The Consumers' Atlas to Mental Health

CONVERSATION STARTERS

Vol. 1: The Medical Model

Vol. 2: Entering the labyrinth: Balancing care and risk in clinical services

Vol. 3: Stigma: The precarious balance between social and personal identity

Vol. 4: Where mental health is made: Personal autonomy and social regulation

Vol. 5: Mad Studies

Vol. 6: Musings about the National Disability Insurance Scheme (NDIS): Are we in or out?

Vol. 7: Holding ourselves together in time and space: Living in community

Vol. 8: In the news: The wider context of mental health and illness

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Vol. 1: The Medical Model

The Consumers' Altlas to Mental Health

1. Purpose and intentions of the Consumers' Atlas to Mental Health:

Conversation Starters is a set of eight volumes each containing 15 statements, intended to initiate and energise conversations about mental health. They are not statements of 'fact'; rather, they are tentative opinions to stimulate insightful conversations about the ways we understand madness, health and other services, community and mad people's politics. We hope they will assist in exploring issues concerning mental health through conversation, supported and informed by materials ranging from the experiential, the narrative and descriptive through to research-based and theoretical work.

The choice of the assembled materials is, of course, biased; some references are controversially 'conservative' whilst others are controversially 'radical'. We included them because they are all part of the full story. We have, therefore, spent less time accumulating 'mainstream' medical material because this is easier to find and many readers would already have absorbed a great deal of this discourse in their everyday interactions with the institutions of psychiatry or, indeed, through information from mass media and other sources.

2. Eight Volumes

Vol. 1: The Medical Model

Vol. 2: Entering the labyrinth: Balancing care and risk in clinical services

Vol. 3: Stigma: The precarious balance between social and personal identity

Vol. 4: Where mental health is made: Personal autonomy and social regulation

Vol. 5: Mad Studies

Vol. 6: Musings about the National Disability Insurance Scheme (NDIS): Are we in or out?

Vol. 7: Holding ourselves together in time and space: Living in community

Vol. 8: In the news: The wider context of mental health and illness

3. Each volume is organised as follows:

1. A series of fifteen conversation *'starter kits'*;

2. Each kit has three sections:

- **Entry Section:** A set of five interesting, quizzical, provocative and sometimes controversial short statements accompanied by cartoons. This is the first, most direct and simplest way to enter the conversation.

- **Middle Section:** *'Wikipedia entries to madness'*, offering 30 initial definitional understandings of the issue or the dimension of madness proposed as the main theme of the conversation.

- **Annotated Reference Section:** References to about 15 articles, discussion papers, academic debates, research, professional psychological or psychiatric literature, newspaper and other journalistic work, different discourses, antipsychiatry literature, medical literature and associated debates.

4. General: Also available and covering all eight volumes are:

- a more comprehensive explanatory introduction to this material; and

- a substantial reference collection with hundreds of references, ordered in 100 *'thematic entry-points'* to be posted on the *Our Consumer Place* website.

The
Medical
Model

1.
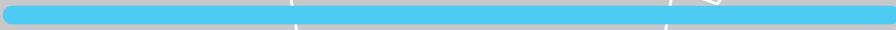
1. The Medical Model

MIND AND BRAIN

Throughout the history of western psychiatry there has been emphasis on the *brain* followed by intense interest in the *mind*, followed by intense interest in the *brain*. "*Plus ça change, plus c'est la même chose*" – the more it changes, the more it remains the same thing.

SOCIAL, CULTURAL AND SPIRITUAL

Alternative ways of knowing have been buried under the weight of scientific self-righteousness in recent years. Ways how Aboriginal peoples understand their health offer critical learnings for mainstream medical beliefs and culture.

CHAINS, SHACKLES AND WATER TREATMENT

The earliest recorded examples of the medical model were in the madhouses of 17th Century Europe. Mad-doctors prescribed physical remedies. Phillip Pinnel, amongst others, led the charge towards better conditions, a development known as Moral Treatment.

THE OPPOSITE OF MEDICAL IS... CHARLATAN?

Many doctors truly believe that unless it's the medicine *they* offer, someone must be trying to rip us of – from which they think they must save us. This may say more about their (assumed) power and authority than it does about the medicine on offer.

FALSE FACTS

Dictionaries tell us that a 'model' might be described as a prototype reminding us the 'Medical Model' might not be about facts but perhaps more about ideas. These ideas could become fact-like through time but many won't. Be careful!

A WIKIPEDIA ENTRY TO MADNESS

1. ALTERNATIVE MEDICINE: https://en.wikipedia.org/wiki/Alternative_medicine

2. ANTI-PSYCHIATRY: https://en.wikipedia.org/wiki/Anti-psychiatry

3. BIG PHARMA: https://en.wikipedia.org/wiki/Big_Pharma

4. BIOLOGICAL PSYCHIATRY: https://en.wikipedia.org/wiki/Biological_psychiatry

5. BIO-PSYCHIATRY CONTR0VERSY: https://en.wikipedia.org/wiki/Biopsychiatry_controversy

6. COMPLEMENTARY MEDICINE: https://en.wikipedia.org/wiki/Research_Council_for_Complementary_Medicine

7. CULTURAL ANTHROPOLOGY: https://en.wikibooks.org/wiki/Cultural_Anthropology/Health_and_Healing

8. EAST-WEST TRADITIONS IN MEDICINE: https://en.wikipedia.org/wiki/Bridging_Eastern_and_Western_Psychiatry

9. HEURISTIC: https://en.wikipedia.org/wiki/Heuristic

10. HISTORY OF PSYCHIATRIC INSTITUTIONS: https://en.wikipedia.org/wiki/History_of_psychiatric_institutions

11. HISTORY OF PSYCHIATRY: https://en.wikipedia.org/wiki/History_of_psychiatry

12. HOLISTIC MEDICINE: https://en.wikipedia.org/wiki/Holistic_health

13. JOHN CADE (Lithium): https://en.wikipedia.org/wiki/John_Cade

14. MEDICAL MODEL: https://en.wikipedia.org/wiki/Medical_model or

http://www.simplypsychology.org/medical-model.html or

http://www.psychedelic-library.org/grof.html

15. MEDICINE: https://en.wikipedia.org/wiki/Medicine

16. PHILOSOPHY OF THE MIND: https://en.wikipedia.org/wiki/Philosophy_of_mind

17. PSYCHIATRIC INSTITUTIONALISATION: https://en.wikipedia.org/wiki/History_of_psychiatric_institutions

18. PSYCHIATRY: https://en.wikipedia.org/wiki/Psychiatry

19. SANISM/ABLEISM & THE MEDICAL MODEL: https://en.wikipedia.org/wiki/Ableism

20. SECULAR SPIRITUALITY: https://en.wikipedia.org/wiki/Secular_spirituality

21. SHORT HISTORY OF PSYCHIATRY (for consumers): http://www.ourcommunity.com.au/files/ocp-consumerguide.pdf

22. SOCIAL MODEL OF DISABILITY: https://en.wikipedia.org/wiki/Social_model_of_disability

23. SOCIAL PSYCHIATRY: https://en.wikipedia.org/wiki/Social_psychiatry

24. SPIRITUALITY: https://en.wikipedia.org/wiki/Spirituality

25. THEORY OF MIND: https://en.wikipedia.org/wiki/Theory_of_mind

26. PSYCHIATRY TIMELINE: https://en.wikipedia.org/wiki/Timeline_of_psychiatry

27. HUMAN BRAIN: https://en.wikipedia.org/wiki/Human_brain

28. MIND: https://en.wikipedia.org/wiki/Mind

29. INDIGENOUS PSYCHOLOGY: https://en.wikipedia.org/wiki/Indigenous_psychology

30. QUACKERY: https://en.wikipedia.org/wiki/Quackery

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

May K Business and the brain: How some scientists hope to cure mental illness in Financial Post January 12th 2015 http://business.financialpost.com/brain-health/business-and-the-brain-how-some-scientists-hope-to-cure-mental-illness?__lsa=9a9c-7d3b

(Newspaper piece with an obvious brain/biology emphasis; looks towards conventional knowledge and argues it's time to be talking about 'cures', even that these conversations have been neglected to everyone's detriment. There is a video/YouTube: 'Psychiatry versus Neuroscience: What is the difference?')

2.

Datta V (MD) Psychiatry and the Problem of the Medical Model – Part 1 in Mad in America: Science, psychiatry and community December 21st 2014 http://www.madinamerica.com/2014/12/psychiatry-problem-medical-model-part-1/

(This is a clear annunciation of the arguments of those who question the worth of 'psychiatry'. For those interested in these arguments and for those who want to defend themselves against them, this is a good and not difficult read.)

3.

Duckett S AMA – Patients Advocate or Doctor's Union? How the AMA flexes its muscle in The Conversation June 9 2016 http://theconversation.com/patient-advocate-or-doctors-union-how-the-ama-flexes-its-political-muscle-60444

(Short, easy read about medical lobby groups. Is the AMA a union? Its role, function and influence.)

4.

Durie M Understanding health and illness: research at the interface between science and indigenous knowledge in International Journal of Epidemiology 2004 33:1138–1143 http://ije.oxfordjournals.org/content/33/5/1138.full.pdf+html

(Academic, Maori research – two case studies, looking at bringing together 'western science' and Maori traditional knowledge with the question asked – what can be gained from thinking outside the square on both sides?)

5.

Emmerich N Appreciating the politics of psychiatry in The Guardian - psychology and political science 28th May 2013 https://www.theguardian.com/science/political-science/2013/may/28/politics-psychiatry

(Bio-politics and psychiatry for an interested lay audience: Foucault, the role of biology – in a short piece)

6.

Karlsson E That's just a brain disease - The poverty of anti-psychiatry dualism BLOG http://debunkingdenialism.com/2012/04/03/thats-just-a-brain-disease-the-poverty-of-anti-psychiatry-dualism/

(Very short pro-medical piece; intentionally polemic, part of a wider 'debunking series'. Nonetheless, may be insightful for further discussion.)

7.

Lake J Emerging paradigms in medicine: implications for the future of psychiatry in Explore (NY) 2007 Sep-Oct 3(5):467-77

(Academic piece; looks really good but is not free; the author describes an understanding of psychiatry that is inconsistent and suggests that Western biomedicine and non-Western understandings could offer a better platform, including being based on human evolution, knowledge about consciousness, the neurosciences, complexity theory and the field of quantum theory.)

8.

Pies R Can Psychiatry be both a Medical Science and A Healing Art? The Case for Polythetic Pluralism in Psychiatric Times BLOG

(Very short and easy to read, Pies speaks from his own position as a psychiatrist to talk about how his profession is troubled by whether they are predominantly an 'art' or a science'. He uses insightful commentary from his peers to search for some solution. It is interesting to wonder whether psychiatric nursing is or is not part of the 'medical model. Pies is renowned for his contemporary commentary. It might be useful to follow his works.')

9.

Psychiatric Myths Dispelled by Doctor – Fighting Antipsychiatry in BiPolar Burble BLOG April 5th 2011 http://natashatracy.com/mental-illness-issues/doctors/ psychiatric-myths-dispelled-doctor-fighting-antipsychiatry/

(BLOG opposed to anti-psychiatry – insight into doctors' assumed authority and probable professional fallibility)

10.

Shah P & Mountain D The medical model is dead – long live the medical model in British Journal of Psychiatry 2007 Nov. 191:375-7 http://bjp.rcpsych.org/content/191/5/375.long

(Psychiatrists (in their territory) defend the medical model without compunction. Makes a very good baseline for others, including consumers, to think about where they sit in the debate – or, have seats in the debate.)

11.

Smith R Limits to medicine. Medical nemesis: the expropriation of health in Journal of Epidemiological Community Health 2003 57:928 http://jech.bmj.com/content/57/12/928.full

(Insightful tribute to Ivan Illich and his work, especially around sites of iatrogenesis - illness created by clinicians and in the medical 'system'.)

12.

Vagg M Doctors or activists? Who draws the line? in The Conversation August 23rd 2016 http://theconversation.com/doctors-or-activists-who-draws-the-line-64227

(Can doctors be advocates? Very Short but useful)

13.

Waitkin H A Critical Theory of Medical Discourse: Ideology, Social Control and the Processing of Social Context in Medical Encounters in Journal of Health and Social Behavior Vol. 30(2) June 1989 pp. 220-239

(Academic arguments that individual relationships between doctor and patient always take place within a social context. This paper examines theories of medical discourse. It argues that: (a) medical encounters tend to convey ideological messages supportive of the current social order; (b) these encounters have repercussions for social control; and (c) medical language generally excludes a critical appraisal of the social context.)

14.

Godot D The Medical Model of Psychology BLOG/Academic Writing August 7th 2005 http://davidgodot.com/medical-model-of-psychology/

(This piece critiques the idea that clinical psychology would follow other than the same 'medical model' as espoused by psychiatry. It is debated by psychologists (excluding this author and some others). It is harder to find references for this side of the argument. It is an easy read).

15.

Kavanaugh PB How Will Bodies of Knowledge Speak the Psychoanalyst in the 21st Century? Some Thoughts on the Art(s) of Psychoanalytic Education in Academy for the Psychoanalytic Arts 1999

The Diagnostic and Statistical Manual

2.

2. The Diagnostic and Statistical Manual (DSM-V): The Psychiatrists' Bubble

WHAT IS THE DSM?

DSM-V stands for the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition. It is put together by a group of psychiatrists (mostly men) in the United States, the American Psychiatric Association (APA). The World Health Organisation (WHO) uses a different tool, the International Classification of Diseases (ICD), now in its 10th version.

THE SIGNIFICANCE OF THE DSM-V

Despite the fact that it is not, some members of the psychiatric profession consider the DSM somewhat 'bible-like'. All our diagnoses derive from it so, in this sense, it is very significant. A volume that is the sole arbiter of whether or not – and to which degree - we have an 'illness' is a powerful part of the structure that holds up the psychiatric industry – for better or for worse.

HOW IT IS USED AND WHY WE NEED TO KNOW ABOUT IT

Some, particularly beginning hospital registrars, may literally speak to (with diagnostic purpose) and observe 'the patient', with close internal and external reference to the DSM-V. This requires counting and ticking-off observed 'symptoms'. In each category of illness a list of symptoms is inserted towards making a diagnosis; if the count is 'high' enough, you've 'got it'... and that's it then.

WHY IT IS PROBLEMATIC

It is not scientific but is believed to be, which is worse. New diagnoses are created and proposed by APA members and then put to the vote. People accuse this process of being imperialistic; each new edition presents an increase in documented pathology. In practice, it is used as a political tool; although not its original purpose, the industry uses it to gate-keep services, lobby governments and maintain control over consumers.

CLASSIFICATION CAN BE USEFUL

It offers clinicians a shorthand way to understand each other and have shared meanings. Some consumers like to look up their diagnoses either to find out more or to challenge the way they have been classified. It gives everyone insight into the way psychiatrists are trained, which is useful because they have so much institutional power... and it makes a good door-stop....

A WIKIPEDIA ENTRY TO MADNESS

1. ALLEN FRANCIS: https://en.wikipedia.org/wiki/Allen_Frances

2. AMERICAN PSYCHIATRIC ASSOCIATION (APA): https://en.wikipedia.org/wiki/American_Psychological_Association

3. CAUSES OF MENTAL DISORDERS: https://en.wikipedia.org/wiki/Causes_of_mental_disorders

4. CLASSIFICATION OF MENTAL DISORDERS: https://en.wikipedia.org/wiki/Classification_of_mental_disorders

5. CLASSIFICATION OF MENTAL DISORDERS: http://www.bahaistudies.net/neurelitism/librsary/classifications-wiki.pdf

6. CLASSIFICATION OF MENTAL DISORDERS: http://www.bahaistudies.net/neurelitism/librsary/classifications-wiki.pdf

7. CLINICAL SIGNS (SYMPTOMS): https://en.wikipedia.org/wiki/Medical_history

8. CRITICISM DSM-V: https://en.wikipedia.org/wiki/DSM-5#Criticism

9. DIAGNOSIS: https://en.wikipedia.org/wiki/Diagnosis

10. DSM-V (Diagnostic and Statistical Manual): https://en.wikipedia.org/wiki/DSM-5

11. ETIOLOGY: https://en.wikipedia.org/wiki/Etiology_(medicine)

12. GLOBAL ASSESSMENT AND FUNCTIONING SCALE: https://en.wikipedia.org/wiki/Global_Assessment_of_Functioning

13. ICD-10 CHAPTER VI: DISEASES OF THE NERVOUS SYSTEM: https://en.wikipedia.org/wiki/ICD-10_Chapter_VI:_Diseases_of_the_nervous_system

14. IDIOPATHY: https://en.wikipedia.org/wiki/Idiopathy

15. LIST OF MENTAL DISORDERS: https://en.wikipedia.org/wiki/List_of_mental_disorders

16. MEDICAL CLASSIFICATION SYSTEMS: https://en.wikipedia.org/wiki/Medical_classification

17. MEDICAL DIAGNOSIS: https://en.wikipedia.org/wiki/Medical_diagnosis

18. MENTAL DISORDER: https://en.wikipedia.org/wiki/Mental_disorder

19. MENTAL ILLNESS: https://simple.wikipedia.org/wiki/Mental_illness

20. MENTAL STATE EXAMINATION: https://en.wikipedia.org/wiki/Mental_status_examination

21. NOSOLOGY: https://en.wikipedia.org/wiki/Nosology

22. PROGNOSIS: https://en.wikipedia.org/wiki/Prognosis

23. PSYCHIATRIC ASSESSMENT: https://en.wikipedia.org/wiki/Psychiatric_assessment

24. PSYCHIATRIC EPIDEMIOLOGY: https://en.wikipedia.org/wiki/Psychiatric_epidemiology

25. PSYCHOLOGICAL PAIN: https://en.wikipedia.org/wiki/Psychological_pain

26. PSYCHOSOMATIC MEDICINE: https://en.wikipedia.org/wiki/Psychosomatic_medicine

27. RESEARCH DIAGNOSTIC CRITERIA: https://en.wikipedia.org/wiki/Research_Diagnostic_Criteria.
28. RISK ASSESSMENT: https://en.wikipedia.org/wiki/Assessment_of_suicide_risk

29. SCIENTIFIC IMPERIALISM: https://en.wikipedia.org/wiki/Scientific_imperialism
30. TAXONOMY: https://en.wikipedia.org/wiki/Taxonomy

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Barsky A DSMv and the Ethics of Diagnosis in The New Social Worker http://www.socialworker.com/feature-articles/ethics-articles/dsm-5-and-ethics-of-diagnosis/

(This is a Social Work perspective on DSMv, arguing that classifying people is inherently judgemental and disrespectful, accentuating the negatives in people whilst clinicians often claim to be doing the exact opposite. Can this be accepted on the basis that the act of diagnosing is done in good faith and that it will 'do good'? Also looks at the pragmatic advantages of DSMv. Short easy read).

2.

Cooksey E & Brown P Spinning on its Axes: DSM and the Social Construction of Psychiatric Diagnosis in International Journal of Health Services July 1998 vol. 28(3) pp. 525-554 http://journals.sagepub.com/doi/pdf/10.2190/1C4D-B7XT-BLLY-WH4X

(A 29 page, well-argued academic piece, a bit dated but available free in PDF format. The authors argue that the common language sought by the authors of the DSM is a truncated language, focussing on the observable and superficial and ignoring the significant influence of community, family and personality. Conclusion: "Because psychiatry cannot comprehend diagnosis as a socio-political phenomenon, alterations to the existing traditional diagnosis models will not lead to a greater under- standing of mental disorder." This paper looks critically at basic tenets of mental health work such as the Mental State Examination (MSE). Tellingly, the authors include social workers, clinical psychologists etc. as proponents of the DSM.)

3.

Darra V Does DSM-5 Matter? Yes, but not for Psychiatrists in Mad in America May 2013 https://www.madinamerica.com/2013/05/does-dsm-5-matter-yes-but-not-for-psychiatrists/

(This piece is short and well argued; a pretty easy read. The author argues that we need to think about the real purpose of the DSM: psychiatrists actually rarely use it, other clinicians don't want to use it, researchers find it limited, and survivors/consumers lobby actively against it. So, why is it so important? He concludes: "What makes the DSM so pernicious is that it is a cultural document whose influence transcends not only psychiatric practice but also the Western civilization from which it originates. Each revision of the DSM rescripts and reimagines how we make sense of our experiences, reinterprets what thoughts, feelings and behaviors are socially sanctioned, and ultimately what it means to be human.")

4.

Frances AJ DSM 5 Is Guide Not Bible—Ignore Its Ten Worst Changes; APA approval of DSM-5 is a sad day for psychiatry in Psychology Today Posted Dec. 2nd 2012 https://www.psychologytoday.com/blog/dsm5-in-distress/201212/dsm-5-is-guide-not-bible-ignore-its-ten-worst-changes

(This piece, like many in Psychology Today, is informal and easy to read. Dr Frances is a medical doctor who is active on the web. Here he critiques the DSMv for including 'fad' diagnoses that will go out of fashion and which pathologises people who do not need to be pathologised. He describes 10 of them (but imposes his analysis onto the people he claims are being abused in this process. It would be interesting to ask them?))

5.

Karger S (2013) DSMv Pros & Cons in Forschungs Perspektiven

(Short and politically controversial this piece, arguing that the DSMv will 'open the floodgates' and money and policy will move away from those who 'most need it' and to those who have 'minor problems'. The author also argues that DSMv is 'anti-science' and has hurt the reputation of the professions of psychology and psychiatry.)

6.

Kawa S and Giordano J A brief historicity of the Diagnostic and Statistical Manual of Mental Disorders: Issues and implications for the future of psychiatric canon and practice, in Philosophy, Ethics and Humanities in Medicine 2012 7:2 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3282636/

(This essay comes from the discipline of philosophy with an interest in exploring the ethical foundations of the DSM. It is a bit dense but really interesting especially for those who are interested in finding out how the DSMv came to be. The author explores and analyses the social and political forces that have been at play over the past 60 years. It starts by exploring the factors that motivated its development in 1952 and the multiple changes and repercussions various editions have affected in psychiatry over the past 60 years. What made the DSMv!)

7.

Levine B DSM-5: Science or Dogma? Even Some Establishment Psychiatrists Embarrassed by Newest Diagnostic Bible in Huffington Post April 2013

(Levine's BLOG is short, sharp and easy to read. Levine is a psychiatrist; you get her meaning straight away. She is angry with the DSM and the effect it has on her profession. "I was spitting mad at the field of psychiatry at the time and its long history of exploiting human suffering in its efforts to become a bona fide medical specialty. I educated myself on the history of the DSM and began to see it as pseudoscience. I became interested in how people organize mental suffering to fit a diagnosis, as well as the impact of diagnoses on identity formation."

8.

Lieberman J DSM-5: Caught between Mental Illness Stigma and Anti-Psychiatry Prejudice in Scientific American May 2013 http://blogs.scientificamerican.com/mind-guest-blog/dsm-5-caught-between-mental-illness-stigma-and-anti-psychiatry-prejudice/

(This author describes the DSMv as an up-to-the minute diagnostic GPS, identifying two types of critiques; the first are those who offer 'constructive' critique of particular diagnoses, for example. He also identifies those who are ant-psychiatry – a totally different position of which he is very critical. He argues that this is a form of stigma and prejudice which results in blighted lives, more suffering. He argues: "No other medical specialty is targeted by such an 'anti' movement. The relatively small 'anti-psychiatry' movement fuels the much larger segment of the world that is prejudiced against people with disorders of the brain and mind and the professions that treat them. Like most prejudice, this one is largely based on ignorance or fear – no different than racism, or society's initial reaction to illnesses such as AIDS.)

9.

Phillips J et al The six most essential questions in psychiatric diagnosis: A pluralogue part 2: Issues of conservatism and pragmatism in psychiatric diagnosis in Philosophy, Ethics and Humanities in Medicine Vol. 7 2012 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3390269/

(These two papers are important but they are also a bit dense and, at times, hard to read, but it's worth sticking to. Two prominent psychiatrists, sometimes with different views, discuss important questions about the DSM and the philosophy behind it, process of creating it, the debates and the science. They describe and discuss the debate between those who would want incremental conservative changes to documents like the DSM and those who would argue for more radical changes or no DSM at all. It's interesting, it's medical. "If, with Dyson, one's attitude toward science is that it "is not a collection of truths" but rather "a continuing exploration of mysteries.", that might lead one toward the activist stance, arguing that we needn't wait for final truth from genetics and neuroscience to make changes in our nosology, but rather see the latter as an ongoing, dynamic process. If we assume this latter approach, the questions become the practical ones of how to redesign the manual in a way that allows for our tentative advances in scientific understanding without creating more practical encumbrance than benefit. The counter argument is articulated by Frances and others: that provisional changes made on the basis of genuine, but provisional, scientific findings may well create more harm than good, and that when dealing with suffering human beings, we had better be pretty sure of our "science" – and of its effects – before making changes that will affect how we deliver treatment.")

10.

Pickersgill M Debating DSM-5: diagnosis and the sociology of critique in Journal for Medical Ethics August 2014 40(8):521–525 http://www.ncbi.nlm.nih.gov/pubmed/?term=Pickersgill%20MD%5Bauth%5D

(This is a more academic article and it is full text by a sociologist who is interested in the social fabric which is wrapped around the debates in relation to the DSMv. He is interested in competing understandings and discourse. He starts from an assumption that psychiatry does not have a unified core set of driving assumptions. He states that he draws on critique of the DSMv that emanates from psychologists and psychiatrists to contain the paper. He writes: "In the idiom of philosopher Ian Hacking, I take diagnosis to be an apparatus through which individuals 'make up' themselves and one another. Through this, individuals and societies learn how to recognise 'normal' and 'pathological' experiences, relate to substances and practices (such as pharmaceuticals and psychological therapies), and negotiate situations saturated with moral feeling and implications (restraint, discharge and access to services being just a few examples). In this sense, diagnostic texts like the DSM come to shape, and be shaped by, a wide range of social actors and institutions, and hence have salience for these—perhaps especially in the case of more contested categories.")

11.

Nemeroff CB DSM-5: a collection of psychiatrist views on the changes, controversies, and future directions in BioMed Central 2013 11:202. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3846446/

(This is an opinion piece with many different opinions – all psychiatrists; some are very technical and laced with jargon, other are not. Most are very biologically oriented. There are many different views coming from different clinical/psychiatric perspectives. They include an early trauma specialist who welcomes the changes in DSMv; commentary about conflicts of interest with funding bodies, a special concentration on PTSD and another on OCD, Mood Disorders and Biological Psychiatry and the Schizophrenias.)

12.

Ryan C DSMv - Why all the Fuss? In The Pulse (ABC) 23/5/2013

(Aimed at a lay audience, this easy piece outlines some of the main issues presented when the DSMv was published. The learned opinions are from psychiatrists in positions of authority (power) – Maria Tomasic, then president of the Royal Australian & New Zealand College of Psychiatry (RANZCP) and Gordon Parker from the Black Dog Institute; a good introduction referencing the fact that most psychiatrists don't use the DSM, no matter what version.)

13.

Ben-Zeev D et al DSMv and the stigma of mental illness in Journal of Mental Health August 2010 19(4):318–32 http://www.a-id.org/pdf/dsm-v-and-the-stigma-of-mental-illness.pdf

(This is an easy article and a good discussion starter. It looks at three identified manifestations of stigma as it relates to diagnosis: public stigma, self-stigma and label

avoidance. *"Through socio-cognitive processes of groupness, homogeneity, and stability, stigmatizing diagnostic labels may impact housing and job opportunities, as well as individuals' self-esteem, self-efficacy, and treatment utilization."*)

14.

Khoury B et al The DSM: Mindful science or mindless power? A Critical Review in Frontiers in Psychology 2014 5:602 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4060802/

(This is an opportunity for clinical psychologists to discuss their take on the DSM process and the DSMv. It is technical and a bit difficult but in order to tease out the different ways clinical psychologists and psychiatrists interpret their medical model it is useful.)

15.

Jones LK & Cureton JL Trauma Redefined in the DSM-5: Rationale and Implications for Counseling in The Professional Counselor http://tpcjournal.nbcc.org/trauma-redefined-in-the-dsm-5-rationale-and-implications-for-counseling-practice/

(A fascinating look at the changes between DSMiv and DSMv in relation to complex trauma especially around the diagnosis of Post-Traumatic Stress Disorder.)

3.

Diagnostic Tribes

3. Diagnostic Tribes

IN THE SLIPSTREAM OF CAPITALISM

Psychiatrists, too, are caught in the slipstream of biomedical ascendency; to promote the discipline under these circumstances and to counter criticism from medical colleagues and the community, scientific competence is keenly enacted. Tribes are not only diagnostically defined, however; political interest groups form around psychotherapy; biological interventions; private provision; early intervention; consumer interests etc. Rather than remaining discreet, issues blend and so do people.

I LIKE THAT!

For some consumers, diagnostic tribes are entities to which they ascribe and to which they are loyal. Although (or because) the diagnosis might have been circumscribed by doctors, they take it on as a useful identity. For others, the diagnostic label is meaningless, damaging and redundant. The only reason they would fly the flag is as a useful means to attack (or escape) psychiatry... but there are gradations in between.

LABELS SERVE AN IMPORTANT SERVICE FOR SOME OF US

People know that tribal activity may bring resources to their particular group; without acknowledgement, Medicare funding and political energy will be absent and we probably won't be heard. Some consumers treat medical identities with disdain but see the necessity of using them sometimes for lobbying. An important political question for consumers is whether we want to be 'inside with potential influence' or 'outside with independence'.

OH NO! NOT POWER AGAIN!

The authority of different tribes waxes and wanes, often related to different therapeutic approaches. Tribal communities consist of leaders, movers and shakers, drivers, hangers-on and supplicants, but no-one can be taken for granted. In diagnostic tribes, leaders are usually very powerful psychiatrists, heads of political lobby groups, influential family carers and a few consumers. Most of us don't get it.

