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the magazine for democratic psychiatry

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Editorial: a dedication

It must be a sign of the times. Mad Studies comes of rage? This would have been music to the ears of Robert Dellar (1964–2016), friend and long-time supporter of *Asylum* magazine. Robert was a gentle, but provocative, advocate for Mad people, culture and politics. As we're getting excited about Mad Studies, let's not forget it couldn't have happened without people like him. Robert was a key activist in organisations like Mad Pride, the Mental Health Resistance Network, and Recovery in the Bin. He wrote the brilliant book *Splitting in Two: Mad Pride and punk rock rebellion* (Unkant, 2014); co-edited *Mad Pride: A celebration of mad culture* (Spare Change Books, 2000); created numerous *Mad Punk* cds and gigs; and helped produce the excellent *Southwark Network Mental Health News*. Those of us who knew him will remember his kindness, humanity and generosity.

We also mourn the loss of Mark Fisher (aka K Punk) who committed suicide earlier this year. In his life Mark had incisively dissected modern society's destructive effects on our mental health, notably in his critically acclaimed *Capitalist Realism: Is there no alternative?* (Zero Books, 2009).

We dedicate this issue to Robert, Mark and other kindred spirits lost to us. We still believe there is an alternative, and we still hold hope in these dark times. Let's hope Mad Studies builds bridges, not walls. ■



Robert Dellar

Mad Studies: One of the most important intellectual developments of the century?

Alex Dunedin

I attended the recent Mad Studies collection of contributions to the Disability Conference at Lancaster University. I believe it marked a watershed moment in our intellectual history, where the vertical structures of who gets to be involved in the discussion about madness are compelled to expand into the horizontal. As academia comes under the pressures of finance and an accompanying type of managerialism, where the profit motive displaces the public good, many people react by critically analysing who gets to dictate the agenda.

As exploitative working conditions and unforgivingly increasing workloads cause more and more 'mental illness' across public sector workforces, the changes have forced many to re-evaluate their position on the arguments around mental health. People are increasingly affected by harmful social practices, but the medical model of mental illness remains ever present, with its ignorant premise that this is a biochemical issue, not a matter of social problems

which we must own. Mad Studies opens itself to all those who have some experience of these matters, or who have thought about them critically, so that there is a movement towards a more appropriate evaluation of the issues.

Only for so long will people accept a poor explanation and types of treatment which do not work. When too many had been harmed or killed by a self-fulfilling paradigm, even the absurdity of the witch trials passed into history. Mad Studies involves a developing body of consciousness and intellect willing to be critical of the self and the other, *as a necessity*. I am one of those who are relieved to see this surfacing of democracy and merit in the production of knowledge. Without these qualities both the access to knowledge and our society become empty and desperate. The best times are yet to come. ■

Alex Dunedin is one of the co-ordinators of The Ragged University. www.raggeduniversity.co.uk

Mad and Queer Studies: Shared visions?

Helen Spandler

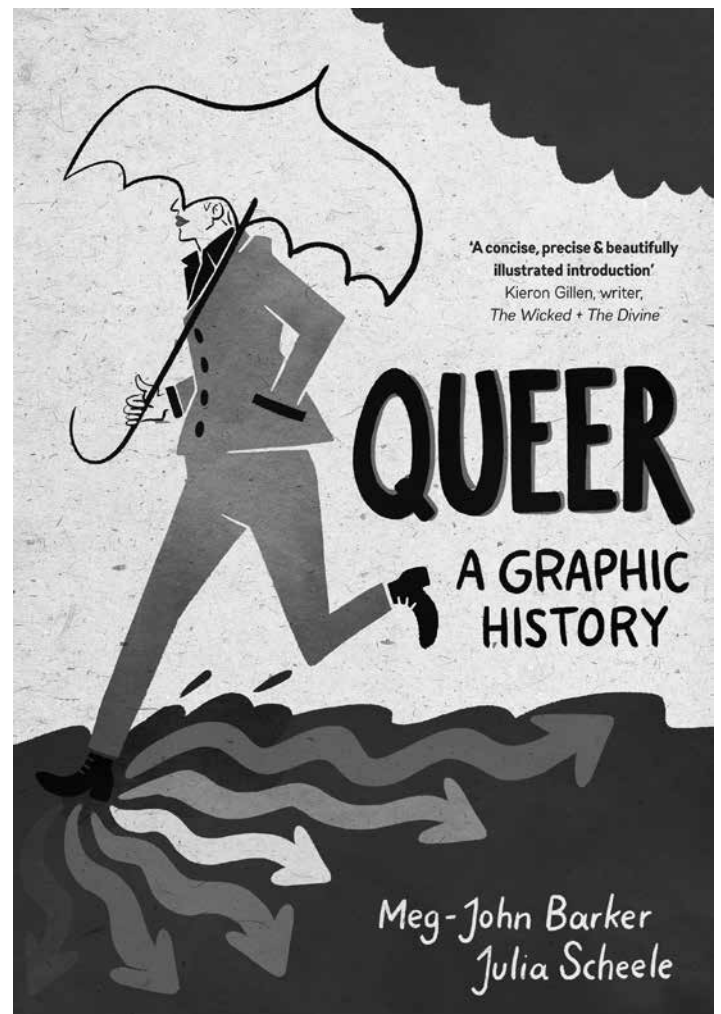
The following is based on a guest blog I wrote with Meg-John Barker. We'd been talking about the links and possible disjunctures between Mad and Queer studies. It's important to say at the outset that there's a complex relationship between Mad studies, mad politics and the psychiatric survivor movement – as there is between Queer studies, queer politics and the LGBT movement. For this piece, however, I'm going to focus primarily on the shared vision of Mad and Queer studies, and ask some questions that concern both.

There is much common ground between the two. First, and most obviously, both intend to subvert the negative connotations associated with the terms Queer and Mad. This, it has to be said, hasn't always been popular amongst the LGBT and user/survivor movement, who often reject those terms as pejorative, unhelpful, and even elitist.

However, 'Queer' and 'Mad' don't necessarily refer to identity categories or experience per se, but to strategies of political critique and resistance; this is signified by capitalising Mad and Queer (like Black or Deaf). Indeed, whilst Queer and Mad bodies and experiences might be central to their respective disciplines, both explicitly reject 'identity politics'. Madness and Queer are not seen as fixed or natural states, but 'socially constructed' and 'performed' through self or other identifications.

Therefore, both Queer and Mad Studies critique dominant and culturally-accepted ways of being 'normal' (what has been called 'normalcy' or 'normativities'). For example, they question certain assumptions about what constitutes 'normal' psychologies or sexualities. Therefore, rather than studying non-normative ways of being (e.g. Mad or Queer people, experiences or behaviour) they question dominant understandings and constructions of what it means to be psychologically or sexually normal. Lucy Costa has referred to this as 'flipping the microscope'.

In addition, they both share the idea that these 'normativities' are kept in place through binary oppositions, where one side is privileged over the other, e.g., man/woman, straight/gay, sane/mad, normal/abnormal. So, in effect, Mad and Queer studies both challenge the existence of these binaries. Mad scholars have sometimes explicitly



drawn on Queer theory in order to question psychology, psychiatry and other 'psy' professions. For example, Brenda LeFrancois has used queer theory to critique psychiatric diagnosis.

Mad and Queer studies also critique practices and discourses of sanism and heterosexism. Moreover, they analyse how sanism and heterosexism are interrelated. For example, Mad studies has highlighted the way that psychiatric diagnoses are often based on damaging gender and sexuality normativities. Similarly, Queer studies has drawn attention to the way that psychiatry – and other psy pros – have historically silenced and pathologized different genders and sexualities.

We could say that Mad and Queer Studies have a shared vision for a wider transformation of society. Thinking back to the early days of Gay Lib and Mad Lib, there was a desire to create a society which accepts and embraces sexual and psychological diversity. These movements demanded more than mere 'acceptance' and 'tolerance' of individual Mad and LGBT people. They demanded sexual and psychological liberation, not 'accommodation' or assimilation.

Arguably, then, Mad and Queer Studies aim to create psychologically and sexually enabling societies – ones which are not heteronormative or psycho-pathologising. A psychologically enabling society would presumably also be sexually enabling, facilitating more diversity and fluidity in sexuality and gender expressions. Equally, a more sexually enabling society should also be more psychologically

enabling. Ultimately, this should benefit society as a whole – not just Mad or LGBT people – as it would challenge unhelpful and harmful psychological, sexual and gender normativities. In other words, it would free us from the tyranny of normalcy. So far so good.

This is an exciting yet challenging project because it questions shared social values. Gay Lib questioned the inevitability or naturalness of heterosexuality, severed links between procreation and sex, and between gender and sexuality. Arguably, Mad Lib takes this even further by questioning prevailing beliefs about subjectivity, personhood, and rationality. Madness is, after all, synonymous with irrationality or at least unintelligibility. Arguably, sexualities – or at least *consensual* sexual relations – are not *intrinsically* harmful. However, it's harder to argue there isn't any intrinsic suffering to madness – whether to self or others. Therefore, the challenge of madness goes beyond celebrating difference and challenging normalities.

This raises lots of big questions. For example, what are the limits – as well as the opportunities – for sexual and psychological diversity? For Queer, limits may relate to consent and paedophilia as off-limits, although these lines aren't always easy to draw in practice, resulting in disagreements within the LGBT rights movement. For example, some lesbian feminists have raised concerns about certain sexual practices, gender expressions and lowering the age of consent. Similar debates have emerged in Mad Pride, which some have criticised as advancing a male-centred view of acceptable Mad behaviour. Some of the best and worst examples of this are portrayed in Rob Dellar's excellent book about Mad Pride, *Splitting in Two*.

So, what are the limits of mad expression? If we don't want psychiatry or psychology to decide, then who should? Currently, limits are not only imposed by dodgy psychiatric taxonomies or sanist prejudices. We all have our own personal limits, and this will vary according to context. Unusual or bizarre behaviour may be fun at a rave or a Mad Pride gig but may be terrifying in the context of an intimate relationship or a family environment. How can we negotiate the limits of acceptable behaviour amongst ourselves? If, like sexuality, we foreground consent, how might this work in relation to madness?

It is often said that social acceptability is related to the 'intelligibility' of behaviour. That is, behaviour is more acceptable if we can understand it or it makes sense. To some extent, the case has been made for the intelligibility of gay and lesbian sexuality – although to a much lesser extent for bisexuality, asexuality or transgender experience, even within Queer communities. In addition, intelligibility has partially been achieved for some experiences such as voice-hearing and self-harm – especially if narrated as a response to trauma, i.e., as 'an intelligible response to an intolerable situation'. However, not all madness has been made intelligible like this. And not all mad expression is acceptable – even within mad communities.

This raises other important questions. For example, how do we avoid creating new 'alternative' norms, hierarchies and binaries? How do we avoid privileging certain identities or mad expressions over others? For example, in Mad studies it might be tempting to privilege mad positive 'survivors' who reject psychiatry (and 'recovery') over 'service users' who value psy services (and want to 'recover').

A similar dynamic happened in Queer politics. There was a tendency to privilege 'radical' queers (e.g. those who challenge sexual and gender norms) over 'assimilationist' queers (e.g. those who marry or adopt traditional gender roles). New alternative norms and binaries can be just as unhelpful as those we want to challenge. They also fix people and oversimplify complexity.

Yet, if we break free from identity categories entirely, how do we make distinctions? More importantly, how do we make political demands, such as the demand for rights or services? Here, identities and diagnoses are sometimes necessary. That's why Gayatri Chakravorty Spivak advanced the idea of 'strategic essentialism' and Peter Sedgwick saw 'illness' as a political demand. These were both attempts to strategically adopt identities for political ends. In addition, are all differences equal? Should some be more valued than others? After all, there are important differences between those of us who live LGBT lives (and are 'out') and those who don't, and those who have experienced the sharp end of psychiatry (and are 'out') and those who haven't. These differences matter.

So, how do we work through these questions and negotiate our differences? I always return to the idea of prefigurative politics. This is a kind of politics which attempts to *be* the kind of change we want to see in the world – in the here and now. This means ensuring our relationships, organising strategies and theories reflect the kind of society we want to create.

One of the things I liked about the Mad Studies stream was the way kindness wasn't just talked about, but actively practised during the event. Self and other compassion has to be at the heart of any politics. We will only create the kind of society we want if we open our minds and hearts to differences of experience *and* opinion.

When we are considering questions about the limits of acceptability, the advice of Kate Bornstein, the Queer and Mad activist, is a good place to start:

Your dreams are not dangerous. Your desires are not damned. Do whatever it takes to make your life more worth living. Anything at all. There's only one rule to follow to make that kind of blanket permission work: Don't be mean. Be Kind.

The original blog can be found at <https://madstudies2014.wordpress.com/> ■

Queer: A Graphic History by Meg John Barker & illustrated by Julia Scheele, provides an illustrated introduction to the world of Queer.

JUST BORDERLINE MAD

Flick Grey

My name is Flick Grey. I'm a mad wandering academic, living between London and Melbourne, Australia. One way of framing what I have to say is as my search for a home. Another framing is as an auto-ethnographic study of my own madness. Yet another is me sharing what's uppermost in my mind, what's most alive in me in this moment, trusting that this will connect with at least some others and maybe we can think a bit together. This is not the academic paper I had intended to write – I am completely mad right now, or rather, I am 'borderline' mad. But if I can't be ('borderline') mad at a Mad Studies conference, I don't want to be here! I understand and value my madness as a deeply generative space.

This particular bout of madness has a context. Last week, I was in Kaunas, Lithuania, for the 21st International Meeting on the Treatment of Psychosis. I had heard this gathering described as "The Home of Open Dialogue" and "a democratic space with no fixed program". I was very excited to be going. I had fallen in love with Open Dialogue in 2013 when, in an auditorium filled with both radical and establishment (sanestream) colleagues, I watched Daniel Mackler's documentary *Open Dialogue: an Alternative Finnish Approach to Healing*.

