

What jokes do

There remains the question of what jokes do in addition to that which racism does anyway. Why, we may ask, does racism need jokes? In a way, we have answered this: 'successful' (popular) racism requires adulteration. Jokes are 'the velvet glove' of racism, the means by which naked racism is made palatable. By adopting the mantle of comedy racism becomes ubiquitous and ubiquity suggests harmlessness. I can hear in my head as I write this: 'Oh come on! It's just a bit of kidding. Don't be so pompous. You know what your trouble is? You can't take a joke'.

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Beyond glass houses in the desert: a case for a mental health 'care' system

With disheartening regularity the media makes a meal of the 'mental health system'. Yet another rape, murder or suicide is attributed to an ailing, failing, under-resourced mental health system. At a more personal level the undereducated, incompetent, over-worked and 'stressed' health professional or those that trained them are held to blame for tragedies that might have been prevented. In an effort to make sense, and deal with the very real public pain, and revulsion at the gravity of the crimes committed by a few who are judged to be mentally ill, blame is passed around like a game of 'pass the parcel'. As a consequence recruiting and retaining nurses in the speciality of psychiatric nursing is becoming increasingly difficult, existing staff are demoralized and the public appear to be losing faith in the system. Mental distress and illness is further stigmatized and the many good and effective initiatives undertaken by dedicated staff, consumer groups and helping agencies are effectively overshadowed by the human tragedy so frequently played out in prime time.

There is no doubt that we can learn, and have learned, something from each and every tragedy.

For example, health professionals need to recognize and be responsive to the expertise of families, who are frequently in the best position to recognize subtle changes in the well-being of their loved ones. In New Zealand the appalling shortage of sheltered accommodation for those with the most challenging behaviours has been highlighted, as has the disgraceful shortage of specialist mental health services for youth, Maori and those with concomitant drug problems. It has also become apparent that health professionals need to be familiar with not only the letter but the intent of the legislation that provides their mandate to practice and dictates the boundaries of the service they provide. However, even if these identified deficiencies in services were ironed out and existing legislation was interpreted correctly and consistently, it is doubtful whether much of the violence towards others attributed to mental illness would be prevented, or the resultant negative public perception of 'mental health services' improved. This is to a large part because societies' response to problems of mental health has been to provide a mental health system of services rather than a system of mental health care that effectively facilitates the mental health of our society.

The difficulties that New Zealand faces in relation to problems of mental health are by no means unique. Despite our unique cultural makeup, many of the issues we face are also faced by most other affluent, western, post-modern societies and our responses to them at an institutional level are borrowed heavily from the traditions and ideologies of larger nations. The capitalist ideology of the 'marketplace', which sees social relations reduced to a commodity and stresses individual over collective responsibility, is a reality that profoundly affects both the personal and the institutional response to mental distress.

Most nations are grappling to determine the extent and scope of mental health services with varying forms of rationing or triage being implemented to target those perceived to be in most need. Services are becoming increasingly specialized in focus, with a corresponding increase in concern about 'advanced practice' preparation for nurses. Consistent with the 'marketplace' ideology people whom mental health services serve have become known as 'clients' or 'consumers' and demand a tangible and quantifiable outcome. Quality assurance methods derived from manufacturing industries require measurability of outcomes and

processes and 'evidenced-based practice' has become the latest 'catch cry'. These changes have in many ways being good for 'consumers', whose rights as such are increasingly being acknowledged and who can expect specialized treatment should they need it. However, it is worth reflecting on how well mental health services live up to the 'name' and whether or not the present 'mental health system' is actually about promoting the mental health of populations.

It is significant that we now talk of mental health 'services' rather than mental health 'care', and not coincidental that proposed solutions to the 'mental health crisis' seek to improve responsiveness of 'services'. Sometime over the last decade, mental health 'care' has insidiously been dropped from the English language and as nurses we ought to be concerned. Nurses may continue to champion 'nursing care' but if we are serious about promoting mental health, we ought to also champion the 'mental health care system'. This is certainly a problematic position, as existing 'services' are funded to provide a well-defined and finite 'service' rather than 'care'. Care is a fuzzy and unfashionable concept that is not so readily reducible to a measurable or predictable outcome. A 'service' can be delivered (at a cost). The onus is on the service provider to come up with the goods to satisfy the consumer. In relation to 'mental health services' one has to first define who the consumer is, what the service is, and how one measures satisfaction. This is a most challenging task which presently occupies the time of many managers, purchasers of services and politicians. However, 'mental health care' is more challenging, in that one first has to define care and then provide it.