MONEY AND INFLUENCE

Nothing comes easily; tribes form to fight and protect territory. It takes a lot of work to maintain or change policy to favour the tribe to which you ascribe. It takes money to produce the research, advertising skills to sell the message and discipline to stick to it. It sometimes takes imported fame to validate the tribal archetypes. Tragically, something going publicly wrong can short-track the process but often horribly corrupts the message.

A WIKIPEDIA ENTRY TO MADNESS

1. ACTIVISM: https://en.wikipedia.org/wiki/Activism

2. ADVOCACY GROUPS: https://en.wikipedia.org/wiki/Advocacy_group

3. ANTI-ESTABLISHMENT: https://en.wikipedia.org/wiki/Anti-establishment

4. CONTROVERSY & PSYCHIATRY: https://en.wikipedia.org/wiki/Controversy_surrounding_psychiatry

5. CRITICISM OF CAPITALISM: https://en.wikipedia.org/wiki/Criticism_of_capitalism

6. CRONY CAPITALISM: https://en.wikipedia.org/wiki/Crony_capitalism

7. DOMINANT IDEOLOGY: https://en.wikipedia.org/wiki/Dominant_ideology

8. EMPIRICAL EVIDENCE: https://en.wikipedia.org/wiki/Empirical_evidence

9. FALLABILISM: https://en.wikipedia.org/wiki/Fallibilism

10. FUNDING OF SCIENCE: https://en.wikipedia.org/wiki/Funding_of_science

11. HEALTHCARE IN AUSTRALIA: https://en.wikipedia.org/wiki/Health_care_in_Australia

12. HEGEMONY: http://en.wikipedia.org/wiki/Hegemony

13. IDENTITY (SOCIAL SCIENCE): https://en.wikipedia.org/wiki/Identity_(social_science)

14. IDENTITY POLITICS: https://en.wikipedia.org/wiki/Identity_politics

15. LOBBY GROUPS: https://en.wikipedia.org/wiki/Lobbying

16. MAD PRIDE: https://en.wikipedia.org/wiki/Mad_Pride

17. MEDICALISATION: http://en.wikipedia.org/wiki/Medicalization

18. MENTAL HEALTH POLICY: https://en.wikipedia.org/wiki/Health_policy

19. METHODS OF OBTAINING KNOWLEDGE: https://en.wikipedia.org/wiki/Methods_of_obtaining_knowledge

20. PHILANTHROPY: https://en.wikipedia.org/wiki/Philanthropy

21. REIFICATION: http://en.wikipedia.org/wiki/Reification

22. ROD OF ASCLEPIUS: https://en.wikipedia.org/wiki/Rod_of_Asclepius

23. SCIENTOLOGY & SCIENCE https://en.wikipedia.org/wiki/Scientology_and_psychiatry

24. SELF-CONCEPT: https://en.wikipedia.org/wiki/Self-concept

25. SELF-SCHEMA: https://en.wikipedia.org/wiki/Self-schema

26. SOCIAL STATUS: https://en.wikipedia.org/wiki/Social_status

27. SPECIAL INTEREST GROUP: https://en.wikipedia.org/wiki/Special_Interest_Group

28. THE ESTABLISHMENT: https://en.wikipedia.org/wiki/The_Establishment

29. THE POWER ELITE: https://en.wikipedia.org/wiki/The_Power_Elite

30. WELFARE ECONOMICS: https://en.wikipedia.org/wiki/Welfare_capitalism

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

De Angelis T A new diagnosis for childhood trauma? in American Psychological Association March 2007 Vol. 38(3) http://www.apa.org/monitor/mar07/diagnosis.aspx

(This is easy reading in a technical sense but not in an emotional sense. It looks at the case of traumatised children and argues that, either as children nor as adults, they don't fit neatly into a diagnostic category and are, for that reason, short-changed on services and they (and those barracking for them) have limited, united lobbying potential.)

2.

Beredjick C DSMv to rename gender identity disorder to 'gender dysphoria' in Advocate July 23rd 2012 http://www.advocate.com/politics/transgender/2012/07/23/dsm-replaces-gender-identity-disorder-gender-dysphoria

(Advocates discuss the ways that a change in diagnosis can change people's experiences (sometimes in contradictory ways), stigma and a group's capacity to lobby.)

3.

Bercow S Autism diagnosis is only the first step in The Guardian August 2010 https://www.theguardian.com/commentisfree/2010/aug/12/autism-breakthrough-only-first-step

(This well-written article looks at the campaign people with autism and their families have had to battle to keep the diagnosis in DSMv. It provides hope of services especially for poor people and a tool to keep lobbying despite the social stigma that they believe wrongly claims that 'normal' people are being diagnosed.)

4.

Goodwin GM Treat the Disability not the Diagnosis in The Journal of Clinical Psychiatry January 9th 2014, http://www.psychiatrist.com/JCP/article/Pages/2015/ v76n06/v76n0629.aspx

(This is written for psychiatrists but it is short. The thrust of the argument is that major depression should be seen as a disability rather than an illness. This might be very interesting in relation to federal welfare cutbacks to pensions.)

5.

Mental Health in schools Program: Just a Label? Some Pros and Cons of Formal Diagnoses of Children in Mental Health in Schools – UCLA Center http://smhp.psych.ucla.edu/pdfdocs/diaglabel.pdf

(This is a very brief, very clear enunciation of why diagnosing children can be both bad and good. The pros and cons are set out clearly in point form. Examples of some specific diagnoses are given.)

6.

Craddock N & Mynors-Wallis L Psychiatric diagnosis: impersonal, imperfect and important in The British Journal of Psychiatry February 2014 204(2):93-95 http://bjp.rcpsych.org/content/204/2/93.e-letters

(This is a series of editorials so it is easy reading. It's a good balance to some of the anti-DSM material. This is not just because the authors are psychiatrists but also because they carefully articulate their arguments including multiple reasons why patients want diagnoses and how they help not just in 'treatment of illness' but also in self-identity in a (supposedly) meritocratic society.)

7.

Moncrieff J Diagnosis as a political device in Social Theory & Health Vol. 8(4):370–382 www.palgrave-journals.com/sth/

(Unfortunately this interesting academic paper is not available for free. People working in organisations can get a copy and reproduce it in small numbers. The author uses the work of Jeff Coulter and David Ingelby to explore the role of diagnosis in routine psychiatric practice. She describes this process as very different from what happens in physical health because psychiatric diagnoses are dependent on social norms, mores and expectations that do not, at least not to the same extent, influence physical diagnoses. She describes two case studies.)

8.

Anon. Missing Page from the DSM Discovered: Personal Taxonomy Disorder (PTD) in Kno News http://knonews.org/missing-page-from-dsm-discovered/

(This is a spoof on the DSM which cleverly pathologises familiar clinical characteristics. It is followed by a discussion balancing ideas of 'serious mental illness' – referred to as SMI; which hasn't seen any apparent improvement since the 1930s with what the authors consider to be the 'epidemic' in spurious new mental illnesses. This bit is interesting but lacks substance and over-indulges in stereotyping to emphasise a political point. Still, easy to read and a useful contribution.)

9.

Loch AA et al Psychiatrists' stigma towards individuals with schizophrenia in Archives of Clinical Psychiatry (São Paulo) Rev. psiquiatr. clín. Vol.38(5) São Paulo 2011 http://www.scielo.br/scielo.php?pid=S0101-60832011000500001&script=sci_arttext&tlng=en

(The authors comment on the lack of knowledge about the way that psychiatrists (and psychiatry) stigmatised patients noting that most of the work on stigma focusses on stigma in the community. They discuss this in relation to Schizophrenia.)

10.

Psycho-Pharma Front Groups CCHR INTERNATIONAL – The Mental Health Watch Dog
https://www.cchrint.org/issues/psycho-pharmaceutical-front-groups/

(There is ongoing concern within the survivor movement that groups that appear to be benign and altruistic may not be. These groups have to speak loudly to be heard by anyone. Hard hitting but worth reading.)

11.

Rose N What is Diagnosis For? (a slightly revised version of a talk given at the Institute of Psychiatry Conference on DSM-5 and the Future of Diagnosis 4 June 2013 Department of Social Science and Social Policy Kings College London) http://nikolasrose.com/wp-content/uploads/2013/07/Rose-2013-What-is-diagnosis-for-IoP-revised-July-2013.pdf

(This essay is written by an influential psychiatrist who argues that diagnosis is a social and political phenomenon that serves many purposes other than the DSM-V intended ones. These include: eligibility for treatment, eligibility for healthcare insurance, legitimacy for time off work… and so on. Certain diagnoses work well and less well in achieving these functions. It is not difficult to read)

12.

Tomes N The Patient as a Policy Factor: a Historical Case Study of the Consumer/Survivor Movement in Mental Health in Health Affairs Vol. 34(9) September 2015 http://content.healthaffairs.org/content/25/3/720.full

(This paper takes a longitudinal look at the way people with severe intractable mental illnesses (usually psychosis) have determined policy and outcomes to inform public policy and lobby for the sorts of changes in public services that give them increased agency to influence policy and outcome in a systemic sense.)

13.

Radden J Recognition Rights, Mental Health Consumers and Reconstructive Cultural Semantics in Philosophy, Ethics, and Humanities in Medicine 7(1):1-8 2012 https://philpapers.org/rec/SCHNDT

(This paper looks at the consumer movement, assuming it is largely about public services and people with psychosis, using case studies of people with psychotic experiences. The agenda is civil rights, stigma, discrimination and social participation. "…theorising about the politics of recognition, 'recognition rights' and epistemic justice. The 'counter stories' (to the medical model) of people with Schizophrenia are used here to represent an alternative to the way people might be reframed and redefined, as part of efforts to acknowledge and honour 'recognition rights and epistemic justice'.)

SLEIGHT OF HAND

HIGH FUNCTIONING

LOW FUNCTIONING

REAL ILLNESS

WORRIED WELL

SERIOUS MENTAL ILLNESS

NON-SERIOUS SUICIDE

14.

Rowe A Why I decided to seek a formal diagnosis at the age of 40 The Curly Hair Project http://thegirlwiththecurlyhair.co.uk/blog/2014/08/15/decided-seek-formal-diagnosis-age-40/

(This is common and yet finding articles on it was almost impossible. This one is about Asperger's. This is no longer a distinct diagnosis in the DSM-V as all related diagnoses have been absorbed under the category Autism Spectrum. This is one area where consumers criticize the DSM-V for contracting rather than expanding. This is a group whose opinions matter because they are sometimes adversely affected by a reluctance to diagnose. The piece is easy to read and important.)

15.

Sweet M The psychological backlash against Hickie and McGorry Crikey Nov 30th 2011 https://www.crikey.com.au/2011/11/30/mind-games-the-psychological-backlash-against-hickie-and-mcgorry/

((This is a shortened version of a public address by Melissa Sweet. The longer version is also available http://insidestory.org.au/its-like-when-a-patriarch-dies-and-the-will-is-read-and-everyone-starts-squabbling on the web). This is important; it is interesting to know who is who and who has done what in mental health lobbying circles. The same faces reappear (Mendoza, McGorry, Whiteford, Hickie, Rosen…) and the same powerful lobby groups (beyondblue, Origen, Black Dog… Australian Psychological Association, the Royal Australian and New Zealand College of Psychiatrists and the Australian Medical Association). The more interesting part is possibly that these 'big players' have broken ranks and are fighting each other for the new money the Federal Government has put into mental health. They fight using reputation, science, claims of superior morality, human rights and potential abuses and economic work that 'shows' value for public money and how it is most usefully distributed which is usually along

diagnostic lines. Each group claims moral and economic superiority. We all need to know something about all these shenanigans. However, perhaps a more interesting learning is that the consumer voice is almost entirely missing (despite what we might believe we have achieved) and there is a sweeping backhander against alternative models and anti-psychiatry. When we are amongst ourselves it is very easy to believe that our shared critique is mainstream; it is not. It is even sometimes easy to believe that the anti-psychiatry lobby within the consumer movement is dominant. It might be, but after reading this there can be no misunderstanding. In the larger scheme of things, the medical model is dominant and the consumers and carers who get heard are the ones happy to work within these parameters.)

16.

Pobjie B 'We've had as much awareness as we can take': fighting symptoms of mental illness and not just stigma http://www.sbs.com.au/news/thefeed/article/2016/10/11/weve-had-much-awareness-we-can-take-fighting-symptoms-mental-illness-and-not-just

(This is a beautifully written little piece. Ben writes as someone with a serious anxiety disorder (although he seems to be pressured to say that it's not really that serious in the scheme of things) and he puts forward the argument that if the money that is presently being spent on anti-stigma campaigns was given to resources for those with serious mental illness, it would be a far better investment.)

Diagnosis: A Psychiatric Fate?

4. Diagnosis: A Psychiatric Fate?

THERE'S A PERSON IN HERE!

As soon as we are diagnosed, some people forget it is still just the person they know inside; *'once diagnosed always diagnosed'* and *'once diagnosed everything that went before is annulled'* are the two predominant assumptions, assumed valid until proven otherwise.

JUST LEAVE ME ALONE

A diagnosis of *'mental illness'* comes with a whole lot of extras. Sometimes people dump all sorts of miscellaneous expectations on us; sometimes the pressure for us to behave in certain sorts of ways and have certain sorts of personal goals and even mix with certain sorts of people is onerous. This is when 'drop-in' centres under eucalyptus trees come into their own...

EXCUSE ME!

Sometimes clinicians believe that a diagnosis helps explaining things and that it is always welcome. They suggest that it may help to explain your life idiosyncrasies to others and keep the community off your back. We believe there is some evidence that anti-stigma campaigns based on medical definitions of people *don't work*. Offering people excuses for their lives is unnecessary ... and diagnosing and not telling us is still *not on!*

THIS IS NOT MY ILLNESS SPEAKING!

At what point do we stop being people and start turning into mobile illnesses with voices? The intention may be to help us by withholding judgement, but this is not the right way for many; most of us *are* capable of making decisions like other (normal?) human beings. Some of us sometimes do need support, but that's OK. Thinking that our speaking position is necessarily driven by pathology is wrong.

LEAVING US WELL ALONE

Sometimes people are tired. Life hurts too much. Energy to fight everyday battles must be rationed. People accept conditions, labelling and frought relationships they otherwise wouldn't. This is not the same as being disempowered.

A WIKIPEDIA ENTRY TO MADNESS

1. AUTHORITY: https://en.wikipedia.org/wiki/Authority_(sociology)

2. AUTONOMY: https://en.wikipedia.org/wiki/Autonomy

3. COLLECTIVE ACTION: https://en.wikipedia.org/wiki/Collective_action

4. COLLECTIVE IDENTITY: https://en.wikipedia.org/wiki/Collective_identity

5. COMMUNITY DEVELOPMENT: https://en.wikipedia.org/wiki/Community_development

6. DEVIANCE: https://en.wikipedia.org/wiki/Deviance_(sociology)

7. EMPOWERMENT: https://en.wikipedia.org/wiki/Empowerment

8. FREE WILL: https://simple.wikipedia.org/wiki/Ethics

9. IDENTITY POLITICS: https://en.wikipedia.org/wiki/Identity_politics

10. LABELING THEORY: https://en.wikipedia.org/wiki/Labeling_theory

11. MERITOCRACY: http://rationalwiki.org/wiki/Meritocracy

12. NORM OF RECIPROCITY: https://en.wikipedia.org/wiki/Norm_of_reciprocity

13. PARTICIPATION DECISION MAKING: https://en.wikipedia.org/wiki/Participation_(decision_making)

14. POWER (SOCIAL & POLITICAL): https://en.wikipedia.org/wiki/Power_(social_and_political)

15. PSYCHOLOGICAL MANIPULATION: https://en.wikipedia.org/wiki/Psychological_manipulation

16. ROLE CONFLICT: https://en.wikipedia.org/wiki/Role_conflict

17. ROLE THEORY: https://en.wikipedia.org/wiki/Role_theory

18. SELF-DETERMINATION: https://en.wikipedia.org/wiki/Self-determination

19. SOCIAL CAPITAL: https://en.wikipedia.org/wiki/Social_capital

20. SOCIAL EXCLUSION: https://en.wikipedia.org/wiki/Social_exclusion

21. SOCIAL GROUP: https://en.wikipedia.org/wiki/Social_group

22. SOCIAL IDENTITY THEORY: https://en.wikipedia.org/wiki/Social_group

23. SOCIAL MOVEMENT THEORY: https://en.wikipedia.org/wiki/Social_movement_theory

24. SOCIAL NETWORK: https://en.wikipedia.org/wiki/Social_network

25. SOCIAL NORMS: https://en.wikipedia.org/wiki/Norm_(social)

26. SOCIOCULTURAL CONTEXT: https://en.wikipedia.org/wiki/Social_environment

27. SELF-DETERMINATION: https://en.wikipedia.org/wiki/Self-determination

28. MEDICAL PATERNALISM: https://en.wikipedia.org/wiki/Medical_paternalism

29. DUMBING DOWN: https://en.wikipedia.org/wiki/Dumbing_down

30. LIST OF DISABILITY-RELATED TERMS WITH NEGATIVE CONNOTATIONS: https://en.wikipedia.org/wiki/List_of_disability-related_terms_with_negative_connotations

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Andreassen HK & Marianne Trondsen M The empowered patient and the sociologist in Social Theory & Health (2010) 8:280–287 http://link.springer.com/article/10.1057/sth.2010.9

(Written by medical sociologists, this paper looks at the term 'empowerment' and examines how it is used and misused in health settings. This is an interesting article but unfortunately it is not available free on line except to academic institutions. Most affiliated mental health services will be able to download it and distribute in small numbers.)

2.

Callard F Psychiatric diagnosis: the indispensability of ambivalence in J Med Ethics 2014 40:526-530 http://jme.bmj.com/content/40/8/526.full

(This is an important piece that argues that the publication of the DSM-V has led to the re-emergence of an old debate (from the 1960s and 1970s), that there is a binary, black and white relationship between "psychiatry is all good or all bad," "diagnoses are very real and diagnoses are a fiction," "black versus white." This paper argues for greater sophistication, ambivalence and mediation between the different views. It is available here in full text.)

3.

Dawber C Gatekeeper versus Concierge: Reworking the Complexities of Acute Mental Health Care through Metaphor in Social Alternatives; Vol. 33(3) July 1st 2014 https://www.questia.com/library/journal/1P3-3555744781/gatekeeper-versus-concierge-reworking-the-complexities

(Written by a psychiatric nurse, this article argues that the role of service 'gatekeeping' is *not only a difficult one where competing claims have to be juggled but also a neglected field of inquiry. It is written for clinicians and some of the claims about patient-centred approaches might be questioned by some consumers. It perhaps also lacks a critical theoretical base which might argue more strongly that 'gatekeeping' experience provide a basis for political lobbying by patients and staff and also for a community development approach to the solution of the dilemmas raised. It is not available free in full text except through academic channels, but can be obtained by those working in mental health services.)*

4.

Deacon B The biomedical model of mental disorder: A critical analysis of its validity, utility and effects on psychotherapy research in Clinical Psychology Review Vol.33(7) Nov. 2013 Pp. 846–861   http://jonabram.web.unc.edu/files/2013/09/Deacon_biomedical_model_2013.pdf

> *(This paper is readable, sophisticated and thorough from the point of view of analytical psychotherapy. An important read not only in the debate about the validity and power of the medical model over the last thirty years, but the author also questions the rapid rise in the popularity of behaviourism and the consequences of this. The author argues that the fate of different approaches to suffering and madness are socially constructed, not biologically given.)*

5.

Frances A Mislabelling Medical Illness As Mental Disorder; The eleventh DSM-V mistake needs an eleventh hour correction in Psychology Today December 8th 2012 https://www.psychologytoday.com/blog/dsm5-in-distress/201212/mislabeling-medical-illness-mental-disorder

> *(Allan Frances writes a lot and he is very critical of psychiatry's present direction and the DSM-V. In this short, very readable, piece, Frances, a psychiatrist looks at the term 'Mental Disorder' and the repercussions of its use particularly in creating the perceptions of people's state of suffering. The specific critique is the use of extremely broad, catch-all phraseology in the new description of Somatoform Disorders which is the place where physical and mental health interventions brush up against each other. The risk is that people, particularly people labelled with already dubious mental illness labels, will cease to report their physical symptoms.)*

6.

Joseph S Agents of Social Control in The Psychologist - The British Psychological Society https://thepsychologist.bps.org.uk/volume-20/edition-7/agents-social-control

> *'This article is an overview of the issues raised by critical psychologists who say that mainstream clinical practice over-emphasises the psychological causes of mental health problems at the expense of social-environmental causes, thus perpetuating social injustice. As a result, it is argued that we need to consider three issues: first, that our conceptions of psychopathology are social constructions that inevitably reflect the wider social ideologies of the day; second, that as a result, the practice of psychology is not politically neutral; and third, that explicit professional self-reflection on these issues and our role in society is required.'*

7.

Needs F Hume's Fork and Psychiatry's Explanations: Determinism and the Dimensions of Freedom in Psychiatric Times August 1st 2007 http://www.psychiatrictimes.com/articles/humes-fork-and-psychiatrys-explanations-determinism-and-dimensions-freedom#sthash.Z1ywhvXv.dpuf

> *(This is an editorial in Psychiatric Times, primarily questioning ideas about 'free will' and social construction particularly as they apply to people diagnosed with mental illness. Short but interesting).*

8.

Scheper-Hughes N & Lovell AM Breaking the circuit of social control: Lessons in public psychiatry from Italy and Franco Basaglia; Social Science & Medicine, Vol.23(2) 1986 pp 159-178 http://www.sciencedirect.com/science/article/pii/0277953686903643

(This is important. It is not available free online and a bit dated, but this is unimportant as the authors are glancing over their shoulder. "Much public discourse in the United States and in Canada acknowledges the dismal failure of the policy to 'deinstitutionalize' mental patients and to return them to some semblance of community living. The American Psychiatric Association has recently called for a reassessment of institutional alternatives—a call for a return to the asylum—in response to the needs of the new population of so-called homeless mentally ill. Here we contrast the failures of North American deinstitutionalization with the relative successes achieved in those regions of Italy where deinstitutionalization was grounded in a grassroots alternative psychiatry movement and professional and political coalition, Psichiatria Democratica. Democratic psychiatry challenged both the medical and the legal justifications for the segregative control of the 'mentally ill': madness as disease, and the constant over-prediction of the dangerousness of the mental patient. In addition, the movement challenged traditional cultural stereotypes about the meanings of madness, and was successful in gaining broad-based community support from political parties, labor unions, student groups, and artist collectives that were enlisted in the task of reintegrating the ex-mental patient. The Italian experiment, although flawed and riddled with its own inconsistencies and contradictions, offers evidence that deinstitutionalization can work without recreating in the community setting the same exclusionary logic that was the foundation of the asylum system.")

9.

Smith L et al The relationship of clients' social class to early therapeutic impressions in Counselling Psychology Quarterly Vol.24(1): 15-27 2011 http://www.tandfonline.com/doi/abs/10.1080/09515070.2011.558249

(This article is about some research conducted by research counsellors, looking at issues of social class and clinical perceptions of the value of clients. This is research that needs replicating with other groups of clinicians. How much does social class predispose some people to more negative clinical outcomes?)

10.

Tucker I "This is for Life": A Discursive Analysis of the Dilemmas of Constructing Diagnostic Identities in Qualitative Research Vol. 10(3) Art. 24 – September 2009 http://www.qualitative-research.net/index.php/fqs/article/view/1376/2872

(This is a really interesting article about Schizophrenia and how people who receive this diagnosis construct their identities around it and how they negotiate hurdles of definition along the way. The synopsis: A key feature of receiving a schizophrenic diagnosis is the potential to see one's identity as under threat from the many negative and predominantly stereotypical ideas that persist regarding schizophrenia. Drawing on literature emerging from the field of service user research in mental health, the paper attempts to go beyond the boundaries of a psychiatric biomedical perspective of diagnosis, in order to illuminate how such classifications impact upon those who receive them. In this paper, the discursive re-workings of individual diagnostic identities included strategies

of resisting diagnosis, attempts to distance oneself from diagnosis, existentialising diagnosis, and recognising but resisting suggestions that people with diagnoses of schizophrenia are a social "risk").

11.

Corrigan P (Ed) Can there be false hope in recovery in The British Journal of Psychiatry Dec. 2014 205(6):423-424; http://bjp.rcpsych.org/content/205/6/423

(Patrick Corrigan offers a short but pithy analysis of the concept of 'recovery'. Is it, for some people, just another disappointing ending?)

12.

Amering M & Schmolke M Recovery in Mental Health: Reshaping scientific and clinical Wiley-Blackwell 2009 pp 99-148

(Chapter 5: Recovery? Why Not? offers an interesting look at recovery and includes pieces by consumers. There are two sections: 'The Slow Demise of Incurability' and 'A Diagnosis or a Verdict: The Example of Schizophrenia'. Really good. Like so many other volumes the interest is particularly on psychotic illness.)

13.

White K I Don't Need False Hope, or Fantasy: Mental Health Recovery in America's Mental Health Challenge March 29th 2011 http://www.healthyplace.com/blogs/treatinganxiety/2011/03/i-dont-need-false-hope-or-fantasy-mental-health-recovery/

(This is a post by someone with debilitating anxiety. The reason it is important is because it captures the difference between the pressures often experienced by people with anxiety and chronic depression and the equivalent pressures on people with more overtly biological conditions, particularly those associated with psychosis. The words for this woman are about the accusations of 'lack of'… maturity, responsibility, effort, gumption etc. Heal thine self! … rather than a lack of 'hope', so often the hallmark of those with a psychotic illness.)

14.

Von Peter S Chronic Identities in Mental Health in Journal of Anthropology and Medicine Vol. 20(1):48-58 2013 http://www.tandfonline.com/doi/abs/10.1080/13648470.2013.772493?scroll=top&needAccess=true&journalCode=canm20,

(This article is not yet available in full text but can be reached by academic affiliation or through a mental health organisation. It addresses the issue of how identities are socially constructed and argues that terms like 'chronic' can actually both carry stigma and help to create the very chronicity that is described.)

15.

Henfling S When You Feel Like You're Not 'Sick Enough' to Treat Your Mental Illness in The Mighty (BLOG) https://themighty.com/2016/06/feeling-like-youre-not-sick-enough-to-get-mental-health-treatment/

(This well-worth reading and not to be dismissed as just one person's opinion. We hear this all the time. What are people supposed to do? Prove they have a serious mental illness or bad enough symptoms by doing exactly what they don't want to do and then just have to 'do' something'. It's not just annoying. It's dangerous.)

5.

Rapid Cycling Diagnoses

5. Rapid Cycling Diagnoses

FASHIONABLE ONE DAY AND UNFASHIONABLE THE NEXT

The new Diagnostic and Statistical Manual (DSM-V) has been out with more possible diagnoses for us than ever before! Like most cultural artefacts, some diagnoses go in and out of fashion whilst others do not. It tends to be that the more *biological* the diagnoses, the more permanent (and stuck) they seem to remain.

MORPHING HISTORIES

People sometimes have up to 14 or 15 diagnoses during their 'career' in the mental illness industry. Experienced consumers pretty much know what their diagnosis is without being told. Staff changes tack (and tact) with changes in diagnoses. The hints are in the behaviour of clinicians and the attention - or lack of attention - one receives.

IN AND OUT OF 'REAL'

In terms of legitimacy, what is a *'real'* illness? There is little room for trying to understand **social** *explanations* for pain or for anything *'the Medical Model'* can't name and treat. We are in deep trouble if our illnesses are not proven to be 'real' and all sorts of sanctions exist for those perceived to be **'making things up'**. If we fail to convince, we are likely to be derided as having a mental illness rather than a physical one. For many, this is catastrophic.

WHAT ABOUT THE SCIENCE?

The pity of psychiatric diagnoses going in and out of clinical (and political) favour is that it brings the science into disrepute. Science in psychiatry is already under scrutiny by often ignorant medical scientists in the more 'physical' disciplines. All this might not be so bad, except that it too often also brings the person with the diagnosis into disrepute.

HOPE THE LUCKY WHEEL WILL STOP ON... BIPOLAR AFFECTIVE DISORDER!

Canadian survivor, writer and photographer Persimmon Blackbridge wrote that the only good thing about diagnoses was that you could suss-out what your psychiatrist thought about you. Cheekily, she suggested that Bipolar Affective Disorder means they like you, Clinical Depression means you are boring, Borderline means that they hate you and Schizophrenia means they are shit-scared of you (Mental Illness in Australia, Volume 3:17).