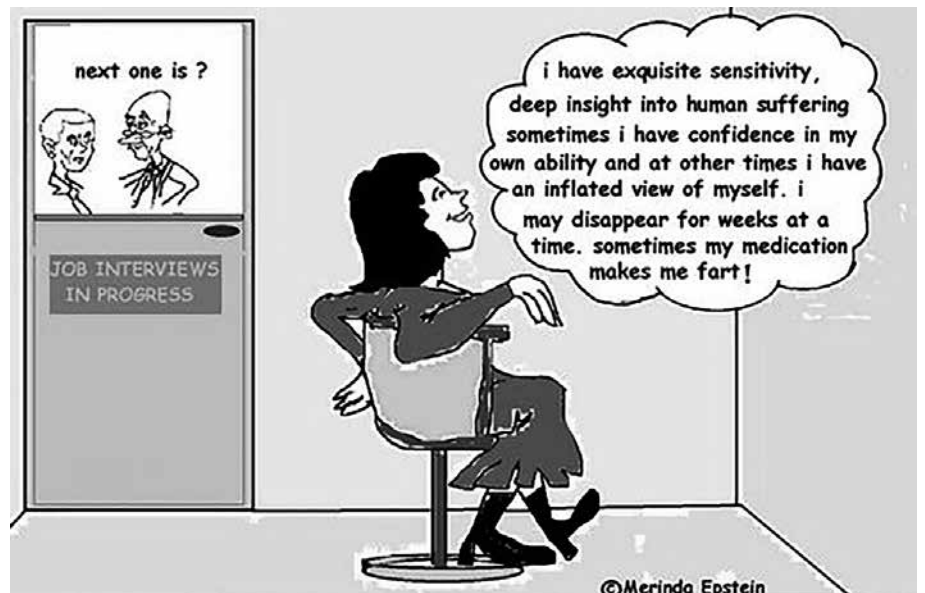
For those unfamiliar with the approach, Open Dialogue offers a *systemic response* to people in emotional crisis. It originated in Finland, beginning in the 1980s, and draws on many diverse philosophical and theoretical strands, including social constructionism, Batesonian cybernetics, systemic family therapy, reflective teams and needs-adapted treatment. In practice, it involves bringing together people in crisis with their social networks, to discuss their various worries and understandings, and to explore ways forward. This process of speaking openly with each other was found to be helpful, and it dramatically reduced the use of neuroleptic medications, hospitalisation and diagnoses. Open Dialogue is currently being trialled by NHS England, and has been taken up enthusiastically by many people in the international Mad movement. For example, it is included in Peter Lehmann's book *Alternatives Beyond Psychiatry* (2007), Will Hall (the curator of Madness Radio) offers workshops on the approach, and it features on *Mad in America*.

While much of the research into the efficacy of Open Dialogue has focused on

psychosis, the approach is offered to everyone approaching mental health services with concerns. Whereas access to the Australian mental health system (the system I am most familiar with) is highly regulated by diagnosis and 'severity' criteria – my own madness has rarely been deemed worthy of response (and even less often a non-shaming response) – Open Dialogue is organised around responding immediately to people, regardless of the concerns they are presenting (e.g. drug use, loneliness, difficulties at school). Moreover, madness is understood to be contextual – between people – rather than a 'disorder' within an individual.

For various reasons, while I was in Kaunas I fell out of (naïve) love for Open Dialogue. As with any human network, there are petty and unspoken rivalries, (disavowed) power hierarchies, ignorance of the critical work of the international Mad movement (and ignorance and disavowal of this ignorance), and an irritating, self-congratulatory, un-self-reflexive chorus of "WE are the ones who GET IT."

I also realised that, as a network of professionals, Open Dialogue privileges psychosis. I was disappointed by the mismatches between rhetoric and practice. While I was there, I was invited to present at the International Society for Psychological and Social Approaches to Psychosis (ISPS) conference, because Eleanor Longden had pulled out. But my experiences are not psychosis. I was also repeatedly asked if I was coming to the Hearing Voices Congress in Paris. I tried to articulate something of the complexity of my relationship with Hearing Voices, but this



THE RIGHT CANDIDATE WAS PROVING HARD TO FIND!

was dismissed with “Just come!” I was confronted with just how much psychosis is centred in the ‘alternatives’ spaces in which I move, and simultaneously this felt painful and stimulated new thinking.

The Hearing Voices Network seems to me one of the most generative spaces in the mental health world today. Specifically, it is a space in which voice-hearers are recognised as subjects and producers of vital knowledge, rather than cast within an epistemic framework imposed by ‘enlightened’ professionals. However, the Hearing Voices Network is politically problematic for me because it constructs a world of centres and margins – and my own ‘borderline’ madness is positioned as peripheral. At the centre are the experiences of those who hear auditory voices and have had ‘psychosis’ experiences (and typically have an identifiable trauma-history and years of involuntary treatment and neuroleptic medications). People whose voices are a spiritual phenomenon, who dissociate or who have unusual beliefs are also carving out spaces for themselves within the Hearing Voices approach.

I’m not sure how to locate my own madness experiences in relation to this world, but I’m tired of feeling or being marginal (or ‘borderline!’). Within the psychiatric system, I was informally labelled as having borderline personality disorder, but today my private (trauma-informed) psychotherapist describes me as having “complex post-traumatic stress disorder” (a diagnosis not recognised by DSM 5). I don’t find either description adequate, although the latter is much less shaming! I understand my own experiences not in terms of a disorder of an individual, but in terms of *relational embodiment*.

Let me try to explain. My mother describes the day I was born as “the best and the worst day of her life”. She finally had a longed-for daughter, but she experienced me as “rejecting her the moment I was born”. Consumed by her own unmet needs, she was unable to attune to mine. I was also sexually abused by my father, for many years and from a very early age. It is excruciatingly painful for an infant to have no safe caregiver with whom to attach. I was left alone to master the all-important task of learning to respond to my own emotional world, a task that infants ideally learn in an attuned attachment relationship with a caregiver. And so I invented creative ways to self-soothe: I would rock myself backwards and forwards, hide in cupboards or in other dark, quiet spaces when I felt over-stimulated, do dangerous things to get an adrenaline rush, or try desperately to ‘earn connection’ (e.g. by precocious achievements, by ‘being a good girl’, etc). At an early age I also discovered that causing pain to my body releases endogenous feel-good chemicals. When life was unbearably painful, I would soothe myself by fantasising about dying – the ultimate act of control for those who feel powerless.

As I grew older, these activities became more worrying to other people, and at age twenty-six I came to the attention of the mental health services. The explanations of my

experiences proffered by the mental health professionals made little sense to me, and they were highly shaming, *blaming me for any relational difficulties*. Ever since, I have been searching for a language that would do justice to my experiences.

One of the places I found refuge was in the work of the Australian cartoonist and ‘high profile nutcase’, Merinda Epstein, an elder in the Australian Mad movement. I credit Merinda with literally saving my life, since she offered non-shaming descriptions of experiences like mine. Judith Herman – a Harvard psychiatrist no less – has proposed that BPD be reclassified as complex post-traumatic stress disorder (C-PTSD), and says the ‘borderline’ label is “little more than a sophisticated insult”.

However, I disagree with her proposal for three reasons. Firstly, I don’t see my experiences as ‘disordered’ but as creative adaptations to my relational context. Secondly, Merinda and I have written together about hierarchies within the mental health system, including hierarchies of trauma. For example, most people would hear my history and locate ‘my trauma’ as the sexual abuse. But while this was indeed traumatic, the mis-attuned relationship with my mother was far more painful. In part this is because *there is no collective language or cultural (or sub-cultural) legitimation for those kinds of experiences*, and so I have tended to blame myself (as children so often do when their experiences of care are painful). Some people are unable to identify any culturally-recognised traumas in their histories (what I call ‘capital-T Traumas’, such as sexual abuse), and so they don’t have the option of the exculpating C-PTSD diagnosis, and I believe it’s important to strive towards what McRuer (a crip theorist) describes as “a rigorous conjunctural analysis that leaves no form of identity behind”. Thirdly, C-PTSD has primarily been theorised by trauma-specialists, not by Mad people, and so their words don’t feel like my words: it still locates mental health professionals as ‘the real experts’ on my most intimate experiences. Even the word ‘trauma’ has a place in my culture that is overly pre-determined, rather than offering space for individual meaning-making (as is offered by the Hearing Voices Network). I ask people “How do YOU understand your experiences?” – especially when they have no obvious, culturally-recognised trauma: too many people with a BPD label describe feeling ashamed for not having “enough trauma to be this fucked up”. But I believe that when we listen carefully to relational context and meaning-making our responses always make sense.

Just as I try not to blame myself for these relational patterns, I try not to blame my mother, either. I recognise patterns of intergenerational trauma in both of my parents’ behaviour towards me. I understand the painful experiences between me and my mother in terms of relational embodiment, the way in which bodies respond to each other. I identify with the concept of ‘sensitivity’ (which I came across through the work of Elisabeth Svanholmer and Rufus May): when I was an infant and my mother



just a little bit batty

© Merinda Epstein

'loomed over me' I felt overstimulated and tried to move away to lessen the stimulation – which she experienced as rejection. Another, less sensitive child may not have responded the same way. My mother then disavowed her own experiences and blamed me, describing me as “an impossible child”.

Jaakko Seikkula is the patriarch of the Open Dialogue world, and in Kaunas he ran a workshop on embodiment in Open Dialogue. It was there that I came to understand that BPD could be described in terms of a relational embodiment pattern, in which a caregiver – a parent, partner, friend or mental health professional – is in contact with someone who is relationally sensitive and struggling with big emotions and complex feelings about attachment. The caregiver has an embodied experience of rejection and feels something – perhaps hurt, anger, confusion – but then *disavows this experience* and instead rejects the person, blaming them for their 'inappropriateness', 'anger', 'manipulation', 'attention-seeking', etc., etc. Indeed, Gunderson (perhaps the biggest name in BPD after Marsha Linehan), has described BPD as “collective counter-transference.”

Another way in which I understand my own experiences is in terms of 'parts'. The Hearing Voices Network does not quite feel like home, because if I am asked the question “Are you a Voice-Hearer?” I believe it would be dishonest to give an unqualified affirmative – and I might be in danger of co-opting the experience of those who do hear voices. But the question itself is problematic for me. Drawing on the work of Rufus May, I suggest that the experience of hearing voices is not a binary yes/no since, in a sense, *all human beings hear voices*. These voices may be the ambivalent parts of us (one part says “have another chocolate” while another says “remember we are trying to lose weight!”), or an introjected (internalised) voice of a judgemental parent (like my mother's voice telling me I am “impossible!”), or an ancestor offering guidance from beyond, the soothing voice of someone who has comforted us, or a child part that wants to get out of this lecture theatre and go play in the sunshine.

During a session of Maastricht Interview training in Melbourne (with Marius Romme, Sandra Esher, Ron Coleman and Indigo Daya), a dear colleague of mine,

Louisa Dent-Pierce, profiled my 'inner voices'. Together we identified them as my inner children and they have come to be an integral part of my healing: *when I fail to listen to and honour these child parts, I go crazy*. But my crazy is not the kind of crazy that is culturally legitimised as 'really mad' – psychosis. I just seem angry or over-sensitive, and am much more likely to experience social rejection. In fact, I might run away, curl up in a ball, sob and rock myself for an hour or so, as I did yesterday. But I seem to be kind of functionally dysfunctional.

At Recovery Camp in Kaunas, in the summer, I tried to offer some of this thinking, first to Marius Romme (the patriarch of the Hearing Voices Network) and then to Jaakko Seikkula. But like many mental health professionals (or people in positions of relative privilege), both seemed unable to position themselves in a relationship of mutual learning with mad folk.

At Kaunas, I tried to explain to a group of people that I am troubled by the question “Are you a voice-hearer?” because the underlying assumption is that I could position myself unproblematically within this binary, rather than problematizing the binary. This led to me being described by an Open Dialogue colleague as “fragile” and “sensitive”. Indeed, *I do identify as 'sensitive'*, but in the sense that canaries are sensitive to toxic gases: canaries used to be taken down coal mines, and their death would signal that something wasn't right – their sensitivity offered invaluable information about the working environment. My colleague didn't hear my words as an intellectual critique. Instead she described me as “being easily hurt”. How quickly our mental health professional 'colleagues' adopt a clinical gaze when faced with emotional distress or challenging ideas from mad folk! Our position as producers of knowledge is so often discounted when they identify an opportunity to 'help' us – especially when they position themselves as one of the 'enlightened' professionals!

In this paper, I've tried to engage with what Helen Spandler called “the project of reclaiming and reframing our experiences of madness”. Right now, I'm exquisitely sensitive, in a way that is both highly distressing to me, and no doubt to anyone emotionally connected with me, *but I hold this space as intellectually productive*.

Finally, I wonder how one might stigmaphilically reclaim these experiences, akin to Ron Coleman's tattoo: Psychotic and Proud. Perhaps I could say Self-Destructive and Proud or Exquisitely Sensitive with Really Big Feelings and Proud; or perhaps: Complex Relational Embodiment Patterns of Sensitivity and Rejection, and Proud. Alternatively, I could take up cultural references like the 'Bunny Boiler' (as in the movie *Fatal Attraction*, which has been used in educational environments as a way of understanding BPD), or: Passes as Normal but Just a Bit Angry and Over-Sensitive, as in the movie *Girl Interrupted...*

I am curious about how others navigate these kinds of questions! ■

Don't Be Mean. Be Kind.

Kirsten Maclean, Elspeth Morrison & Anne O'Donnell

Find a way into the academy. Once you're in you have to find your way around. You have to bring Mad students and teachers in, too. Then you have to find your way back out into the community again. It is my hope that others will pick up this recipe, adapt it to their local conditions and set about using it.

David Reville (2014)

Who we are and why we went

We belong to a group of people based in Edinburgh who have been involved in a course at Queen Margaret University, called Mad People's History and Identity (MPHI). It's for five weeks, and is open to anyone outside the university with 'lived experience of mental health issues'. We are now developing community-based courses.

David Reville and Kathryn Church have developed Mad people's courses at Ryerson University (Toronto), and we are influenced by their work. David's quote has guided how we work.

So we went into the university for MPHI, and now we are bringing it back out to the community. We went to Lancaster in the same spirit – not just to talk about what we've done but also to carry on and develop the back-and-forth between the university and the community, the community and the university.

In developing the community courses, we want to provide space for service-users and psychiatric survivors, from assimilators to activists, from reformists to radicals. We want to include people who are not used to academic ways of working – even put off by them – as well as those interested in further education.

We use a community education approach: we are not teachers imparting knowledge to students, but a community of learner/teachers.

For example, we used pizza as a way of designing the curriculum. We decided on a topic for each week, and that became a slice of pizza. Then people added their ideas for the content as pizza toppings – see the photo! This was an inclusive and unpressured way of doing it, allowing the range of perspectives amongst those contributing to be represented on the pizza slices, and consequently in the course.

To keep the relationship between academia and community alive, and being from a community group, we felt it was important for us to be at a predominantly academic conference. So we went to the conference as learners/teachers to share our work and to learn from others.

What we found there: be kind

Unusually, and refreshing for an academic conference, the Mad Studies stream was topped and tailed with reminders of the importance of kindness. Peter Beresford talked about the need to be kind to one another, and Helen Spandler quoted Kate Bornstein: "Don't be mean. Be Kind".

We were very struck by Helen Spandler talking about those LGBT people who embraced equal marriage as being assimilators, and we worry that similar divisions happen amongst Mad people. Our communities can be as divisive and cruel as the rest of the world. Human nature veers between judging people as different to us and conversely wanting to belong to something.

