Warp & Weft

Lisa Fannen

2021

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Warp & Weft stands alone, and can also be read as a companion book to a feminist health book *Threads* (2009). Both books are housed on that book's pre-existing website for continuity.

threadsbook.org

In the spirit of DIY/Zines/info sharing, *Warp & Weft* is creative commons and not-for-profit, there is a pdf of the book on the website. Please feel free to distribute it widely but please cite it as a source of reference and especially cite individuals' work referred to within it.

Introduction

Warp & Weft gathers ideas together to explore consciousness, and ways of understanding experiences of distress within social and systemic contexts. The ideas have been the basis of workshops that I have run which have been spaces to pick apart the dominant stories that are given about what gets called ‘mental health’. The workshops have been spaces to explore ways we might collectively *prevent* the causes of distress, *tend* to and *respond to* distress, honour freedom and diversity of consciousness, and support wellbeing (in the broadest sense of that word). Together we considered what personal and collective transformation might, could and does look like. The workshops included information sharing, group conversations, and exploring embodied practices and plant medicine together to support psycho-emotional health. They generated energising and vital exchange, and motivated me to collate and expand their content (content that is often found spread across disparate sources) to be a more widely shareable re-source.1

I came to run the workshops for several reasons. Because of some of my own experiences which have included periods of crisis, struggle and meaning making, and because of many years of explorative, sometimes difficult, life-affirming conversation with friends, family, acquaintances and strangers, and with people I ally with through one-to-one bodywork. Conversation that has explored (and continues to explore) being a human being in the context and contradiction of joy, pleasure, connection, possibility, hope, and the intolerable disconnection, injustice, violence and atrocities which are the surround frames of imperialist, white supremacist, patriarchal, consumer capitalism.

...a constant negotiation of consciousness...

The core of *Warp & Weft* are ideas, frameworks and reference points woven together that I think can be valuable and liberatory as part of personal and collective transformation. The book also actively and intentionally points to some of the incredible work – the many voices and vital labour – which has already been done, and is being done, in relation to the concerns in the book. Some of the quotes and citations are to people and work in which I’ve found sustenance, illumination and inspiration that I want to pass on. In that sense it is a kind of distillation, and anthology.

passing the shuttle through the shed this rich tapestry they say

the warp and the weft

The book is intended to be read from start to finish – the sections and ideas build on each other. But they all interrelate and so I’ve woven some threads backwards and forwards between things, in the way I might have had the freedom to do if I were speaking in workshops or personal conversation. The threads point to ideas ahead, return from ideas ahead, point to

ideas that are behind or come from ideas that are behind. The arrows show the direction of the thread. If you are reading on p.10, then the arrow will show whether it has come from an idea on page 2 (>2) or if it will take you to an idea on p.20 (>20), or if it is taking you back to an idea on p.2 (<2) or is coming back from an idea found on p.20 (<20). I’ve also included questions and structures for group conversations at

the end of each of the four parts that were explored in workshops, in case they are of interest/ use.

step 1 | pass the weft under 2 warp threads, then over 2, under 1, over 1. Now repeat the pattern.

Part One begins by looking at what gets called 'mental health' and challenges the idea that our experiences of distress, struggle, disorientation or variable consciousness are just 'mental' and located in the mind. It challenges the way biomedicine splits mind from body and soul, and names that we are *embodied* beings, and are shaped by and unfold within the contexts we have inherited and live in. It picks apart the biomedical idea that people are individually 'faulty' and need to be individually 'fixed', and begins to talk about everything that shapes, impacts on and informs health and wellbeing. It critiques drives to *destigmatise* 'mental health' because they perpetuate the idea that we have personal 'mental health' issues. It offers other ways we might understand experiences together, and so address and heal personal, relational, systemic and structural imbalances.

step 2 | weaving in the opposite direction, start with 1 under, 2 over, 2 under, repeating 2 over/2 under.