A WIKIPEDIA ENTRY TO MADNESS

1. BIOLOGICAL PSYCHIATRY: https://en.wikipedia.org/wiki/Biological_psychiatry

2. BODY LANGUAGE: https://en.wikipedia.org/wiki/Body_language

3. BODY LANGUAGE: https://en.wikipedia.org/wiki/Body_language

4. CHRONIC CONDITION: https://en.wikipedia.org/wiki/Chronic_condition

5. CLASSIFICATION OF MENTAL DISORDERS: https://en.wikipedia.org/wiki/Classification_of_mental_disorders

6. CROSS-CULTURAL PSYCHIATRY: https://en.wikipedia.org/wiki/Cross-cultural_psychiatry

7. CULTURAL HEGEMONY: https://en.wikipedia.org/wiki/Cultural_hegemony

8. CULTURE-BOUND SYNDROME: https://en.wikipedia.org/wiki/Culture-bound_syndrome

9. DIFFERENTIAL DIAGNOSIS https://en.wikipedia.org/wiki/Differential_diagnosis

10. DISEASES OF AFFLUENCE: https://en.wikipedia.org/wiki/Diseases_of_affluence

11. GENDER ROLES: https://en.wikipedia.org/wiki/Gender_role

12. HEALTH ECONOMICS: https://en.wikipedia.org/wiki/Health_economics

13. INSTITUTIONS OF PSYCHIATRY: https://en.wikipedia.org/wiki/Social_psychiatry

14. KINESIC: https://en.wikipedia.org/wiki/Kinesic

15. LABELING THEORY: https://en.wikipedia.org/wiki/Labeling_theory

16. LIST OF MENTAL DISORDERS: https://en.wikipedia.org/wiki/List_of_mental_disorders

17. MENTAL DISORDER: https://en.wikipedia.org/wiki/Mental_disorder

18. NON-VERBAL COMMUNICATION: https://en.wikipedia.org/wiki/Nonverbal_communication

19. OUTLINE OF PSYCHIATRY: https://en.wikipedia.org/wiki/Outline_of_psychiatry

20. PATHOLOGICAL LYING: https://en.wikipedia.org/wiki/Pathological_lying

21. PAUL EKMAN: https://en.wikipedia.org/wiki/Paul_Ekman

22. PSYCHIATRIC ASSESSMENT: https://en.wikipedia.org/wiki/Psychiatric_assessment

23. PSYCHIATRIC GENETICS: https://en.wikipedia.org/wiki/Psychiatric_genetics

24. PSYCHOPATHOLOGY: https://en.wikipedia.org/wiki/Psychopathology

25. ROSENHAN EXPERIMENT: https://en.wikipedia.org/wiki/Rosenhan_experiment

26. SELF-FULFILLING PROPHECY: https://en.wikipedia.org/wiki/Self-fulfilling_prophecy

27. SOMATIC SYMPTOM DISORDER: https://en.wikipedia.org/wiki/Somatic_symptom_disorder

28. STEREOTYPES: https://en.wikipedia.org/wiki/Stereotype

29. TRAIT THEORY: https://en.wikipedia.org/wiki/Trait_theory

30. VALUE JUDGEMENT: https://en.wikipedia.org/wiki/Value_judgment

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Levine B Why Anti-authoritarians are diagnosed with mental illness in Mad in America: Science, Psychiatry and Community February 26th 2012

(This is a terrific little piece coming from the anti-psychiatry tradition. It is brief and questions why diagnosing mental illness is fallible. Most Mental Health Acts have clauses pertaining how political ways of being are not and must not be seen as mental illness in and of themselves. Levine leaves us questioning whether diagnoses are not treated similarly. A bonus is lots of leads to similar contributions.)

2.

Makin S Can Brain Scans Diagnose Mental Illness? in Scientific American June 6th 2013 http://www.scientificamerican.com/article/can-brain-scans-diagnose-mental-illness/

(Attending to the criticism of psychiatry that it is wishy-washy science and diagnostically too subjective, this article puts forward an ideal that all diagnosing should be left to brain scans. There are, however, several caveats identified by the author.)

3.

Charland LA Madness for Identity: Psychiatric Labels, Consumer Autonomy and the Perils of the Internet in Philosophy, Psychiatry & Psychology 2004 11(4):335–34 http://www.researchgate.net/publication/236728645_A_Madness_for_Identity_Psychiatric_Labels_Consumer_Autonomy_and_the_Perils_of_the_Internet

(Read this if you have an interest in diagnoses and 'iatrogenic identity'. The argument is that much has been written about the problems of diagnosis from the point of view of labelling (and judging) people but little has been written about patients' deriving an (unhealthy) identity from their diagnoses. Special attention is given to the role of the internet and on-line communities. This paper looks (unsurprisingly as it is authored by a psychiatrist) at Borderline, Multiple Personality Disorder (sic) and Anorexia. A failure to 'give up' one's label even when it is not needed or relevant (as viewed by psychiatry) is seen here as a new identity disorder. This is 'grit your teeth' stuff particularly as it reinforces stigma against women and people labelled with already insidious diagnoses. However, it is also intriguing.)

4.

Pierre J (psychiatrist) A diagnosis of mental illness is more common than ever – did psychiatrists create the problem, or just recognise it? http://aeon.co/magazine/psychology/have-psychiatrists-lost-perspective-on-mental-illness/

(This is useful logic, well presented. It defends psychiatry from the critics from the right, from critics from the community who are often misinformed and from the internal criticism as arguments rage between clinicians in a way not seen in other medical specialties. Pierre suggests that people worry that psychiatrists think everyone is crazy because they make the mistake of equating any form of psychiatric illness with being crazy. But that's like equating a cough with tuberculosis or lung cancer. This is interesting stuff were consumers might find mixed loyalties.)

5.

Ramsay W (MD) The Myth of Psychiatric Diagnosis http://www.wayneramsay.com/diagnosis.htm

(This is a well-written piece using lots of quotable quotes. It is in the tradition of anti-psychiatry and it references widely including the famous Rosenhan Experiment. It concludes: "The bottom line is this: Psychiatric "diagnosis" is nonsense and should be ignored by all. Psychiatric "diagnosis" serving as the basis of state and federal laws and judgments of courts is the triumph of pseudoscience over justice." There is a solid reference section at the end if you want to follow the trail.)

6.

Ruscio J Diagnoses and the Behaviours they Denote: A Critical Evaluation of the Labelling Theory of Mental Illness in The Scientific Review of Mental Health Practice Spring - Summer 2 http://www.srmhp.org/0301/labels.html

(The idea of diagnoses as labels was first coined by American sociologist Irving Goffman in the 1950s. It has many supporters and just as many doubters since that time. Many consumers find it a useful concept. This article, written by a clinical psychologist, looks at the literature on labelling theory and finds it wanting. An alternative theory to understand what is called 'stigma' is put forward and this seems to involve clinicians educating consumers (from the position of 'expert') about what diagnoses are and are not.)

7.

Turnquist K Problems with Psychiatric Diagnosis in Readings in Humanistic Psychiatry http://kevinturnquist.org/problemsindiagnosis.php

(This is a classic. Great cartoons and raises the issues about diagnoses simply and informally. If you haven't seen it, have a look.)

8.

Double D The Limits of Psychiatry in British Medical Journal 2002 http://www.academyanalyticarts.org/double-limits-of-pyschiatry

(The author is a analytically-orientated psychiatrist, so his emphasis is unsurprising. He is neither pro-medical model nor anti-psychiatry. He describes his position as 'post psychiatry'. It's an interesting argument well-written and with helpful dot points and lists that make it easier to read. He laments that some of the most important work in psychiatry during the first half of the 20th Century was by Adolf Meyer, a psychiatrist and theorist who championed a philosophical approach that has long been forgotten, championing the person rather than the 'illness', now long forgotten. Meyer's work is now largely neglected in the modern biological consensus in psychiatry. He warned against going beyond statements about the person to wishful "neurologising tautology" about the brain.)

9.

Kirk SA & Kutchins H The Myth of the Reliability of DSM reprinted in Academy for Psychoanalytical Arts (2015) https://www.academyanalyticarts.org/kirk-myth-reliability-dsm

(This is not an uncommon critique but it is a very readable one. It is important to take into account the journal in which this essay sits; this is not neutral territory but it is a voice that we don't hear so much anymore and the arguments seem sound enough. This is a quote from the conclusion: "Twenty years after the reliability problem became the central focus of DSM-III, there is still not a single multi-site study showing that DSM (any version) is routinely used with high reliably by regular mental health clinicians. Nor is there any credible evidence that any version of the manual has greatly increased its reliability beyond the previous version. There are important methodological problems that limit the generalisability of most reliability studies... Most reliability studies have been conducted in specialised research settings and may have little bearing on the actual use of DSM by clinicians in normal, uncontrolled clinical settings, where external bureaucratic demands, reimbursement probabilities and potential stigma influence their judgements...")

10.

Stone L Blame, shame and hopelessness: medically unexplained symptoms and the 'heart sink' experience in Australian Family Physician Vol. 43(4):191-195 April 2014 http://www.racgp.org.au/afp/2014/april/blame-shame-and-hopelessness/

(This is an important short, easy to read commentary. Although the central theme is about physical symptoms, the argument transfers to people with 'less well accepted and poorly explained' psychiatric issues as well. Often, like their physical counterparts, these people are dismissed as having symptoms that are 'non serious' or 'not real'. These people often have a negative effect on clinicians, the system and the community. This is stigma and yet we hesitate to name it. The most hurtful language in a psychiatric context is 'the worried well'. This piece is written by a doctor and the dilemma for medical staff is as real as the powerlessness of the patient. It is good that people are talking about the social construction of the 'sick role'. There is much more needed to continue the conversation in this arena. The tone is OK but at times feels a bit patronising. It perhaps needs an honest paper written by a consumer who has found themselves in this dilemma.)

11.

Ahn W et al Mental Health Clinicians' Beliefs about the Biological, Psychological, and Environmental Bases of Mental Disorders in Cognitive Science 2009 March 33(2):147-182 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2857376/

(For those interested in the different meanings behind psychological and biological diagnoses, this will be interesting research. It is a research document and therefore, at times, a bit of a struggle to understand if you aren't used to it. (Hint: read the introduction and then the conclusion before you decide whether to read the middle.) It's a pity that there seems to be a hole in the middle of this work and that is some consideration of 'the social.')

12.

Rosenberg C Contested Boundaries: Psychiatry, disease and diagnosis, Perspectives in Biology and Medicine 2006 49(3):407–424 https://dash.harvard.edu/bitstream/handle/1/4730323/Rosenberg_Contested.pdf?sequence=2

(This is a long but worth reading essay from Harvard University. It is both a philosophical and pragmatic look at the world of psychiatry as it creates and recreates itself through time. The boundaries are, by definition, malleable and different groups put in claims not only for inclusion but also for exclusion. The author writes: "I have tried to describe a phenomenon that is always in process, always contested, and never completed. Sociologists and historians have described the linked phenomena of medicalization and bureaucracy as having mounted a powerful campaign for cultural and institutional authority over problematic behaviours and suspect emotions. And, in fact, the boundaries of presumed disease have in general expanded relentlessly in the past century and a half. But these boundaries remain contested even as they move outward. At least some medical and lay hearts and minds remain only partially converted to these new and expansive models of pathology...")

13.

Nease DE Mental Health Disorders and Their Descriptive Criteria in Primary Care: Clarifying or Confounding? In The Primary Care Companion to the Journal of Clinical Psychiatry 2005 7(3):89–90 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1163280/

(This editorial is aimed at an audience of General Practitioners who are challenged interpreting the dense tomes of the DSMs in a way that makes sense for them and their patients and reduces diagnostic roundabouts for people relying on GPs to work out what is going on for them. While this may not require adoption of the "new model", "it certainly requires that we (GPs) remain intellectually humble about the limitations of our disorder descriptions and not confuse the description with the disorder." The second argument is about using tools outside the context of the setting and the life and history of the patient. This is an interesting article and OK to read if you can deal with the complexity of the footnoting.)

14.

Baca-Garcia E et al Diagnostic stability of psychiatric disorders in clinical practice in The British Journal of Psychiatry Feb. 2007 190(3):210-216 http://bjp.rcpsych.org/content/190/3/210

(This is a professional research report. The methodology, the sample size, the results, the interpretation and the conclusion are carefully written in specific medical research objectified language which is professional for 'good research'. However it is interesting. The research was longitudinal with a relatively large sample. The aim was to see whether diagnoses stayed the same over time and whether diagnoses changed between clinical settings. The conclusion was: The findings are an indictment of our current psychiatric diagnostic practice. "The results of our investigation raise worrisome concerns regarding the validity of results of epidemiological, clinical and pharmacological psychiatric research, particularly in studies of chronic disorders with short follow-up periods that may not allow enough time to reach the right diagnosis or in studies that do not take setting into account. This underscores the inherent weaknesses in our diagnostic system, leading to instability of diagnoses which could reflect limitations of the nosology and result in inappropriate treatment recommendations or interventions.")

15.

Palmeri JJ & Stern TA Lies in the Doctor-Patient Relationship in Prim. Care Companion Jrnl. Clin. Psychiatry 2009 11(4):163–168. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2736034/

(Have you ever lied to your patients or been surprised to learn that one of your patients lied to you? Have you considered it important to learn why lies emerge in the treatment relationship? Have you wondered whether (or how) you should confront such untruths? If you have, then the following discussion should provide the forum for answers to these and other questions related to the exploration, detection and management of lies in the medical arena...)

6.
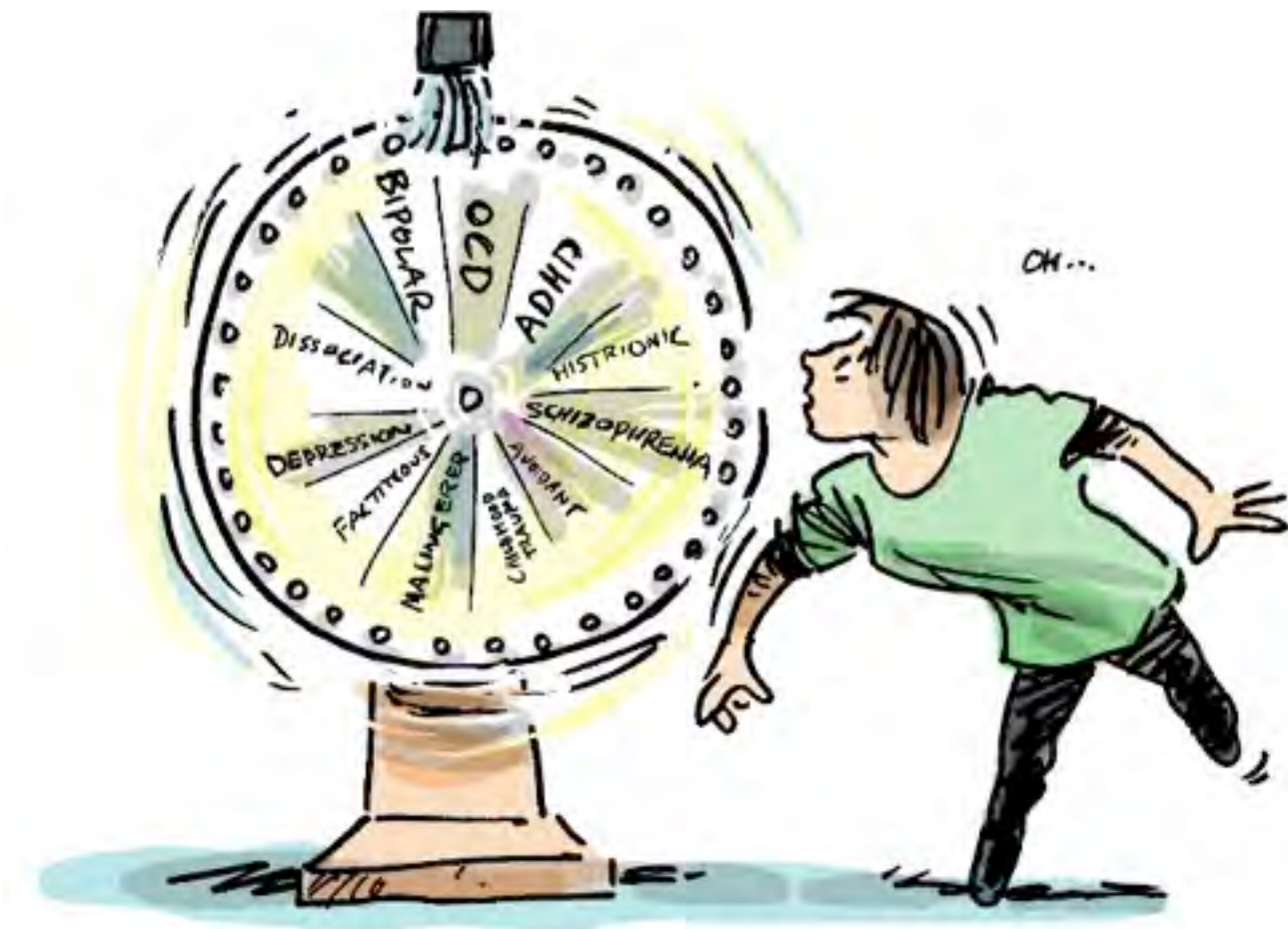
Side-effects of Diagnosis

6. Side-effects of Diagnosis

AN ACT OR A PRODUCT

The word 'diagnosis' is both a verb and a noun; if stigmata describe marks of disgrace, for many people the act of being diagnosed is one of being stigmatised. Doctors probably wouldn't have thought of this. As a noun, a diagnosis is a descriptor or a label. As a verb, it can be seen as inflicting the stigma itself. It all depends on whether we like the diagnosis!

UNWANTED EFFECTS

There is nothing *'side'* about effects! Sometimes diagnoses seem senseless and people resent them enormously as they just seem to lead to force and *'treatments'* they don't want. People's human rights are denied and feelings of self-worth slashed as a direct result and for many people, all such effects are negative ones.

SECONDARY TUMOURS

Diagnoses like Schizophrenia and Borderline may come with *'secondaries;'* with the Schizophrenias, secondaries may spread through our friendships, our accommodation, our love life, our whole world. With Borderline, they spread through our past, our relationships with clinicians and our capacity to love ourselves. Whether this is the experience or the labelling of it remains a moot point.

COLLECTABLES

One of the rotten effects of diagnosis, if we are public patients anyway, is that we tend to collect diagnoses, sometimes at great speed. Good and bad, diagnoses or traits, they bring more judgement and secondary meanings not only of the particular but also of the collection. In Victoria, we can only *add* to our files; we can't unburden our histories of diagnoses that no longer fit and which are, perhaps, very offensive.

SIDE-EFFECTS OR NOT, DIAGNOSIS MEANS SERVICES (sometimes)

Some argue that stigma and unwanted effects are bearable if a diagnosis brings services. Even if this proves to be unrealistic, it can keep some people going. Some consumers do value a diagnosis that makes sense to them; they are not stupid or easily conned or deficient in some way. They understand being diagnosed as empowering, either because they can now self-govern 'symptoms' and stay in control or because they are freed from nameless distress for which they used to be blamed.

A WIKIPEDIA ENTRY TO MADNESS

1. POVERTY LINE: https://en.wikipedia.org/wiki/Poverty_threshold

2. PERSONAL EXPERIENCE: https://en.wikipedia.org/wiki/Personal_experience

3. SOCIAL ACCEPTANCE: https://en.wikipedia.org/wiki/Acceptance

4. SOCIAL EXCLUSION: https://en.wikipedia.org/wiki/Social_exclusion

5. OPPRESSION: https://en.wikipedia.org/wiki/Oppression

6. STIGMATA (RELIGIOUS ORIGINS): https://en.wikipedia.org/wiki/Social_exclusion

7. PHENOMENOLOGY: https://en.wikipedia.org/wiki/Phenomenology

8. MENTALISM: https://en.wikipedia.org/wiki/Mentalism_(discrimination)

9. PREJUDICE: https://en.wikipedia.org/wiki/Prejudice

10. PATRIARCHY: https://en.wikipedia.org/wiki/Patriarchy

11. COMMUNITY BUILDING: https://en.wikipedia.org/wiki/Community_building

12. BLAME & SHAME: https://en.wikipedia.org/wiki/Blame   https://en.wikipedia.org/wiki/Shame

13. DEVIANCE: https://en.wikipedia.org/wiki/Deviance_(sociology)

14. SOCIAL MOBILITY: https://en.wikipedia.org/wiki/Social_mobility

15. HOMELESSNESS: https://en.wikipedia.org/wiki/Homelessness_and_mental_health

16. HOUSING STRESS: https://en.wikipedia.org/wiki/Housing_stress

17. IATROGENESIS: https://en.m.wikipedia.org/wiki/Iatrogenesis#Sources

18. MEDICAL DIAGNOSIS: https://en.wikipedia.org/wiki/Medical_diagnosis

19. MEDICAL ERROR: https://en.wikipedia.org/wiki/Medical_error

20. MENTALISM: https://en.wikipedia.org/wiki/Mentalism_(discrimination)

21. REDUCTIONISM: https://en.wikipedia.org/wiki/Reductionism

22. SELF-ESTEEM: https://en.wikipedia.org/wiki/Self-esteem

23. SOCIAL MOBILITY: https://en.wikipedia.org/wiki/Social_mobility

24. SOCIAL REJECTION: https://en.wikipedia.org/wiki/Social_rejection

25. VICTIMISATION: https://en.wikipedia.org/wiki/Victimisation

26. ADVERSE EFFECTS: https://en.wikipedia.org/wiki/Adverse_effect

27. IATROGENESIS: https://en.wikipedia.org/wiki/Iatrogenesis

28. PERSONALITY TRAIT THEORY: https://en.wikipedia.org/wiki/Trait_theory

29. PSYCHOLOGICAL STRESSS: https://en.wikipedia.org/wiki/Psychological_stress

30. DYSFUNCTIONAL FAMILY: https://en.wikipedia.org/wiki/Dysfunctional_family

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Arguments against Charity - Ethics Guide BBC http://www.bbc.co.uk/ethics/charity/against_1.shtml

(This is a short, easy to read piece that identifies why charity has limits. Becoming the victim of someone else's largesse is a problem for some. This reminds us why, perhaps.)

2.

Breggin P The Hazards of Psychiatric Diagnosis in The Huffington Post (BLOG) 22/6/2010 http://www.huffingtonpost.com/dr-peter-breggin/mental-health-the-hazards_b_618507.html?ir=Australia

(This short piece reaffirms the argument that diagnosis is more likely to lead to more problems than they solve. The author, a psychiatrist, comments: "The destructiveness of psychiatric diagnoses could fill a book. You and your loved ones, and those you seek to help can never be understood through a psychiatric diagnosis. Psychiatric diagnosis is like looking at the world through the wrong end of a spiritual telescope. Instead you have to open your heart and your mind to knowing what you have endured, and the mistakes you have made, and the right choices you have made, and the good things you have done that have led you to this moment in your life. You must be ready to appreciate your life and the life of anyone you seek to help.")

3.

Campbell P Diagnosis Special Issue Part 4: a service-user's perspective on the impact of diagnosis British Psychological Society May 2007 Vol. 20:298-299 https://thepsychologist.bps.org.uk/volume-20/edition-5/diagnosis-special-issue-part-4

(Peter Campbell is a well-known consumer researcher and writer. This is a service user's account of the impact of diagnosis.)

4.

Collier M Mental illness my crooked path to enlightenment (BLOG) in Elephant –dedicated to a mindful life August 24th 2014 https://www.elephantjournal.com/2014/08/mental-illness-my-crooked-path-to-enlightenment-michele-collier/

5.

Fox JW Social Class, Mental Illness, and Social Mobility: The Social Selection-Drift Hypothesis for Serious Mental Illness in Journal of Health and Social Behavior Vol. 31(4):344-353 Dec. 1990 http://www.jstor.org/stable/2136818?seq=1#page_scan_tab_contents

(This is a research paper – an academic write-up of psychological research into the effects of depression on children and grandchildren. It is hard to read if you are not used to this sort of article. It has confusing diagrams and uses jargon and symbols familiar to psychology rather than a lay audience. Nonetheless, it is an attempt to 'scientifically' study something that many of us worry about.)

6.

Hudson CG Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses in American Journal of Orthopsychiatry 2005 vol.75(1):3-18 http://frihetspartiet.net/dokumenter/ort-7513.pdf

(This is a technical document. If you are unsure go to the introduction and then to the discussion at the end, which will indicate whether you want to read the rest. From the introduction: One of the most consistently replicated findings in the social sciences has been the negative relationship of socioeconomic status (SES) with mental illness: The lower the SES of an individual is, the higher is his or her risk of mental illness. Yet there have been remarkably inconsistent findings concerning the causal structure of this relationship. Do poor socioeconomic conditions predispose people to mental disability? Or do pre-existing, biologically-based mental illnesses result in the drift of individuals into poor socioeconomic circumstances? Are there particular types of conditions—whether unemployment, little family support, noisy work conditions, or lack of autonomy—that mediate this effect?)

7.

Drift Hypothesis https://en.wikipedia.org/wiki/Drift_hypothesis;

(Drift hypothesis, concerning the relationship between mental illness and social class, is the argument that illness causes one to have a downward shift in social class. The circumstances of one's social class do not cause the onset of a mental disorder, but rather, an individual's deteriorating mental health occurs first, resulting in low social class attainment. The drift hypothesis is the opposing theory of the social causation thesis, which says being in a lower social class is a contributor to the development of a mental illness.)

8.

Hartwell S Triple Stigma: Persons With Mental Illness and Substance Abuse Problems in the Criminal Justice System in Criminal Justice Policy Review Vol. 15(1): 84-99 March 2004 http://www.antoniocasella.eu/archila/Hartwell_2004.pdf

(Research findings of a 2004 research project; the consequences of mental illness in terms of dual diagnosis and criminality – especially when both come together - are discussed.)

9.

Bell G The Worried Well: The Depression Epidemic and the Medicalisation of our Sorrows in Quarterly Essay Feik S (ed.) 18(1) 2005 https://books.google.com.au/books?id=aRf9AAAAQBAJ&pg=PA73&lpg=PA73&dq=%27worried+well%27+Gail+Bell+psychiatry&source=bl&ots=-znm3KrJWn&sig=QL3tNpTfBW79Ooev HjeB3_BYk_k&hl=en&sa=X&ved=0ahUKEwiq59DEmdTRAhXKf7wKHQYgCboQ6AEIOTAG#v=onepage&q='worried%20well'%20Gail%20Bell%20psychiatry&f=false

(This essay questions the over-diagnosis of depression arguing that people who don't have a real mental illness are being diagnosed and that this is not good for them, for other 'legitimate' patients who get pushed out of care, the reputation of 'depression' as a diagnosis and the health budget bottom-line. The language is 'superior doctor' and the depictions of patients grate a little as they are described as 'wilful' in their 'deliberate' attempts to get antidepressant drugs.)

10.

Parker G Gordon Parker responds to Gail Bell's Quarterly Essay Article 'The Worried Well' in Black Dog Institute http://www.blackdoginstitute.org.au/docs/TheWorriedWellCorrespondence.pdf

(Gordon Parker is the Director of the Australian Black Dog Institute. He responds to the article by Gail Bell. His is only one response, so if you are interested look up the others, including one by consumer/survivor, David Webb. Parker argues that "more subtlety, compassion and respect for the diagnosis of 'depression' are called for.")

11.

Payne S Mental Health, poverty and Social Exclusion (Conceptual Note 9) in Economic and Social Research Council December 2012 http://www.poverty.ac.uk/sites/default/files/attachments/Conceptual%20note%20No.%209%20-%20Mental%20Health%20(Payne%20Dec2012).pdf

(Easy; author wrestles with the big questions of causation. Put simply: Does poverty create the necessary conditions for mental illness or does mental illness cause poverty? It's more complex than this.)

12.

Pridmore S Medicalization/Psychiatricization of Distress Download of Psychiatry Chapter 32 Last modified December 2013 http://eprints.utas.edu.au/287/40/Chapter_32._Medicalization.pdf.pdf

(This is an easy read – with cartoons – that looks at how psychiatry can medicalise all our lives until we become less human. This isn't a good thing.")

13.

Sabry WM & Vohra A Role of Islam in the management of Psychiatric disorders in Indian Jrnl. Psychiatry January 2013 55(Suppl.2) https://www.ncbi.nlm.nih.gov/pmc/ articles/PMC3705684/

(This is but one of many articles that can be found focusing on the need to provide culturally and technically as well as spiritually appropriate therapies if psychiatric and psychological treatments are to do no harm. As Islam is receiving so much attention at the moment, this seemed an appropriate starting place for those who are interested.)

14.

Free will and mental disorder: Exploring the relationship in Theor. Med. Bioethics Dec. 2010 31(6):429–443 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2975916/

(Loss of self-determination. This is the loss of what our society considers a fundamental human right. This is also a key theme in forensic practice where the issues become a bit more muddled. From the viewpoint of a bioethicist, this is interesting reading. One of the most overt consequences of mental illness for many people is their loss of freedom; see also: Seattle MindFreedom Stop saying Mental "Illness"! Please say my Name! Petition to the American Psychiatric Association https://www.change.org/p/american-psychiatric-association-stop-saying-mental-illness-please-say-my-name; produced by MindFreedom, a more radical survivor group in America. It reminds us that mental illness – more correctly the public (and mental illness industry's) attitudes to 'mental illness' can not only rob people of their dignity but indeed also their identity.)

15.

Õtsmnen M & Kjellin L Stigma by association: Psychological factors in relatives of people with mental illness in The British Journal of Psychiatry Dec. 2002 181(6):494-498 http://bjp.rcpsych.org/content/181/6/494

("Stigma affects not only people with mental illnesses, but their families as well. Understanding how stigma affects family members in terms of both their psychological response to the ill person and their contacts with psychiatric services will improve interactions with the family." This is one of many articles relating to the fact that one side-effect of diagnosis (we should perhaps say there is nothing 'side' about it) is that on the family – genetic or chosen; extended on nuclear – who live intensely with the effects of distress and stigma.)

16.

Caplan PJ Elephant in the Living Room: "Obesity Epidemic" in Psychiatric Drugs and Psychiatric Diagnosis Vol. 1(1) 2012 http://www.tandfonline.com/doi/abs/10.1080/21604851.2012.627787?src=recsys&journalCode=ufts20

(This is an important document by an important writer. It looks at the interconnection between mental illness and obesity and wonders why this link seems to be invisible).

7.

Accumulated Seriousness

7. Accumulated Seriousness

MULTIPLE DISADVANTAGES

Autism is a very different experience if picked up in childhood, interventions are engaged and parents have the money to provide lots of them. Take poor people, add lack of English, little parental education, a family of six that can't afford shoes, the same autism becomes a whole lot more serious...

CONTAGIOUS MENTAL ILLNESS

The mother has a terrible hoarding disorder that no one cares about. It's a secret. The boy with Asperger's is hitting his head against the wall. On top of a huge pile of boxes sit twenty copies of one death notice: the oldest sister suicided, time and date supplied. The younger sister has just been told that her deep mental distress isn't serious (mental illness). She cuts herself. Services hate her.