In her keynote, Jijian Voronka asked: Whose voices get heard? Whose experiences are valid and acceptable and whose are considered too angry or unpalatable to the powers that be? This tied in with a question from Helen Spandler: Who is "mad enough, queer enough, disabled enough" to be part of Mad Studies?

As Mad people, we police ourselves and recreate new hierarchies, often based on psychiatric experiences, e.g., Have you been sectioned or not? Or on normative standards: Are you too angry? Are the experiences of psychosis more Mad than depression or dissociation? Can you identify as Mad if you have never been a psychiatric patient?

We need to realise how damaging this kind of policing and judging is to us, individually and collectively. We need to acknowledge the diversity of experiences in the Mad movement, and not silence any perspective; we need to be critical, but welcoming, accepting both those who identify as 'service-users' and those who feel they are 'psychiatric survivors'. From activists to assimilators, we all have something to say and we all deserve to be heard.

We know that, in the name of rigour, academia can also be cruel. It can also be very competitive and damaging to people. But do we have to treat each other in that way? What does 'being kind' mean in terms of what we do and how we treat each other? How can we "not make each other feel stupid?" as one person put it. How can we successfully bridge the gaps between Mad Studies in the academy and Mad Studies in the community? Can we have room for critical debate without getting cruel or personal? Can we allow space for individual experience rather than look for a homogenous academic standpoint?

Don Kulik's critique of Disability Studies affirmed our commitment to ground Mad Studies in Mad people's real lives and experiences. We take this to mean that we

need to be careful to include a wider range of voices and experiences – not just the people already comfortable (or at least able to tolerate the discomfort) in the academic world or in existing Mad people’s groups and networks. So how do we make Mad Studies attractive and welcoming to a diversity of voices and realities? It can be difficult to include people who we have excluded: we are excluded from so much ourselves, so it can be intensely painful to realise that we are acting exclusively. But we need to face up to this tendency, accept the pain rather than ignore or deny it, and find ways to be as truly open as we can possibly be. To do this, we need to stop judging ourselves and each other so harshly, accept our vulnerability as human beings – and in particular as Mad human beings – and yes, be kind.

Kindness may seem like a very soft, apolitical word. However, throughout the conference, we were impressed by how a speaker might disagree with other points of view, while being clear about how that affected the others intellectually and emotionally, and disagreeing without it coming across like a personal attack. This was kindness in action and it meant that the conversations were all the richer for it. Kindness offers the possibility of being more inclusive and open to a variety of views and experience.

Since there were some difficult issues under discussion, the need to be kind was all the stronger. Probably the most difficult was around violence. Lucy Costa told us about one

psychiatric survivor in Canada making a series of attacks on other survivors, and the need for the community to deal with it. Instead of getting caught up in the usual argument about who is the victim and who the perpetrator, survivors in Toronto developed an anti-violence framework which looked at violence in and against the psychiatric survivor community.

Lucy challenged us to think about how Mad Studies can respond to such violence. Too much of the discourse around mental health and violence has been through the media and is countered by anti-stigma campaigns. Much of the research has been done by psychiatrists. We need to develop our own concepts and our own vocabulary, and take ownership of the discussion. We need to look at the complex experiences of violence in our communities. More and more people with mental health issues are incarcerated not in hospitals but in prisons. Forced treatment, poverty, homelessness, the countless micro-aggressions we face are all forms of violence that many of us have to deal with.

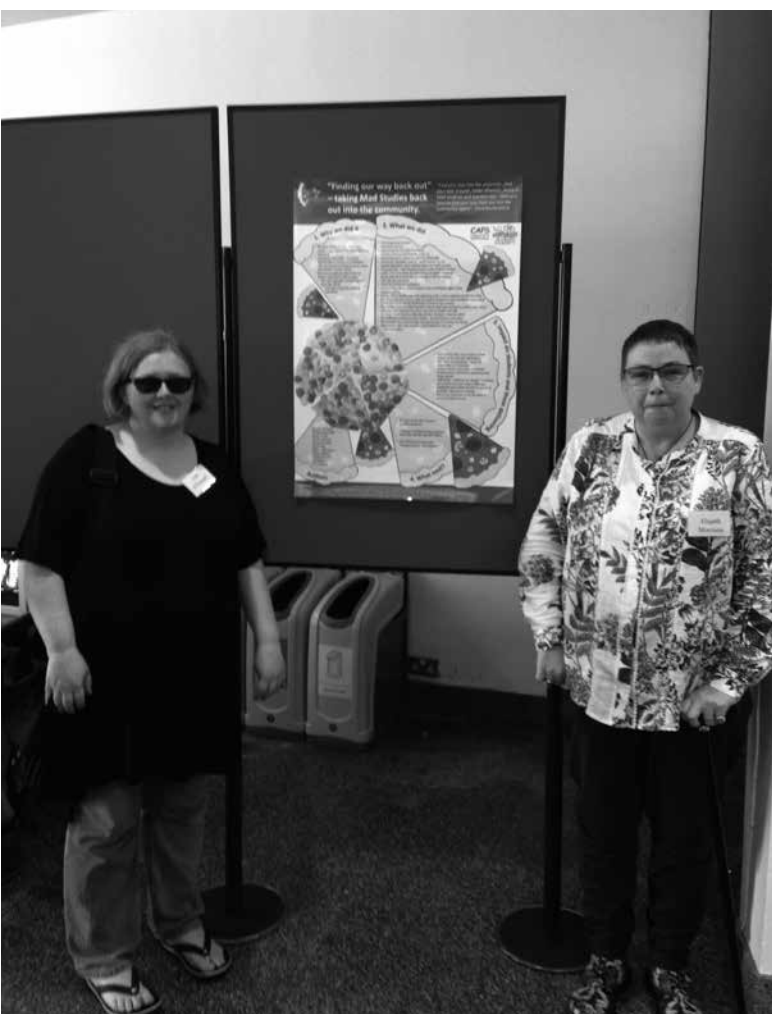
We need to make spaces for each of us to talk to each other about this. That isn’t easy. Some people are reluctant to give space to those of us who have committed violent acts. How do we include everyone’s voice? When we are talking about violence, it is hard to think about being kind and it is hard to include the voices of those who have been violent. However, without this kindness and openness, it will be even harder.

What we’re taking back

We’ve come back inspired by the many discussions and conversations. We are planning the community course for a new group as well as taster sessions, including one at the LGBT Health and Wellbeing Centre in Edinburgh. We are even more committed to a Mad Studies that includes the diversity of Mad people and our voices, and above all, to being kind.

Developing or co-producing curricula at the grassroots is one way to bring in new perspectives and knowledge. It can help bridge gaps, and it gives us a practical way to ensure we remain vigilant about Mad Studies representing and including the diversity of perspectives. For example, we will co-deliver the taster session at the LGBT Health and Wellbeing Centre in Edinburgh, designing the curriculum again by using a community development methodology with the people using the centre, and focussing on LGBT experiences of Madness and psychiatry. We think knowledge generated in this way, by learner/teachers, invigorates the curricula of the community based courses, but also informs future university-based courses and Mad Studies generally. As the university course has informed the development of the community courses, so must the community courses inform the university course.

But most of all, we are taking back the message: Don’t be mean. Be Kind. How this will change how we do things and why, we don’t know yet, but we are sure it is the right way to go. ■



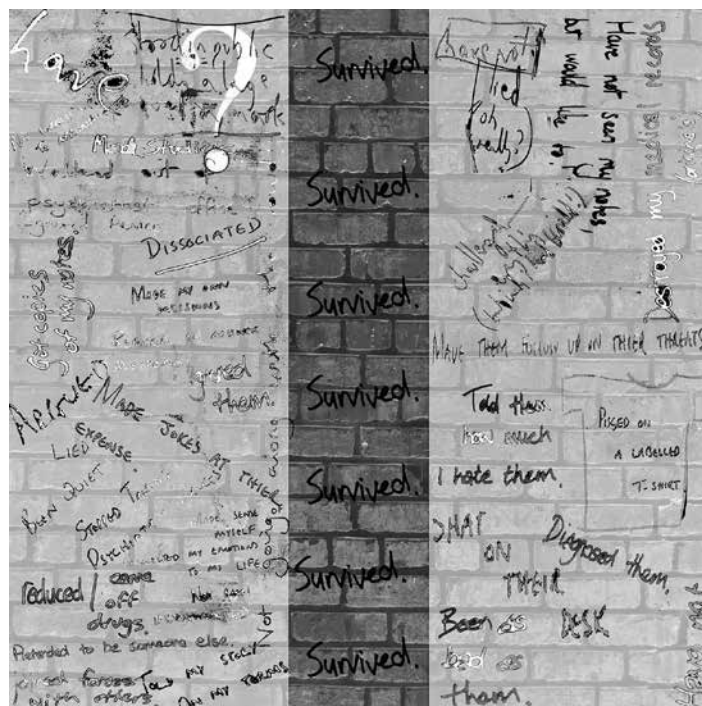
Anne O'Donnell & Elspeth Morrison

Mad studies North East collective community course

Mad Studies North-East Collective are activists mad as hell yes, all of who challenge living with mental distress in multiple ways in trying times across the region. Together with our allies, we've run reading groups and staged an international conference bringing together activists, academics, artists and others – all with lived experience. We also established #everydaysanism – we really do need yr contributions of examples of everyday sanism. We have now just run a pilot community mad studies course for anyone with lived experience. The idea was for us to analyse some of our histories, activisms, intersectionalities, and more. Some of us had previously attended (and one facilitated on) the mad studies course: Oor Mad History/qmu musselburgh

We discussed and then planned this course over some months, deciding early on that the right place for us was in the community not in academia. We said to participants: "No prior experience is necessary or required, just an inquisitive mind, some experience of madness and distress, and a desire to fight for equality." The course ran at the Waddington Street centre for four full days and two half-days. The centre kindly provided the space for free, but otherwise the course was completely unfunded. (How mad is that!)

The opening session raised the question that we are often seen as unreliable: we came to celebrate being unreliable narrators. From this, we looked at mad peoples histories, big pharma, confinement, identities, activism and resistance, and on to a final soapbox where everyone



had a slot to say anything they wanted. We covered a lot of ground, while also making it clear that this course always was provisional, partial and not 'owned' by us or anyone else. We also made it clear that folks are always welcome to change what's looked at, and how and why. Several times we also suggested that folks might like to go and establish their own projects or actions. However, we had carefully planned the course so that threads ran throughout, and on the whole each session flowed and built on previous ones.

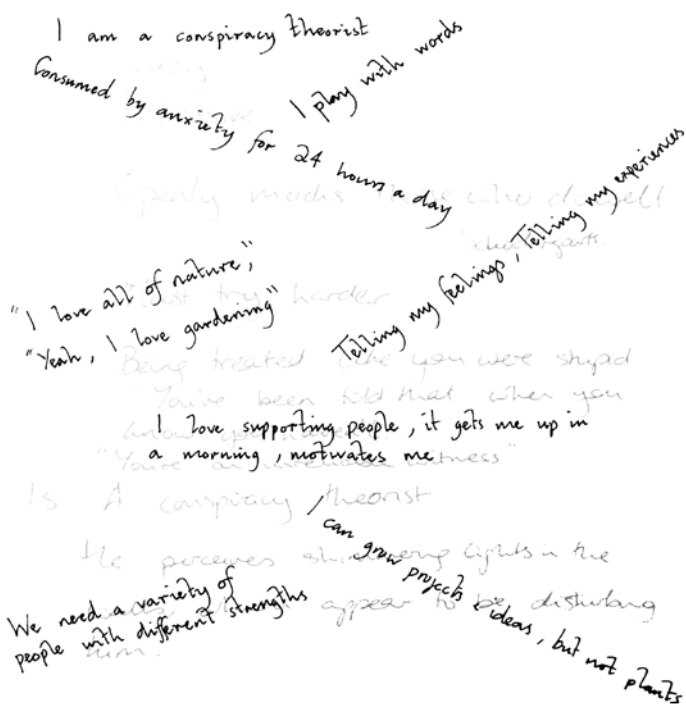
Alongside provocations (including a half-brick), silent debates (by writing up comments in answer to topics, they are great for ensuring everyone has their say), using historical material (e.g., the outrageous claims in drugs ads from the last hundred-plus years – what's new?), watching videos, much discussion and making art – individual and collective – we came to greater understanding of our histories.

Three key themes seemed to recur – two are illustrated by collective artworks which accompany this write-up:

1. Who 'owns' our narratives/who tells our stories? (In this visual the top layer of writing is what we have chosen to say about ourselves, the ghostly layer underneath is what has been said about us.)
2. (Many of us) have survived.
3. Acts of creative resistance. (Watch this space for pissing on tee-shirts and more!)

Would we do it again? Probably, but very differently! Options seem to be spacing it across the year as workshops, with maybe two sessions or so at a time. Also we might want to take it out as a roadshow across our region – but with support. It was seriously knacker, we weren't able to recruit as many people as we liked, we're not that experienced in co-facilitating... That said, we've all learnt, grown individually and collectively, cried and laughed, and are proud to be part of a growing international movement!

More at: <http://madstudiesne.weebly.com/> ■



Homosexuality, psychiatry and diagnostic politics: Madness and gay liberation

Sarah Carr

Introduction: "A treatment for which there is no illness"

In February 2014, the Department of Health (DoH) requested that the UK Council for Psychotherapy, along with other professional organisations, prepare a consensus statement on 'conversion' or 'reparative' therapy. This was in the wake of concern about therapists offering to cure lesbian, gay or bisexual people of their same-sex attraction. The signatories assert that there is no evidence that conversion therapy works and that it is more likely to be damaging to LGB individuals who are distressed because of rejection and discrimination, feel conflicted because of their religious beliefs or who experience mental health problems. They are clear that it is unethical and wrong to offer "a treatment for which there is no illness".

By 1973 homosexuality was declassified as a mental illness in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association (APA), and in 1990 it was removed as a mental illness from the World Health Organisation's *International Classification of Diseases (ICD)*. So why in 2014 did the DoH need to commission this statement on conversion therapy, and why is it still prevalent in the UK and the USA? Paradoxically, part of the answer to this question may lie with the 1973 deal struck by American gay liberation activists with the APA, following an eight-year battle over the classification of same-sex attraction as a mental disorder.

At one point, in the course of becoming civil rights movements, the gay liberation movement and the mental health service-user and survivor movement seem to have developed parallel critiques of psychiatry. During the late-1960's and early-70's the gay liberation movement in the USA and the UK constructed reasoned arguments against the pathologisation of same-sex attraction (often conflated with gender non-conformity) and its classification as a mental disorder. Initially, this amounted to a broader critique of the discourse and discipline of psychiatry itself: they argued that psychiatry was subjective, political and moral. They also employed disruptive direct action

tactics to change the American Psychiatric Association (APA) and allied medical organisations. But did they go far enough?

