around them to go to therapy, have never had a practitioner make good on the implicit threat of psychiatric violence.

THE ROLE OF SANEISM

It would be incomplete for me to talk about the role of kindness without talking about the role of prejudice.

Saneism is a different form of bigotry than say, racism. It is not hatred of an "other" group that the "perpetrator" is not and never will be a part of. It's more like fatphobia: hatred of a body state that every human being has the potential to experience. It is self-inflicted as much as it is wielded against the other.

Saneism is a tool to select who is and isn't crazy. It should be clear at this point that there is no "sane" human being; sanity is only the ideal they beat you with. If you can emulate sanity well enough, driven by fear of internal and external hatred of madness, you are sane. If you can't, you are insane, and either you can be mentally ill, assimilate to the categories and modes of behavior that are deemed acceptable for people like you; or, if you can't do that, you're crazy, and your options are either to submit to lobotomistic violence or to refuse to participate in psychiatry.

PART 2: PRAXIS

As I said at the beginning: The experiences that psychiatry addresses are real. Critique is all well and good in that it helps us name and understand the systems we live in, but it is only part of the process towards doing something better. Here is my attempt at building a model. It's not perfect, but it's a start.

A lawn is an artificially maintained shape, but a prairie is created organically through small and large events, which lines up nicely with the idea that mental health, as a noun is a standard that must be maintained, but desire, as a verb is a process of seeking, experiencing and evaluating that builds and grows in symbiosis.

MENTAL HEALTH IS A LAWN

The process of maintaining mental health through the reduction of suffering is like the process of maintain a lawn. A lawn is a pre-defined shape created through the prescription of behaviors and chemicals (weeding/mowing; herbicides/pesticides); regulated to be non-challenging and "safe" (no spikey plants, bee or wasp nests, etc) in the name people's comfort and at the cost of native species; and prioritizing a certain socially-imposed aesthetic at great cost to the environment. Lawns have to be nourished (fertilized and watered) to grow, but are not allowed to get taller or more robust than a set value so that they're easy to trim regularly with minimal effort. Lawns are monocultures with shallow roots that do not stand up to environmental conditions like drought without intervention. Lawns are also a standard everyone knows–and holds each other to, judges each other based on.

Likewise, to maintain "mental health", people are regulated to a predefined standard that prioritizes "normal" aesthetics and the "safety" and comfort of others through the prescription of chemicals and habits (medication and therapy). Everyone knows the rules enough to police themselves and each other. Peoples' material and emotional needs are taken into consideration enough for them to survive (and not commit suicide), but no one is well-supported enough to not feel the pressure to work; and people do not have the freedom to self-regulate on their own so when crisis occurs, you either have to keep working or rely on psychiatric intervention such as hospitalization.

DESIRE IS A PRAIRIE

Seeking desire is like how a prairie or grassland maintains itself as an ecosystem. Many types of plants grow deep symbiotic root systems that create resiliency and allow the ecosystem to survive through many environmental changes. Critters and bugs may kill/destroy plants at times, but they also reuse and decompose detritus and allow the ecosystem to recycle material and stored energy, spread seeds, etc. A prairie is too tall to be mowed easily by a conventional lawn mower and must be poisoned or crushed via heavy machinery. It is a complicated, compelling and beautiful organism that takes years of interaction to understand.

Desire cultivates varied experiences that let us practice the flexibility to survive distress emotionally, and shapes our lifestyles to prioritize self-regulation. Pain, whether external, self inflicted, or both, is an inherent part of life; but pain can allow us to grieve, process and grow, to clarify our desires, and maintain our bodyminds. When we live by desire we become unwilling to bend to social rules that don't suit us, become uncontrollably mad, and are accustomed to freedom such that we can only be recuperated through incarceration and lobotomistic violence.

A prairie takes a long time to grow, and is difficult to support in a society that demands lawns. Switching from a mental health model to a desire model isn't a simple or quick thing. Most of us will resemble something more like an overgrown lot, which is just as valuable.

PART 3: WHAT THIS MEANS FOR ME

It's taken a long-ass time to be able to articulate these concepts, so it feels extremely good to have finally made the pieces click.

Ultimately, what I offer isn't substantially changing—at least right now, though I do have a new offering I'll be announcing in the near future that incorporates herbalism into pleasure-seeking activities. I'll still be here for consultations, workshops, and informal support; but the foundations are different, and I will be more explicitly incorporating these ideas into how I teach and discuss concepts. You might notice that the pages on my website have been rewritten and restructured, hopefully in ways that represent these ideological changes.

Something that comes up fairly frequently in conversation with my friends and accomplices who do similar public-facing non-hierarchical healing work is how to respond when people come to us expecting more standard frameworks: When people talk to us expecting to be told things about their bodies, or for us to diagnose a sickness and tell them what to do about it. To me, figuring out how to deal with these interactions is a matter of building and improving social skills; figuring out what questions to ask to break the script. This is just as much practical as it is ideological: What I do is in no way compatible with Western Medicine or psychiatry—the tools I have work granularly, effecting a few parts of the body at a time in specific ways. I can help you sleep, eat, relax, play, reduce fear, increase focus, cope with grief, ground thoughts and emotions, feel pleasure… but I do not use diagnostic categories, I do not offer "antidepressants" or treat disease. Someone telling me they have PTSD gives me exactly 0 information about what they want me to be doing for them. In some ways what I think what I already do in these interactions does more to ground my practice outside of psychiatry than any long-ass manifesto or theoretical explanation; but if you want to know why I do what I do, well, there you have it I guess.

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