CHILDOOD TRAUMA

(1) Services accept the *illness part* of your distress, but they don't get the *trauma part*. They disbelieve and/or re-traumatise you; (2) Services say you haven't got a 'serious' mental illness – not even a mental illness - and they don't believe your memories of trauma. No one cares about your distress or your story or the present debilitating experiences from which you want relief.

MULTIPLE DISABILITIES

You have a physical disability but it's not greatly disabling; you have a mental illness, but it is considered not to be a 'grave' one; you have a marginal intellectual disability, but you can 'function'. The problems morph into drug and alcohol issues as you are ignored and no one talks with one another (or with you).

AFTER THE FACT

Often people with psychiatric disabilities tumble into homelessness, alcohol and drug problems and criminality and are violated in any number of ways: assault, rape, fraud. People might start with mental illness but end up socially isolated and dehumanised.

A WIKIPEDIA ENTRY TO MADNESS

1. ACCUMULATION BY DISPOSSESSION: https://en.wikipedia.org/wiki/Accumulation_by_dispossession

2. ALCOHOLISM IN FAMILY SYSTEMS: https://en.wikipedia.org/wiki/Alcoholism_in_family_systems

3. CLINICAL FORMULATION: https://en.wikipedia.org/wiki/Clinical_formulation

4. CO-DEPENDENCY: https://en.wikipedia.org/wiki/Codependency

5. COMPLEX POST-TRAUMATIC STRESS: https://en.wikipedia.org/wiki/Complex_post-traumatic_stress_disorder

6. CONSERVATIVE CORRECTNESS: http://rationalwiki.org/wiki/Conservative_correctness

7. CULTURAL CAPITAL: https://en.wikipedia.org/wiki/Cultural_capital

8. CUMULATIVE DISADVANTAGE THEORY: https://en.wikipedia.org/wiki/Cumulative_inequality_theory

9. DIFFERENTIATION OF SELF: http://www.familybusinesswiki.org/Differentiation+of+Self

10. DISABILITY & POVERTY: https://en.wikipedia.org/wiki/Disability_and_poverty

11. DYSFUNCTIONAL FAMILIES: https://en.wikipedia.org/wiki/Dysfunctional_family

12. HEALTH EQUITY: https://en.wikipedia.org/wiki/Health_equity

13. HOMELESSNESS & MENTAL HEALTH: https://en.wikipedia.org/wiki/Homelessness_and_mental_health

14. IDENTIFIED PATIENT: https://en.wikipedia.org/wiki/Identified_patient

15. IDEOGRAPH (RHETORIC): https://en.wikipedia.org/wiki/Ideograph_(rhetoric)

16. LIFE CHANCES (THEORY): https://en.wikipedia.org/wiki/Life_chances

17. MENTAL DISTRESS: https://en.wikipedia.org/wiki/Mental_distress

18. MULTIPLE DISABILITIES: https://en.wikipedia.org/wiki/Multiple_disabilities

19. POST-TRAUMATIC STRESS DISORDER: https://en.wikipedia.org/wiki/Posttraumatic_stress_disorder

20. PSYCHOLOGICAL PAIN: https://en.wikipedia.org/wiki/Psychological_pain

21. PSYCHOLOGICAL TRAUMA: https://en.wikipedia.org/wiki/Psychological_trauma

22. REIFICATION: https://en.wikipedia.org/wiki/Reification_(fallacy)

23. RHETORIC OF HEALTH AND MEDICINE: https://en.wikipedia.org/wiki/Rhetoric_of_health_and_medicine

24. SOCIAL DETERMINANTS OF HEALTH: https://en.wikipedia.org/wiki/Social_determinants_of_health

25. SOCIAL EXCLUSION: https://en.wikipedia.org/wiki/Social_exclusion

26. SOCIAL VULNERABILITY: https://en.wikipedia.org/wiki/Social_vulnerability

27. SOCIOLINGUISTICS: https://en.wikipedia.org/wiki/Sociolinguistics

28. STOLEN GENERATIONS: https://en.wikipedia.org/wiki/Stolen_Generations

29. TRAUMA MODEL OF MENTAL DISORDERS: https://en.wikipedia.org/wiki/Trauma_model_of_mental_disorders

30. DIAGNOSIS OF ASPERGER'S SYNDROME: https://en.wikipedia.org/wiki/Diagnosis_of_Asperger_syndrome

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Aletta E What Makes a Family Functional vs Dysfunctional? in World of Psychology http://psychcentral.com/blog/archives/2009/12/15/what-makes-a-family-functional-vs-dysfunctional/

> *(This is an easily readable look at functional and dysfunctional families with an assumption that dysfunctional families do not have to provide demonstrably abusive situations to do harm. Eds. note: "Many consumers actively dislike the term, 'dysfunctional family' in part because it lacks sound social grounding. The family is situated in a social context. This is not discussed in this article.")*

2.

Arndt B Society wedded to fallacies on families in The Australian August 24th 2014 http://bjp.rcpsych.org/content/181/6/494

> *(As always, Bettina Arndt is controversial. This is an opinion piece in the Australian newspaper. How it is received by consumers might depend on whether they are a parent and/or whether their childhood traumas – perceived by them as big or small – have impacted on their adult lives in significantly bad ways. For many in the latter group, this might just be a breath of fresh air.)*

3.

Australian Story - See How She Runs (Transcript) Dissociative Identity Disorder May 2006 http://www.abc.net.au/austory/content/2006/s1645137.htm

> *(This was a fantastic, non-sensational Australian Story on someone diagnosed with Borderline Personality Disorder who was also an Australian swimming star. Unfortunately the footage is no longer available but the text is here.)*

4.

Bolton SL & Sareen J Sexual orientation and its relation to mental disorders and suicide attempts: findings from a nationally representative sample in Canadian Journal of Psychiatry 2011 5(1):35–43 https://www.ncbi.nlm.nih.gov/pubmed/21324241

(This names a very common precursor to a diagnosis of mental disorder. In many ways, sexual orientation and mental illness bring together two pernicious sites of social disdain. It is very serious for mental health services and for the person but the fight is in two places at the same time. People may not want to be labelled (it is often difficult to separate pathologising difference from pathologising illness), but they don't want to be neglected or vilified by services either. There is a literature about sexual preference and mental illness. This is just a starter, especially for consumers who are not LGBTI. These issues are everybody's issues.)

5.

Carney J Poverty & Mental Illness: You Can't Have One without the Other in Mad in America March 2012 https://www.madinamerica.com/2012/03/poverty-mental-illness-you-cant-have-one-without-the-other/

(This is a compelling read. Introduction: If you've spent any time in the public mental health system, you know that folks diagnosed or labeled as having serious mental illnesses are poor. If you've been poor or worked with poor folks, you know that many poor folks suffer from affective and cognitive disorders or, to quote Bentall, "complaints" (1,2). But what comes first, the poverty or the presumed mental illness? Does poverty play a role in causing a person's mental illness or does a person become ill and simply drift down the socioeconomic ladder into poverty? And how many people are we talking about?)

6.

Cook A et al Complex trauma in Children and Adolescents in Psychiatric Annals 35(5) May 2005 http://www.harriscountytx.gov/CmpDocuments/86/Annual%20Reports/Complex%20Trauma%20in%20Children%20and%20Adolescents.pdf

(Reading this article written so clinically it is tempting to yell and say, "this is a tragedy! Where is the money, passion and compassion to do something about it!" It's important to read. There seems to be no doubt childhood trauma should be treated as serious and our social health capacity (not necessarily organised systems) should be funded to do so with respect. There are many articles and commentaries out there about childhood trauma. This is just one).

7.

Creagh S Both bullies and their victims are at greater risk of mental illness in The Conversation 21st February 2013 http://theconversation.com/both-bullies-and-their-victims-are-at-greater-risk-of-mental-illness-12339

(Those who know firsthand the pernicious effects of being bullied know that it often has very serious consequences and sometimes destroys relationships and lives. In Australia if you have no money, it's not treated seriously until it festers into mental illness – often (not always) the kind that don't get treated seriously either. There are other ways… but you have to have the networks and resources to find them. This paper argues that bullies suffer too.)

GET A GRIP

SOCIAL CLASS MATTERS

8.

Dayton T Growing Up With Toxic Stress or Addiction and Its Long-Term Impact in PARENTS March 30th 2015 http://www.huffingtonpost.com/dr-tian-dayton/toxic-stress_b_2109402.html

(If we grow up with toxic stress in childhood, does it change us? Does growing up with parental addiction, abuse or neglect affect out physical, mental and emotional health? Are we making it up? Researchers tell an interesting story. No! Toxic stress from childhood has, according to Dayton, profound impacts on the adults children grow into. It is very serious and worth investing in because it is likely to be multi-generational.)

9.

Comment: Why Schizophrenia is three times higher in refugees in The Conversation March 17th 2016 http://theconversation.com/why-risk-of-schizophrenia-is-three-times-higher-in-refugees-56307

(A recent study in Sweden (published in the British Medical Journal) reported that refugees in Sweden were about twice as likely to experience schizophrenia and other psychoses compared to non-refugee migrants and three times as likely as native born Swedes.)

10.

Klemnetti R et al Infertility, mental disorders and well-being – a nationwide survey in Acta Obstetricia et Gynecologica 2010 89:677–682 (in English).

(This is an interesting academic piece which needs to be comprehended carefully. Best read the introduction and the conclusion first if you are not used to such works. It basically looks at a nation-wide survey in Finland and proffers psychological and social explanations. One important dimension is differences in degree and nature of the psychiatric problems faced by men, by women and by the couple – social role of nuclear family in sponsoring distress.)

11.

Thoburn J The effects on child and adult mental health of adoption and foster care in Gelder M et al (eds.) New Oxford Textbook of Psychiatry Oxford University Press February 2012 http://oxfordmedicine.com/view/10.1093/med/9780199696758.001. 0001/med-9780199696758-chapter-00200103

(This chapter looks not only at the mental health of children involved in adoption and fostering arrangements but also at the relinquishing mothers and the care parents particularly when they are people who are unintentionally childless. There is an Intersection with all three groups and mental illness.)

12.

Turner RJ and Lloyd DA Lifetime Traumas and Mental Health: The Significance of Cumulative Adversity in Journal of Health and Social Behavior Dec. 1995 Vol. 36(4):360-376 https://campus.fsu.edu/bbcswebdav/institution/academic/social_sciences/sociology/Reading%20Lists/Mental%20Health%20Readings/Turner-HealthSocial-1995.pdf

(This is a large sociological research report. It is written in 'research-ese' and in the pursuit of good science its meaning is sometimes a bit hard to understand. It is also a bit old so build that into your thinking and use the document to launch into more recent material. Go to the results and commentary section if you just want to understand the core findings and then make a decision about what's worth reading – for your needs. The key finding is that social events and experiences play a significant role in a person's mental health.)

13.

Balshern H et al A Critical Review of the Literature Regarding Homelessness Among Veterans Department of Veterans Affairs (US) 2011 April https://www.ncbi.nlm.nih.gov/books/NBK55702/

(This is a detailed look at the position of returned veterans who have slipped into homelessness in the US. It asks questions about the relationship between trauma, mental illness and homelessness – which comes first. Towards the end of the article, attention turns to what can be done and the authors propose: Legal diversion programs for veterans, mental health and drug courts and veterans courts, concluding; " homeless Veterans are at risk for imprisonment because of the criminalization of the activities of daily living while homeless, and as a result of activities to help cope and survive while homeless." The need is to break the cycle of homelessness gincarceration ghomelessness.)

14.

Lewis M Addiction as self-medication, Brain Patterns Formed by Trauma Sometimes Need Fixing in Psychology Today August 22nd 2012 https://www.psychologytoday.com/blog/addicted-brains/201208/addiction-self-medication

("A while back I promised to survey the three most common models of addiction—disease, choice and self-medication—and say something about the advantages and disadvantages of each... The self-medication model seems to be the kindest of the three. It has the advantage of the disease model, in absolving the addict of excessive blame, but it has the additional advantage of avoiding the stigma of "disease" and all that goes with it. In fact, it gives control (agency) back to the addict, who is, after all, acting as his or her own physician. Whereas the disease model places agency in the hands of others and casts the addict as a passive victim. Furthermore, the self-medication model just might be the most accurate of the three.")

15.

Collingwood J The Relationship Between Mental and Physical Health in Psych Central http://psychcentral.com/lib/the-relationship-between-mental-and-physical-health/0002949

(Professor David Goldberg of the Institute of Psychiatry, London, UK, reports that the rate of depression in patients with a chronic disease is almost three times higher than normal. He explains: "Depression and chronic physical illness are in reciprocal relationship with one another: not only do many chronic illnesses cause higher rates of depression, but depression has been shown to antedate some chronic physical illnesses.")

16.

Alley C Sleeping Rough – Acting Tough: Is Mental Illness a Precedent for Homelessness? in The Gist July 22nd 2011 https://the-gist.org/2011/07/ sleeping-rough-%E2%80%93-acting-tough-is-mental-illness-a-precedent-for-homelessness/

(Research suggests that behaviour which can increase the likelihood of homelessness may be associated with mental health problems such as post-traumatic stress disorder (PTSD), complex trauma, conduct disorders in children, attachment disorders and borderline personality disorder (BPD), particularly when interpersonal problems and self-harm are evident)

17.

DeAngelis T More PTSD among homeless vets: Homeless Iraq and Afghanistan veterans are more likely to be haunted by PTSD than homeless vets of previous eras in American Psychological Association March 2013 Vol 44(3) and Gamache G et al Overrepresentation of Women Veterans Among Homeless Women in American Journal of Public Health July 2003 Vol 93(7)

(Two papers about war veterans, PTSD and homelessness; the first is about the plight of more recent veterans compared to those from earlier engagements. The second is about women veterans, mental illness and homelessness.)

8.

The Chemical Malfunction Method

8. The Chemical Malfunction Method

NOT OUR FAULT

Society uses medical tools to define legitimacy; for some people and those close to them there is a belief that finding *'scientific validity'* to explain their pain and medically sanctioned ways to heal it is the most important thing. Science, they believe, will not only justify how they feel, but will, with time perhaps, also find the answer for it.

WHEN IT IS NOT WHAT IT APPEARS

Understandably perhaps, some families refuse to even entertain that an adult child may have been traumatised under their watch as parents and siblings. Sometimes frantic searching for 'science' is a way of deflecting listening, accepting and respecting. Remember: Absence of Evidence is not evidence of absence!

PHARMACEUTICAL COCKTAIL

Over-medication is common; people sometimes become zombies. Some call it 'chemical restraint' when it happens in hospitals. Understanding the ways chemicals work to cause great pain is a great idea but only if the response doesn't cause as much pain as the original experience.

I HAVE A PSYCHOSIS CALLED 'BRIAN'!

Some people with horrible episodic psychotic 'symptoms' give these experiences a persona ('Brian'), thus making it possible to separate their true self (Mary or John) from the 'Brian' that intrudes into their lives - *'othering'* for sanity.

BEEN ON THE CIRCUIT

Perhaps some of us may have been duped by a drug culture in the community and the power of the medical model; others have perhaps been duped by questionable charlatans; and yet others have reacted to force used in the system with a determination to resist all medical drugs... realise that nobody's experience is wrong.

A WIKIPEDIA ENTRY TO MADNESS

1. ADVERSE EFFECTS: https://en.wikipedia.org/wiki/Adverse_effect

2. ALTERNATIVE THERAPIES: https://en.wikipedia.org/wiki/Alternative_medicine

3. ANTI-HERO: https://en.wikipedia.org/wiki/Antihero

4. APPLIED SCIENCE: https://en.wikipedia.org/wiki/Applied_science

5. ASSUMED GOOD FAITH: https://en.wikipedia.org/wiki/Wikipedia:Assume_good_faith

6. AUTONOMY: https://en.wikipedia.org/wiki/Autonomy

7. BIG PHARMA: https://en.wikipedia.org/wiki/Bad_Pharma

8. CHARLATAN: https://en.wikipedia.org/wiki/Charlatan

9. COMPLIANCE: https://en.wikipedia.org/wiki/Compliance_(medicine)

10. DRUG REPS. INFLUENCE PHYSICIANS: https://en.wikipedia.org/wiki/Good_faith

11. EMPOWERMENT: https://en.wikipedia.org/wiki/Empowerment

12. ETIOLOGY: https://en.wikipedia.org/wiki/Etiology_(medicine)

13. FALSE CONSCIOUSNESS: https://en.wikipedia.org/wiki/False_consciousness

14. HOPELESS: https://en.wikipedia.org/wiki/Hope

15. NARRATIVE IDENTITY: https://en.wikipedia.org/wiki/Narrative_identity

16. OVER-MEDICATED: https://en.wikipedia.org/wiki/Overmedication

17. PHARMACEUTICAL LOBBY: https://en.wikipedia.org/wiki/Pharmaceutical_lobby

18. PHARMACEUTICAL MARKETING: https://en.wikipedia.org/wiki/Pharmaceutical_marketing

19. POLYPHARMACOLOGY: https://en.wikipedia.org/wiki/Polypharmacy

20. PRIMUM NON NOCERE (Latin: 'FIRST, DO NO HARM'): https://en.wikipedia.org/wiki/Primum_non_nocere

21. PSYCHOLOGICAL INTERVENTIONS: https://en.wikipedia.org/wiki/Psychological_intervention

22. PSYCHOSIS: https://en.wikipedia.org/wiki/Psychosis

23. PSYCHOTROPIC MEDICATIONS: https://en.wikipedia.org/wiki/Psychoactive_drug

24. READING THE PACKET: https://en.wikipedia.org/wiki/Package_insert

25. ROD OF ASCLEPIUS: https://en.wikipedia.org/wiki/Rod_of_Asclepius

26. SELF-ACTUALISATION: https://en.wikipedia.org/wiki/Self-actualization

27. SELF-DETERMINATION: https://en.wikipedia.org/wiki/Self-determination

28. THE TECHNOLOGICAL FIX: https://en.wikipedia.org/wiki/Technological_fix

29. TIMELINE OF PSYCHIATRY: https://en.wikipedia.org/wiki/Timeline_of_psychiatry

30. TRADITIONAL MEDICINE: https://en.wikipedia.org/wiki/Traditional_medicine

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Anti-depressants get a bad rap but they saved my life in The Guardian Wednesday 9th September 2015 https://www.theguardian.com/commentisfree/2015/dec/09/mental-health-antidepressants-ssri-anxiety-medication

(This is far from a rant. It is in the Guardian and reflects careful thought. It is not ignorant or desperate but there is passion and relief. In the present social and cultural context, it takes guts to publicly say anti-depressants helped me, despite myself. This is perhaps harder for a clear thinker to say than 'I've got depression'. This isn't about stigma 'perhaps as much as it is about social pressure including from some people diagnosed with mental illness'.)

2.

Perlis RH et al Industry Sponsorship and Financial Conflict of Interest in the Reporting of Clinical Trials in Psychiatry in American Journal of Psychiatry 2005 (162):1957-1960 http://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.162.10.1957

(This is an interesting research study about the relationship between drug trials and pharmaceutical companies. As a 'scientific' document it presents with all the literacy accessibility problems such studies have but nonetheless it is interesting and useful. It's best to read the introduction and the results (at least) but the conclusion was pretty straight forward: "Conflict of interest appears to be prevalent among psychiatric clinical trials and to be associated with a greater likelihood of reporting a drug to be superior to placebo.")

3.

Wolinsky H Disease mongering and drug marketing. Does the pharmaceutical industry manufacture diseases as well as drugs? in EMBO Rep. 2005 July 6(7):612–614 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1369125/

(This is an article in defence of pharmaceutical companies and the role they play in keeping people well. "Pharmaceutical companies research, develop and exploit drugs to prevent, control and cure diseases and treat symptoms. Companies then market these medications to recoup their investments and reward shareholders. It would seem to serve the interests of society, but some critics characterize it as a vicious circle in which businesses invent new diseases to match their existing drugs. Increasingly, industry has found itself under fire from detractors who contend that, in the pursuit of profits, companies are in league with medical doctors and patient advocacy groups to 'disease monger': convince people that their usually mild ailment urgently needs drug treatment.")

4.

Moynihan R et al Selling sickness: the pharmaceutical industry and disease mongering in BMJ 2002 April 13th 324(7342):886–891 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1122833/

("A lot of money can be made from healthy people who believe they are sick. Pharmaceutical companies sponsor diseases and promote them to prescribers and consumers. Ray Moynihan, Iona Heath and David Henry give examples of "disease mongering" and suggest how to prevent the growth of this practice.")

5.

Shankar PR & Subish P Disease mongering in Singapore Med Jrnl. 2007 April 48(4):275-80 https://www.ncbi.nlm.nih.gov/pubmed/17384871

("Disentanglement from the pharmaceutical industry and development of a capacity for critical analysis are required. Educating patients and empowering them to make decisions are important. Several initiatives have been undertaken to combat disease mongering. Initiatives at the level of the patient and the physician are especially important. Studies on the extent and knowledge of disease mongering among doctors and medical students, and their economic and social consequences are urgently required.")

6.

Earley P Why don't you take your medication? Family carers discuss their disagreements (BLOG) http://www.peteeearley.com/2010/03/12/why-wont-you-take-your-medication/

(This is really interesting as 'parent carers' grapple with differing beliefs about medication, their own mortality and their love for their children. It does leave you realising that there is possibly no such thing as unconditional love.)

7.

Emery L Is shaming the 'pill-shamers' shutting down debate? in Turnbridge Wells: Solomon's Blog 18th November 2013 http://discursiveoftunbridgewells.blogspot.com.au/2013/11/is-shaming-pill-shamers-shutting-down.html

(This is fascinating and well worth a read. There is new term that has emerged from the web, coined largely by consumers angry that they are being shamed and treated like they are dumb and easily conned by those who are anti-psychiatry and anti-bigPharma. The author writes: "Pill shaming' is an emotive term and one, I think that may be hard to challenge. It's grounded in the idea that, for some, medication is the only thing that can make day-to-day life tolerable. That medication can, literally, be the difference between life and death. To be told that such medication is simply part of an elaborate con devised to make money for pharmaceutical companies may be seen as unhelpful at best; and at worst, insulting.")

8.

Jennifer CD et al Attitudes Toward Antipsychotic Medication; the Impact of Clinical Variables and Relationships With Health Professionals in American Medical Association 2005 http://davidhealy.org/wp-content/uploads/2012/05/2005-Antipsychotics-and-Compliance-Ach-Gen-Psych.pdf

(This has been included as an example of 'doctor think'. Firstly the language of compliance (and how this may affect data interpretation) is not discussed. What appears at first to go outside the parameters of medical judgement about 'compliance' in fact doesn't make it out of the hospital. For many consumers it would seem pertinent to conduct such research outside hospital wards where there is for so many of us an 'Act' going on in which we play an active part in deception – so we can get out. This is not to say this is necessarily bad research – perhaps ignorant (and a bit arrogant) with a specific need to have a consumer as a central and influential member of the research team. This is the conclusion of the researcher: "The quality of relationships with clinicians during acute admission appears to be an important determinant of patients' attitudes toward treatment and adherence to medication. Enhancing such relationships may yield important clinical benefits." I expect consumers who have been involved with public admissions might go: "sure!")

9.

The Non-compliant Patient in Psychiatry: The Case For and Against Covert/Surreptitious Medication in Vol. 8(1) Jan–Dec 2010 National Institute of Health http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3031933/ **and** Lewing LR et al The unusual case of subterfuge in the Emergency Department : Covert administration antipsychotic and anxiolytic medications to control the agitated patient in American College of Emergency Physicians 2006 http://ttuem.org/page2/files/Lewin%20 Subterfuge%20in%20ED.pdf **and** Kala AK Covert medication: the last option; A case for taking it out of the closet and using it selectively in Indian Journal of Psychiatry 2012 Jul-Sep 54(3):257–265, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3512364/

(These are three different papers about covert drug giving: One in an emergency setting and one in 'psychotic patients' homes and old people's nursing homes. What are the ethics with doing this? Can it ever be justified?)

10.

Millum J Are Pharmaceutical Patents Protected By Human Rights? in Journal of Medical Ethics 2008 Nov. 34(11) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4704437/ **and** Motsoeneng T South Africa slams Big Pharma in generic drugs row in Reuters, Jan 17th 2014 http://thoughtbroadcast.com/2012/11/25/explain-to-me-again-why-psychologists-cant-prescribe-meds/

(These papers describe a totally different ethical problem in which pharmaceutical companies are exposed and it includes psychiatric drugs. The two issues here are that of companies pushing up the price of pharmaceuticals by manipulating patents. The second article is about clashes over BigPharma's refusal to sell cheaper, generic drugs to poor countries.)

11.

Ornstein C et al How money from Big Pharma sways doctors' prescriptions in The Atlantic Sun, 20th March 2016 https://www.sott.net/article/315015-How-money-from-Big-Pharmasways-doctors-prescriptions *and* Schowalter JE How to manage conflicts of interest with industry? in Int. Rev. Psychiatry 2008 April 20th (2):127-33 https://www.ncbi.nlm.nih.gov/pubmed/18386202' *and* Mintzker Y et al General practice ethics: Continuing medical education and the pharmaceutical industry in Australian Family Physician Vol.44(11) 2015   http://www.racgp.org.au/afp/2015/november/eneral-practice-ethics-continuing-medical-education-and-the-pharmaceutical-industry/

(These are three articles about ethical relationships between doctors and drug companies and their representatives.)

12.

Paquette A The Stigmatization of Mental Health Medication in Healthy Place Posted on July 9th 2014   http://www.healthyplace.com/blogs/survivingmentalhealthstigma /2014/07/the-stigmatization-of-mental-health-medication/

(This a personal commentary about being judged for taking medication. The author writes: I feel a lot of trepidation writing this article because it is based on such a controversial topic — medication and stigma, or what I fondly refer to as med-igma. The stigma of taking medication is something many of us know all too well. Hiding the fact that we take medications, feeling ashamed and fearful that other people will find out and the internal med-igma that taunts us as we fill yet another glass of water to swallow our daily dose of prescribed medications.")

13.

Pies RW How Antipsychotic Medication May Save Lives in Psychiatric Times June 1st 2016 http://www.psychiatrictimes.com/blogs/how-antipsychotic-medication-may-save-lives

(This says little that is new; it's basically a reframing of the argument that for 'real big mental illness' psychotropic drugs are life-saving – with the suggestion that this was about all there is. Two things interested me; first, the need for anyone responding to this BLOG to offer their full name and qualifications. The second was that it appealed to parent carers (who seemed not to have to give their qualifications.) Comments by carers fascinated me and it is worth a peak. How different this is from consumer sites about complex trauma.)

14.

Shilhavy B Legal Drugs versus Illegal Drugs: Are we Fighting the Right War? in Health Impact News September 21st 2015 http://healthimpactnews.com/2012/legal-drugs-vs-illegal-drugs-are-we-fighting-the-right-war/

(This is a USA site so some of the figures might be less useful. The general thesis is that "We are taught from a very young age in this country that illegal drugs are dangerous and can lead to addiction and even death. The truth is, however, that more people in America are addicted to legal drugs and deaths related to legal drugs far outnumber deaths due to illegal drugs.")

15.

International Mental Health Collaborating Network in Soteria Program Web Site http://www.imhcn.org/?page_id=3725 **and** Carlton T et al A Systematic Review of the Soteria Paradigm for the Treatment of People Diagnosed With Schizophrenia in Schizophrenia Bull 2008 Jan. 34(1):181–191 http://jos.sagepub.com/content/41/3/267.abstract

> *(Leon Mosher founded the Soteria program which is a program for people diagnosed with Schizophrenia and provides treatments which are pharmaceutical drug-free. The first article describes the program and its research and written material. The second report is an evaluation of the results of the Soteria program and comparison with more traditional, pharmaceutical-based regimes.)*

16.

Thought Broadcast: A psychiatrist's thought straight to your head: Explain to me why psychologists can't prescribe meds? in The Carlat BLOG https://thoughtbroadcast.com/2012/11/25/explain-to-me-again-why-psychologists-cant-prescri **and** Kavanaugh PB - The Neurosciences, Prescription Privileges and A Little Bit of Sugar Still Don't Make The Medicine Go Down in Academy of Psychanalytical Arts (reprinted) http://www.academyanalyticarts.org/kavanaugh-the-neurosciences

> (These two papers address the vexed question of whether psychologists should be *allowed to prescribe medications. It is a reasonable question to pose, although one can't help wondering whether it's just psychiatrists and psychologists (of a kind) locking horns again. Undoubtedly, there would be some psychologists appalled by the suggestion and some psychiatrists who would be glad to handball a testy job and get back to important relationships and their maintenance. The second paper is by a psychoanalytical psychologist so the critique of such an idea is predictable but still interesting. Kavanaugh concludes: "An excitement grows in the psychological community as the medical model of psychology in dialogue with a bio-chemical imbalance model makes it possible for the psychologist to provide humanistic interpretations addressed to the psychic conflicts of the mind (the content of delusions and hallucinations) while prescribing anti-psychotic drugs for the biochemical imbalances of the body (brain chemistry). ..Two separate questions need to be addressed by the psychological community. First, irrespective of the psychologist's theoretical orientation, what is the therapeutic effectiveness of the atypicals [antidepressants]? And a second question for the analytic practitioner, what is the effect of medications on the analytic process?)*

The Consumer's Atlas to Mental Health

Psychiatry: The Science Medicine Forgot

9. Psychiatry: The Science Medicine Forgot

SCIENCE WITH A CAPITAL 'P'

Why do clinical psychologists chase scientific principles so keenly? Is it an effort to reassert their discipline after a dodgy past or is it the profession's constant battle against psychiatrists for status? Or perhaps it is, for some true believers, all about reliable knowledge in a reductive epistemological age.

EVIDENCE-BASED CARE RELATIONSHIPS

Clinical (and other) psychologists are well-placed to assert themselves when governments increasingly demand an evidence-base for their assertions. Thus far, psychologists have been able to swim with the tide, switching from *psychotherapeutic* approaches to *behavioural* ones which are more amenable to 'test proven success.'

PATHOLOGISING? MEDICAL MODEL!