The battle of "the true authorities"

The story of psychiatry's relationship to homosexuality is perhaps one of the crudest demonstrations of how the discipline determines what is 'normal' and 'abnormal', upon which it overlays a discourse of 'sickness and health'. Even today we are living with this complex legacy. It is a pen-portrait of psychiatry's politicized role in maintaining social order and the medical categorisation of behaviour in order to exercise moral control and combat 'social deviance'.

Even very early on in the emerging movement, lesbian and gay people feared psychiatry: "Now that inverts have almost escaped the stake and the prison...they are threatened with the new danger of the psychiatric torture chamber", wrote the anonymous author, Parisex, in a 1932 essay: 'In defence of homosexuality'. And in 1965, Franklin Kameny, the pioneering American gay liberation activist who co-led the depathologisation campaign, wrote in an essay entitled 'Does research into homosexuality matter?': "I feel that the entire homophile movement...is going to stand or fall upon the question of whether or not homosexuality is a sickness, upon taking a firm stand against it."

The fight against psychiatry heralded the pre-Stonewall politicisation and increased militancy of the previously conservative American lesbian and gay rights lobby. They were influenced by black civil rights and ideas from the anti-psychiatry movement - particularly the idea that psychiatry is not an objective science but a replacement for religious institutions which enforce moral conformity, and that so-called 'experts' are biased by conservative social and moral values. From 1965 the lesbian and gay rights movement entered into what Bayer in his 1981 history of homosexuality and American psychiatry calls 'diagnostic politics', as they came to a political understanding of the cultural and moral power of psychiatry, criticising it as a discreditable branch of medicine, and pointing out that there is "no valid evidence that homosexuality is a sickness,



'Psychiatry: Friend or Foe to Homosexuals: A dialogue', 1972 APA Convention, Dallas.

disturbance or pathology". Kameny declared: "We are right; those who oppose us are morally and factually wrong. We are the true authorities on homosexuality whether we are accepted as such or not".

One of the major problems was that psychiatric disqualification undermined the lesbian and gay civil rights movement. Kameny's co-lead in the campaign, Barbara Gittings, reflected on this in 1993: "Psychiatrists were one of the three major groups that had their hands on us... Religion and Law were the others... So, besides being sick, we were sinful and criminal. But the sickness label infected everything that we said and made it difficult for us to gain any credibility for anything we said... The sickness issue was paramount." The campaigners sought to take back from psychiatry control of their own lives and futures. Kameny wrote: "Psychiatry has waged a relentless war of extermination against us... We're rejecting you all as our owners. We possess ourselves and we will take care of our own destinies."

As well as employing intellectual and moral arguments, from 1968 until 1972, activists and 'counter-cultural' allies from the feminist and anti-war movements, co-ordinated by Kameny and Gittings, disrupted the conventions of the American Medical Association, the APA, and the Association for the Advancement of Behaviour Therapy. At the latter, the New York Gay Activist Alliance distributed a flyer entitled 'Torture anyone?', and called for an end to experiments in social engineering. There were carefully coordinated disruptions and interruptions, known as 'zaps', where protestors shouted over and argued with speakers who were pro-pathologisation or promoted aversion techniques. (The technique was later used by Queer Movement activists in 1990's, the latest version of which was 'glitter bombing' during recent US equal marriage campaigns.) In 1968, Gay Liberation Front protestors stormed the stage of the American Medical Association convention: "We interrupt this program and psychiatric propaganda to bring you a message from Gay Pride!" At a meeting on aversion therapy and behavior-modification, at the 1970 APA convention, activist Kay Lahusen shouted: "We are the people whose behaviour you're trying to change. Stop talking about us and start talking with us!"

The "non-patient homosexual" and the binary trap

In June 1971, Kameny wrote a letter to *Psychiatric News* threatening the APA with not only more but worse disruptions. In the letter he stated, "Our presence there was only the beginning of an increasingly intensive campaign by homosexuals to change the approach of psychiatry toward homosexuality or, failing that, to discredit psychiatry." Finally, at the 1971 APA convention, Kameny and Gittings forced the organisers to let gay men and women speak for themselves on a panel headed: 'Lifestyles of the Non-Patient Homosexual'. It is important here to highlight the strategic conceptualisation of the 'non-patient' homosexual.

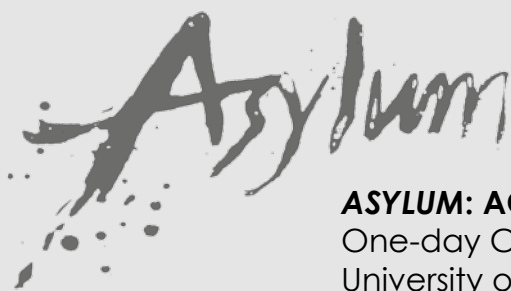
By the following year it seemed that the activists had made some kind of breakthrough with the APA. At the 1972 convention a heavily-disguised participant named Dr H

Anonymous appeared with Gittings and Kameny on a panel called 'Psychiatry: Friend or foe to homosexuals - a dialogue'. Dr H Anonymous was a gay psychiatrist called John Fryer, who had been identified by the activists as an inhabitant of both worlds. From behind a mask, he challenged psychiatric practice and asked clinicians to look at society rather than individual pathology. Was this to be a turning point in their campaign, in more ways than one? By 1972 the lesbian and gay rights activists had sought gay allies from within psychiatry, and were presenting themselves and their case as being 'Gay, Proud and Healthy'. 'Gay is Good' was also one of their key slogans - but there remains a question about the extent to which this meant 'gay is normal and healthy' as opposed to 'gay is abnormal and sick'. Despite their heroic campaigning efforts, were the activists inadvertently falling back into the psychiatric binary trap?

Disturbed but not diseased?

Finally, in 1973, after many years resisting the demands of the lesbian and gay rights movement, the APA Committee on Nomenclature decided to delete homosexuality from the list of mental illnesses in *DSM-II-R*. They replaced the previous 'disorder' of homosexuality with 'sexual orientation disturbance' - thereby placing same-sex attraction as 'suboptimal' but not actually a disorder. The APA passed this resolution: "Whereas homosexuality in and of itself implies no impairment in judgment, stability, reliability or vocational capabilities, therefore, be it resolved that the APA deplores all public and private discrimination against homosexuals." Crucially, they defined the category of 'sexual orientation disturbance' as being for "for individuals whose sexual interests are primarily towards people of the same sex, and who are disturbed by, in conflict with, or wish to change their sexual orientation". Although it marked a victory at the time, did this compromise in fact represent a tactical error with future implications for LGB people who experience mental distress?

The deletion of same-sex attraction as a mental illness listed in *DSM* had great symbolic importance and real implications for civil rights. In a 2006 interview, Gittings said: "The gay community's mental health improved dramatically when we spoke up for ourselves and took charge of our own destiny", and there is no doubt that the success of the groundbreaking activism has transformed the life chances and civil rights of LGB people. But, in defining the 'non-patient homosexual', had gay liberation activists constructed a sanist entity in their bargaining with APA? Was the performance of psychological normalcy a condition of the liberation of LGB people from psychiatry? In January 1974, a headline in *The Chicago Gay Crusader* joked '20,000,000 Gay People Cured', but on closer examination of the compromise, were lesbian, gay and bisexual people who did experience mental distress still at risk of pathologisation and treatment? Did they trade heteronormativity for psychological normalcy? Was the 'cure' only available for lesbian and gay people who were 'normal' in psychiatric terms? At the time the leading thinker in anti-psychiatry, Thomas Szasz, was critical



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of this implication, which he claimed tacitly legitimized psychiatry's power to determine what is and what isn't normal or healthy. He said the activists had been 'co-opted'.

Conclusion: "Why be happy, when you could be normal?"

Today various 'psy' interventions, including reparative or conversion therapies with religious overtones, continue to be offered to people who are attracted to the same sex or are gender non-conforming. This may or may not be because they're distressed by their situation; it may be because they have mental health problems or experience emotional distress and also happen to be lesbian, gay, bisexual or transgender. It seems possible that this situation could be the negative legacy of the 1973 compromise with the APA.

So perhaps the energy of those early gay liberationists needs to be revived in order to challenge the continued problems with mental health services and 'psy' interventions – and, more importantly, to address the LGB and T

community's acceptance of madness and understanding of our mental distress? In order to be 'normal and healthy', must we also not be mad, or experience mental or emotional distress? To paraphrase the lesbian feminist writer Adrienne Rich who wrote about the oppressive power of 'compulsory heterosexuality', do LGB and T people and communities experience the oppressive power of 'compulsory sanity'?

If so, it is surely time to revisit Franklin Kameny's 1965 declaration: "I for one am not prepared to play a passive role in such controversy, letting others dispose of me as they see fit. I intend to play an active role in the determination of my own fate". ■

Dr Sarah Carr is Associate Professor of Mental Health Research, Middlesex University, London, and Vice-chair of the National Survivor User Network (NSUN).

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LIKE A HOLE IN THE HEAD?

Why mad studies and disability need each other

Kay Inckle

Some of the most traumatic and damaging experiences of my life were orchestrated by medical professionals in reputable institutions. As a child with 'difficulties', I had no input or control over what was done to me. The immediate and wider contexts in which I experienced medical 'treatment', as well as the direct violence involved, have irrevocably shaped my body, my identity and my life. I am not a psychiatric survivor, however, in that I have never used statutory mental health services. All the same, I have spent around 12 years in weekly therapy, as well as engaging with a range of 'alternative' and holistic supports. I have also certainly had a number of experiences which could be called psychiatric, but I choose not to define my experiences by a belief system to which I do not subscribe. I am a person with a physical disability, or as I prefer to describe myself, I am non-normatively embodied.

What does this have to do with Mad Studies? Well, firstly, my experience of physical disability and enforced medical treatment is inseparable from my 'mental health'. My well-being is also damaged by the relentless prejudice, mistreatment, discrimination and exclusion that I experience on a daily basis. More broadly, however, the politics of Mad Studies and the Mad challenges to medical dominance offer a more revolutionary approach to disability than the social model.

Here I will highlight how Mad Studies perspectives on diversity, lived experience, rights, enforced treatment and inequalities are crucial for a political understanding of disability. I will also argue that it is essential that both madness and disability are incorporated within Mad Studies if we are to fully challenge medical dominance, medical abuse and the social inequalities which emerge from them.

Many of the debates around the parallels between madness and disability have revolved around the degree to which disability perspectives - and particularly the social model of disability - can be applied to experiences of madness and distress. These debates have frequently highlighted the problems with the concept of 'impairment' which is integral to the social model of disability. In the social model, 'impairment' is used as a supposedly accurate, non-judgmental description of any physical, mental or sensory 'deficit'. However, not only is 'impairment' a medical term (and therefore already biased), it is also based on the belief that there is a biologically-based, ideal human norm without any imperfections or 'impairments'. This ideal norm equates the lie of physical perfection with able-bodiedness - as well as categories of age, gender, sexual orientation, class and 'race'. Thereby, the concept of 'impairment' reinforces the perception that there is something quantitatively wrong

with people with disabilities - and this is why it has been so contentious from a Mad Studies perspective. However, as a non-normatively embodied person I also object to being defined as 'physically impaired' in precisely the same way I would object to my queerness being defined as a sexual impairment. Therefore, along with its patriarchal and colonialist underpinnings (which have been challenged by feminist disability perspectives), attachment to the medical concept of impairment is a significant problem within the social model of disability

In contrast to an approach which views one minority group as an ideal, and unfavourably measures everyone else against it, I would prefer to see humanity in which an endless diversity of experiences and capacities are equally incorporated and valued. That approach is not only the most effective way to produce real equality but it also specifically values those experiences which may be pathologised in other contexts. For example, I much prefer to receive information, support and guidance about what kinds of mobility-aids might be most suitable for me from someone who uses similar equipment. Likewise, I would consider someone with lived-experience of similar kinds of distress as much better equipped to understand and guide me than someone who has only a very narrow medicalised, text-book understanding. (Of course, in both cases I would also want the person to be appropriately trained and regulated, etc.) Mad Studies has pioneered two crucial ideas: that distress and 'difference' is an integral part of human diversity rather than pathology to be 'cured' (i.e. eradicated), and that lived experience is important. This could be incorporated and developed for disability studies and activism, to the benefit of both. In sum, I would advocate for a Mad Studies perspective on disability, rather than a (social model of) the disability perspective on madness and distress.

Another area where madness and disability converge is in the social and individual impacts of medical interventions into madness and disability, and in particular the practice of enforced treatment. Enforced psychiatric treatment and involuntary detention on the grounds of a psychiatric diagnosis have a long history - and nearly as long a history of vociferous challenges by activists, survivors and latterly Mad Studies. Indeed, the UN Declaration on The Rights of Persons with Disabilities defines enforced psychiatric treatment as a human rights violation and akin to torture. It is less widely known that people with physical, sensory and intellectual disabilities are also subjected to involuntary treatment, both as children and adults. This may include attempts to 'correct' the physical or sensory

feature that is deemed pathological, or it may involve more gendered forms of medical abuse such as the suppression of sexuality and/or enforced sterilisation; for example, see the infamous case of Ashley X. For both psychiatric and disabled survivors such enforced treatments are not only a violation of human rights and bodily integrity but they are also extremely traumatic, and result in (further) mental distress. Finally, those kinds of medical interventions, and the violation of rights that they rest upon, also reinforce the social stigma and inequalities that position madness and disability as 'less than human' and in need of 'repair', rather than simply part of the spectrum of human experience. The challenge Mad Studies poses to medical dominance and abuse is essential to the rights of people with disabilities, and integrating disability within Mad Studies can only strengthen this challenge.

The perceptions and definitions of humanity upon which medical practice and power is based are also areas where madness and disability have much in common. For example, throughout much of medical history no distinction was made between people with specific learning disabilities and those deemed insane, and all were consigned to the same institution - a practice which continues today in some parts of the world. At a more abstract level, the medical approach to both disability and madness (as well as health and illness more generally) relies on an artificial dualism of mind/body. Not only are body and mind considered completely distinct - requiring separate medical disciplines - but they are also viewed in isolation from self, society, emotion, life-experiences and beliefs or spirituality. Clearly, we do not experience ourselves and our lives in this fragmented way. Likewise, we are often all too keenly aware of the mental, emotional and social impacts of a physical illness, as well as the physical impacts of emotional or mental distress. Mad Studies has much to contribute with respect to challenging the official

medicalised binary conceptual framework, and in providing a more holistic perspective of distress which incorporates all the facets of human experience: mind, body, belief, self, society, life-context. But this alone is not enough. If disability remains excluded from Mad Studies, ultimately Mad Studies risks reinforcing the very binaries and power structures that underpin the medical dominance it seeks to challenge. Therefore, in order to provide a comprehensive and strong challenge to medical domination, Mad Studies must not only transcend the mind/body dualism in its conceptions of madness and distress but also incorporate disability into its analysis and activism.