Barker (1989) used the analogy of the gardener who care's for a plant to illustrate the concept of care. A successful gardener needs to do more than just love and sing to a plant to make it grow. The gardener who cares will ensure that the plant is placed in the best environment and will exercise serious 'attention, concern and protection' to ensure that it grows and develops (Barker 1989, p. 139). Nurses are aware of the action dimension of caring, having debated the meaning of care in relation to their roles, identity and relationships with patients. However, analysis of 'care' has seldom been extended to encompass the mental health system.

A system of mental health care ought to seriously promote an environment conducive of mental

health and protect those who need nurturing. The present service-orientated mental health system is not focused on fostering an environment of mental health. Rather, services are aimed at identifying and treating those with a mental illness, or responding to those with acute psychological distress. Services may facilitate mental health care to some and do meet the needs of people, but they do so in a manner akin to erecting a temperature-controlled glass house in a desert. A microenvironment is constructed in which some will be nurtured to survive in the inhospitable desert, but most will surely perish without the support of the artificial and carefully controlled environment. While some species of plants will thrive and strengthen in the glass house, this environment will not be suitable to other varieties of plants. The response is to create more specialized glass houses or to make regular sorties into the desert to attend to those plants most in need.

The gardener working in the desert will find it difficult to care for all plants and will be forced to select certain varieties such as those 'most likely to succeed', or certain varieties most vulnerable and precious to care for. Creating glass houses for every variety is untenable with limited resources. Mental health services have necessarily become experts at identifying and responding to people with certain defined forms of mental distress. A combination of perceived seriousness, dangerousness, incapacity, diagnosis and treatability underlie the perceived need for mental health care. The availability of financial and human resources dictate eligibility. For some, the right conditions for growth and development will be facilitated. For a significant number of people factors within their environment will mitigate against the best efforts of others to be successful in caring. If the gardener in the desert is to raise plants to survive outside the glass house, irrigation and fertilizer must be provided. A system of mental health care must also facilitate at a family, community and societal level, the right conditions for mental health.

It is absolutely necessary that a system of mental health care focuses attention and exercises care and concern at the level of the most vulnerable and distressed person. Just as there will always be a need for constructing an artificial environment in a desert to sustain life, so there will be a need for mental health professionals to become expert in responding to and facilitating an intrapsychiatric and immediate social environment that is con-

ducive to mental health, or which provides sustenance to the distressed individual. An 'integrated approach' to providing services will equip or strengthen many with the internal resources for survival in an inhospitable world. However, without making the world a more hospitable place there will never be an end to the need for more mental health services or the remotest possibility of attaining 'mental health for all' at any time in the future.

A variety of lenses provide views on the conditions required for the mental health of an individual. These can be brought to bear on the conditions necessary for the mental health of society. For example, the person experiencing depression may be perceived as having a biochemical disturbance amenable to therapy in the form of medication; it is likely that the person filters events in a negative light, makes unrealistic demands of him or herself; the person may experience a spiritual void, feel hopeless, alone, isolated and detached from humanity and indeed themselves; their sense of trust and faith in others may be tenuous and their repertoire of interpersonal skills and armoury of coping strategies to protect against a hostile world may mitigate against the formation and maintenance of genuine, loving relationships that the person craves. Mental health services may effectively address each of these areas but a system of mental health care must address some of the fundamental reasons for the person's state of being. This may require society to examine its dominant values that lead to a person's worth being dependent on their productivity, stresses instant gratification above enlightenment, individualism above co-operation, and fosters an intolerance of difference and indifference to the suffering of others.

A system of mental health care may appear to be an insurmountable and unrealistic proposition. The crudest risk factors for mental illness provide some indication of the scope of the problems which a system of mental health care must address, for example, unemployment, poverty, prejudice, forms of discrimination, being a victim of colonization, violence, hostility, a poverty of love and genuine caring relationships. These pose considerable barriers to the success of mental health services, let alone a system of mental health care. Those that work with chronically addicted adolescents will testify to the difficulty that these factors pose. It is not uncommon to encounter adolescents who have never had a sustained relationship with an adult that was not characterized by physical, sexual and

emotional abuse. For them schooling and social development is curtailed before their teenage years, around the time that their careers in theft, violent crime and drug use began. It is hard to convince the young person that someone actually cares, let alone equip them with the skills to cope in 'normal' society. However, 'normal' society must accept some responsibility for this state of affairs rather than locating the problem exclusively within the individual.