It is intriguing how many clinical psychologists individualise and pathologise people but don't see their practice as falling within the *'medical model'*. It surely is! The further *talking therapies* move away from this model, the less status they have: counselling psychologists, counsellors, social workers… Interesting?

WHATEVER HAPPENED TO PSYCHOANALYSIS?

In the first half of the 20th Century, psychoanalysis was fashionable and worked for many people. Amongst other things, it was defeated by a rapidly consumerist and technologically-oriented western society demanding quick fixes and often superficial 'evidence'. Perhaps *Narrative Therapy* can be traced back to these roots and hold on to its good and useful elements?

"WORRIED-WELL", PRIVATE PRACTICE & ETHICS

Science and medicine have brought with them breakthroughs and slogans; using *'worried-well'* language is a form of stigma perpetrated by public sector lobbyists and psychiatrists and is often aimed at clinical psychologists, harming innocent consumers *'in the middle'*. Such slogans get mixed up with ideas about social class, privilege and *'good endeavour'*.

A WIKIPEDIA ENTRY TO MADNESS

1. ANTI-SCIENCE: https://en.wikipedia.org/wiki/Antiscience

2. BIOETHICS: https://en.wikipedia.org/wiki/Bioethics

3. BIOPSYCHOSOCIAL MODEL: https://en.wikipedia.org/wiki/Biopsychosocial_model

4. CLINICAL EMPATHY SCALES: https://en.wikipedia.org/wiki/Clinical_empathy

5. CLINICAL PSYCHOLOGY TESTS: https://en.wikipedia.org/wiki/Category:Clinical_psychology_tests

6. CLINICAL PSYCHOLOGY: https://en.wikipedia.org/wiki/Clinical_psychology

7. COUNSELLING PSYCHOLOGY: https://en.wikipedia.org/wiki/Counseling_psychology

8. CRITICAL THEORY: https://en.wikipedia.org/wiki/Critical_theory

9. DEVIANCE: https://en.wikipedia.org/wiki/Deviance_(sociology)

10. EPISTEMOLOGY: https://en.wikipedia.org/wiki/Epistemology

11. EVIDENCE-BASED PRACTICE: https://en.wikipedia.org/wiki/Evidence-based_practice

12. FREUD: https://en.wikipedia.org/wiki/Sigmund_Freud

13. GROUNDED THEORY: https://en.wikipedia.org/wiki/Grounded_theory

14. HISTORY & PHILOSOPHY OF SCIENCE: https://en.wikipedia.org/wiki/History_and_philosophy_of_science

15. HOLISM IN SCIENCE: https://en.wikipedia.org/wiki/Holism_in_science

16. LIST OF PSYCHOTHERAPIES: https://en.wikipedia.org/wiki/List_of_psychotherapies

17. ORTHODOXY: https://en.wikipedia.org/wiki/Orthodoxy

18. PHENOMENOLOGY: https://en.wikipedia.org/wiki/Phenomenology_(philosophy)

19. POSITIVISM: https://en.wikipedia.org/wiki/Positivism

20. PSYCHOANALYSIS: https://en.wikipedia.org/wiki/Psychoanalysis

21. PSYCHOLOGICAL RESEARCH ASSUMPTIONS: https://en.wikipedia.org/wiki/Qualitative_psychological_research

22. QUALITATIVE RESEARCH: https://en.wikipedia.org/wiki/Qualitative_research

23. REDUCTIONISM: https://en.wikipedia.org/wiki/Reductionism

24. RELATIVISM: https://en.wikipedia.org/wiki/Relativism

25. RESEARCH EVIDENCE & PSYCHOTHERAPY: https://en.wikipedia.org/wiki/Therapeutic_community

26. SCIENTIFIC METHOD: https://en.wikipedia.org/wiki/Scientific_method

27. SCIENTISM: https://en.wikipedia.org/wiki/Scientism

28. SOCIAL THEORY: https://en.wikipedia.org/wiki/Social_theory

29. SUBFIELDS OF PSYCHOLOGY: https://en.wikipedia.org/wiki/Subfields_of_psychology

30. WORLD VIEW: https://en.wikipedia.org/wiki/World_view

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Goldenberg MJ On evidence and evidence-based medicine: Lessons from the philosophy of science in Social Science & Medicine (2006) 62:2621–2632 http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.648.7290&rep=rep1&type=pdf and Murray S & Holmes D Another Post-Modernist Attack on EBM (Evidence-based Medicine) in Health Care Renewal, December 1st 2006 (in response to Murray SJ & Holmes D http://hcrenewal.blogspot.com.au/search/label/postmodernism

(Here are two very different takes on evidence-based medicine (EBM). Goldenberg argues that we should not see EBM as a panacea for medicine's troubles. She critiques some of the 'science'. She also critiques medicine's over-reliance on science and suggests that there is a threat of losing the art of practice and she is concerned about pharmaceutical company involvement in research designed to create and evidence base to support an hypothesis that might be driven by profit. Some things lend themselves to evidence-finding than others. Murray and Holmes directly address Goldenberg's paper. Postmodernism emphasizes the importance of power relationships, personalization and discourse in the "construction" of truth and worldviews. Various postmodernists deny that an objective reality exists and deny that there are objective moral values. (Wikipedia https://www.google.com.au/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=postmodernism%20wiki) This brief article challenges postmodern and feminist arguments as they criticise evidence-based practice.))

2.

Calderstoe J 10 Big Ideas In Brain Science in Scientific American November 6th 2014 http://www.scientificamerican.com/article/10-big-ideas-in-10-years-of-brain-science/

(For those interested in brain science this is fascinating. There is one reference to applied science and this is in praise of cognitive Behavioural Therapy and Mindfulness work that came out of it. This is less-well argued. The other 9 ideas are fascinating.)

3.

Emsley R & Hawkbridge S The quest for a meaningful evidence base in psychiatry in World Psychiatry 2009 Feb 8(1):33–34 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652896/

("While the rest of the medical profession moved swiftly and confidently into the era of evidence-based medicine, psychiatry was initially reluctant to follow and slow to warm to its principles. However, more and more psychiatrists are now enthusiastically embracing an evidence-based approach and demanding "the evidence" for all therapeutic

interventions. The trouble with this approach is that the evidence is often inconclusive, inconsistent and even contradictory, giving rise to the danger that those with specific interests can select the evidence to suit their needs.")

4.

Hackman R A poor brain is as worthy as a rich brain: psychotherapy faces a privilege problem in The Guardian June 9th 2016 https://www.theguardian.com/world/2016/jun/09/psychotherapy-psychology-class-race-discrimination

(This is an interesting article in the Guardian. Like all journalism, it is a snapshot but references other work. It looks at important issues to do with knowledge particularly in the area of psychotherapy and argues for change. "Researchers argue poor communities and communities of colour face an inordinate amount of suffering and trauma, by virtue of their positioning at the very bottom of the US's deeply unequal socioeconomic and racial ladder. For the field of psychotherapy, this is a remarkably controversial framing to advance. It repositions at the centre of psychotherapy populations (non-white and non-privileged ones) that have previously been removed from it. It also places certain groups as priorities over others, and therefore possibly suggests a hierarchy of human suffering. Finally, it raises a larger moral and societal question tied to the controversial idea of "reparations": if we admit to the damage that our society causes people on the losing end, what responsibility do we have to repair it?")

5.

Levine R & Fink M Why Evidence-Based Medicine Cannot Be Applied to Psychiatry in Psychiatric Times 1st April 2008 http://www.psychiatrictimes.com/articles/why-evidence-based-medicine-cannot-be-applied-psychiatry

(Levine and Fink in an easily accessible piece argue that psychiatry is not like any other branch of medicine and that search for an evidence base is not such a good idea [searching for professional status perhaps]. "EBM supposedly allows the clinician to offer the most effective treatment for each patient. This goal is laudable, but the model is not appropriate for psychiatry because precise and stable diagnostic criteria are lacking in our specialty. Treatment outcomes in psychiatry are not defined by remission or cure.")

6.

Littlefield S Evidence-Based Practice: The Misunderstandings Continue [A recent essay displays startling misconceptions regarding science and therapy] posted Jan 27th 2014 https://www.psychologytoday.com/blog/the-skeptical-psychologist/201401/evidence-based-practice-the-misunderstandings-continue

(This is an argument for evidence based medicine as the only (known at the moment) way to sort out the muddle of theories and counter-theories in psychotherapy. He notes: "Crucially, by sorting the wheat from the chaff, evidence-based practice can also tell us which treatments are extremely unlikely to be effective – and thereby decreases the odds that clients will be harmed directly (by iatrogenic interventions) or indirectly (by opportunity costs incurred by the loss of time, energy, effort, and resources that could have otherwise been invested in effective interventions".)

7.

Moncrieff J Diagnosis Special Issue Part 3: Psychiatrist Joanna Moncrieff dismantles the foundations of her profession in British Psychological Society May 2007 Vol. 20:296-297) https://thepsychologist.bps.org.uk/volume-20/edition-5/diagnosis-special-issue-part-3

(Moncrieff, a psychiatrist, is a much published critique of the medical model. In this paper, she refutes the idea that psychiatry has to build its reputation on being a 'big science' and why the institutions of psychiatry believe they have to do so: "The institution of psychiatry is built on two assumptions: that mental distress and deviant behaviour arise from biological abnormalities, and that biological interventions can resolve them. These foundations form the basis of the claim of the psychiatric profession, as a branch of the medical profession, to be best equipped to manage madness.")

8.

Peterson B et al Century of the Brain: History & Philosophy 26th February 2015 http://brainconnection.brainhq.com/2013/02/26/century-of-the-brain/

(The 21st Century has been designated The Century of the Brain. It is the most complex organ in our body. There is much we know but there is also much we don't know and a lot we think we know when we don't. The authors argue that there is also a bit of an adrenalin rush that comes to scientists on the frontier. The authors are critical, and careful, but they tentatively conclude: "The genetic, evolutionary, and physiological evidence all suggests that though the brain is complex, it must contain some general principles within its specification.... We cannot delude ourselves into believing that we know more than we do. We must continue to struggle to achieve the understanding that only our descendants may know. ..")

9.

Rossier J What has neuroscience ever done for us? in The Psychologist April 2015, Vol.8:284-287 https://thepsychologist.bps.org.uk/volume-28/april-2015/what-has-neuroscience-ever-done-us

(This brief piece argues that up until this point neuroscience has offered little to practitioners but this is about to change.)

10.

Safran J Clinical Psychology, Psychological Science and Neo-liberal Times in Public Seminar January 30th 2015 http://www.publicseminar.org/2015/01/clinical-psychology-psychological-science-and-neo-liberal-times/#.VfKCEHkVj7A

(In 1949 a conference was convened by psychologists in Boulder Colorado to develop a training model for the clinical psychologist of the future. The consensus was that future clinical psychologists were to be trained as scientist-practitioners." This paper goes on to map the roles of clinical psychologists as they have changed [and continue to change] including understandings of working with others and their relationship to science.)

REAL STORY — REAL SCIENCE

TRAUMA INFORMED
SOCIAL RELATIONSHIPS
KNOWLEDGE OF OPPRESSION
COMPETING WAYS OF KNOWING
POWER & POWERLESSNESS
HEALTH & 'ILLTH'
CRITICAL CONSUMER PERSPECTIVE
EMPIRICAL UNDERSTANDING

FACTS?
DRUG COMPANY FUNDED 'TRIALS'
PEER REVIEWED EVERYTHING!
EVIDENCE?
CLINICAL UNIONS
AMA, RANZCP, APS...
ETHICS & RESEARCH COMMITTEES
PRACTICE STANDARDS
CLINICAL EXPERIENCE
GRADUATE PROGRAMS
EMPIRICAL UNDERSTANDING

REAL KNOWLEDGE: REAL PERSON

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11.

The Trouble With Double-Blind Placebo Studies: Two flaws in double-blind placebo studies in Psychology Today November 23rd 2010 https://www.psychologytoday.com/blog/looking-in-the-cultural-mirror/201011/the-trouble-double-blind-placebo-studies

(Double blind placebo trials are accepted by many as the pinnacle in sound research method. Few dare to criticise. This is one author who does.)

12.

Makin S Big Data help Psychiatry Unravel the Complexity of Mental Illness? in Scientific American March 21st 2016 https://www.scientificamerican.com/article/can-big-data-help-psychiatry-unravel-the-complexity-of-mental-illness/

(For the physical scientists amongst us this is a beauty. It looks at why laboratory/large scale science has not influenced psychiatric practice as much as it should and starts to use psychological theory and tools to try to come to terms with why the complexity of context and decision making might have rendered the Big Science (which creates artificial surroundings) less useful. This is reductionist and positivist but maybe beckons some ways ahead.)

13.

Jussim L The Scientific Critique of (Mostly) Psychological Science: A Compendium of Resources Justifying Skepticism About Science in Psychology Today, Posted July 5th 2013 https://www.psychologytoday.com/blog/rabble-rouser/201307/the-scientific-critique-mostly-psychological-science and The "Is Psychology a Science?" Debate: Reviewing the ways in which psychology is and is not a science in Psychology Today, January 27th 2016 https://www.psychologytoday.com/blog/theory-knowledge/201601/the-is-psychology-science-debate

(These are two considered contributions; the second author comes to the conclusion that psychology is not a science.)

14.

Glasby J & Beresford P Who knows best? Evidence-based practice and the service user contribution in Critical Social Policy 2006 26 (1):268-284 http://journals.sagepub.com/doi/pdf/10.1177/0261018306059775 and Laugharne R et al Psychiatry, postmodernism and postnormal science in Journal Soc Medicine 2002 April 95(4):207–210, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1279521/

(The first paper reviews the assumptions underlying traditional medical research and critiques the concept of 'evidence-based practice'. In particular, it identifies and counters three basic tenets of this approach: the alleged need for objectivity in research, the notion of hierarchies of evidence and the primacy of systematic reviews. This article is steeped in a tradition that respects user (consumer/survivor) knowledge. The case is put for consumer-led and consumer-informed research as rigorous and important. The second paper notes that psychiatry has many postmodern (beyond science…)

features, but reiterates the importance of science in the development of psychiatry. The paper concludes: "If this is accepted there is no need for psychiatry to strain to be 'modern' through an overemphasis on EBM [Evidence Based Practice] and biologism. As a postnormal clinical science, psychiatry can legitimately build on the foundations it has already laid through increased dialogue with individual patients, user groups, politicians and other bodies."

15.

Khoury B et al The DSM: mindful science or mindless power? A critical review in Frontiers in Psychology 2014(5):602 https://www.researchgate.net/publication/263710035_The_DSM_Mindful_Science_or_Mindless_Power_A_critical_review

(In this paper we review the Diagnostic and Statistical Manual of mental health (DSM), its scientific bases and utility. The concepts of "normality," "pathology" and boundaries between them are critically reviewed. We further use the concepts of mindfulness and mindlessness, and evidence from cognitive and social sciences to investigate the DSM clinical and social impact and we argue against its assigned overpower. We recommend including alternative perspectives to the DSM, such as mindfulness and positive psychology. We also argue for including mindfulness training in psychiatric residency and clinical psychology programs.)

10.

Unlearning for Good Practice

10. Unlearning for Good Practice

WILLING TO DARE

Consumers sometimes describe 'best practice' surprisingly, possibly referring to ways of working that may seem unprofessional in others' eyes. Practitioners taking risks sometimes results in approaches that are empowering and truthful and, through their practice, they advocate with integrity and demonstrate esteem for consumers.

THE NEW CONSUMER WAY

With others, Yoland Wadsworth worked with nurses; the defining theme was a nursing belief in 'caring' which (to them) meant 'second-guessing' patients. For consumers, this is very kind but problematic. We are trying to teach clinicians to genuinely ask us instead of guessing, a hard lesson for many nurses who so want to be kind – their way.

WHAT'S THE DSM, DID YOU SAY? WHY, I'VE QUITE FORGOTTEN!

When medical clinicians are junior, they are often glued to the DSM-V or the ICD. They are learning. As they become more experienced, some clinicians leave them behind as they have developed a working understanding; in the public services world, however, this is not acceptable as categorisation has become compulsory for legal and insurance purposes.

FROM THE INDIVIDUAL TO THE RELATIONAL

Medical professionals do their preliminary training in silos, practicing in isolation, separation and privilege, even as they practise on hospital wards. In a power-saturated environment, this is not a culture of mutual respect and some clinicians see the harm in this; they understand that knowledge of and respect for the work of other clinicians in mutual relationship is central to respecting patients.

FROM FEAR TO LOVE

The mental health system is replete with fear; even senior staff can be afraid of violence, getting it wrong, witnessing bad staff practice, losing it, not understanding and of the complexity of the work. People try to change this; some become narrow, judgemental, superior and rude; others fight back against the fear with love of a kind; the latter are the ones consumers most admire.

A WIKIPEDIA ENTRY TO MADNESS

1. AESCULAPIAN SNAKE: https://en.wikipedia.org/wiki/Aesculapian_snake

2. CLINICAL EMPATHY AND BIOLOGICAL PSYCHIATRY: http://digest.bps.org.uk/2015/01/psychologists-and-psychiatrists-feel.html

3. CLINICIAN SELF-DISCLOSURE IN THERAPY: https://en.wikipedia.org/wiki/Self-disclosure

4. ORGANISATIONAL CULTURE: https://en.wikipedia.org/wiki/Organizational_culture

5. SYNDROME: https://en.wikipedia.org/wiki/Syndrome

6. THERAPEUTIC BOUNDARIES: http://www.zurinstitute.com/demyth_clinicalupdate.html

7. THERAPEUTIC MISTAKES: http://etheses.whiterose.ac.uk/2923/1/Corrections_-_Therapists'_experiences_of_therapeutic_mistakes_-_200131994.pdf

8. CULTURE-BOUND SYNDROME: https://en.wikipedia.org/wiki/Culture-bound_syndrome

9. CRITICAL PSYCHOLOGY: https://en.wikipedia.org/wiki/Critical_psychology

10. RECIPROCITY (Social Psychology): https://en.wikipedia.org/wiki/Reciprocity_(social_psychology)

11. MEDICAL HUMANITIES: https://en.wikipedia.org/wiki/Medical_humanities

12. THE HOUSE OF GOD: https://en.wikipedia.org/wiki/The_House_of_God

13. CULTURAL HUMILITY: https://en.wikipedia.org/wiki/Cultural_humility

14. DOCTOR-PATIENT RELATIONSHIP: https://en.wikipedia.org/wiki/Doctor%E2%80%93patient_relationship

15. BAREFOOT DOCTOR: https://en.wikipedia.org/wiki/Barefoot_doctor

16. HEALTH EQUITY: https://en.wikipedia.org/wiki/Health_equity

17. CONTROVERSY SURROUNDING PSYCHIATRY: https://en.wikipedia.org/wiki/Controversy_surrounding_psychiatry

18. POWER DISTANCE: https://en.wikipedia.org/wiki/Power_distance

19. UNCERTAINTY AVOIDANCE: https://en.wikipedia.org/wiki/Uncertainty_avoidance

20. YAVIS (YOUNG, ATTRACTIVE, VERBAL, INTELLIGENT & SUCCESSFUL): https://en.wikipedia.org/wiki/Yavis

21. NORM OF RECIPROCITY: https://en.wikipedia.org/wiki/Reciprocity_(social_and_political_philosophy)

22. THE GOLDEN RULE: https://en.wikipedia.org/wiki/Golden_Rule

23. CRITICAL PEDAGOGY: https://en.wikipedia.org/wiki/Critical_pedagogy

24. MENTAL HEALTH CARE NAVIGATORS: https://en.wikipedia.org/wiki/Mental_health_care_navigator

25. HEALTH SYSTEM: https://en.wikipedia.org/wiki/Health_system

26. ETHICS OF CARE: https://en.wikipedia.org/wiki/Ethics_of_care

27. BIOETHICS: https://en.wikipedia.org/wiki/Bioethics

28. NURSING ETHICS: https://en.wikipedia.org/wiki/Nursing_ethics

29. CAPACITY BUILDING: https://en.wikipedia.org/wiki/Capacity_building

30. UNCONDITIONAL POSITIVE REGARD: https://en.wikipedia.org/wiki/Unconditional_positive_regard

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Singh A & Singh S Resolution of the Polarisation of Ideologies and Approaches in Psychiatry in Mens Sana Monographs 2004 Nov-Dec 2(2):5–32 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3369165/

> *(This article articulates and attempts to explain the two predominant ideologies within psychiatry. It's not difficult to read but the style is a bit patronising but don't be put off. For student psychiatrists this is only given perfunctory notice but it is important not only to inform practice but also, essential for many consumers, to describe practice: the psychosocial- psychotherapeutic approach and the biological approach which is in ascendency today. The authors look at industry-wide and individual experiences and their political importance: schism, eclecticism and rejection of the debate.)*

2.

Donetto S Medical students' views of power in doctor–patient interactions: the value of teacher–learner relationships in Medical Education Vol.44(2);187–196 February 2010 https://www.ncbi.nlm.nih.gov/pubmed/20059675

> *(This research sets out with the following hypothesis: Why do medical students have uncritical views of professional practice? The author draws upon this larger body of data and focuses here on two examples in particular: "the more general uncritical readings of medical professionalism I encountered at Sundown Medical School (an invented name), namely: students' often reductive views of medical power and their simplistic formulations of patient education." He concludes that: effective integration of participative and critical pedagogical strategies in medical curricula and more structured involvement of patients in the role of teachers may represent valuable strategies for the development of learning relationships that better promote reflexive and collaborative forms of professionalism.)*

3.

The Royal Australian & New Zealand College of Psychiatry Eight Ways to Make the Most of your Psychiatry Rotation 2013 https://www.ranzcp.org/Pre-Fellowship/Psychiatry-as-a-career/Your-psychiatry-rotation.aspx and McArthur JA Letter to my nephew: Medicine of the Mind, a consumer's guide to a medical student for a psychiatric rotation in Our Consumer Place, 2017 http://www.ourconsumerplace.com.au/consumer/index.

(The RANZCP has a brief list of eight important points that the college hopes will be useful for medical students on their psychiatric rotation. It is compiled by a number of groups which are listed. Jane McArthur is an experienced consumer advocate. The second document lists ten challenges she set her nephew, a medical student, as he went into a psychiatry rotation, in an acute unit. The difference between the two documents is interesting.)

4.

Gordon S, Ellis P, Gallagher P & Purdie G Service users teaching the recovery paradigm to final year medical students - A New Zealand approach [online] in Health Issues No. 113 Summer 2014:15-17 http://search.informit.com.au/documentSummary;dn=834822827 421339;res=IELHEA and Lyons Z & Janca A Impact of a psychiatry clerkship on stigma, attitudes towards psychiatry and psychiatry as a career choice in BMC Medical Education 2015 15:34 http://www.biomedcentral.com/1472-6920/15/34

(Sarah Gordon is a consumer academic. The authors' proposal was that: Stigmatising attitudes in medical students lead to discriminatory behaviours in medical professionals. This study examined the impact of introducing into the final year medical student curriculum two one-hour tutorials on the recovery paradigm. The tutorials had been developed and are delivered by service users. The results were not convincing but this perhaps reflected limitations of the research design where medical students were simply second-guessing what a consumer-led research project would probably want them to say. Pre-test post-tests methods don't tend to work in these sorts of circumstances. The second study may have had similar methodological challenges.)

5.

Jones N The Absence of Psychiatric C/X/S Perspectives in Academic Discourse: Consequences and Limitations in Disabilities Studies Quarterly Vol 33(1) (2013) http://dsq-sds.org/article/view/3433/3198

(This paper looks at the inclusion (and exclusion) of people representing C/X/S (consumer/survivor/ex-patient,), survivor, consumer voices in academe and research and particularly in relation to Disability Studies. It is a coherent well-argued piece that suggests that if the presence of the C/X/S voice is missing from Disability Studies - one of the most liberal – areas than this bodes badly for other areas of study which concern people diagnosed with mental illness.)

6.

Stastny P Involuntary Psychiatric Interventions: A Breach of the Hippocratic Oath? in Ethical Human Sciences and Services Vol. 2(1) 2000

(This paper refigures the debate about involuntary treatment as one of contrasting understandings of health and knowledge. On the one hand it is about medical/ authoritarian and on the other, subjective/empathic. The article includes a fascinating historical story of how the Hippocratic oath came to be and makes some suggestions that what it means to doctors depends to some degree on where they stand in relation to psychiatry's coercive powers.)

7.

What are the pros and cons of 'unconditional positive regard'? in Everyday Counselling Practice https://us.sagepub.com/sites/default/files/upm-binaries/34065_02_Feltham_Ch_01.pdf

(This is oldish but goodish; it is useful to look at counselling in relation to training for the profession. Counselling is the profession active in psychiatry and related fields which is most denigrated. Even counselling psychologists claim a bit more status. And yet, when you read this article, the carefulness of the training is obvious. 'Unconditional positive regard' is central to this paper. It has been around a long while and is an ideal. Unlike two papers previously mentioned academics are all too well aware that to be a 'good' counsellor people need to be pushed out of their comfort zone and challenged when they claim omnipotence: 'of course, I love everyone – isn't that what you want me to say?' However 'unconditional positive regard' plays a central part in understanding the non-judgemental role of the counsellor and this is covered in detail in this chapter. In the end, there has to be limits. The chapter concludes: "Pragmatically, we might say that a high level of aspirational acceptance is necessary but this must be balanced by honesty, realism and therapeutic constraints". If you scroll down from the above article there are several short pieces that are interesting as starting points for further reading: Is eclecticism as bad as the bad press? How crucial are counselling ethics? Can you counsel effectively when affected by Illness or Personal troubles? Does it Matter if Empathy is not matched by personal experience?)

8.

Beresford P & Croft S Service users' knowledges and the social construction of social work in Journal of Social Work 1 (3):295 – 316 2001 http://www.reclaimingfutures.org/members/sites/default/files/documents/beresford&croft-service_users_knowledges.pdf and Smith M & Khanlou N An Analysis of Canadian Psychiatric Mental Health Nursing through the Junctures of History, Gender, Nursing Education, and Quality of Work Life in Ontario, Manitoba, Alberta and Saskatchewan in ISRN Nurs. 2013 https://www.ncbi.nlm.nih.gov/pubmed/23710367 and Galvin D et al Utopian visions∕ dystopian realities: Exploring practice and taking action to enable human rights and occupational justice in a hospital context in Australian Occupational Therapy Journal 2011 58:378–385 http://www.crouch-trust.org.za/Files/COMM%20OF%20PRACTICE%20EX.pdf

(These three papers provide a tiny snapshot of some of the educational concerns in the disciplines of social work, mental health nursing and occupational therapy. In this volume we have concentrated on psychiatry and psychology only because they are the most able (through present power relationships) to frame psychiatry and its meanings. They perhaps have more to unlearn. This article considers the implications for social work and social care education, policy and practice of including the viewpoints and knowledges of service users. The development of policy and practice for user involvement is critically discussed and the role of service users and their organizations in the construction of social work explored. The Canadian paper about mental health nursing provides a terrific broad brush across the issues and challenges for mental health nurses. It contains pertinent papers about education in historical context, gender, and nurse education. The paper about OT preparation is the result of an action research project which concluded that: "A human rights framework may have great potential for helping occupational therapists to better see and address issues of enabling occupation and justice, not only at a population level, but also as part of their work with individual clients. To facilitate the translation of utopian ideals into practice reality, localised, contextualised discussions may prove to be most effective." It is interesting to explore

what constitutes knowledge between psychiatry and psychology education on one hand and social work, mental health nursing and occupational therapy on the other. This is not, as it is too often portrayed, purely a difference in content or a different set of knowledge, skills and competencies. Nor is it just a difference in attitudes and values although these can be very different. Nor is it just a difference in academic capacity of students, role or knowledge hierarchy although this counts too. It seems to be also a difference in inquiry – what matters, who matters, science as a metaphor for worth – or not. Doctors explore issues of power and justice. We see this with asylum seekers, for example. It seems to be that things are perhaps harder in the mainstream.)

9.

Bainbridge R et al Government, Cultural competency in the delivery of health services for Indigenous people in Issues Paper no. 13 produced for the Closing the Gap Clearinghouse 2015 http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Our_publications/2015/ctgc-ip13.pdf

(How does cultural competency translate into essential learning for all mental health professionals – everyone comes into contact with Aboriginal people and competency sensitises all non-Indigenous people working in health settings to rethink morals and ideas we have learnt. Everyone has to unlearn in this area and it can be uncomfortable – if it's not we are probably failing to unlearn. Unlearning is hard and sometimes tests who has the authority to get out of it and who doesn't and resists within it. Here are guidelines for doing it.)

10.

Mahood SC Medical education, beware the hidden curriculum in Canadian Family Physician September 2011 vol. 57(9):983-985, http://www.cfp.ca/content/57/9/983.full

(The "hidden curriculum" refers to medical education as more than simple transmission of knowledge and skills; it is also a socialization process. Wittingly or unwittingly, norms and values transmitted to future physicians often undermine the formal messages of the declared curriculum. The hidden curriculum consists of what is implicitly taught by example day to day, not the explicit teaching of lectures, grand rounds and seminars. I am increasingly aware of how those of us engaged in family medicine education are blind to it.)

11.

Hooker C Understanding empathy: why phenomenology and hermeneutics can help medical education and practice in Med Health Care and Philosophy 2015(3):1-12. https://ses.library.usyd.edu.au/bitstream/2123/14514/1/Hooker-understanding-empathyPP-2015.pdf

(Often we use terms like 'empathy' as if we know what they mean when the meaning has long ago got lost in logistics, far-off ideals and our keenness to impress important people by saying we are working empathetically. This article acknowledges that patients really value 'empathy' and then systematically tries to work out, for doctors, what it is and how to do it. See also: Whitehead CR The Good Doctor in Medical Education 1910-2010: A Critical Discourse Analysis; PhD thesis University of Toronto; 2011 (This is long but worth it. It's quite easy to navigate using the headings. It's important because unless we have community agreement,

or at least some consensus, about what good doctoring looks like, education falls back on apprenticeship models that may replicate unfortunate relationships and technical training. As Whitehead suggests: "Ideas of what constitutes a good doctor underlie decisions about medical student selection, as well as curriculum design and the structure of medical education at both undergraduate and postgraduate levels of training. Factors at play include knowledge paradigms (what does a good doctor need to know), identity paradigms (who can become a good doctor) and notions about the relationship of doctors to society (the social responsibility or social accountability of a good doctor.")