In conclusion, my life and my work both involve disability and madness/distress, but not as two distinct fields or experiences. Rather, I understand and experience them as interrelated and intersecting facets of social identity, medical dominance and devalued human experience. Therefore, just as the mind/body dualism (upon which medical beliefs and practice are founded) creates hierarchy, oppression and misunderstanding, so too does the separation of disability and madness. As an emerging discipline, Mad Studies is best placed to confound all of these structural inequalities and to transform the understanding, experience and social structuring of human diversity. In this way Mad Studies can also become a profound celebration of the whole of human diversity, and simultaneously benefit from all the knowledge, wisdom and experience that such diversity affords. ■



Kay Inckle's latest book *Safe with Self-Injury: a practical guide to understanding, responding and harm-reduction* (PCCS Books, 2017) is available now.

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'To End All'
2017 Remix
by Sean Burn

It's not about past hurt. It's about the way you call for alliances.

Jasna Russo

As a participant in the Mad Studies stream at the Lancaster conference, I read the last issue of *Asylum* 23(4) with great interest, only to find myself referred to anonymously in Mick McKeown's article: "Can we put hurt behind us?" (pp. 8–9) Since my words were reported both wrongly and selectively, I would like to set the record straight and point out the systemic nature of this kind of distortion.

Mick McKeown's call for mental health service users and the mental health workforce to engage in a "deliberative dialogue to shape the provision of care" deserves more comprehensive consideration, which I could elaborate another time. Here, my reply focuses only on the way my argument was (mis)represented in his text.

It is true that after McKeown's presentation on recalcitrance, I joined the discussion and spoke of my own experience of forced psychiatric treatment, and the things I witnessed in that context. However, in response to his call for survivor–mental health worker alliances, I did not say "You don't know what you are asking me to do." What I actually said was "You have no idea what you're asking for."

This small alteration – reducing my remark to autobiography – makes perfect sense in light of his overall interpretation of my contribution, but it completely erases my main message. The point I was trying to make was not about the way (along with other inmates) I was 'hurt'. What I described was a conversation with a staff member who had opted to refrain from violent institutional practices; in particular, I described the limits of our encounter.

I have reflected on the possibilities of such alliances elsewhere:

Whether he personally uses restraint or not, and especially how he feels about this, is completely irrelevant to me, someone who may be restrained in that clinic because those are the rules. Even if this never happens, what kind of communication could there be between the two of us: I, who may be kept in restraints and he, who may use restraint even if he doesn't want to? What could connect us? What is the common denominator of 'our' experience? And must there be one at all? For me, there is certainly no such thing as 'our' experience. (Russo, 1998, p. 130)

After all these years, the issues remain the same for me. In the interim, I have co-operated with various mental health professionals on research and other projects. The times when I experienced this joint-work as constructive and enriching were rare, but it did happen. However, such work did not stem from a conviction that a working alliance with mental health professionals was something good or necessary. The teams that I would describe as 'good' had their foundation in shared stances on core questions about psychiatry and the fair distribution of funds and responsibilities, as well as a capacity to treat all participants equally. What we put behind us was not survivors' 'hurt' but the designated roles that mental health services are based upon. No ambition 'to heal' was involved in this joint undertaking with people on 'the other side' of the system. Clarity, honesty and respect for each other's perspectives were sufficient. This included room for feelings and experiential perspectives, as something that everybody has and brings with them.

McKeown's simplistic emphasis on "our mutual interest in fighting neo-liberalism" skips over too many nuances in the word 'mutual.' Tellingly, he focuses on survivors' feelings while saying very little about his own emotional state beyond the fact that he felt "obliged to provide an answer" as well as "uncomfortable and even a little unfairly dealt with". He is, however, certain that his "unease was in no way commensurable to the distress of [his] interlocutor".

This sense of having a natural right to observe, compare and draw conclusions about others while hardly ever talking about oneself reinforces the role-division inherent in the psychiatric enterprise. It also speaks to traditional gender roles where women belong entirely to the realm of feeling while men are there to think and theorise. That I drew on my personal experience to support my argument resulted in the instant reduction of all that I had to say to "hurt", "raw experiences and emotions", and an implied need to "heal" – none of which are terms I would choose. Rather than hearing me and acknowledging that there is such thing as a legal framework for psychiatric 'care' provision (which is never a mere matter of personal choices and negotiations), McKeown took a shortcut through the debate I was trying to open up, declaring me

unable to enter alliances due to my negative experiences with psychiatric treatment.

As I have said, the point I was making was not about 'hurt' and 'healing'. Instead, I wanted to question the broader context in which proposed alliances are meant to take place, and the ways that context is (not) addressed. It is not good politics simply to call for alliances between those whose job is to provide care and those who receive it, without making due efforts to be clear and honest about the main features of that 'care', and the interests and the potential conflicts involved. Furthermore, the demand that we "put the hurt behind us" raises legitimate questions about whose 'hurt' this is about and who 'we' are. This is an area where mental health workers – including the author of that text – have been asked to address their own issues and stop talking for and about us.

Mad Studies opens up a space where this could happen. What I like about it is that it provides for many different points of entry. Mad Studies isn't built around the

psychiatric system and mental health services, so there is no need to constantly define and re-define ourselves in relation to those systems. Above all, there is no need to lock each other into narrowly defined roles in order to work together. This is obviously hard for people who always choose to think within the current system and promote that course as 'realistic' and 'strategic', in contrast with other approaches which they assess as 'naive'. Many of the good discussions in Lancaster as well as other work produced in Mad Studies have already demonstrated the strength of thinking that leaves the current system behind and dares to explore the real life features and connections of madness. ■

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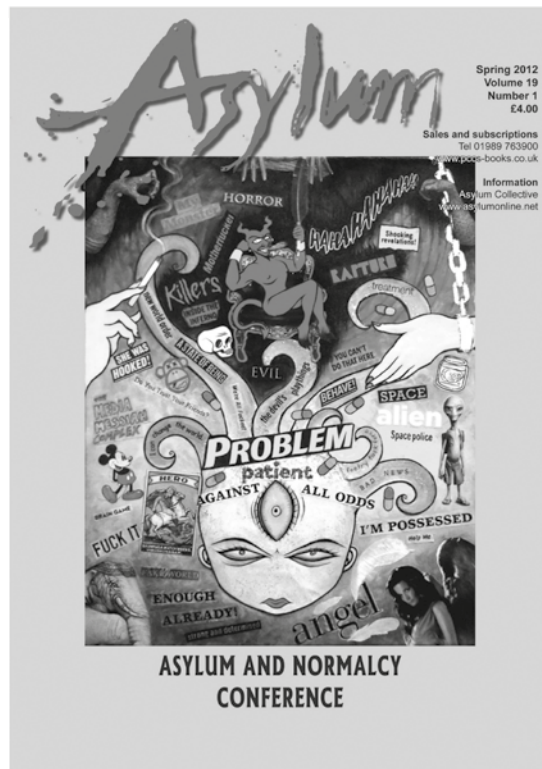
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MAD STUDIES? a response

Tim Wilson

Some people are happy to define themselves as 'mad', and of course that is their prerogative. But others are not, including those who have experienced the mental health services and people who have worked and cared for people with mental health problems, and do not see them as mad. On the other hand, one can easily make the case that psychiatry is mad, dangerous, damaging, traumatic, coercive, brutal, and deluded. For example, see *Psychiatry an Industry of Death* (on youtube), and 'Psychiatry vs Garth Daniels' (in *Asylum* 23:4)

In fact, psychiatry is a pseudoscience with a faulty epistemology. (See: 'Five ideological myths of psychiatry' by Tim Wilson, revision madness in digital age the FACT four Blogs, 2015). It is also very mistaken ontology: a person is not just his DNA or neurochemical self. Humans are social beings, and the social, economic, political and environmental (SEPE) arrangements affect our lives, including mental health and distress.

If people want to call themselves mad, so be it, and of course Mad Studies may flourish - if we already don't have them, soon there will be Professors of Mad Studies. Many might find Mad Studies liberating. Respect for those who define themselves as mad. But a warning: Is Mad Studies another box to put people in, another label by others, or another box we put ourselves in, another possible trap curtailing possibilities, another form of social control? Perhaps it is better never to let others define us. And what will happen to the people who don't consider themselves mad or don't consider other people in the mental health system mad, who think that sometimes it is society that is mad, and that the mental health system is mad?

Many people who become psychiatric patients simply have normal emotions but react to appalling situations, e.g. bullying, abuse, powerlessness, lack of autonomy and control, alienation, homelessness, trauma, unfairness and poverty. Many have been drugged and suffer from a doctor-induced illness (iatrogenesis) that pushes them into the psychiatric services: Whitaker (2010) gives clear evidence that during the last sixty years people have been

medicalised and harmed. In the meantime, psychotropic drug prescriptions have rocketed, leading to an explosion in chronic disabling mental health conditions. If the drugs are so good, why have chronic mental health conditions increased so much? No-one denies the reality of mental distress, but that is not illness. Today, psychiatry is a marriage of convenience with neo-liberalism, big pharma corporations, governance (control of the populace) - a form of ideological hegemonic power.

Surely the children in the USA and the UK who are now medicalised with toxic drugs aren't all mad? Did the children ask for these drugs? Do all the women and the poor put into institutions by husbands or families consider themselves mad? Would all the Jews exterminated by German psychiatrists in T4 consider themselves mad? Would the Soviet dissidents tortured in Russian psychiatric hospitals and sent to gulag consider themselves mad? Would all the BME people labelled and tortured by psychiatry consider themselves mad? And all the people getting on in years, and particularly women given electric shock at an alarming increasing rate, are these people all mad? When you listen to people who have experienced abuse, rape, oppression, poverty, trauma (including psychiatric trauma and psychiatric rape), who experience the cruelty of the state, would they consider themselves mad? Maybe nearly driven mad, but that's something else...

Biological and genetical nonsense is talked about the aetiology of madness. Especially when, in the 21st century, real scientists are aware of epigenetics - i.e., that genes get switched on and off and by social economic political and environmental (SEPE) influences, including poor diet. Again, there are no conclusive findings from genome studies for biological explanations for mental distress. What is truly mad is to believe in the ideology of the four myths of psychiatry: the pseudoscience of diagnosis, biological biomarkers, chemical imbalance, and the 1960's marketed drug 'illness model' of drug action. Add to that, coercion and iatrogenic mad practices; another madness is the invention of mental illnesses, the

DSM and all the classifications/fabrications of psychiatry; yet another madness is the idea that a psychotropic drug will cure mental distress. I also count it mad not to provide the social prerequisites for health and wellbeing: it is also a crime against humanity. Psychiatry is a crime: an industry of death.

In the previous issue of *Asylum* two people said it was naïve to want to abolish psychiatry without putting something in its place. I would argue that abolishing psychiatry is a necessary prerequisite for change, and it is naïve not to want to do it. Replace psychiatry with more doctors of medicine who are trained to deal with real health problems; adopt a new, public health approach to mental health, adopt community preventative medicine, not dualistic but holistic, including changes in SEPE, and increase resources for mental distress twenty times over - not less resources but more. Have a 100% state funded NHS, have no private provision in the NHS, have a national work occupation health service in every organisation so as to promote health and reduce mental distress. Get rid of the current National Sickness Service, and introduce a proper National Health Service. More up-stream public health measures to prevent and enhance health, a more just society, reduce the disgusting income differentials, introduce a universal wage - there are numerous alternatives - promote open dialogue, exercise, social solidarity, HVN, peer groups, Soteria houses, Dial House in Leeds, activity for life, retreats, safe spaces, quiet spaces, night cafes, more social engagement, more healthy workplaces, encourage autonomy, control and a regular income for all - and so on. Adopt a social model of health and mental distress. Tackle alienation. Prevent abuse. Maybe social transformative change has to occur before psychiatry is abolished? Just think if annoyed, angry, discontented, irritable, unhappy, grief stricken, put-upon people, the disadvantaged, down and depressed people, agitated people, traumatised people, abused people, if they all decided to use their energy as a catalyst by joining alliances to change things, to demand a fairer and less abusive society! That would upset the status quo.

I acknowledge the reality of serious mental distress which needs resources, but the crucial question is: What type of resources? I also acknowledge that some people are happy with the present mental health services and the drugs, but others are not: many are trapped and damaged by the drug regime.

If you get rid of psychiatry and its ideology there will be less stigma and more possibilities. It's easy enough to make the case that capitalist society drives people mad. Education, with all the obsessive testing, labelling and pressurising of children, all the social media pressure, too much computer time, sedentary children priming a future public health 'time-bomb' - isn't it all madness?

These issues are real and need addressing now. Excessive medication is harmful. Of course, some drug use might still be required, but one should be honest about it and use drugs with extreme caution and mainly only for the short term. Electroshock, psycho-prisons, CTO's, harmful mental health laws and human rights violations are still rampant. There isn't an issue of psychiatric neglect so much as SEPE neglect: social injustice, a lack of power and resources, and psychiatric abuse. It is abusive that the resources for mental distress are so severely rationed - but these are decisions made by people in power with a vested interest in the status quo. Just think how much money we could save without a pill for every ill, think how many people could be saved from chronic disabling mental health conditions, how many children could be saved. We need to put money into alternative mental health schemes and up-stream preventive public health schemes.

The crux of it is that too many people have a vested interest in psychiatry and the whole psych-pharma industry. Unfortunately, in a neo-liberal state, and with the ideology of individualism, these people are also very powerful, and they support a form of social control that is ideal for making profits.

I admit I may have missed the complete Mad Studies picture. I could be totally wrong. Maybe Mad Studies addresses all my concerns. What do *Asylum* readers think? Please convert me to Mad Studies, but you will have to convince me with argument.

Bonny Burstow is someone with a similar point of view. See her excellent book *Psychiatry and the Business of Madness* - an epistemological and ethical audit which advocates an abolition.

After consulting the public in four workshops and fourteen discussion groups, our organisation, Revision, has recently come up with a manifesto for change. It will be launched later this year.

So some suggestions: *Asylum - the magazine for the abolition of psychiatry!!* Or *Asylum - the magazine for the abolition of psychiatry and enhancement of education around mental health and distress.* ■

If you would like to join our group please contact: revisionmentalhealth@gmail.com

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- Burstow, B (2015). *Psychiatry and the Business of Madness*. Palgrave Macmillan.
- Whitaker, R (2010). *Anatomy of an Epidemic*. Broadway Paperbacks.

Tim Wilson is a member of Revision, a mental health alliance promoting a social model of mental health and mental distress. The views expressed above are his own.

POEMS

by Bruce E Saunders

I Don't Love Anyone

I don't love anyone
And it's getting heavy
I don't need it
At all.