The effectiveness of mental health services are constrained by, and highlight the need for, a system of mental health care. People are fundamentally different from plants in that they have the capacity to think, feel, make choices and relate to each other at many different levels. We accept that people have the right to choose what is best for them, even though the choices people make may be constrained by structural factors, influenced by the experience of illness or noxious to mental health. People interact with and shape the conditions in their environment. Except when a person's choices may result in serious danger to themselves or others, mental health services do not have the legal mandate to control the choices that a person makes or their immediate environment. Neither do they have an ethical mandate to curtail the person's freedom without a high degree of certainty that their actions will lead to conditions of serious danger. Frequently, mental health services are impotent to prevent a person from returning to an abusive relationship, crime or choosing to resume a pattern of drug taking that is not in their best interests. The person may choose the security and familiarity of a noxious environment, one in which they have learned to cope (albeit through dysfunctional patterns of relating) rather than being displaced in an unfamiliar and artificial environment.

Unlike the gardener who is charged with caring for, that is, protecting and nurturing the garden, mental health services also have a responsibility to protect the wider public. Perhaps, the most unrealistic expectation of mental health services is that they will be able to predict who will be violent towards others and intervene to protect the public. The difficulties were highlighted in a recent case of a man with bi-polar affective disorder who raped and murdered an elderly woman. The consultant forensic psychiatrist who had recently assessed the man considered that there were at least 10 other people who he perceived as more likely to have perpetrated such a heinous act. Of course, violence

towards others is endemic in society, and while we understand the general conditions that are likely to lead to violence, they are crude and inaccurate predictors at the level of the individual. The skilful practitioner will recognize the idiosyncratic conditions that predispose someone towards violence (Mulvey & Lidz 1995). Some of these may include specific symptoms of mental illness, but they are far more likely to include other factors common to most violence and indicative of the ill-health of society, for example a history of previous violence in the family of origin (Blomhoff, Seim & Fris 1990).

Mental health services should, and do, take the responsibility of protecting the public seriously. However, increasing the surveillance and public protection role of services may come at the cost of mental health care at the level of the individual and society. A focus of services on the most 'dangerous' has about as much to do with improving the mental health of a population as installing a burglar alarm has to do with addressing the reasons why people may commit crimes.

In the best sense the 'mental health service' model may better be described as a system of 'psychiatric' care in as much as it seeks to provide care to those with defined 'psychiatric problems'. Its sphere of influence may extend to the individual and their immediate social environment and may provide the necessary conditions for growth and development for those whose form of distress meet certain diagnostic criteria. This is a good thing. Psychiatric services are fundamental to a system of mental health care and require that nurses and other health professionals become expert at providing mental health care to those with special needs. However, psychiatric services do not in themselves constitute a system of mental health care.

A system of mental health care would acknowledge that the conditions required for mental health are the concern and responsibility for all of society rather than one particular service. It would see a dissolution of socially constructed barriers between people that presently mitigate against successful community living for the most vulnerable. Rather than contain and care for people in constructed environments it would seek to nurture the wider environment so that it is habitable for all. It requires an appraisal of whose interests the dominant ideologies that shape social relations serve. It requires us to locate the source and solution to problems of mental health in societies' institutions,

and in our relationships with each other as well as within the individual.

Mental health services are necessary and require that nurses take heed of the need to do what is necessary to become as effective as they are able in their various roles with the people whom they serve. However, the present specialist service response to mental distress does little to promote mental health in the wider population and nurses ought to be proponents of a wider system of mental health care. It is reassuring to see the beginnings of an approximation to a systematic approach to mental health care, for example in New Zealand's response to the problem of youth suicide. In the education sector some schools are integrating 'building positive relationships' into the curriculum and taking a pro-active response towards 'bullying'. Such small localized responses may, in time, be woven together to form the fabric of an enduring system of mental health care that will ensure the best conditions for the mental health of all groups

in society. A system of mental health care is not an unattainable goal, but it is a challenging one. One that is necessary to pursue if we are serious about mental health.

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