12.

Salwitz JC Doctors are not in control. Perhaps this is our greatest challenge in The Physician January 4th 2016

(It is difficult when doctors are hurting. We have for half a century given them so much authority, even righteousness, that, as a community, we don't know what to do when it seem not to be OK any more. Fallen pride? Rapid changes in the way they have to work? Social changes in the way the community relates to medicine. It's difficult to read this and not feel that things need to be rejigged, or doctors need to be educated differently to accommodate social change. Salwitz starts the discussion in this simple piece about robots.)

13.

Murthy R & Khandelwai Undergraduate training in Psychiatry: World perspective in Indian Jrnl. Psychiatry 2007 Jul-Sep 49(3):169–174 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2902088/

(This paper gives readers a baseline about how doctors assess 'good' and 'bad' undergraduate education in psychiatry.)

14.

Leseth AB What is culturally informed psychiatry? Cultural understanding and withdrawal in the clinical encounter in British Jrnl. of Psychiatry Bulletin 2015 Aug 39(4):187–190

("What is culturally informed psychiatry? What does it mean and why is it important? These questions are discussed with a focus on the cultural aspects of the clinical encounter. The DSM-V Outline for Cultural Formulation was developed as a method of assessing the cultural factors affecting the clinical encounter. It calls for the assessment of the cultural features of the relationship between the patient and the clinician; however, there is a lack of debate about what this means in practice. Clinicians run the risk of withdrawal rather than cultural understanding when facing patients with different cultural backgrounds.")

15.

Chur-Hansen A An investigation of the English language proficiency and academic and clinical performance of University of Adelaide Medical School Undergraduates in PhD Thesis Department of Psychiatry University of Adelaide July 1998 file:///C:/Users/Merindz/Downloads/02whole%20(2).pdf

(This is long, slightly old but important systematic analysis. It can be navigated through the subject headings. So many consumers get upset and angry because the doctor they are trying to tell confidences to doesn't speak English and then no-one will take their real problems seriously. Psychiatry is a special and important case. Psychiatrists are not technicians. Communication is their job. This thesis attempts to name and discuss some of the issues that are often taboo beyond the informal literature of patients and families.)

The Medical Model: Consumers and Exclusion

11. The Medical Model: Consumers and Exclusion

WHEN YOU'VE GOT A HISTORY... IS 'MAD PRIDE' INCLUSIVE?

We know that the reclamation of damaging language is purposeful and powerful. The problem, however, remains for people who have frequently been told that 'there is nothing 'wrong' with them'; the people who just don't fit. What is their identity to be proud of? They surely can't be 'mad', can they? Pathetic human beings perhaps?

THE MENTAL HEALTH REALITY SHOW

Defining territory is fraught when we continue to operate in a euphemism. Whilst services and systems feel obliged to call themselves mental health systems, there is no logic for arguing they should be the mental illness systems they actually are. This causes exclusion, unease and defensiveness amongst consumer activists, patients, families and diverse groups of clinicians.

MENTAL ILLNESS AND CRIMINALITY

Regardless of diagnosis, there is prejudice around criminality. We know that disadvantages strongly influence who goes to prison and who does not. How could this be any different for consumers who are detained? This is the intersection between disabilities, infamy, law-breaking and often many social and cultural disadvantages. The 'criminal fringe' belongs whether we like it or not.

I WANT EVERYONE INCLUDED... EXCEPT THEM!

Too often we witness inclusion initiatives which are tokenistic. They don't even do it well with groups that are obvious (different cultures for example). It is often one more nametag on the consumer table regardless of whether that's useful. Real inclusion is hard and often leads to difficult personal questioning. If it doesn't feel awkward, we are probably not doing it.

TRAUMA AND TRIBULATION: CREATING 'DEVIANCE'

Many people with histories of trauma sit where four paddocks meet: 'mental illness,' deviance, trauma and addiction. On 'mental as' (ABC TV), the rosy-faced jolly psychiatrist was very accepting of drug and alcohol use by people diagnosed with psychosis; on the other hand, with people diagnosed differently, there was little tolerance of anything. Childhood trauma was ignored even after disclosure.

A WIKIPEDIA ENTRY TO MADNESS

1. ABLEISM: https://en.wikipedia.org/wiki/Ableism

2. ANTI-PSYCHIATRY: https://en.wikipedia.org/wiki/Anti-psychiatry

3. ATTACHMENT THEORY: https://en.wikipedia.org/wiki/Attachment_in_children

4. CHILD ABUSE: https://en.wikipedia.org/wiki/Child_abuse

5. CHILD NEGLECT: https://en.wikipedia.org/wiki/Child_neglect

6. CRITICAL THEORY: https://en.wikipedia.org/wiki/Critical_theory

7. CRITICAL PSYCHOLOGY: https://en.wikipedia.org/wiki/Critical_psychology

8. ASYLUM MAGAZINE: https://en.wikipedia.org/wiki/Asylum_(magazine)

9. CULTURAL IMPERIALISM: https://en.wikipedia.org/wiki/Cultural_imperialism

10. FAMILY DYSFUNCTION: https://en.wikipedia.org/wiki/Dysfunctional_family

11. HISTORICAL TRAUMA: https://en.wikipedia.org/wiki/Historical_trauma

12. IDENTITY POLITICS: https://en.wikipedia.org/wiki/Identity_politics

13. INDIGENOUS AUSTRALANS: STOLEN GENERATIONS IN AUSTRALIA: https://en.wikipedia.org/wiki/Stolen_Generations

14. INSTITUTIONAL ABUSE: https://en.wikipedia.org/wiki/Institutional_abuse

15. INTERSECTIONALITY: https://en.wikipedia.org/wiki/Intersectionality

16. MAD PRIDE: https://en.wikipedia.org/wiki/Mad_Pride

17. MALINGERING: https://en.wikipedia.org/wiki/Malingering

18. MENTALISM: https://en.wikipedia.org/wiki/Mentalism_(discrimination)

19. MOVEMENTS FOR SOCIAL CHANGE: https://en.wikipedia.org/wiki/Social_movement

20. PSYCHIATRIC SURVIVOR MOVEMENT: https://en.wikipedia.org/wiki/Psychiatric_survivors_movement

21. REAPPROPRIATION: https://en.wikipedia.org/wiki/Reappropriation

22. RECLAMATION: http://geekfeminism.wikia.com/wiki/Reclamation

23. ROSENHAN EXPERIMENT: https://en.wikipedia.org/wiki/Rosenhan_experiment

24. SANISM: https://en.wikipedia.org/wiki/Mentalism_(discrimination)

25. SELF-HARM: https://en.wikipedia.org/wiki/Self-harm

26. SOCIAL CONSTRUCTION OF SCHIZOPHRENIA: https://en.wikipedia.org/wiki/Social_constructionism

27. SOCIAL DEVIANCE: https://en.wikipedia.org/wiki/Deviance_(sociology)

28. SOCIAL EXCLUSION: https://en.wikipedia.org/wiki/Social_exclusion

29. SOCIAL MOVEMENTS (self-destruct) https://freeskoool.wikispaces.com/file/view/Gamson+Identity+Movements+Self+Destruct.pdf

30. SUB-CULTURE: https://en.wikipedia.org/wiki/Subculture

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Ameil J Beyond Intersectionalities of Identity or Interlocking Analyses of Difference: Confluence and the Problematic of "Anti"-oppression in Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity and Practice Vol. 4(1) 2015 http://journals.library.mun.ca/ojs/index.php/IJ/article/viewFile/1407/1226

> (Have a go at this (if you dare or tackle it together). It is quite radical, it asks very many vital questions about the buzz concept of 'intersectionality'. The difficulty of the writing can be overcome, the conclusions are based on studies and is much learned. This is, in part, the conclusion: "Without a historical, social, and political analysis in context, ideas such as anti-racism or anti-oppression and biomedical psychiatry can appear to be commensurate and possible. An analysis of confluence allows for a refusal to accept solutions such as those that propose that "anti-racist" and "psychotherapy" can be commensurate. In a confluence analysis, technologies and disciplines such as psychotherapy are held as complicit in the formations and advancement of a normative subject (often centered as a white, Christian, able-bodied, -minded, heterosexual, cis-gendered, male, speaking the King's English, compliant with the law, etc.). The formations of this normative subject were and are, of course, dependent on identifying himself in relation to the Other, often at work to delineate himself by what he is not, generating an image of the savage, the uncivilized, the mad, and those deserving of violence.")

2.

Veysey SA Look at the human being in front of you who is hurting http://www.mentalhealth.org.nz/assets/A-Z/Downloads/Look-at-the-human-being-in-front-of-you-whos-hurting.pdf and Lawn S Experiences of care by Australians with a diagnosis of borderline personality disorder in J. Psychiatr Ment Health Nursing 2015 Sept. 22(7):510–521 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4755162/ and Epstein M The Emperor's New Clothes: On Being Invisible and Neglected within The Mental Health System - A Gendered Perspective From a "Borderline Pioneer" http://www.takver.com/epstein/articles/emperors_new_clothes_themhs_2006%20.pdf

> (This is a series of pieces on Borderline. The depiction of Borderline in the 'mental-as week', - if there was any depiction at all - was just prejudice. Questions are raised, and need to be raised, about the consumer movement which also struggles with definitions of 'real illness purity' and arguments about good and bad, right and wrong. How does this fit with ideas about inclusion. Lots to think about.)

3.

Medical Expert Discourse And The Construction Of Mental Illness in Internet Journal of Criminology ©2008 http://www.internetjournalofcriminology.com/ware%20-%20the%20chemical%20generation.pdf

(This is a dissertation, so it is long but it's not difficult if you pick out bits at a time. Medical drugs are seen as a technology for social control; but the work is interesting because of the groups that are specifically chosen as examples of those needing to be controlled: children diagnosed with ADHD, people with depression, and people diagnosed with Post Traumatic Stress Disorder. It uses survivor literature, discourse analysis (Foucault) and explores criminality using these tools. It is much more nuanced and argued more tightly than I can address here. Here is a sample: "The invisible technologies of governing take particular forms that ensure we have a sense of autonomy while at the same time ensuring that we follow a specific route that is productive to a society as a whole. In this case, we can see how we govern ourselves with the aid and guidance of establishments, such as the medical establishment, and rely on their perspective of what the social norm is. Non-compliance of these social norms results in the application of the deviant label, and perfection, responsibility and productivity. Individuals who appear to fail at these tasks are singled out as troubled/troublesome."

4.

Bell G Depression and the Medicalisation of our Sorrows in Quarterly Essay 18th June 2005 https://www.quarterlyessay.com.au/essay/2005/06/the-worried-well and Parker G The Worried Well Correspondence: A Response to Opinion Piece by Gail Bell in Quarterly Essay 19 https://www.quarterlyessay.com.au/correspondence/1183 and ALAS [BLOG} How to Avoid Being Seen as a Drug-Seeker January 31st 2011

(Bell argues that too often people who are not sick and do not deserve services use up doctors' time, utilise too many services and draw money out of the system. She seems to lay most of the blame with the individual person and has little analysis of a system of 'care' that marginalises people in this way. There is a lack of good gender analysis even though the accepted visualisation of 'a worried well' is almost always female. Gordon Parker is the CEO of the Black Dog Institute in Sydney. He responds to Bell's 'argument'. He starts with the following: "Let's look at the essayist's style before addressing issues of substance, for the question is whether such polemic dressed in the cloak of reason leads to unbalanced conclusions." He remains captured by the medical model and defends his position by arguing at length that depression is real. He is arguing against this dismissive terminology by drawing on the dimensions of depression that make it legitimate: Serious Mental Illness too. I had to resort to the third reference which is a BLOG. Nowhere, it seems, is stuff written about the deficiencies in the way medicine is organised that recognises the shortfalls of doctors and services when it comes to psychological pain that is not or has not yet been named. Often people say, the worst diagnosis I've ever had is 'there's nothing wrong with you, disorder.' After years of experiencing the derision of the system, people name child abuse, trauma, and dysfunctional families and so on and they have already been put through the pain and judgement that all the references I was able to find obviously thought they deserved. Where is the social analysis? We construct professionals and systems that hold an aura of omnipotence and then blame when it doesn't work.)

5.

Friedrich B From act of terrorism to mental health symptom: we're shifting blame but at what cost? in The Conversation July 29th 2016 https://theconversation.com/from-act-of-terrorism-to-mental-health-symptom-were-shifting-blame-but-at-what-cost-63060

(This is a short conversation piece. Many of us have noticed the community lurching between blaming Muslims and blaming "the mentally ill" for shocking crimes, rampages, bombs and fatal shootings. Unfortunately, sometimes these two groups of interest blame each other. This short piece articulates the issues.)

6.

Grey F To live is to fight [including ideas about 'stigmaphobia'] in Our Consumer Place http://www.ourcommunity.com.au/files/OCP/Dax.pdf

(This is very short, must read. The concept of 'stigmaphobia' is not just jargon; rather, it is attempting to describe an idea that has no conceptual place in discourses of disadvantage. It's rather like institutional 'pass-the-buck: the more abject the group the more buried in judgement and we all escape that fate by blaming a different group'.)

7.

Obesity: An Insidious Effect of Childhood Trauma in SERPENDA The Trauma and Mental Health Report October 5th 2012 http://trauma.blog.yorku.ca/2012/10/obesity-an-insidious-effect-of-childhood-trauma and Browne JL Back off, fatists – obesity blame games don't help anyone February 9th 2012 in The Conversation http://theconversation.com/back-off-fatists-obesity-blame-games-dont-help-anyone-2417 and McGrath M Femininity as mental illness in The Telegraph 17th February 2008 http://www.telegraph.co.uk/culture/books/non_fictionreviews/3671232/Femininity-as-mental-illness.html

(We mostly do judge others and our own. Obesity and 'fat pride' is just an example. Many consumers, even politically active ones, who theoretically know only too well that psychotropic drugs are largely responsible for their weight gain, are still ashamed of "mental illness" and weight. What does the consumer movement do to link with the fat pride movement? This is inclusion in practice. What do we really do when drug companies publish pink pamphlets telling women they are now guilty of fat as well as of 'mental illness'? Now they have created an obesity epidemic as well as mental illness awareness campaigns profits spiral up at the expense of personal grief and shame.)

8.

Wible P (MD) Patient Profiling: Are You a Victim? [BLOG] Ideal Medical Care, January 21st 2014 http://www.idealmedicalcare.org/blog/patient-profiling-are-you-a-victim/

(Doctors jumping to conclusions – diagnoses based on attributes that advertising agents understand but doctors seem not to. This is short and easy to read. This is a commentary.)

9.

Maiese M Social Structural Change - Beyond Intractability July 2003 http://www.beyondintractability.org/essay/social-structural-changes

(As we develop our 'mad' identity, it is important to start to understand more about what a social change movement is, how they work and our theoretical positioning in relation to our society and the social institutions, including medicine. "Social and political institutions set the context for individual and group behavior and are meant to provide the resources individuals need to survive. How people act and live is shaped in large part by the social structures in which they find themselves. Social justice is, in part, a matter of ensuring that these structures and institutions do in fact satisfy basic human needs.")

10.

Schneider J Medicalisation of Deviance: From badness to sickness in Goode E Handbook of Sociology of Deviance 2015 http://www.drake.edu/media/departmentsoffices/studyofculturesociety/documents/MedicalizationofDeviance.pdf

(This is long and quite difficult to read but if you are interested in theory and understanding psychiatry as sometimes used as a means to keep the community safe from those who deviate from community expectations, it is good.)

11.

Osteen M Autism & Representation: A Comprehensive Introduction Routledge 2008 https://b.domainstatic.com.au/w800-h533-2013277487_1_pi_161209_093009 and Gabbard C Review of Osteen M Autism & Representation in Disability Studies Quarterly 2010 Vol 30(1) http://dsq-sds.org/article/view/1071/1253

(This book is expensive to get hold of but easily copied at libraries. It's important to realise that it was published before the 2013 launch of DSM-V where substantial changes were made to the definition and labelling of Autism, putting all autism experiences under one heading –'autism spectrum disorder'. Thus the category Asperger's has upset many people with what was Asperger's because they were being lumped in with people with intellectual disabilities. This is a really good example of hierarchies in action. And yet this is so difficult to name.)

12.

Crocheter Cat person [BLOG] As Small as a World and as Large as Alone: Disability Hierarchies http://withasmoothroundstone.tumblr.com/post/86673135065/disability-hierarchies and CripleScholar Fighting My Internalization of the Hierarchy of Disability August 23rd 2015 https://crippledscholar.com/tag/heirarchy-of-disability/

(It is really interesting that within the heterogenic disability movement there is a preparedness to name truths about disability hierarchies and at the same time note that these change according to which group you are affiliated with. It's very hard to find out anything about this information because everyone seems to be intimidated by social mores that this is 'not on'. Do we really prefer euphemisms and whispers above a solid discussion about the sociological implications of this ordering that always seems to happen? It's contextual and contradictory and that seems to be why we need to think about it.)

PATIENT CENTERED CARE

13.

Lindblom J A Deviance Perspective on Social Movements: The Case of Animal Rights Activism in Journal of Deviant Behaviour (2013) Vol.35(14) Issue 2 http://www. tandfonline.com/doi/abs/10.1080/01639625.2013.834751

("This article outlines a theoretical framework for understanding deviance and deviance-management in a social movement context. Such a deviance perspective is useful because in striving for social change, activists challenge existing social norms and may readily be defined by their environments as "outsiders" or deviants. However, activists also differ from traditional deviant groups. The article therefore conceptualizes activists as "entrepreneurial deviants," combining features of both moral entrepreneurs and deviants in society...")

15.

Slorach R Marxism and disability in International Socialism Issue 129 January 2011 http://isj.org.uk/marxism-and-disability/ and Soldatic K & Pini B The three Ds of welfare reform: disability, disgust and deservingness in Australian Journal of Human Rights Vol. 15(1) 2009 http://www.austlii.edu.au/au/journals/AUJlHRights/2009/10.pdf

(These two articles have been chosen out of many who are writing about disability from a human rights perspective. They are politically predictable but they also position the debate theoretically which is useful.)

16.

Rowland M Angry and Mad: A Critical Examination of Identity Politics, Neurodiversity and the Mad Pride Movement in Journal of Ethics and Mental Health 2015 http://www.jemh.ca/issues/open/documents/JEMH_Open-Volume_Article_Angry_and_ Mad-Oct2015.pdf

(This article questions the mad pride's capacity to become a strong minority political force, in part because it doesn't adequately represent the heterogeneity of 'mad people'. Rowland writes: "Though heterogeneous in perspective, the movement's activities are influenced by broader identity pride activism, and they are ideologically related to the neurodiversity and disability subcultures. Therefore, although precedent exists for the creation of group political identity through shared experience of pathology or abnormality, the Mad identity in its current conception lacks the coherence to become a culturally and politically meaningful minority identity.")

12.

The Medical Model: Competing Discourses

12. The Medical Model: Competing Discourses

LANGUAGE IS WHAT WE USE TO THINK WITH

No language is neutral. Language is not just the spoken and written word but it also supplies us with thinking fuel. Those who talk 'medicine' fluently often fail to recognise the power, exclusivity and limitations of this discourse.

THE POWER OF MODERN POLITICAL-ECONOMIES

The languages of medical science and the economy are intrinsically interrelated even if they sound very different. So, how does this affect consumers? Whilst Gross National Product (GDP) is assumed to show us how well our economy functions, we may be better off with a general measure of Bhutan's Gross National Happiness (GNH) to understand why so many of us suffer from 'mental health' issues.

DISCOURSES OF PSYCHIATRY

Psychiatry itself is a repository for many discourses, all competing to be heard and believed. Some of them compete from the 'inside' of psychiatry, others compete to be accepted into the psychiatric mainstream and a third group remains outside, proud to not belong. Discourses include biological medicine, which is an important one, but also self-help; alternative therapy; behavioural therapy; narrative work; anti-psychiatry discourse, as well as patient, carer and peer world views.

DOMINANCE IS TIME LIMITED

The medical model discourse dominates in post-modern capitalism. Before that, many ways of thinking about madness co-existed, including humanitarian as well punitive institutionalisation and therapeutic communities. Paradoxically the discourse supporting therapeutic communities died with de-institutionalisation.

TALKING SCIENCE

Apart from being about truth-finding and problem solving, science and scientists are also seen as 'status seeking'; as well, as they touch human interest and strive for influence, they are often politicised and are saturated with power differentials. When bringing medicine into the scientific realm, that aspect and the technical skills it requires are often elevated to a dominant status, sidelining all other considerations to just 'bedside manner'.

A WIKIPEDIA ENTRY INTO MADNESS

1. BLINDED EXPERIMENT: https://en.wikipedia.org/wiki/Blinded_experiment

2. BODY LANGUAGE https://en.wikipedia.org/wiki/Body_language

3. CAPITALISM: https://en.wikipedia.org/wiki/Capitalism

4. CLINICAL TRIAL: https://en.wikipedia.org/wiki/Clinical_trial

5. CONSERVATIVE CORRECTNESS: http://rationalwiki.org/wiki/Conservative_correctness

6. DISCOURSE: https://en.wikipedia.org/wiki/Discourse

7. DISEASE MONGERING https://en.wikipedia.org/wiki/Disease_mongering

8. ECONOMC DETERMINISM: https://en.wikipedia.org/wiki/Economic_determinism

9. EMPIRICAL LIMITS OF SCIENCE: https://en.wikipedia.org/wiki/Empirical_limits_in_science

10. GINI COEFFICIENT: https://en.wikipedia.org/wiki/Gini_coefficient

11. GROSS NATIONAL HAPPINESS: https://en.wikipedia.org/wiki/Gross_National_Happiness

12. GROSS NATIONAL PRODUCT: https://en.wikipedia.org/wiki/Gross_national_product

13. HEALTH EQUITY: https://en.wikipedia.org/wiki/Health_equity

14. HISTORY OF PSYCHIATRY: https://en.wikipedia.org/wiki/History_of_psychiatry

15. MEDICALISATION (PATHOLOGISATION) https://en.wikipedia.org/wiki/Medicalization

16. MERITOCRACIES: https://en.wikipedia.org/wiki/Capitalism

17. NEUROETHICS: https://en.wikipedia.org/wiki/Neuroethics

18. PARTICIPATORY ACTION RESEARCH: https://en.wikipedia.org/wiki/Participatory_action_research

19. PEOPLE-FIRST LANGUAGE: https://en.wikipedia.org/wiki/People-first_language

20. POLITICAL CORRECTNESS: https://en.wikipedia.org/wiki/Political_correctness

21. POSITIVISM: https://en.wikipedia.org/wiki/Positivism

22. QUALITATIVE RESEARCH: https://en.wikipedia.org/wiki/Qualitative_research

23. QUANTITATIVE RESEARCH: https://en.wikipedia.org/wiki/Quantitative_research

24. RANDOMISED CONTROL TRIAL: https://en.wikipedia.org/wiki/Randomized_controlled_trial

25. SOCIAL CONSTRUCTIVISM: https://en.wikipedia.org/wiki/Social_constructivism

26. SOCIOLOGY OF LANGUAGE: https://en.wikipedia.org/wiki/Sociology_of_language

27. THE BIRTH OF THE CLINIC: https://en.wikipedia.org/wiki/The_Birth_of_the_Clinic

28. THE TECHNOLOGICAL FIX: https://en.wikipedia.org/wiki/Technological_fix

29. WELFARE STATE: https://en.wikipedia.org/wiki/Welfare_state

30. WORLD VIEW: https://en.wikipedia.org/wiki/World_view

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1

ABC's Mental As … it's OK to laugh about mental health in The Conversation October 9th 2014 http://theconversation.com/abcs-mental-as-its-ok-to-laugh-about-mental-health-32689 and Franschild D Breakin' Open the Asylum in The Guardian Wednesday 4th June 2008 https://www.theguardian.com/society/2008/jun/04/mentalhealth

(Consumers have known forever that laughing with people who have had like experiences is not only OK but sometimes good therapy. People have watched Adam Hill's The Last Leg and laughed along. It's very funny. So is the older film, Takin Over the Asylum (1994 and re-released in 2008) which starred Spike Milligan and was obviously silently (behind the scene) directed by people who had experienced such places: again, very funny)

2.

Beresford P (2000) Service users' knowledges and social work theory: Conflict or collaboration? The British Journal of Social Work 30 (4):489-503

(Peter Beresford is a service user who works as a social work academic. His summation of this piece: So far, service users have not been systematically involved in social work theorizing. But, disabled people's movements, mental health service users/survivors and other service users have developed their own knowledges based on direct experience and they have generated their own conceptual frameworks and bodies of theory. There are fundamental problems in social work seeking to interpret service user knowledges. Their developments and interpretation require the direct involvement of service users and their organization in social work theorizing.)

3.

Druce V Military Metaphors In Medicine: Waging War in Refractive Index 8th February 2013 https://refractiveindex.wordpress.com/2013/02/08/military-metaphors-in-medicine-waging-war/ and Epstein M Pluck, acceptance, defiance and fortitude: telling mental illness stories to change the world in Our Consumer Place 2016 http://www.ourcommunity.com.au/files/ocp-stories2016.pdf

(In Illness as Metaphor (1978) Susan Sontag, after her own experience of having cancer, argued that some of the metaphors society uses to describe disease could result in victim-blaming (https://en.wikipedia.org/wiki/Illness_as_Metaphor). This reference is described by the above authors in relation to the use of the military metaphor which addresses illness as if it were real people. Words associated with epidemics (the bigger the better) and about beating the enemy. These might be good for raising money but less helpful for people whose experiences are described in these ways. Epstein describes several different metaphoric scenarios: their purpose, their politics, shortcomings and influence.)

4.

Farrell CT & Lillis JP An adaptation to Michel Foucault's medical authority: The Lucid Succor of the informal caregiver in Social Theory & Health November 2013 Vol.11(4):327–343 http://link.springer.com/article/10.1057/sth.2013.4

(Michel Foucault was one of the most important social thinkers of the 20th Century. His legacy lasts. He was a pioneer of Discourse Analysis. "Michel Foucault's understanding of how knowledge/power, as supported by the knowledge apparatus, made possible the Medical Gaze that has been one of the primary foundations of our understanding of the medical experience for the past 45 years… This paper "provides a short review of Foucault's model of medical authority, and introduces an adaptation to the model that accounts for the role, and impact, of the informal caregiver of the care-dependent geriatric within the existing medical milieu.")

5.

Zeeman L et al Queer challenges to evidence-based practice in Nursing Inquiry 2014 21(2):101–111 https://www.researchgate.net/profile/Alec_Grant/publication/237058760 _Queer_challenges_to_evidence-based_practice/links/54de1e720cf23bf2043a8478.pdf

("This paper aims to queer evidence-based practice by troubling the concepts of evidence, knowledge and mental illness. The evidence-based narrative that emerged within biomedicine has dominated health care. The biomedical notion of 'evidence' has been critiqued extensively and is seen as exclusive and limiting, and even though the social constructionist paradigm attempts to challenge the authority of biomedicine to legitimate what constitutes acceptable evidence or knowledge for those experiencing mental illness, biomedical notions of evidence appear to remain relatively intact. Queer theory offers theoretical tools to disrupt biomedical norms and challenges biomedical normativity to indicate how marginalisation occurs when normative truths about mental health classify those who differ from the norm as 'ill' or 'disordered'. Queer theory's emphasis on normativity serves the political aim to subvert marginalisation and bring about radical social and material change.")

6.

Radden JA Recognition rights, mental health consumers and reconstructive cultural semantics in Philos Ethics Humanit Med. 2012 7:6 http://jos.sagepub.com/content/41/3/267.abstract

("Those in mental health-related consumer movements have made clear their demands for humane treatment and basic civil rights, an end to stigma and discrimination, and a chance to participate in their own recovery… The political category of recognition rights allows us to see the extent and scope of mental health consumer movements' demands. Not only are social and economic transformation called for, so are transformed meanings and identities. My goal in this paper has been to identify and applaud the first steps towards a reconstructive cultural semantics that can be found in today's mental illness memoirs, but also to draw attention to the magnitude of the challenge involved - for consumers, practitioners, and for the rest of us - as these new meanings and realities are negotiated.")

7.

Council of Victoria WordsAtWork - Building inclusion through the power of language See more at: https://www.dca.org.au/dca-research/wordsatwork---building-inclusion-through-the-power-of-language.html#sthash.1JgSNaaZ.dpuf

(This is basic but very helpful particularly if you are new to the area and want to touch base somewhere before reading further.)

8.

Shelly J People with lived experience: The only thing more important than what you say is what other people hear when you speak http://jamesshelley.com/2016/02/13/people-lived-experience/

(This a nice little piece about whether language is stigma, whether changing the ways we call ourselves changes stigma and whether we agree on what language denotes stigma and what does not.)

9.

Pichot PJ DSM III and its Reception: A European View in American Journal of Psychiatry 154(6) 1997 http://search.proquest.com/openview/cf4caebc80b2d9d813cbe546022017b6/1?pq-origsite=gscholar&cbl=40661

(Looking back to the early editions of the DSM provides fodder for those who are interested in the presentation of American culture between the pages. It was as much about America as it was about psychiatry.)

10.