But I see that it
Is a word of all light
And feeling to be able
To kit-out the whole moonful of jargon and
Deceit

Into the knee-down show called
The Earth and its even newer flake
Called You

The Native

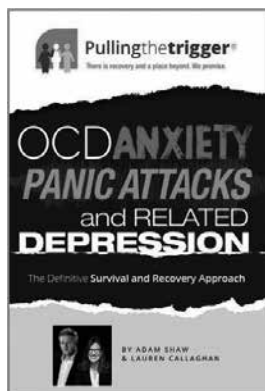
Like native time watchers
I see you flock and flurry like cats
Around a canary-dish of cream and 'sorted anima
But you do know to take the water
Out first to stop it running
I will be then and wend there in be shall be and to
It all then I will stand
And wen' all to summing it all up and
Seeing it is there but not here
Not here
Sow and row but she'll not be taken for
She is too there and there not
I shall be here but then everyone shall see it
For what it truly is
A lie and a damsel of feelings.

The Mad Scientist

The mad scientist reached out
And raised the sonic boom
So we could walk through without
Damaging our minds
That were not built for that
The heart of the moment is
Here.
There.
Everywhere.
In this instant of maid-mockery
I wonder
What is the right way to open a bar
Without closing you to the one
Who goes in without drinking
But only to imbibe
The atmosphere of renewal and faith in the good Lord
Jesus. I will be truthful and see here
That it is the most surprising thing for me to
Read that here but it is the demand of my skryf, my Art
That I put it as it comes out for I need
A brain to sing with too.
I am the Christian Scientist you dreamt about
Not the one who opens the flow
With a count of the bodies but with
A float of real change to come.
It is about the one who comes last in this case for he
Brings up the rest of the crowd and shows them the
Ideal such as is to come
Without fear of retaliation
For he is a One and an "O"
As you see it, in parts a more than
And in the other
A less.
I will see it here but I will
Not believe it when I read this back to
Me.

Bruce E Saunders was born in Hazlemere, Bucks but grew up in Philadelphia and Johannesburg, before returning to the UK to avoid conscription to the South African Defence Force. He worked in London, at the head office of a union. In 1998 he returned to higher education to study a Masters in Mechanical Engineering before embarking on a PhD proposal he had never seen before, rejected by all other students, in a subject area he had never heard of. As it turned out, he was sitting on a goldmine - and the rest shall be told another time. The PhD certainly changed him, and the success of publication led to the poetry and expressing himself by means of self-publication on the web. Violently assaulted at the commencement of the PhD, this led to a trauma-induced psychosis, misdiagnosis and abuse of his rights. It also led to a change in thought pattern which he has had to get used to...

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Book Review

Pulling the Trigger: OCD, anxiety, panic attacks and related depression – the definitive survival and recovery approach.

Adam Shaw & Lauren Callaghan (2016)

London: Trigger Press.

ISBN: 978 1 911246 00 8

This is a handsomely produced self-help manual by a recovering businessman (of a bespoke will-writing service) who is now co-founder of global charity The Shaw Mind Foundation, and Lauren Callaghan, originally from New Zealand and now a psychologist based in London.

Perhaps I should immediately reference the websites www.shawmindfoundation.org and www.pulling-the-trigger.com because there are plentiful mentions throughout the book. There is also a companion book aimed at teenagers and families, with guidance for parents.

The design of *Pulling the Trigger* is worth mentioning again: it is 254 pages of clear text in A5 format, with a card dividing the two sections. I made a note of 'Fusion Graphic Design Ltd'.

The first section consists of Adam charting his journey from mental health difficulties to being in recovery, along with a follow-up by Lauren Callaghan which details the 'PTT' approach she pioneered. The second half of the book reverses these roles, and Callaghan writes in more detail about the PTT philosophy and action plans, with Adam writing a follow-up piece, again talking about his life. The book concludes with chapters on Fitness and Diet, Family and Friends (written by Adam's wife Alissa), Medication, and Life after Anxiety; it ends with a co-written chapter.

That last chapter interested me, because throughout the book I couldn't distinguish much difference in their ways of writing, between Adam's more personal pieces and Lauren's explanations of the PTT methodology.

This methodology isn't anything brand new. It has strong affiliations with cognitive behaviour therapy (CBT) and some aspects of Mindfulness and the non-judgemental 'Acceptance' part of dialectical behaviour therapy, along with a 'Compassion Focus'.

The core element involves Acceptance (of thoughts), then Embracing the disturbing thoughts without fear, thereby Controlling the negative impact through a skilful analysis. The analysis relies on recognising that we all have thousands of thoughts each day, some of them problematic and 'odd'. But their impact depends on how we attribute meaning to some thoughts: when we connect a catastrophic meaning to everyday thoughts, this can lead to obsessional thinking in order to 'avoid' the fears and worries. Instead, we should Accept, Embrace, Control: not fight the symptoms, but gradually desensitize through questioning

their validity, along with a compassionate exposure to the fears themselves.

The authors are careful to point out that these methods are for those with mild to moderate mental health problems, and also to identify that an underlying depression before the onset of OCD/anxiety symptoms needs to be treated separately. But depression following OCD/Anxiety is a result of the tensions and stresses of coping with OCD/anxiety.

I have no doubt that some – if not many – people will be helped by the suggestions in this book. The authors say that they don't intend to be 'prescriptive', and yet, to my reading, that is exactly how it comes across. Their writing is couched in the fashionable jargon of today's CBT approach, with a promise that 'recovery is within reach'.

Therein lies the difficulty I have with this book. There are too many platitudes, such as: 'it will pass', 'learn to accept the thoughts as just thoughts', 'face the fear and embrace it', 'remember to look after yourself', 'peace is much better than war', 'life is there for the taking', 'take the journey – you will never look back.' I found the tone monotonous and relentlessly 'instructive'.

However, I'm sure the various graphics, the Tables and Figures, will be helpful and illustrative for many people, and some of these may be convincing by their precision: such as 'How My Problem Interferes With My Life', while various questions can be filled-in as one works through 'Challenging catastrophic thinking'.

According to their approach, the key is in reprogramming one's thoughts – so fashionable with CBT these days. Emotional reasoning is dismissed as 'basing things on how you feel' rather than on 'reality'. You should 'accept your illness for what it is' and look forward to 'the recovery' from 'illness'; this firmly situates their philosophy within the domain of a renewed 'medical model'.

As I say, there is enough in this manual to be helpful for people, and I particularly welcomed some aspects, such as 'Shifting the awareness' (for instance, onto objects, thus concentrating our thoughts in a 'mindfulness' fashion), and undoubtedly there is much to be recommended in the researched methodology. I just suspect that swallowing the whole philosophy will not be palatable or the best approach for everybody. ■

William Park

NEWS & FINDINGS

GOVERNMENT FAILS ON SUICIDES

In 2012 the Government introduced its Suicide Prevention Strategy. This has had no noticeable effect. According to the latest report by Parliament's Health Select Committee, the Strategy "has been characterised by inadequate leadership, poor accountability and insufficient action".

Suicides rates in the UK, mainly driven by the behaviour of working-age men, fell steadily for the decade until 2008, and then began to rise again. In 2010 there was a total of 5,600, and by 2014, 6,122. In 2015, there were 6,188. This is a rate of 10.8 per 100,000: 16.8 per 100,000 for men and 5.2 for women. The highest rate in the UK in 2014 was for men aged 45–49, at 26.5 per 100,000.

Dr Sarah Wollaston, the committee's chair, said: "4,820 people are recorded as having died by suicide in England last year, but the true figure is likely to be higher." She said government needed to do better and support needed to be more accessible to those at risk.

Suicide: facts and figures. www.samaritans.org Scale of suicide unacceptable, say MPs (2016) *BBC News* 19 Dec.

BIG RISE IN PRISONER SUICIDES

Official figures show an average of one suicide every three days in the English and Welsh prisons: in 2016 there were 119 – the most on record, and double the number for 2012. The likelihood of self-inflicted death in custody is now 8.6 times higher than in the general population. Last year there was also a 23% increase in incidents of self-harm – nearly 38,000 for a prison population of 85,000.

Deborah Coles, of Inquest, the charity that monitors deaths in custody, said "This unacceptable death toll reflects the desperate reality of overcrowded, dehumanising and violent prison conditions and the failure of prisons to protect those in their care." And this is despite "...a constant stream of investigations, inspectorate and monitoring reports and enquiries... the vast majority of [which] are never acted upon..."

In the twelve months to September there was also a 40% rise in assaults on staff, and a 28% rise in prisoner-on-prisoner attacks. The total number of assaults was 25,000 (3,372 were classed as 'serious'), 31% more than the previous year; on average, each day there are 68 assaults in the prisons.

Many jails have chronic staff shortages and need to draft in prison officers from elsewhere just to keep order. This is due to poor pay and a 40% cut in the number of officers since 2010. Because of staffing levels, many prisoners are confined to their cells 23 hours a day, and their anger is boiling over. This was cited as a major factor behind the rise in prison suicides, self-harm, violence and riots.

The Prison Officers' Association (POA) says that in 2016 the National Offender Management Service, which oversees the country's prisons, classed 12 jails as "red sites", meaning they do not have enough staff to operate a standard regime. A similar number are classed as "amber

sites", indicating that they also suffer from acute staffing issues; in all, about one-third of the country's prisons have serious staffing problems.

Concerns about safety in the prisons mounted in the last few months. Disturbances were reported at Bedford and Birmingham jails in August. The following month an officer at Lincoln was taken hostage and beaten up during a riot. In October, specialist officers had to be brought in after prisoners "went on the rampage" at Lewes prison. In November, a member of staff was held hostage during a "mini-riot" at HMP Exeter. Pentonville is also plagued by problems: two prisoners escaped in November, and in October a prisoner died after being stabbed; within a month there were six more attacks on the same wing – all carried out with weapons made from razor blades.

Dave Todd, national representative for the POA, said a common picture was emerging. Staff are getting more burned out, morale is plummeting, and there are now more officers leaving the prison service than being recruited – during 2016, the number of full-time prison officers fell by almost 600. Justice Secretary Liz Truss promises 2,500 new officers, but that's how many were taken out over the previous three years. The Royal College of Psychiatrists says that mental health teams are struggling, and because of prison officer shortages are often denied access to prisoners who need help.

Todd talks of an increasingly violent culture in the prisons. "Many have gang issues. Prisoners end up in debt after using new psychoactive substances such as spice. If they don't pay for it, the dealers will take retribution and usually that's in physical harm. We've got drones dropping drugs off. We've got old Victorian prisons where you can get access to the prison wall from a public footpath and throw things over."

But he says the main problem is the lack of staff. "We haven't got enough to effect a decent searching strategy. We used to search a cell once every month, but we don't do that any more. It's all intelligence-led now. It's reaction rather than pro-action. If you look up and down the country, where there's a lack of staff then there's a lack of regime, and then there is violence and self-harm."

Meanwhile, an anonymous prison doctor told the *Guardian* that the crisis was essentially because half the inmates shouldn't be there in the first place: "We need to stop locking up addicts and people who are mentally ill." In fact, the UK has the highest pro rata prison population in the whole of Europe.

Doward, J (2016) Suicide, self-harm, stabbings and riots – prisons reach crisis point. *The Guardian* 12 Nov; Travis, A (2017) Record number of prisoners take their own lives. *The Guardian* 27 Jan.

YOUNG WOMEN'S MH GETTING WORSE

The government-funded Adult Psychiatric Morbidity survey for England finds startling increases in women aged 16–24 who screen positive for PTSD (now 12.6%), who self-harm (19.7%), or have a mental health condition (28.2%).

Psychological distress is now so common that one in four women in that age group have self-harmed at some

time, while one in eight experience PTSD. The latter is an increase from 4.2% in 2007 to 12.6% in 2014 (although more accurate screening could explain some of the increase): young women are more than three times at risk than young men (3.6% PTSD). Also, from 2007 to 2014, reports of self-harm trebled for young females to 19.7% and doubled for young males to 7.9%.

Young women are also more likely than any other group to have experienced a common mental disorder (CMD) in the past week: more than one in four (26%) women aged 16–24 screened for anxiety, depression, panic disorder, phobia or obsessive compulsive disorder – compared with 9% of young men. Overall, 19% of women of all ages experienced one of those conditions, and 12% of men.

These findings are from a study of 7,500 people of all ages. While caution was needed due to some of the sample sizes being relatively small, the findings for young women were consistent with those recently found by other research, including the Children's Society. The report acknowledges that these increases could be somewhat due to changes in reporting behaviour and people feeling more able to disclose that they had self-harmed. Sexual violence, childhood trauma and pressures from social media are blamed for these increases.

Rates of serious mental illness have remained largely unchanged among men over the years that they have been rising among women. The proportion of the general population with a common mental disorder has risen steadily since the survey was first conducted. It has gone from 6.9% of adults (aged 16–64) in 1993, to 7.9% in 2000, 8.5% in 2007, and now 9.3%. Prevalence of CMD symptoms in men has remained stable since 2000 – all the increase in CMD was driven by the rise amongst women. And while 10% of all women exhibited symptoms of a more serious mental illness, only 6% of men did so.

Sarah Brennan, chief executive of the charity Young Minds, said the gender gap that emerged from the report might be explained by the sexes reacting differently to troubling events. "The gender difference can be associated with the different ways young men and young women respond to distress. Young men tend to externalise pressure – for instance by being angry or violent – while young women are more likely to internalise their feelings, and take them out on themselves, for example by cutting or through eating disorders."

The research also found that: 17% of the population suffers from a common mental disorder; 37% of those with anxiety or depression get treatment (up from 24% in 2007); one in three people now undergo some form of MH treatment – either counselling or medication – compared with one in four in 2007; and between 1993 and 2014 there was a 35% rise in adults reporting severe symptoms of common mental disorders (9% in 2014).

Prof Sir Simon Wessely, president of the Royal College of Psychiatrists, commented: "With just one in three people with a mental illness receiving treatment, the need for mental health services is far outstripped by the demand."

A DoH spokesman said the government was increasing investment in mental health services with an extra £1bn

each year until 2020. "This survey shows that more people than ever are receiving vital mental health treatment, but we are determined to do more. We want to make sure that everyone, regardless of gender, age or background, gets the mental health treatment they need."

Campbell, D & Siddique, H (2016) Mental illness soars among young women in England – survey. *The Guardian* 29 Sept.

RISE IN SELF-HARM AMONG YOUNG

The NSPCC has found that nearly 19,000 children received hospital treatment for self-harm in 2015 – a 14% increase since 2012. Those most likely to harm themselves are aged 13 to 17. Last year Childline delivered 50 self-harm counselling sessions a day to children and young people.

In fact, the latest NHS statistics show that the number of children and young people self-harming has risen dramatically in the past 10 years. The sharp upward trend in under-18s being admitted to hospital after poisoning, cutting or hanging themselves is more pronounced among girls, though there was also a major increase for boys. This increase seems to be a shocking confirmation that more young people are experiencing serious psychological distress: not only are many struggling to cope with neglect or a history of abuse but, heightened by the social media, a whole generation is under unprecedented social pressures.