Johnson D Psychiatric Power: The Post-Museum as a Site of Rhetorical Alignment in Communication and Critical/Cultural Studies Vol.5(4) 2008

(Unfortunately, this is only available free through an academic library or through an institution if you are working there. Nonetheless, it is interesting. It looks at a lovely

BRINGING THE DIS-COURSES TO OUR TABLE

© MERINDA EPSTEIN & YOLAND WADSWORTH
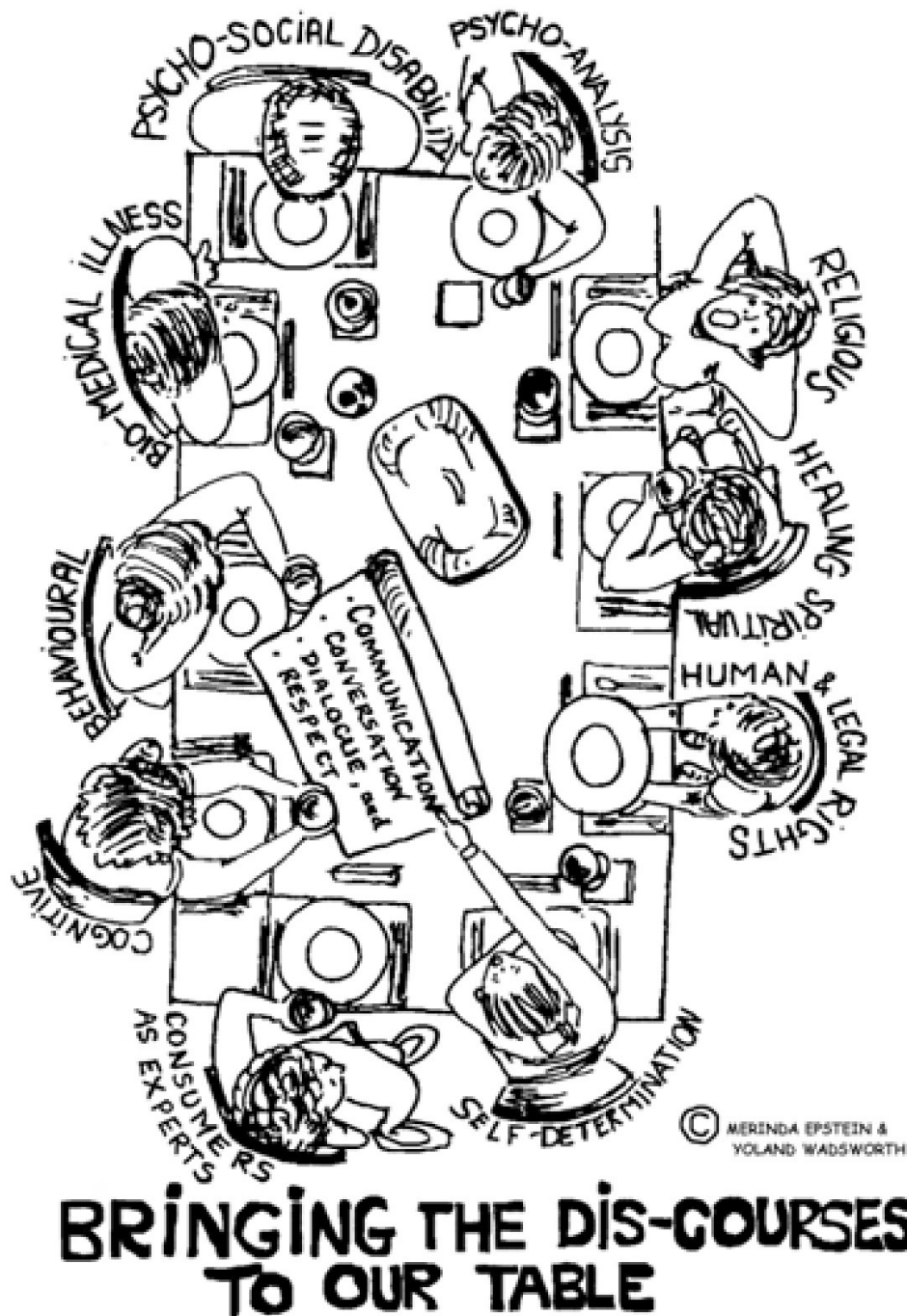
gentle quietly persuasive attempt by a pharmaceutical to see its product in a way that leaves people feeling responsible as a citizen [at last!!].)

11.

Wadsworth Y Becoming responsive—and some consequences for evaluation as dialogue across distance in New Directions in Evaluation December 2001

(Unfortunately, this is not available free except if you are an academic or affiliated to a university. It is a reflective piece written by a dedicated researcher committed to people empowerment, including work with mental health activists/consumers. Among

other things, it follows her frustrations doing this work in a social service environment (Australia-based) that says one thing and does another. Our supporters can become targets. There is also some useful evaluation theory in this paper.)

12.

Laugharne R & Laugharne J Psychiatry, postmodernism and postnormal science in Journal of the Royal Society of Medicine 2002 April 95(4):207–210.

(One of the sayings proliferated by survivors on T shirts and badges simply says 'I am the evidence'. This paper searches for a way to 'soften' evidence-based medicine to enable systems to genuinely respond to the input of consumers, not as anecdotes but as knowledge. It is interested in how to recognise and value applied science and how to recognise and applaud democracy in psychiatry.)

13.

De Leon J Is Psychiatry Scientific? A Letter to a 21st Century Psychiatry Resident in Psychiatry Investigation Sept. 2013 10(3):205–217. https://www.ncbi.nlm.nih.gov/ pmc/articles/PMC3843011/

(An experienced psychiatrist writes a letter to a psychiatry resident. He muses about psychiatry and the importance of science: "This article has attempted to provide a brief, simplified, thought-provoking description of very complex topics for interested 21st century psychiatry residents. The scientific validity of psychiatry has been systematically questioned in the US media during the last few years as the DSM-V was being developed. Is psychiatry scientific? This article tries to provide an answer in case a psychiatry resident needs to defend psychiatry from attacks by lay people who read lay media and documents found on the Internet.")

14.

Pies R Psychiatry Remains a Science, Whether or Not You Like DSM5 in Psychiatric Times, February 25th 2010 Bipolar Disorder, Major Depressive Disorder, DSM-5 http://www.psychiatrictimes.com/bipolar-disorder/psychiatry-remains-science-whether-or-not-you-dsm5

(This article describes psychiatrists' decision-making in terms of scientific method logic. Pies argues that it is a science and the scientific nature if it is imperative for successfully helping people).

15.

Epstein M   MAD MEETINGS: Consumers and Committees in Our Consumer Place http://www.ourcommunity.com.au/files/OCP/MadMeetings.pdf

(Some consumers (some clinicians, some bureaucrats) find formal meetings useful. Many don't. This is not just a matter of personal attributes, experience and bureaucratic maturity. Many present this as a given. In this booklet, Epstein argues that, especially for consumers, the discourse of medicine and the discourse of bureaucracy often silence or corrupt the consumer voice. The question is asked: How can consumers be heard when their knowledge comes from a very different place from the others around the table, especially when what they have to say is judged deviant by others who tightly control 'normal'.)

Calling Our Experiences 'Symptoms'

13. Calling Our Experiences 'Symptoms'

LOST IN A WORLD OF SYMPTOMS

Once diagnosed, attributes of healthy everyday life seem to gain layers of pathology 'as we go,' like a rock gathering moss through service systems. Alternative ways of understanding what others call symptoms may be spiritual, alternative, mystical or ecological, but lacking the authority of the 'medical' at this point in time. These understandings may bring down the full strength of the establishment as a 'duty of care' issue.

DEFICITS

Concentrating on 'symptoms' means that we are forever looking at and talking about what is wrong with us. It's unhealthy to put so much effort into criticising ourselves as we are simultaneously being lectured to "not dwell on things but do something positive". Contradictions cemented in policy, practice and everyday beliefs harm people.

TRAUMA-RESISTANT TREATMENT

People interested in how mental illness is 'made' differ in understanding its attribution. Many consumers want to know why clinicians persist in asking: "what's wrong with you?" Instead, they should say: "what happened to you?"

ONE SMALL BOOKLET

Young homeless woman. Flinders Street station. The book is called 'In a Nut Shell'. It's very small. Just right for a pocket. Poems by homeless people. The project is defunded prematurely. What's the point? One poem endured:

"I thought I would write my life story - but instead I'll just photocopy my arms."

Self-harm is a reality for many and judged harshly. It often gives meaning to lives: an act of safety. Self-harm is a storyteller's aid and not just a symptom of badness.

CATCH IT !

Sometimes consumers are relieved to see their experiences recognised by systems, the DSM, their friends and family. This occurs because the way the system works requires this 'imprimatur' to establish that their need is genuine and they therefore can no longer be demeaned as 'the worried-well'. This is sad; catching the ball is a choice that should not be judged or ridiculed by anyone.

A WIKIPEDIA ENTRY TO MADNESS

1. BIOLOGICAL PSYCHIATRY: https://en.wikipedia.org/wiki/Biological_psychiatry

2. COMPLEX POST-TRAUMATIC STRESS DISORDER: https://en.wikipedia.org/wiki/Complex_post-traumatic_stress_disorder

3. COPING MECHANISM: https://en.wikipedia.org/wiki/Coping_(psychology

4. CRITICAL PSYCHOLOGY: https://en.wikipedia.org/wiki/Critical_psychology

5. CULTURAL COMPETENCE: https://en.wikipedia.org/wiki/Cultural_competence

6. MEDICAL TEST: https://en.wikipedia.org/wiki/Diagnostic_test

7. DIFFERENTIAL DIAGNOSES: https://en.wikipedia.org/wiki/Differential_diagnosis

8. DUTY OF CARE: https://en.wikipedia.org/wiki/Duty_of_care

9. EXISTENTIAL CRISIS: https://en.wikipedia.org/wiki/Existential_crisis

10. FLOURISHING: https://en.wikipedia.org/wiki/Flourishing

11. FOLIE À DEUX: https://en.wikipedia.org/wiki/Folie_%C3%A0_deux

12. GENDER BIAS IN DIAGNOSIS: https://en.wikipedia.org/wiki/Gender-bias_in_medical_diagnosis

13. HUMANISTIC PSYCHOLOGY: https://en.wikipedia.org/wiki/Humanistic_psychology

14. MEDICAL SIGN: https://en.wikipedia.org/wiki/Medical_sign

15. MEDICALLY UNEXPLAINED PHYSICAL SYMPTOMS: https://en.wikipedia.org/wiki/Medically_unexplained_physical_symptoms

16. MEMORY & TRAUMA: https://en.wikipedia.org/wiki/Memory_and_trauma

17. MENTAL DISTRESS: https://en.wikipedia.org/wiki/Mental_distress

18. MYSTICISM: https://en.wikipedia.org/wiki/Mysticism

19. PORTAL: COMPLEMENTARY AND ALTERNATIVE MEDICINE: https://en.wikipedia.org/wiki/Portal:Complementary_and_alternative_medicine

20. POSITIVE PSYCHOLOGY: https://en.wikipedia.org/wiki/Positive_psychology

21. PSYCHIATRIC ASSESSMENT: https://en.wikipedia.org/wiki/Psychiatric_assessment

22. PSYCHOLOGICAL PAIN: https://en.wikipedia.org/wiki/Psychological_pain

23. PSYCHOLOGY – MODELS OF ABNORMALITY: https://en.wikipedia.org/wiki/Models_of_abnormality

24. SELF-HARM: https://en.wikipedia.org/wiki/Self-harm

25. SHAME: https://en.wikipedia.org/wiki/Shame

26. SOCIAL PSYCHIATRY: https://en.wikipedia.org/wiki/Social_psychiatry

27. SPIRITUAL CRISIS: https://en.wikipedia.org/wiki/Spiritual_crisis

28. SYMPTOMATOLOGY: https://en.wiktionary.org/wiki/symptomatology

29. TRANSPERSONAL PSYCHOLOGY: https://en.wikipedia.org/wiki/Transpersonal_psychology

30. TRAUMA MODEL OF MENTAL DISORDERS: https://en.wikipedia.org/wiki/Trauma_model_of_mental_disorders

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Alderman T The Relationship Between Self-Injury and Sexual Orientation: Does sexual orientation relate to self-injury? in Psychology Today Nov. 16th 2009 https://www.psychologytoday.com/blog/the-scarred-soul/200911/the-relationship-between-self-injury-and-sexual-orientation

(Consumers who have tried to find out more about the LGBTI community and self-harm have run into a road block. There has been precious little research despite the anecdotal 'evidence' suggesting there is more deliberate self-harm in the LGFBTI than in the heterosexual community – especially amongst youth. This article supports both the contention that this area has been neglected and the proposition.)

2.

Perry BL The labeling paradox: stigma, the sick role, and social networks in mental illness in Jrnl Health Soc Behaviour 2011 Dec. 52(4):460-77

(This is not available free in PDF form however if you are studying or connected to a service you can retrieve it. This paper explores whether diagnosis in itself causes stigmatising and discriminatory attitudes?)

3.

Pierre J Rebranding Psychiatry: Euphemisms, Stigma and Progress: Revising the nomenclature of psychiatry December 18th 2014   https://www.psychologytoday.com/blog/psych-unseen/201412/rebranding-psychiatry-euphemisms-stigma-and-progress

(This is well worth a read. It is short. It looks firstly at the way the names (not the generic ones) of medications change to corner markets and sell new ideas as well as products. As importantly, it then looks at the role of change in the naming of illnesses in the pursuit of neutrality which then gets undone by social attitudes as rebranding is not followed by real changes in real perceptions. It's good and easy albeit challenging in the content.)

4.

Grixti N Exploring Meaning in Experience 2016 file:///C:/Users/Merindz/Downloads/ b2657f19b1f04c14b2c9ea0ed04fb2c8ngrixticrowdfunding2016explorngmeaninginexperience%20(1).pdf

(Nathan Grixti explores psychosis as a very human, healthy, spiritual phenomenon which can be enlightening rather than looking for symptoms of illness to be blunted with psychiatric drugs.)

5.

Cassani M "Madness" as a spiritual and awakening journey in Everything Matters: beyond meds December 13th 2008 https://beyondmeds.com/2008/12/13/madness-as-a-spiritual-and-awakening-journey/

(While many people diagnosed with mental illness do experience high levels of distress, a large number of people who have received diagnoses describe their experiences as being positive, helpful, and often useful in their lives, while many others report a mix of both positive and negative experiences. Many people find psychiatric models of mental illness and treatment helpful, however research suggests that medication is only effective for a relatively low number of people, while others report not wanting treatment for their experiences as they feel they are an important part of who they are…)

6.

Chandler A Narrating the self-injured body in Journal of Medical Humanities 2013 http://mh.bmj.com/content/early/2014/06/16/medhum-2013-010488.full

(This is a fascinating paper which looks not only at the narrative of self-harm but also the narrative of living with the externalised consequences of talking to society through a self-harm narrative. "Illness narratives have traditionally been used as a conceptual tool for exploring experiences of chronic illness or disease. In this paper, I suggest that Frank's typology of illness narratives (chaos, restitution and quest) also offers an illuminating approach to analysing accounts of self-injury, demonstrating the diverse ways in which self-injury is practiced, experienced and narrated.")

7.

Daya I When I went down the rabbit hole: my beginnings of madness http://www.indigodaya.com/downtherabbithole/

("I was anxious in grade one, was that the beginning? What about when I tried to overdose on Paracetamol at thirteen, was that madness? What about when I was 22, couldn't stop my mind racing and found it hard to sleep? Or when I was 26, struggled with existential questions and contemplated stepping in front of trucks when I crossed the road?')

8.

Diamond RJ Psychiatric Presentations of Medical Illness: An Introduction for Non-Medical Mental Health Professionals in Safe Harbor 1/7/2002 http://www.alternativementalhealth.com/psychiatric-presentations-of-medical-illness/

(Those interested in consumers having physical illnesses missed because all symptoms are seen as psychiatric will find this article interesting. Misdiagnosing physical illness (or not reporting signs of physical illness) is more common than we think. There's a theory amongst consumers that once someone is diagnosed with mental illness (or before someone is diagnosed with mental illness if he/she presents in certain ways) everything

will be seen as masked mental illness, sometimes even when they are blatantly not... all things will point to crazy or manipulative or... This paper takes a peek behind the scenes.)

9.

Jacob KS Psychiatric assessment and the art and science of clinical medicine in Indian Jrnl of Psychiatry 2012 April-June 54(2):184-187 http://www.ncbi.nlm.nih.gov/ pmc/ articles/PMC3440915/

(This paper looks at the medicine of psychiatry – the medical model. It is designed as a teaching tool to train registrars the science of clinical medicine and the interpretation of symptoms and responses to them. This is a classical read to balance against some of the alternative ways of interpreting consumers' experiences.)

10.

Lickerman A When Doctors Don't Know What's Wrong in Reflections of a Buddhist Physician http://www.happinessinthisworld.com/2009/04/26/when-doctors-dont-know-whats-wrong/#.VfqYpnkVj7A

(This is a terrific little paper. Do not be put on or off by the graphics. This experienced doctor teaches us in easy point form how doctors are taught to diagnose – the formula(s) they are taught to follow to turn our experiences into diseases. Ironically, in a family physician/physical illness context the emphasis is on finding ways to express things so the GP will take what you say seriously and offer attention if not a proper diagnosis. In the case of a psychiatric diagnosis, it is often the opposite. Some people don't want to be forever diagnosed with something they don't believe is pathological.)
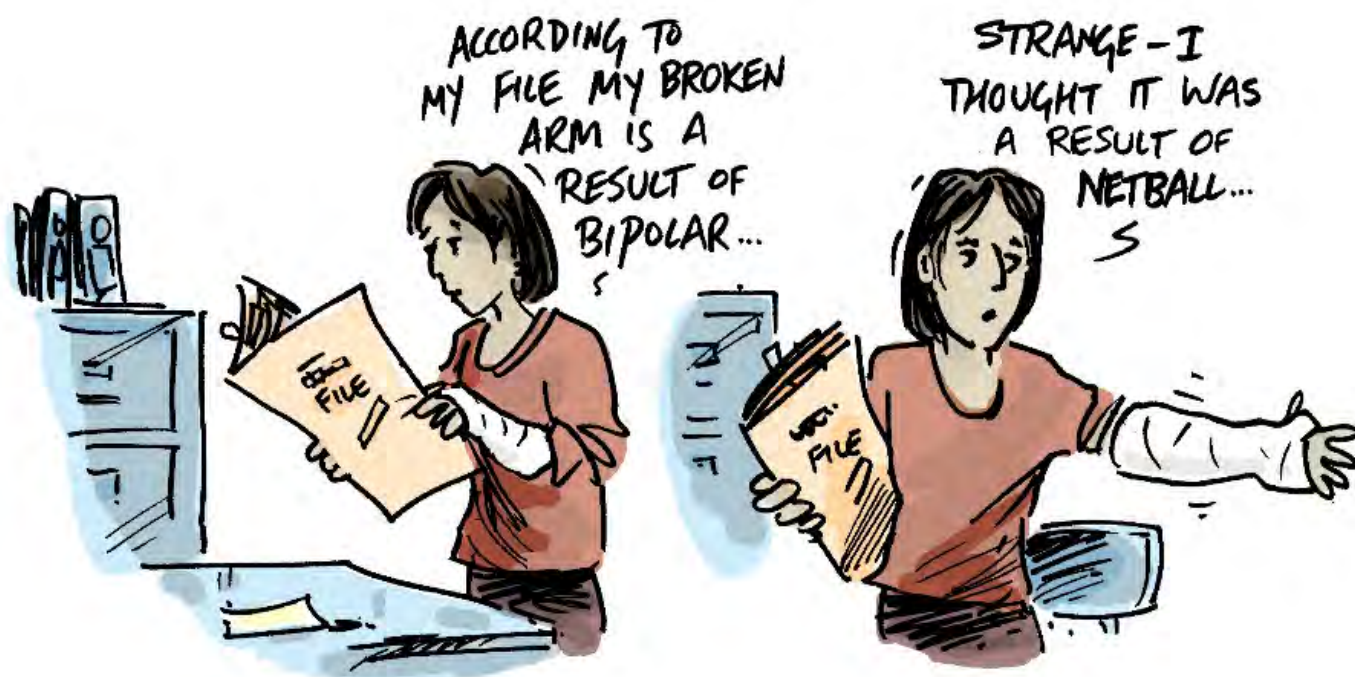
11.

Mitchell S Spiritual aspects of psychosis and recovery in Cook C, Powell A & Sims A eds. Spirituality and Psychiatry 2009 London http://www.rcpsych.ac.uk/pdf/Susan%20 Mitchell%20Spiritual%20aspects%20of%20psychosis%20and%20recovery%20edited. pdf

(How do we make sense of spirituality and the psychotic experience? Psychiatrists often struggle to make sense of and progress with people suffering from psychosis and to support their personal journeys towards recovery. Yet, while psychosis is at the heart of psychiatry, psychiatrists have often dismissed or regarded with distrust the spirituality that is valued by many of their patients)

12.

Unger R Trauma, Psychosis and Spirituality: What's the Connection? Recovery from 'Schizophrenia' and other 'psychotic disorders' January 8th 2011 http:// recoveryfromschizophrenia.org/2011/01/trauma-psychosis-and-spirituality-whats-the-connection/

(This piece looks at psychosis and spirituality: "There is a perennial question directed toward those of us who see madness as having a spiritual dimension, and it goes something like this: "How can "psychotic" experiences that are both terrifying and debilitating be seen as at all spiritual? Isn't it true that looking for spirituality within psychosis is just a case of "romanticizing madness"?)

ACCORDING TO MY FILE MY BROKEN ARM IS A RESULT OF BIPOLAR...

STRANGE – I THOUGHT IT WAS A RESULT OF NETBALL...

13.

Poussaint AF Is Extreme Racism a Mental Illness? Yes! It can be a delusional symptom of psychotic disorders in West Journal of Med. 2002 Jan. 176(1):4 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071634/

(This will put the cat among the pigeons… what can be generalised from this – if anything?)

14.

Metzi JM & MacLeish KT Mental Illness, Mass Shootings and the Politics of American Firearms in Am. J. Public Health 2015 February 105(2):240–249

(This is about public diagnosis (our experiences are your symptoms!) "Four assumptions frequently arise in the aftermath of mass shootings in the United States: (1) that mental illness causes gun violence, (2) that psychiatric diagnosis can predict gun crime, (3) that shootings represent the deranged acts of mentally ill loners, and (4) that gun control "won't prevent" another Newtown (Connecticut school mass shooting).")

15.

Medically Unexplained Symptoms in Royal College of Psychiatry (UK) http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/medicallyunexplainedsymptoms.aspx

(This is a great little pamphlet trying to describe in a non-judgemental and non-patronising way what happens when we have experiences that seem to sit on the border between physical and mental illness and are thus far unexplained. The word that is often used to describe these experiences that don't seem to indicate physical illness but 'present' in believed symptoms is Somatoform Disorder. This can be judgemental and cruel. This pamphlet is great because it does not use these labels. Hopefully they are fair dinkum.)

16.

Heathmont GP Bringing it up: 13 tips for talking with your physician about depression; September 11th 2016 http://mentalhealth.fitness/bringing-it-up-13-tips-for-talking-with-your-physician-about-depression/

(This is written by a GP. Despite some tone problems it is useful. The reason it is included is to remind everyone that the assumptions made by people who have similar experiences may be quite different from those of another group of individuals. Many people with depression need guidance in how to turn their experiences into medically recognisable symptoms in order to find relief and be taken seriously. The very last thing many people need is to 'lose their symptoms' again. This is in no way a comment about seriousness, legitimacy or worth. It is a comment about the politics of mental illness in all its complexity. This article reminds us.)

False Gods and Demagogues

14. False Gods and Demagogues

BOUND BY SOCIETY

To some extent, all diagnoses are a social experience. Small-scale societies have particular experiences we don't encounter in western societies. Interpreting these through our (perhaps) very odd perspective is pretty pointless and patronising. It's good to remember this and that all of us are culturally bound and our experiences are forever relative.

BUYER BEWARE, LEARNED DEPENDENCE

Mental illness systems can breed dependence and then make people feel guilty for being dependent - which is cruel. This problem crosses the spectrum of the mental illness industry. This problem is perhaps worse in the private system, where people lose confidence to fight the myriad of 'therapy goods' on offer by hospitals in consort with health insurance companies and the pharma industry.

'TOO-POOPED' TO PARTICIPATE

Sometimes life is just too difficult, prejudiced too much, experiences too trying, consequences awful. For some, the acute unit is community. Embroiled in the culture of medical institutions, people sometimes experience them as good, safe places. Paradoxically, our culture decrees that you are supposed to say you 'hate them.' Sometimes trying to find 'safe' gets you dismissively labelled a 'frequent flyer'.

POWER CORRUPTS IN STRANGE WAYS

As active players in the consumer movement, we believe (most of us do anyway) to be ethically restrained about promoting private psychiatrists, private hospitals and pharmaceutical products. Being unethical to promote this industry does not mean that some people don't find them useful. There is a very murky line between what is 'care and hope' and what is the commercialisation of despair.

YOU ARE RESPONSIBLE FOR YOU LIFE AS LONG AS YOU LIVE IT OUR WAY!

There are organisations which promote recipes for hope, recipes for health and for staying well, recipes for daily living and even recipes for staying alive. These recipes usually come with an implicit proviso that 'if it doesn't work, it's our fault'. It's hard to understand how another layer of shame could possibly be helpful.

A WIKIPEDIA ENTRY TO MADNESS

1. ASCLEPIUS: https://en.wikipedia.org/wiki/Asclepius

2. ACEPHALOUS SOCIETIES: https://en.wikipedia.org/wiki/Acephalous_society

3. COMMUNITY PSYCHOLOGY: https://en.wikipedia.org/wiki/Community_psychology

4. COMPLIANCE: https://en.wikipedia.org/wiki/Compliance_(medicine)

5. CONSERVATIVE CORRECTNESS: http://rationalwiki.org/wiki/Conservative_correctness

6. CULTURALLY BOUND SYNDROME: https://en.wikipedia.org/wiki/Culture-bound_syndrome

7. CODEPENDENCE: https://en.wikipedia.org/wiki/Codependency

8. TRANSFERENCE: https://en.wikipedia.org/wiki/Transference

9. EMPIRICISM: https://en.wikipedia.org/wiki/Empiricism

10. EPISTEMOLOGY: https://simple.wikipedia.org/wiki/Epistemology

11. FEMINIST THERAPY: https://en.wikipedia.org/wiki/Feminist_therap

12. HEGEMONIC: https://en.wikipedia.org/wiki/Hegemony

13. IATROGENIC: https://en.wikipedia.org/wiki/Iatrogenesis

14. INDEPENDENCE: https://en.wikipedia.org/wiki/Independence

15. INTERDEPENDENCE: https://en.wikipedia.org/wiki/Interdependence

16. INFANTILISM: https://en.wikipedia.org/wiki/Paraphilic_infantilism

17. INTERDEPENDENCE THEORY: https://en.wikipedia.org/wiki/Interdependence_theory

18. LEARNED HELPLESSNESS: https://en.wikipedia.org/wiki/Learned_helplessness

19. LIAISON PSYCHIATRY: https://en.wikipedia.org/wiki/Liaison_psychiatry

20. MEDICAL ETHICS: https://en.wikipedia.org/wiki/Medical_ethics

21. MEDICAL HISTORIES: https://en.wikipedia.org/wiki/Medical_history

22. MEDICAL RECORDS: https://en.wikipedia.org/wiki/Medical_record

23. NEOLIBERALISM: https://en.wikipedia.org/wiki/Neoliberalism

24. ONTOLOGY: https://en.wikipedia.org/wiki/Ontology

25. ORGANISED RESISTANCE: https://en.wikipedia.org/wiki/Resistance_movement#Other_resistance_movements

26. PEOPLE'S HEALTH MOVEMENT: https://en.wikipedia.org/wiki/People's_Health_Movement

27. PHILOSOPHY OF HEALTH CARE: https://en.wikipedia.org/wiki/Philosophy_of_healthcare

28. PSYCHIATRIC SURVIVORS MOVEMENT: https://en.wikipedia.org/wiki/Psychiatric_survivors_movement

29. PSYCHOLOGICAL RESISTANCE: https://en.wikipedia.org/wiki/Psychological_resistance

30. THE FOURTH ESTATE: https://en.wikipedia.org/wiki/Fourth_Estate

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Sartorius N Iatrogenic stigma of mental illness: Begins with behaviour and attitudes of medical professionals, especially psychiatrists in BMJ 2002 June 22nd 324(7352):1470–1471 https://en.wikipedia.org/wiki/Intersectionality

(Norman Sartorius is a famous psychiatrist. In this paper he still travels 'the psychiatry route' but tries to examine the ways that labels and the assumptions that go with them can be damaging to the health of the patient. The contradictions seem obvious when you think about them. "Psychiatrists and other mental health staff also stigmatise patients in other ways. Until recently psychiatrists in some European countries and elsewhere were requesting longer holidays and a higher salary than other doctors because they had to work with mentally ill patients who are dangerous, while arguing, at the same time, that mental illness is no different from other illnesses. Psychiatrists are among those who recommend separate legislation for people with mental illness to protect some people with mental illness, often unaware of the effect that such legislation might have on all other patients. They should certainly continue to do whatever is necessary to protect their patients; but it would help if they also advocated the notion that the rights and duties of people with mental illness should be decided by their behaviour and capacities in the same manner as for other people rather than by the diagnostic label alone.")

2.

Eastman M & Starling B Mental disorder ethics: theory and empirical investigation in Journal of Medical Ethics 32(2):94-99 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563333/

(This paper is included partially because it demonstrates how easy it is to dismiss the 'consumer-as-expert' or especially the most central expert knowledge. "[The] Trust's biomedical ethics programme convened a meeting, "Investigating Ethics and Mental Disorders", in order to review some current research and to stimulate topics and methods of future research in the field. The meeting was attended by policy makers, regulators, research funders, and researchers, including social scientists, psychiatrists, psychologists, lawyers, philosophers, criminologists, and others. Once again, we were cast as an 'other' and in the area of ethics this is very disappointing. This is especially so as the conclusion noted that: "Perhaps the most significant outcome of the meeting, however, related not to topics but to methods. Out of what threatened to be a divisive interdisciplinary war over the 'territory' of biomedical ethics arose consensus. Although different disciplines, both theoretical and empirical, may variously conceptualise and

operationalise 'ethics', the subject is not defined by any one method. There is likely to be much advantage in methodological pluralism and in pursuing a 'circle of inquiry' between theory and empiricism, both within any single project and across projects. Finally, based on the deliberations of this meeting, biomedical ethics is clearly not a discipline but a field of inquiry." I was intrigued that we were excluded in a paper that, at its conclusion, listed the first two references as Thomas Szasz's: 'The myth of mental illness: foundations of theory of personal conduct; and 'Law, Liberty and Psychiatry'. As the father of anti-psychiatry it doesn't make sense to invite Szasz (the works of) and not us. It's worth reading, ethics is interesting and it's a discipline to explore how things could have been different if the central players had been given seats at the table.)

3.

Edwards K Inside a Psychiatric Ward in The Sydney Morning Herald July 21st 2016

(This is pretty easy journalism. The journalist describes going to see her friend, Jill, in a psychiatric ward. She gets a big shock. She is particularly concerned about the way her friend is infantilised and how so many patients play along with this to get out. "'Everybody hates being here. People talk about killing themselves, not because they want to die but because they want to get out of the hospital', said my friend Julie.")

4.

Hyde J Commentary: Lessons From Australia in the Public Funding of Mental Health Services in Canadian Psychology/Psychologie Canadienne © Canadian Psychological Association 2014 Vol. 55(2):139 –143

(I opened this with great excitement thinking I had found something most interesting. It is difficult to find really good discussions about the link between public and private funding of psychological services. Unfortunately it seemed to turn into a dissertation of the worth of one group of psychologists over another (or others who provide therapy – social workers and occupational therapists) within the context of competing with other professional groups, particularly psychiatry. When will they learn that what makes the difference for us is not the sophistication of the scale but rather the qualities of the person?)

5.

Verhaeghe P What about Me? The Struggles for Identity in a Market-Based Society Scribe Publications Melbourne 2014

(This is a terrific little paperback, well-written and illustrated with stories and clever anecdotes as well as sound arguments. It's very readable. Written by a psychiatrist and university lecturer from Belgium, it contains the European moderation and nuance in the way ideas are expressed. The chapters are: Identity; Ethics: from self-realisation to self-denial; The Perfectible individual; The essence of Identity;   Intermezzo: society and disorder Enron Society; Identity: powerless imperfectibility; The New Disorders: rank and yank & The Good Life. Verhaeghe contends that in 21st Century psychiatry we have lost our understanding of the social and its impact on mental illness and health. "Despite the neurobiological hype, a strong link has now been scientifically and clinically established between certain forms of social organisation and the mental disorders that occur in a given society. As usual, this is easiest to see with hindsight; we are blind to what goes on in our own day and age." (193) He notes that: Where previously the

focus had been on social progress, in the last quarter of the 20th Century it shifted to the perfectibility of the individual. This took on three dimensions. First, individuals were expected to perfect their minds; they were also expected to perfect their bodies; and last, but certainly not least, they were given the message to perfect themselves in a socio-economic sense. P 73)

6.

Leighton AH & Hughes JM Cultures as a Causative of Mental Disorder 2005 Dec. 83(4):10 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690278/

(This article is fascinating. Written by anthropologists, it looks at how small-scale societies sometimes support people who experience very specific perceptions that are never seen in other cultures. These are described and some seen bizarre. The authors suggest that we must be very careful not to put modern western labels on these experiences. The importance of this anthropological work is to demonstrate that mental illness is relative to society and its culture – including our own.)

7.

White RC The Culture of Mental Health: Does culture matter in mental health? in Psychology Today September 19th 2011 https://www.psychologytoday.com/blog/culture-in-mind/201109/the-culture-mental-health

(This BLOG looks at the culture of mental illness and mental health. Depending on who we are, where we are and what we are doing, there are different norms and mores – different accepted ways of doing things, understanding things and experiencing things. This is an important lesson and an easy read.)

8.

Wasserman JA & Clair MJ At Home on the Street: People, Poverty and a Hidden Culture of Homelessness https://www.rienner.com/title/at_home_on_the_street_people_poverty_and_a_hidden_culture_of_homelessness and Philipps K Homelessness: Causes, Culture and Community Development as a Solution Thesis Submitted at Salve Regina University April 21th 2012 http://digitalcommons.salve.edu/cgi/viewcontent.cgi?article=1088&context=pell_theses

(Wasserman's and Clair's book is not available on-line but it looks great. It is available in paperback and might be worth the investment. It is well reviewed. "Calls attention to the complexities and contradictions of research on homelessness and offers insights about how to think about homelessness in new ways…. The reflections provided by the researchers about their research experiences will be very helpful to students who are learning about fieldwork and ethnographic research." (Harriett Romo, Teaching Sociology) The second document (Philipps) is a doctoral thesis, so it's long but it is really easy to read and the headings make it easy to navigate. I'm impressed with the term, 'psychological unsteadiness' to describe some of what others may have partitioned-off as 'mental illness'. Philips contends that: "There are a myriad of contributing factors that lead to homelessness. The strongest predictor is a tumultuous upbringing. Instability within the home is the greatest catalyst of most mental health problems and by extension substance abuse and other psychological unsteadiness. First definitions of the major terms used are examined. ")
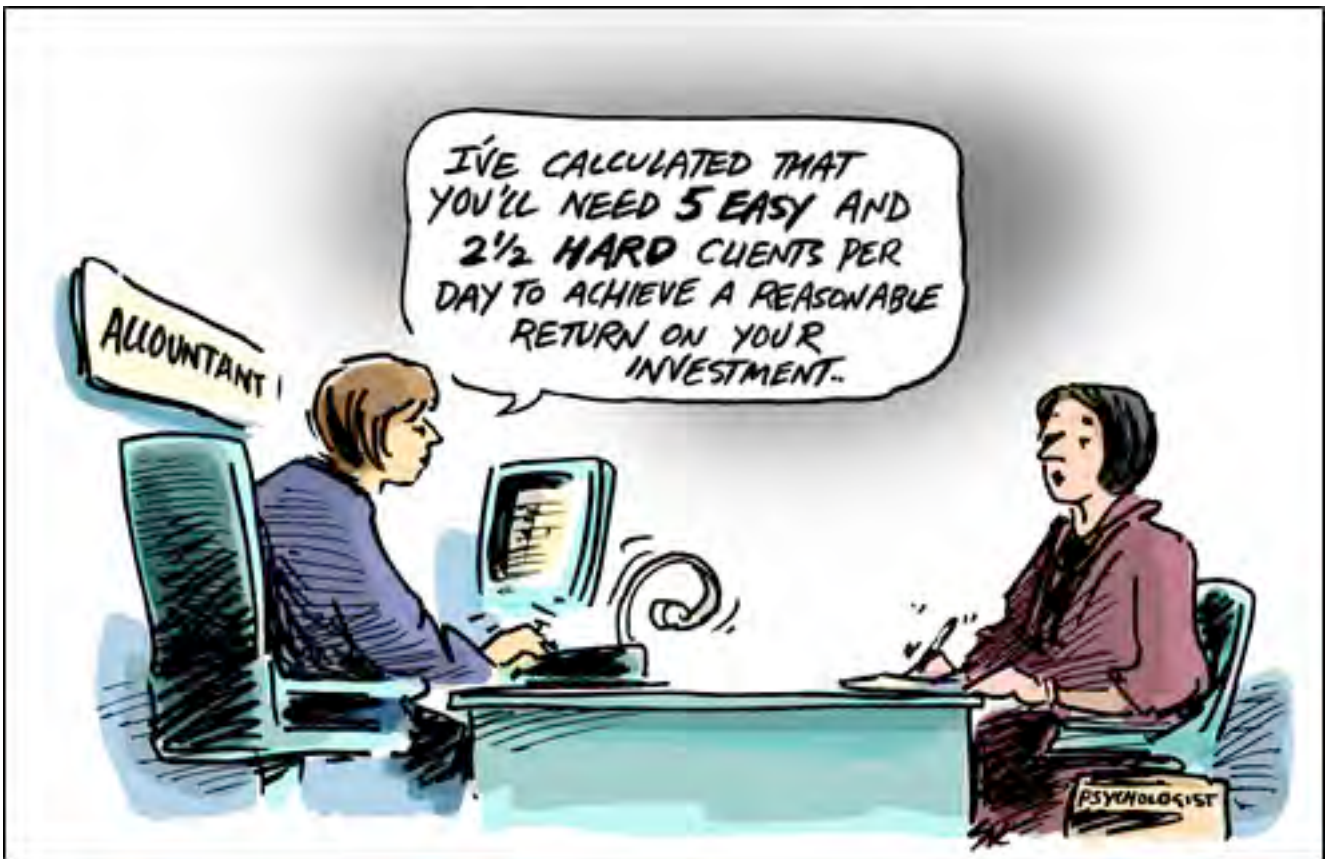
9.

Wright ER, McCabe H & Kooreman HK Institutional Capacity to Respond to the Ethical Challenges of Patient Sexual Expression in State Psychiatric Hospitals in the United States in Journal of Ethics in Mental Health 2012 7:1-5 http://scholarworks.gsu.edu/cgi/viewcontent.cgi?article=1005&context=sociology_facpub

(This is an issue that is important to a lot of consumers, often for very different reasons. Some call for 'women's only' units (which did not get a mention here; on the other hand, many of us really do not want to be treated like children especially when we are forced to endure residency when we had committed no crime. For many of us who have been sexually traumatised in psychiatric units, this is an important issue. It also crosses over with issues to do with caring for people with co-existing intellectual issues in psychiatric units. Some illness experiences leave women disinhibited and vulnerable. The paper concludes: 'Patient sexual expression poses complex ethical challenges for clinical staff and administrators in state psychiatric institutions. While there has been some progress in the development of formal policies and procedures, the situational nature of patient sexual expression as well as the complex relationship between mental illness and sexuality demand that treatment providers be well prepared to intervene and balance the individual rights and needs of patients with protecting the group treatment milieu.')

10.

Namysłowska I & Siewierska A Ethical dilemmas of family therapy in the adolescent psychiatric ward in Archives of Psychiatry and Psychotherapy 2008 3:61−64 http://www. archivespp.pl/uploads/images/2008_10_3/61_p_Archives_3_08.pdf

(The culture of a psychiatric hospital or unit is a particular one with many loyalties crossing paths and multiple sensitivities. This paper looks at the possibilities and pitfalls of introducing family therapy into this mix.)

11.

What happens when doctors are patients? Qualitative study of GPs in British Journal General Practice 2009 Nov 1st 59(568):811−818. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2765832/

(This is qualitative research and there are some insightful quotes. The study concluded that there are four effects treating a patient who is a doctor or being a doctor who is the patient has on the dyad and on the individual: "Four main categories emerged from the data. The category, 'Who cares when doctors are ill?' embodies the tension between perceptions of medicine as a 'caring profession' and as a 'system'. 'Being a doctor–patient' covers the role ambiguity experienced by doctors who experience significant illness. The category 'Treating doctor–patients' reveals the fragility of negotiating shared medical care. 'Impact on practice' highlights ways in which personal illness can inform GPs' understanding of being a patient and their own consultation style." These learnings are generalizable to other areas of medicine including psychiatry although one would imagine there would be a fifth dimension of 'secrecy and perhaps shame'.)

12.

Williamson AE et al Understanding "revolving door" patients in general practice: a qualitative study in Biomedcentral Family Practice 2014 (1)5:33 http://bmcfampract. biomedcentral.com/articles/10.1186/1471-2296-15-33

(This is a fascinating article. It is, in part at least, a response to an article about those who misuse primary services by being 'inappropriate, demanding, turning up too often, taking too much time and so on. The original study and article named this as 'the good and bad patient'. This piece moves back from this. This is a qualitative study of GP attitudes towards and explanations for 'revolving door patients'. Many GPs were perplexed, even mystified. Many were judgemental because they felt powerless. In relation to mental illness, nearly all the GPs did not include people with 'real' mental illness in this group even when their behaviours were challenging. This seems to be because it was explainable – something medical doctors hold dear. At the same time, nearly all GPs labelled people in this group (that so annoyed them and their practice) personality disorders. This is a tradition and it is circular logic that goes: "We don't like you so you must have a personality disorder. You have a personality disorder so we don't like you." Part of their frustration was that they couldn't refer anywhere. They were angered by a mental health system that seemed to take no responsibility for people the General Practitioners saw as mentally ill. In the minds of some of the GPs it was a choice, if any choice at all, between being angry with the individual people or being angry at the psychiatric system. Coming through was a compassion of sorts but it was an unharnessed one. Complicating matters, there can sometimes be a stand-out GP

in a practice who sincerely likes working with the complexity these people bring and works well with them recognising real need. Unfortunately, the way GP practices run, doctors who work in this way can be seen by their peers as losing money for the practice and encouraging dependence. It is handy for consumers to get a bit of insight about 'doctor work' that comes through this paper. It is still a doctor piece in a journal about biomedical medicine. Alternatives outside medical services were not introduced.)

13.

Discharged from a mental health admission ward: is it safe to go home? A review on the negative outcomes of psychiatric hospitalization in Psychol. Res. Behavioral Managment 2014 7:137–145 https://effectivehealthcare.ahrq.gov/ehc/products/596/1959/psychiatric-readmissions-protocols-140904.pdf

(There are multiple issues raised in these two papers (and many more similar ones if you want to follow this trail). The first paper is interested in what happens immediately after discharge. There is commonly a spate of people suiciding within fourteen days of discharge from a psychiatric hospital in both the private and public sectors. This is one of the reasons why the Victorian governments introduced PARC services: a step up, step down facility for patients who actually get into a public psychiatric hospital to gradually get back to ordinary life. The first paper mainly talks about this crucial time post admission. It is very medical. It is very interested in what others can do to and on people who have become institutionalised. It says nothing about the private sector.)

14.

What is the experience of being in a psychiatric hospital like? in Quora BLOG https://www.quora.com/What-is-the-experience-of-being-in-a-psychiatric-hospital-like

(This shows what our modern digital age can produce when it's behaving! Eighty-two people talk about their time in a psychiatric hospital. They have mixed reviews and some are in more detail than others. Quite a few described their experience of these psychiatric units as Kafkaesque (http://www.nytimes.com/1991/12/29/nyregion/the-essence-of-kafkaesque.html?pagewanted=all). Some of them have caught so well the very important things that make these experiences so surreal: The well-meaning matronism; the medication queue; the hand written lists of what you can and can't say, can and can't do, can and can't be –mostly with spelling mistakes in public hospitals; being searched by kind nurses who don't want to do it and being searched by others who do want to do it; the routine, boredom, idiotic groups you have to go to for no reason, having no vases (not even cardboard ones) because there is no expectation that anyone will be given flowers. And the learning of the culture and how to be a 'good' or 'bad' patient. On it goes. It's a pot of gold in terms of helping others to understand the small things about being admitted to these places. Of course there is also tragedy. Some people were abused, forced, locked up, damaged and badly manipulated with threats (and realities).These sit side by side with more healthy descriptions. It has strength in that there is no attempt to analyse. The descriptions stay whole. This is recommended reading for consumers to see some of their experiences on print and to help people address a reluctant family, school, church, Mothers' club, Auntie and Grandad , showing that talking about these places isn't so dangerous after all. I was really pleased to say that most people used their real name. This is a statement of strength. If they didn't the pseudonyms were good.)

15.

Poulton C Beyond a medical model of mental illness: Part 1 – What's in a name? http://www.growingawareness.com.au/beyond-a-medical-model-of-mental-illness

(This is a clearly written summation of many of the references you may have already read. It describes some of the major issues discussed in other sections: What is the medical Model and how sound is this conceptualisation? Is psychiatry scientific? How does diagnosis work? What are different sorts of treatment... It uses story which is refreshing and it encourages people to see beyond pathology. The thesis is that you don't have to be 'sick' all the time to deserve care. Don't ever feel guilty for having a need. It's the opposite of the 'worried well' contentions and assumptions.)

15.

We Don't Talk About Diagnoses!

15. We Don't Talk About Diagnoses!

MEDICAL DEFINITIONS OF SELF

There is wariness within the consumer movement about using the language of the dominant discourse – medicine. Language and discourse can be tools of oppression. The language of diagnosis is not our language and we are more than just a category of pathology. This is not an agreed position, but it is a widely supported one.

LANGUAGE OF THE NUTHOUSE

Many consumers prefer to reclaim language that has been used against us (and sometimes still is). This has been a political strategy of many social change movements, including the women's and queer movements. Mad, crazy, nutty, loopy or 'having a roo loose in the top paddock' is a statement of pride, not an admission of pathology!

LOCKED IN and LOCKED OUT

There seems to be some differences between people who are locked-in the system and those who are locked-out, because their diagnosis fails to attract what they believe will be 'care.' As much as it is a statement of oppression to some, to others it is blessed relief. There are also those who jump at changes in their diagnostic circumstance to flee institutional control.

DIAG-'NO'-STICK GROUPS

Some groups hold as a guiding principle that - as far as they are concerned - comparing people using diagnostic criteria is unacceptable. Such groups are proud of the 'no diagnosis' policy. Other groups congregate around a diagnosis. For many, accepting one's diagnosis and being able to attend a specific support group gives a sense of achievement and hope. For others it is intolerable.

CODE?

Groups not wanting to use the language of medicine sometimes end up replacing diagnoses with code; most common is 'voices,' which people know mostly means psychosis. Other more sinister examples include attempts to curtail people of their chance to be proud of themselves and their diagnosis (sometimes with the most abject labels); 'somatoform,' 'factitious' and all the 'personality labels' are never cover girls of Mad Pride.

WIKIPEDIA INTRODUCTION TO MADNESS

1. ACTIVISM: https://en.wikipedia.org/wiki/Activism

2. ADVOCACY GROUP: https://en.wikipedia.org/wiki/Advocacy_group

3. CONSCIOUSNESS RAISING: https://en.wikipedia.org/wiki/Consciousness_raising

4. CONSENSUS DECISION MAKING: https://en.wikipedia.org/wiki/Consensus_decision-making

5. GROUP COHESIVENESS: https://en.wikipedia.org/wiki/Group_cohesiveness

6. GROUP DECISION-MAKING: https://en.wikipedia.org/wiki/Group_decision-making

7. HEARING VOICES MOVEMENT: https://en.wikipedia.org/wiki/Hearing_Voices_Movement

8. LABELING THEORY: https://en.wikipedia.org/wiki/Labeling_theory

9. MAD PRIDE: https://en.wikipedia.org/wiki/Mad_Pride

10. MEDICAL SLANG: https://en.wikipedia.org/wiki/Medical_slang

11. MEDICAL TERMINOLOGY: https://en.wikipedia.org/wiki/Medical_terminology

12. MENTALISM: https://en.wikipedia.org/wiki/Mentalism_(discrimination)

13. MORES: https://en.wikipedia.org/wiki/Mores

14. NORMS: https://en.wikipedia.org/wiki/Norm_(social)

15. PEER GROUP: https://en.wikipedia.org/wiki/Peer_group

16. POLITICAL AGENDA: https://en.wikipedia.org/wiki/Political_agenda

17. POPULAR CULTURE: https://en.wikipedia.org/wiki/Popular_culture

18. RE-APPROPRIATION: https://en.wikipedia.org/wiki/Reappropriation

19. RECLAIMED WORDS and LEXICOGRAPHY: https://en.wikipedia.org/wiki/Category:Reclaimed_words

20. THE PERSONAL IS POLITICAL: https://en.wikipedia.org/wiki/The_personal_is_political

21. REFORM MOVEMENTS: https://en.wikipedia.org/wiki/Reform_movement

22. SANISM & DANGEROUSNESS: LANGUAGE OF MEDICINE: https://en.wikipedia.org/wiki/Mentalism_(discrimination)

23. SELF-CONCEPT: https://en.wikipedia.org/wiki/Self-concept

24. SELF-ESTEEM: https://en.wikipedia.org/wiki/Self-esteem

25. SICK ROLE: https://en.wikipedia.org/wiki/Sick_role

26. SOCIAL MOVEMENT THEORY: https://en.wikipedia.org/wiki/Social_movement_theory

27. SOCIAL MOVEMENTS: https://en.wikipedia.org/wiki/Social_movement

28. SUPPORT GROUP: https://en.wikipedia.org/wiki/Support_group

29. VOICE HEARING (PSYCHOSIS) https://en.wikipedia.org/wiki/Auditory_hallucination

30. WHAT IS SELF-HELP REALLY? https://en.wikipedia.org/wiki/Self-help

ANNOTATED REFERENCES TO SUPPORT THE DISCUSSION

1.

Alpern SK Dismantling the dominant narrative of the irreversibility of schizophrenia: three meaning-making approaches to psychosis in Theses, Dissertations and Projects 2013 Paper 594 http://scholarworks.smith.edu/cgi/viewcontent.cgi?article=1671&context=theses

(This is a PhD thesis – long but easily navigated. It is not easy, especially for people unused to academic writing. Nonetheless it is important. This is about moving the thinking about Schizophrenia away from objective science and towards subjective experience and inter-subjectivity. In so doing, the author discusses the Hearing Voices Movement, phenomenological psychiatry/psychology and the Open Dialogue Movement.)

2.

Corstens D Auditory hallucinations: Psychotic symptom or dissociative experience in Hearing Voices Maastricht November 7th 2014 http://www.dirkcorstens.com/publications/

(This is a video by Dirk Corstens about hearing voices; his other academic work can be found following the above link.)

3.

Learning to Hear with Voices in Your Head: Some Experts Think the Problem is how Doctors and Society treat People who Hear Things, not the Voices Themselves in The Atlantic November 5th 2014 http://www.theatlantic.com/health/archive/2014/11/learning-to-live-with-the-voices-in-your-head/382096/#disqus_thread

(This is mainstream media, the experts are consumers and this is acknowledged. The comments add to it.)

4.

Morrison LA Matter of Definition: Acknowledging consumer/survivor experiences through narrative in Radical Psychology 2006(5) http://www.radicalpsychology.org/vol5/Morrison.html and Epstein M Pluck, acceptance, defiance and fortitude: telling mental

illness stories to change the world in Our Consumer Place, February 2016 http://www.ourcommunity.com.au/files/ocp-stories2016.pdf

(Linda Morrison is an important thinker and writer in this area. Follow her if you are interested in a sophisticated discussion of survivor critique and creative new ways of knowing and speaking. This paper looks at alternative narratives to the medical model. The second article, by Merinda Epstein, searches for ways to understand the way consumers find to describe their identity in the face of mental illness.)

5.

Seeman M What's the best term for 'psychiatric patient'? University of Toronto [BLOG] https://www.researchgate.net/post/Whats_the_best_term_for_psychiatric_patient and

Epstein M The Language of Consumerism http://www.ourconsumerplace.com.au/consumer/helpsheet?id=3563 and

Mastors P We need a new word for patient in KevinMD November 10th 2013 http://images.pps.console.com.au/resize/portplus/storage/3785/3785_3094246_300816043629_5904.jpg?width=249 and

Leng S Patients are not customers; here are 6 reasons why in Kevin MD The Physician February 27th 2015 http://www.kevinmd.com/blog/2015/02/patients-not-customers-6-reasons.html and

Seidel B I specialise in patients, not consumers, clients or users in Medical Republic 18th January 2016 http://www.medicalrepublic.com.au/i-specialise-in-patients-not-consumers-clients-or-users/ and

Pearl R Are you a patient or a healthcare consumer? In Pharma and Health Care http://www.forbes.com/sites/robertpearl/2015/10/15/are-you-a-patient-or-a-health-care-consumer-why-it-matters/#79095e745c3a

(This is a small collection of brief pieces talking about the language people diagnosed with mental illness choose to describe themselves with. I tried to find something about the difference between 'psych survivor' and 'consumer' but couldn't. My understanding is that in the US the 'psych survivor' is at the radical end. Many of us are sick of talking about it because there appears to be no solution but it's worth having a look.)

6.

Kin-Kwun Tsao E Upping the Ante: Psychiatrization, Survival and the Politics of Alterity in Department of Anthropology University of Toronto 2013 https://tspace.library.utoronto.ca/bitstream/1807/68970/1/Tsao_Eugenia_K_201306_PhD_thesis.pdf

(This is a readable thesis and the chapter headings help. It is interesting to look at the ways consumers are defined, framed and identified by Big Pharma and western medicine. Abstract: Due to both the extensive credibility that psychiatry enjoys throughout civil society and pharmaceutical firms' enthusiasm for marketing not just drugs but diseases, individuals who are averse to medical intervention must contend with the twin stigmata of diagnosis and distrust; fully aware that they are viewed as unruly and inauthentic by both the public and their own families, they learn to dissemble and prevaricate about their lives in acts of protective self-silencing. Because forcible detention is always a latent threat, there is little manoeuvring room for people who wish to recover from lives of hardship but emphatically reject the equation of recovery with

biological normalization, and of madness with illness.)

7.

An Introductory Guide to Disability Language and Empowerment http://sudcc.syr.edu/LanguageGuide/

(This is great and asks (and answers) some of the important questions that everyone needs to think about in relation not only to disability but also other areas of disadvantage. An important read.)

8.

Schumaker E It's Time To Stop Using These Phrases When It Comes To Mental Illness in The Huffington Post 7/4/2015 http://www.huffingtonpost.com.au/entry/mentalillness-vocabulary_n_7078984

(Schumaker takes a look at the language that is used at the interface between psychiatry, consumers and the public and suggests some changes.)

9.

Cheung I Sanism and the language of mental illness [BLOG] http://www.ivacheung.com/2015/05/sanism-and-the-language-of-mental-illness/

(This is a piece concentrating on the intersections between mental illness prejudice and other social prejudices: Islamophobia, homophobia & racism. It is researched and easy to read – as are the responses. Posts like this beg new questions. I was particularly intrigued by the 'mental illness'/'radical Islam' interpretations of community violence.)

10.

McWade B Researching Mad Pride: The Stigma and Violence of Knowledge Production, The Stigma Doctrine in the Leverhulme Trust "Rethinking the Sociology of Stigma" https://thestigmadoctrine.wordpress.com/2016/02/03/researching-mad-pride-the-stigma-and-violence-of-knowledge-production

(This is a brief introduction to Mad Studies)

11.

Oaks D Let's Stop Saying 'Mental Illness': Let's Find Language More Inclusive Than the Phrase 'Mentally Ill' in Mind Freedom August 2012

(David Oaks presents some alternatives)

12.

Rahman Haghighat R & Littlewood R What should we call patients with schizophrenia? A sociolinguistic analysis in Psychiatric Bulletin (1995) 19:407-410 http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.1007.2101&rep=rep1&type=pdf

(This is old but the analysis is much more sophisticated than much of what I have read. It is about the language which is used around the identities of schizophrenia. Worth a look with a rear-view mirror as it was written in 1995)

13.

Epstein M "Let's face it! She's just too f*****d" – the politics of borderline personality disorder in Sisters Inside Conference Brisbane 2006 http://www.sistersinside.com.au/media/papermepstein.pdf

(In this paper I talk about the politics of psychiatry as it relates to Borderline. The important point is the argument that although those locked within the system are desperate not to be defined by their diagnosis there are also legitimate needs of desperate people locked out, told they are bad and not mad (not real, just behaviour, using services they don't deserve etc. They are just as desperate to have their legitimacy and identity (often a diagnosis that is less shunned) confirmed, talked about, heralded,

respected by consumers and understood. Herein lies a complication when the consumer movement tries to be inclusive. Diagnosis is to some as anti-diagnosis is to others – not always but often enough to make it of central importance to the way we choose to name ourselves.)

14.

Gawne L Why the words matter in Ramp Up 13th Sep 2011 http://www.abc.net.au/rampup/articles/2011/09/13/3316570.htm

(This is great. Keep it in back your pocket/purse/wallet/baby's pram/ running socks/ hand bag/office!)

15.

Summerfield D The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category in British Medical Journal Volume 322 13th January 2001 https://www.researchgate.net/profile/Derek_Summerfield/publication/12174237_The_Invention_of_PTSD_and_the_Social_Usefulness_of_a_Psychiatric_Category/links/5508204e0cf2d7a281273e5c.pdf

(This is both fascinating and unsettling. This psychiatrist uses the example of Post-Traumatic Stress Disorder to demonstrate the way that diagnosing is a political act. After the Vietnam War many soldiers came home and didn't cope (in big part due to social disdain of the war) At first, they got diagnosed with personality disorders, drug and alcohol disorders… However, there was an assumption that these people we wanted to be heroes could not be described in these ways. Passionate and caring psychiatrists fought very hard to take the pressure off the person and on to the awful experience. This article questions the scientific and moral veracity of this, especially as PTSD has now grown to other groups of people. It's a debate worth having and the piece describes well why some diagnoses are highly sought. There's precedence. Summerfield concludes: Society confers on doctors the power to award disease status and the social advantages attached to the sick role. Current practice, which labels people as being mentally ill when they are not, calls this public duty of doctors into question. To conflate normality and pathology devalues the currency of true illness, promotes abnormal illness behaviour, and incurs unnecessary public costs.)

16.

Twenty-one Films that Actually Understand Mental Illness in Screen Rant http://screenrant.com/best-films-depicting-mental-illness/?view=all

(Whether or not anyone wants to see any of these may be a moot point but the reason for its inclusion is that it takes mental illness out of psychiatrist's ownership. No matter how disturbed psychiatrists (and other clinicians) might be on our behalf, they do not own us and they can no longer control what we read and don't read, watch and don't watch. It is good to see a listing of films with many different plots, many different experiences and many different diagnoses. Some of these leave diagnoses hanging which actually forces us to be what we want others to be and not get involved with diagnosing, tempting as it might be.)