The number of girls under-18 who have needed hospital treatment after poisoning themselves went up from 9,741 in 2005–06 to 13,853 – a rise of 42%. The numbers of boys ingesting a poisonous substance was almost unchanged: 2,234 in 2005–06 and 2,246 in 2014–15.

However, the number of girls treated as inpatients after cutting themselves almost quadrupled over the same period: from 600 to 2,311 – a rise of 285%. The number whom A&E teams have treated after hanging themselves has also risen during that decade, from 29 to 125.

Far fewer boys end up in hospital after cutting themselves, but the numbers went up from 160 in 2005–06 to 457 in 2014–15 – a rise of 186%; the numbers of boys who hanged themselves also doubled from 47 to 95 over the same period.

"This is a depressing confirmation of the clinical experience of child and adolescent psychiatrists' experience on the ground, ...mental health disorders are rising, for both girls and boys," said Dr Peter Hindley, chair of the Faculty of Child and Adolescent Psychiatry at the Royal College of Psychiatrists. Experts agree the rises were likely due to a variety of factors, including pressure to succeed at school, the damaging effects of social media, family breakup, growing inequality in recent years, children's body-image fears, a history of abuse (including sexual abuse), and increasing sexualisation.

Health secretary Jeremy Hunt had criticised NHS care of troubled young people. Child and adolescent mental health services (CAMHS) were the "biggest single area of weakness in NHS provision" and beset by "big problems", including failure to intervene early enough when problems such as eating disorders emerged, which meant that "too many tragedies" were occurring, he said.

Sarah Brennan, chief executive of Young Minds, said that troubled young people were harming themselves partly because help for them is so inadequate that some do not receive specialist support once it is obvious they have psychological problems. "There needs to be far more investment in early intervention, so that problems are dealt with when they first emerge." She said that budget-driven local council cuts to social workers, educational psychologists, parenting classes and mental health services in schools had reduced care and support for under-18s in distress, and CAMHS teams were responding to the rising demand by rationing care.

"The pressure on CAMHS has forced services to raise the bar for access to treatment. Consequently, about a quarter of young people are being turned away, and this will include many who self-harm. At the moment too many vulnerable children end up going to A&E because no other help is available."

Young Minds is concerned that children who self-harm and then turn to the internet for help could come across unhelpful information about, and even encouragement to continue, their behaviour. According to a survey Young Minds conducted last March with Childline, Self-Harm UK, and The Mix, young self-harmers are most likely to go online for information, and few seek their parents' support. While 76% of youngsters said they would search the web, only 16% would look to their mother or father; 61% would ask a friend, 27% cited a GP, and 17% a teacher.

The government has promised to put an extra £1.4bn into care of troubled children between 2015 and 2020, to ensure that at least 70,000 more under-18s get high-quality care. However, NHS England chief executive, Simon Stevens, has admitted that even if that target is met, it will still only increase the proportion of young people being helped from a quarter to a third.

Hunt says he will make children's mental health a top priority. NHS England created 56 extra beds in specialist inpatient units for children and young people in the last two years, and is putting £30m into improving services for those suffering from an eating disorder such as anorexia nervosa. In October it allocated £25m to help cut young people's waiting time for treatment and reduce the backlogs of those awaiting urgent care.

Campbell, D (2016) NHS figures show 'shocking' rise in self-harm among young. *The Guardian* 23 Oct. Boseley, S (2016) Self-harm by children rises steeply in England and Wales. *The Guardian* 9 Dec.

SOME CHILDREN STILL ON ADULT MH WARDS

In 2010, ministers were supposed to have outlawed treating anyone aged 17 or under on an adult psychiatric ward. Figures from NHS Digital show that during last July this was not the case for 47 children and young people aged 17 or under: 21 were aged 17, 18 were 16, and the other eight were aged 15 or under. If the same trend is maintained for the rest of the year, that would be a total of 446 under-18s being treated on adult wards – the highest

for many years: in 2014–15, 391 children spent time on an adult MH ward.

Between them, under-18s spent 1,938 days on adult mental health wards during April and June, nearly double the 1,102 days they spent there from January to March. Most were in the North of England, where bed days soared from 35 in the first three months of the year to a massive 1,405 in the second quarter. In that same period, there were 225 such bed days in the Midlands and East of England (down 650 from the previous quarter), 185 in London (down from 220) and 125 in the south of England (down from 195).

Health Secretary Jeremy Hunt responded that the number of children on adult psychiatric wards has fallen by 60% since 2010.

In another study, 66% of 316 parents surveyed by Young Minds complained that their child had to wait a long time to get treatment. Almost half (49%) said no-one believed them when they first raised concerns about their offspring's mental welfare. 41% said thresholds for accessing treatment were too high, which meant the child was deemed not ill enough to warrant NHS care, while 36% had paid a private counsellor, psychologist or other therapist because no NHS care was available.

Campbell, D (2016) Revealed: dozens of children still treated on adult psychiatric wards. *The Guardian* 13 Nov.

MH NURSE NUMBERS DOWN 15% UNDER TORIES

Since the Conservatives came to power in 2010, the number of mental health nurses has fallen from 45,384 to 38,774. MH hospitals saw the biggest cuts: 24,581 nurses in 2010, but by last July only 19,170 – a loss of 5,411 posts (22%). There has been a slight increase in the number of community MH nurses, but the overall decline shows that the Tory-Lib pledge in 2014 to bring about "parity of esteem" in NHS treatment of patients with mental and physical health problems will not be honoured any time soon.

Campbell, D (2016) Number of NHS mental health nurses has fallen by 15% under Tories. *The Guardian* 1 Nov.

CRISIS, WHAT CRISIS?

There has been a 50% increase in the use of Section 136 over the last ten years. In response, the police have just started an initiative to help officers cope with the mental health crisis being played out on Britain's streets. Each officer is to get at least two days training on mental health issues, and some will get more. The College of Policing has also launched guidelines aimed at getting police to avoid using force when having to deal with those they believe may be suffering from acute mental health problems. Some cases have ended in deaths, with families left grieving and police under investigation. A police chief pointed out: "The officer dealing with an emergency very rarely knows the history of the person standing in front of them."

Section 136 of the Mental Health Act permits the police to remove someone from a public place and take them to a place

of safety. Police chiefs blame cuts to community psychiatric care for a rise of more than 50% in a decade in the use of Section 136: 28,271 last year, up from 17,417 in 2005–06.

As well as government funding, police have put a greater effort into reducing the number of mentally ill people being held in cells because health services do not have enough beds. That initiative has been successful, although there are sharp local variations, probably due to local health service capacity. For example, in the Avon and Somerset area one in six people detained due to concerns about their mental health spend time in a police cell; in Merseyside the figure is zero.

Last year 200 people took their own lives while under psychiatric care in the community. Everyone except the Government seems to agree that the community mental health crisis teams are under too much pressure.

Since 2010 there has also been a steep rise in the numbers arriving at English A&E departments with mental health problems. Data from NHS Digital shows that between 2011–12 and 2015–16 the number of patients at A&E units with psychiatric problems rose by nearly 50%, to 165,000. For under-18s, the numbers nearly doubled to nearly 22,000.

These figures represent a small minority of overall A&E attendances – just over 1% in total. But the Royal College of Emergency Medicine said that this was likely to be the ‘tip of the iceberg’ since the figures only included cases where the primary diagnosis was a psychiatric condition – patients coming in with self-harm or after an attempted suicide may have been recorded as having an organic problem.

Some trusts told the BBC that as many as a tenth of all patients at A&E come due to mental health problems, and insufficient early support means many people unnecessarily reach a crisis.

Meanwhile, NHS England data also shows that delays in discharging people from hospital are rising more rapidly in mental health trusts than in other parts of the NHS. While acute care has seen a 30% increase, there was a 56% rise in the number of bed-days lost to delayed discharge in psychiatric trusts in October 2016, compared to November 2015. In the twenty-four trusts which particularly specialise in mental health and learning disability care, 17,509 bed-days were lost in October 2016. A broader analysis – including trusts that provide community as well as mental health services – shows a 43% increase.

Many of the problems are caused by a lack of social care packages available to support people once they leave hospital. This is due to cuts in local authority budgets and rising demand. Mental health patients are further disadvantaged by poor community psychiatric provision and reduction to other support services such as detox, which has had a disproportionate impact on mental health.

A spokeswoman said the Department of Health was investing £400m over four years to support people in their homes.

Dodd, V (2016) Police say they are becoming emergency mental health services. *The Guardian* 9 Oct. Trigg, T & Woodcock, S (2017) Steep rise in A&E psychiatric patients. *BBC News* 10 Jan. Buchanan, M (2017) Blocked beds blight mental health care. *BBC News* 6 Jan

GOVERNMENT LIES ABOUT CHILD MH FUNDING

Last year the Government pledged £1.4bn for child mental health by 2020. But according to a report by the Education Policy Institute Independent Commission on Children and Young People’s Mental Health, little of the cash is getting to front-line services. Instead, it is being used to offset NHS cuts elsewhere, and specialist CAMHS teams turn away 23% of the youngsters referred to them.

In 2015 the coalition government promised an extra £250m a year up to 2020, but last year only £75m made it to the clinical commissioning groups. Part of the problem is recruiting staff, including mental health nurses and psychiatrists.

Bev Humphrey, chair of the Mental Health Network, representing mental health and learning disability service providers in England, said the Government had “failed to come close to fulfilling its existing promises on mental health funding”.

Child mental health money not making frontline – report (2016) *BBC News* 15 Nov.

EFFECTS OF STRESS DIFFER BY SEX

A Stanford University School of Medicine study suggests that very stressful events affect the brains of girls and boys differently.

As reported in the journal *Depression & Anxiety*, researchers scanned the brains of 59 children aged 9–17. One group (14 girls, 16 boys) had suffered at least one episode of severe stress or trauma; a second group (15 girls, 14 boys) had not been exposed to any. The size and volume in one area of the insula cortex was unusual for the traumatised group.

Deep inside the brain, a part known as the insula processes feelings and pain, emotions and empathy. It was found to be particularly small in girls who had suffered trauma, but in traumatised boys it was larger than normal. Perhaps this is why girls are more likely than boys to develop post-traumatic stress disorder (PTSD): girls who develop PTSD may suffer from a faster than normal ageing of part of the insula.

These findings suggest boys and girls could exhibit different trauma symptoms, requiring different approaches to treatment; other studies suggest that high levels of stress could contribute to early puberty in girls.

Stress ‘changes brains of boys and girls differently’ (2016) *BBC News* 12 Nov.

CHILDHOOD ABUSE LINKED TO ILLNESS LATER

A study by Public Health Wales confirms what we already knew: children who suffer abuse, violence or other trauma are more likely to develop a chronic illness. It finds that someone who endured four or more adverse childhood experiences (ACEs) is more than twice as likely to be diagnosed with a chronic disease in later life, compared with those who report no ACEs. Adverse childhood

experiences include verbal, physical and mental abuse, and exposure to domestic violence.

Such children are four times more likely to develop type 2 diabetes, three times more likely to develop heart disease, and three times more likely to develop respiratory disease. Also, compared with people who report no ACEs, over one year, those with four or more ACEs were three times more likely to have attended accident and emergency units, three times more likely to have stayed overnight in hospital, and twice as likely to have visited their GP. Strangely, no evidence is offered for mental health outcomes.

This is the first nationwide study of its kind produced by a public health body in the UK. More than 2,000 adults aged 18–69 took part, providing anonymous information on their exposure to ACEs before the age of 18 and their health and lifestyles as adults. The results take into account socio-demographic factors and show it is not only children from obviously ‘deprived’ homes who suffer ACEs.

The authors argue that the reasons are not simply cyclical: that a child who has a challenging home life, where, for example, adults smoke or drink heavily, is more likely to do the same and suffer bad health as a consequence. It points out there is growing evidence that early-life trauma also leads to changes in neurological, immunological and hormonal developments that have detrimental effects on health across a lifetime. Children who are constantly exposed to stress can become permanently prepared to respond to further trauma – which can increase strain on the body.

Previous research by Public Health Wales showed that ACEs increase the uptake of health-harming behaviours such as smoking and drug use, as well as reduce mental wellbeing in adults. These findings are confirmed by a University College, London study (published in *Pediatrics*). This tracked 8,076 people born in the UK in 1958 until the age of 50. It found that neglected children tended to have worse reading and maths skills in adolescence than their peers, and compared to those not abused or maltreated when children, those who were maltreated were 70% more likely to have long-term illnesses and much lower living standards decades later; those who had experienced more than one form of abuse had doubly bad outcomes.

Mark Bellis of the Welsh study said that finding solutions needs a change in approach: “This cannot be achieved by the NHS alone. That is why we are working with our key partners, including the government, police, local authorities, charitable and voluntary sector organisations, to develop a joined-up approach to prevent ACEs and support adults whose health is suffering because of childhood trauma.”

Morris, S (2016) Abused children more likely to be seriously ill as adults, says report. *The Guardian* 1 Nov. Richardson, H (2016) Child abuse ‘affects health decades later’. *BBC News* 19 Dec.

LOW STATUS DAMAGES IMMUNE SYSTEM & MH

At Duke University, an experiment with monkeys found that low status affects the immune system to increase the risk of heart disease, diabetes and mental health problems (particularly

depression). As reported in *Science*, the findings had nothing to do with the unhealthy behaviours common with low-income humans: with all the human social factors stripped out, low status still had a significant impact on the organism.

Taking 45 female Rhesus monkeys, the newest member introduced to a group nearly always ended up at the bottom of the social order, became “chronically stressed”, received less grooming and was more harassed by the others. A detailed analysis of all the monkeys’ blood showed 1,600 differences in the activity levels of genes involved in running the immune system between those at the top and bottom of the social hierarchy. This made the immune system run too aggressively in those at the bottom, and high levels of inflammation caused collateral damage to the body to increase the risk of other diseases.

Prof Graham Rook of University College, London, said “All the evidence is showing the findings are terrifically applicable to humans.” People with low social status end up with worse health when the top gets richer, even if they themselves do not get any poorer.

Gallagher, J (2016) Low social status ‘can damage immune system’ *BBC News* 25 Nov.

IMMUNE DISORDERS COULD CAUSE SOME PSYCHOSES

As reported in *The Lancet*, an Oxford University research project examined 228 patients who had visited mental health service sites across England having experienced psychosis for the first time. Brain cells communicate via the NMDA receptors, and blood samples showed that 3% (7) of the patients had antibodies which attack the receptors. This suggests they might have been successfully treated with immunosuppressant drugs.

The report called for routine blood testing: “Our study suggests that the only way to detect patients with these potentially pathogenic antibodies is to screen all patients with first-episode psychosis at first presentation.”

Ough, T (2016) Some cases of schizophrenia and bipolar disorder could be misdiagnosed immune disorders. *The Telegraph* 8 Dec.

FOR BETTER MH – BE PREPARED!

The National Child Development Study is a lifelong project that includes nearly 10,000 people from across the UK who were born in November 1958. It now finds that children who participated in organisations which aim to develop qualities such as self-reliance, resolve and a desire for self-learning are likely to experience better mental health in middle age. The activities of such groups, which frequently involve being outdoors, also seem to remove the normally higher chances for poor mental health in people from low-income backgrounds.

About one-quarter of the participants had been in the Scouts or Guides, and at the age of fifty they were 15% less likely than the average to suffer from an anxiety or mood disorder.

Scouts and Guides at lower risk of mental illness in later life – study (2016) *The Guardian* 10 Nov.

Anatomised

Danny Taggart

The issue of childhood sexual abuse often dominates the news, and interest in the area continues to grow within mental health services. With the increasing recognition that psychiatric diagnoses are often discursive fig-leaves which cover up underlying childhood trauma, psychology is revisiting its troubled past with the victims of childhood sexual abuse. However, due to a range of methodological and theoretical limitations, the models available to the psy disciplines often further confuse the issue.

It is in this context that I consider my own perspectives on the topic. I am a survivor of institutional childhood sexual abuse who has suffered from intermittent mental health problems ever since, a clinician working with victims of similar forms of abuse, and an academic interested in the ways in which these experiences can affect people. These multiple perspectives offer the possibility of an illuminating triptych through which the perspective of each can clarify and sharpen the image of the others, even offering the possibility of a synthesis of views into a coherent whole. However, this tripartite perspective also risks alienating me from the different vested interests of which I am member. On the one hand, taking up a survivor perspective risks rejection from academia, which emphasises objectivity, while on the other, the authenticity of the survivor-voice may be compromised by the privilege afforded through professional status. This risks illuminating nothing and being situated nowhere. What conditions need to be met for these multifaceted perspectives to be utilized in a way that can be helpful both to victims of sexual abuse and those charged with helping them?

The diagram I offer as a part-answer to the above question can be considered in a number of ways. Firstly, it is a modification of an actual poster that was used as a prop for what is euphemistically referred to as 'grooming.' The Christian Brother who abused me took certain boys to his office for sex education, and a poster just like this one was used to illustrate his lectures. A second meaning behind the poster is that it

was what I did to my mind to escape the horror of what was happening to me: I put myself in the picture to get away from what was happening in my body. The genius and resourcefulness of this never ceases to strike me. To call it dissociation seems dismissive: it was life-saving, escapology, a little boy's magic. The final meaning of this image is the ways in which psy practices at their worst mimic the objectification and anatomical dissection represented here. What is most concerning is that they risk inadvertently mirroring the very fetishisation of parts of my being that must have been part of what allowed that Christian Brother to do what he did to me and my peers. Breaking us down into little parts of symptoms or deficiencies in order to satisfy the needs of a categorical methodology risks missing the totality of our experience and ignoring the fact that as we are being observed and delineated, we are in there, in our bodies, looking out and making some meaning of what is happening to us. The lack of imagination which allowed that Christian Brother to do what he did cannot be allowed to fester in the very disciplines that are supposed to help people like me recover from those experiences. We must develop methods of enquiry that give victims of abuse their own minds, active minds, meaning-making minds, and not just ones to be passively studied by outside experts.

This is the point at which my own critical reflections on the subject of research in the area links to the emergent discipline of Mad Studies. I am not suggesting that the harm caused by the theoretical and intellectual limitations of psy models of human distress is comparable to the harm caused to children by sexual abuse. In my experience as a psy clinician and service-user, mental health professionals are mostly well intentioned, but they work within limiting paradigms and in a context of fear, and in the main they do not have sufficient self-knowledge to untangle their own process from those of the people they are paid to serve. In my view, this is what leads to the majority of the failings, rather than conscious malevolent intention. However, I can appreciate that this is not the case for everyone.

Nonetheless, there are processes of dehumanization and categorization that occur in some psy research into victims of abuse that are too close for comfort to the relational characteristics of the abuse itself. The most glaringly obvious is that our experience of abuse is denied in the first place by both the abuser and then later the mental health system. We are not known as survivors of human rights abuses: we are labelled schizophrenic, borderline, manic-depressive and personality disordered. In that manner we can be safely hidden away in real or virtual psychiatric silos where we will not trouble civil society with the unpleasant reminder that we exist – and we all know how thinly-veiled the illusions of civility can be. As Judith Herman says, these crimes are unspeakable, and too often we psy professionals collude to render it so.

Furthermore, in separating out our reaction to the underlying trauma and in labeling it in such an alienated and alienating manner, there is a risk that we get dissected in an anatomical way similar to this diagram. This means that we suffer a sort of epistemic injustice, whereby our experience is no longer our own but the preserve of others who have an externally validated expertise. It is for them to know, and for us to be told. Now medicine and associated disciplines have been ‘cutting people up’ into little segments, labeling and dissecting them for centuries. Why would we expect the psy disciplines to be any different? However, what needs to be pointed out is that these are not only physical and psychological injuries; they are moral, social and relational injuries, too. They pervade every aspect of our being. There is no escape or straightforward recovery from them. In trying to relay the specificity of psychological as opposed to physical trauma I am at a loss to compete with the late psychologist Peter Sedgwick who in his seminal book *Psychopolitics* (1982) says:

Trauma and resistance to trauma can in the human case be understood not in the analogy of a physical force striking a more or less brittle object nor on the lines of the invasion of an organism by a hostile bacteria, but only through the transformation of elements in a persons identity and capacity to relate to other persons and social collectives.”

In other words, mental health problems and the traumas that often underlie them are in essence social and interpersonal problems that infect all aspects of our sense

of who we are and how we relate to each other. It is for this reason that alternative paradigms are needed and for this reason why they need to come from within survivor movements.

What all this means from a research vantage point is interestingly open-ended. On the one hand, the call for epistemic justice in mental health research is clear, and for the reasons discussed, morally above reproach. However, the means of working towards this are likely to be pluralistic. Anastacia and I present my data in both visual and verbal forms, so as to try to grasp the complexity of my experience in the context of what has been described by Mad Studies scholars as a ‘hermeneutical lacunae’. In other words, the available psy discourses are inadequate and, if anything, part of the problem when I try to relate a complex subjectivity. We have used our respective strengths to try to frame the age-old problem of childhood sexual abuse in a novel way, to offer a qualitatively distinct sense of what it might be like to be objectified in this way when young. In this dynamic, Anastacia becomes the artist as researcher, trying to piece together and disseminate my fragmented subjectivity in a way that can be understood, thought about and given an epistemologically congruent name. She has helped me make the unspeakable nameable – or in this case, visible. These creative collaborations with all their attendant complexities might offer one way forward.

One final point relates not to the producers of these new forms of Mad Studies but rather to some of the intended recipients. Fricker refers to the sensitivity of hearers being necessary for epistemic justice to be reached. I would concur that we are right to ask much of the psy professions in order to promote restorative practices. However, all of us can only hear what we can hear. The late Senegalese novelist and filmmaker Ousmane Sembene said “We do not tell stories for revenge, but to find our place in the world.” The challenge for me in writing about my own and my fellow survivor’s experiences of institutional sexual abuse in childhood is how to develop the critical reflexivity to ensure my intentions are to educate and liberate, and not to seek revenge against misguided ‘experts’. For it is by this more ethical intention – to do differently to what my body and mind often tell me – that I can transcend the moral quagmire of sexual abuse, the clutches of that sick man who did those terrible things to me, and become a more fully moral person with something better to offer my fellow citizens. ■

Anatomised

thought disorder

paranoid delusions

dissociation

false memory syndrome

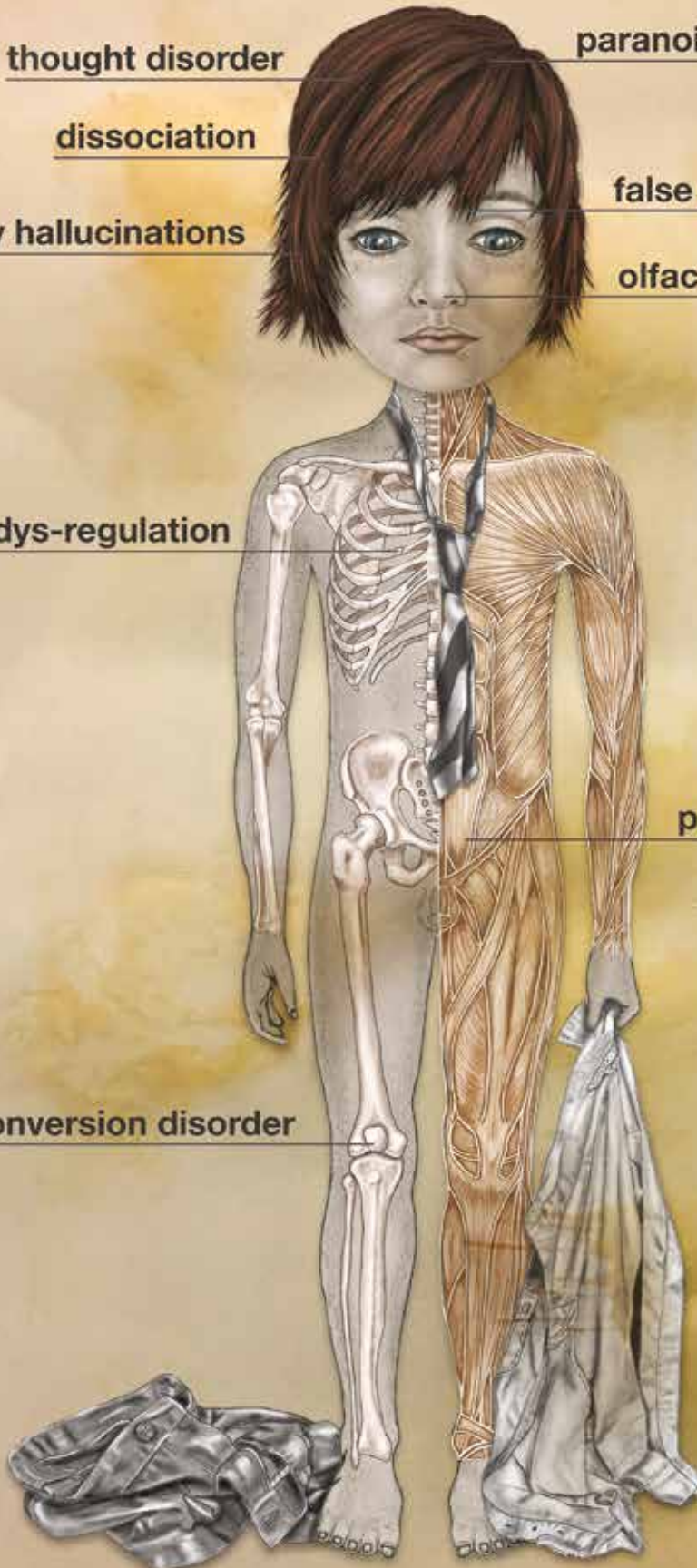
auditory hallucinations

olfactory hallucinations

emotional dys-regulation

panic disorder

conversion disorder



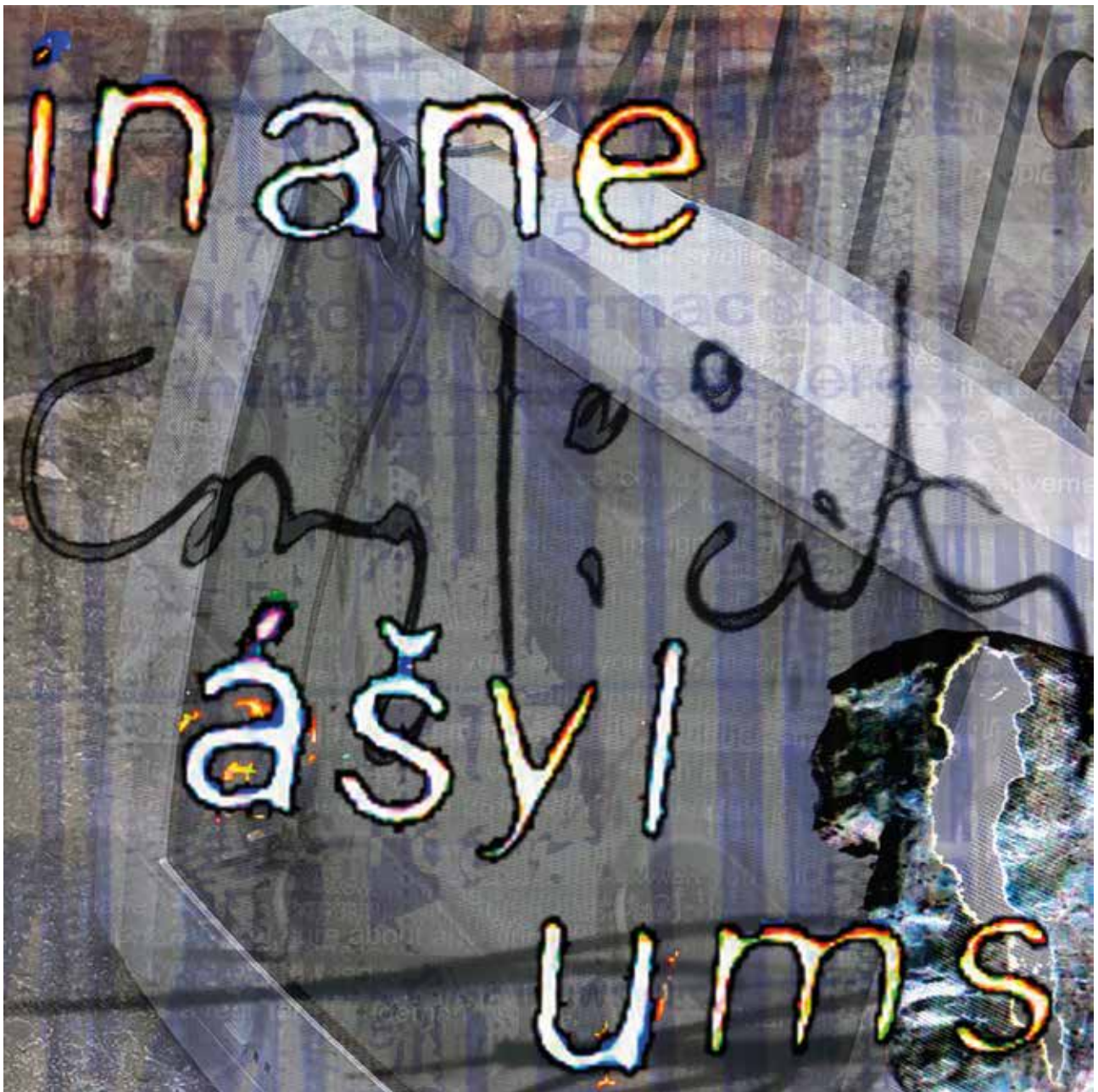
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