Part Two briefly explains a handful of concepts like *Epistemic Injustice, Decoloniality* and *Deconstruction* which can be useful as part of examining knowledge, and power dynamics. It looks at the concept that ideas, understandings and perspectives are all *culture bound*, meaning that they emerge from a particular culture at a given time, and that this applies to global Northern psychiatric ideas,2 which present and enforce themselves as a universal truth about human experience. Part Two then looks at the institution of psychiatry and at some of its history and legacy as a violent, colonial force around the world, giving specific examples of the ways that has been enacted. Part Two also looks at the way *decolo- niality* and *deconstruction* can be applied to dominant biomedical paradigms as a way to decentre and challenge them. Part Two speaks to honouring Indigenous knowledge systems and healing practices, and supporting more holistic, life affirming and radical approaches to wellbeing.3

step 3 | pass the weft 2 over, 2 under, over 1, under 1, repeating

Part Three builds on Part Two, exploring current global Northern understandings of trauma (the Greek word for wounding). It looks at the short and long-term effects of trauma in the bodymindsoul, and examines the intersection of both personal *and* broader systemic trauma. It lists some different forms of trauma as part of a process of naming and validating experiences and moving towards mitigating and healing trauma together. Part Three also *decentres* global Northern ideas about trauma (ones that are culture bound in, for example, their focus on the brain and nervous system) and

2. I have used the terms global South and global North throughout the book to demarcate different global circumstances relating to power, economics, histories and the legacies of colonialism. The terms feel limited, but better than any of the problematic language like developed/developing countries, etc. While global issues can't be divided

neatly geographically, the terms global South and North relate to dominant historical and current patterns.

I don't use the terms West and East (though some sources I cite do) as they reinforce a colonial mapping that centres (Greenwich in) the UK, and locates everywhere else to the west and east of that point.

3. I use the term radical throughout the book, from the Latin *radix*, meaning root, to speak about the desire for exploring and addressing root causes, also to speak of far-reaching, thorough, progressive and significant change. considers some conceptualisations of healing in the bodymindsoul. It also looks at ways we might foster collective healing.

step 4 | 1 over, 2 under, 2 over, repeating 2 under/2 over

Part Four builds on all the previous parts to look at the way various experiences of consciousness and distress have been pathologised and classified within global Northern biomedicine. It looks at the construction of diagnoses, honours the uses of diagnoses, and focuses more so on what I feel are their limitations and dangers. Diagnoses often define experiences as 'disorders' in someone's 'personality' and Part Four examines these concepts. It also explores an idea of 'symptoms' as protest against the conditions that we live in. Part Four considers how we are given scripts for experience, and how we might understand, rescript and give new language to experiences, and foster more holistic responses and remedies. This idea of these scripts that we are given, together with the concept of everything being culture bound (explored in Part Two) underpins a lot of the book. I think both can be portals for us to examine and question what we are told and offered about experiences, and decide where it has come from and how we feel about it. Part Four takes the word diagnosis – *dia gnosis* meaning *discerning* and *knowing* – to look at the many ways of knowing we might use as guiding frameworks for experience. Like Part Three, Part Four also explores what collective care and collective healing might, could and does look like.

Warp & Weft was never intended to be a (self) help book as such, but it includes an appendix sharing simple embodied practices, and there is an online repository for information about plant medicine, food and nutrition and further re-sources related to psycho-emotional health and transformative social justice.

step 5 | here the pattern is a repeat of step 1; under 2 warp threads, then over 2, under 1, over 1

What I've written and gathered together isn't attempting to be definitive in *any* way, and is obviously subjective; it's representative of just my voice (at a given point in time) which is shaped, enriched, and limited by my lived and inherited experience. I'm a white, non-disabled, queer, middle-class, cis woman living in Scotland, UK. I'm a bodyworker and community herbalist. I'm also a poet and performer. I've been involved with radical health activism for most of my adult life, which has been out of necessity; to speak and learn with others about being a human being in the context of oppression and alienation, and explore radical alternatives to foster health and healing. It's been a doorway time and time again for sharing energising, politicised

conversation and solidarity with so many different people in so many different settings and communities. I'm not any kind of 'expert', academic or scientist; some content has involved blending experience, research, analysis and intuition. My inquiring, sense-making, learning, feeling, thinking and observing has just got to *this* place. I could keep writing, rewriting and adding to this book indefinitely. Making sense of life, learning and sharing, is of course an ongoing process. step 6 | repeating step 2; 1 under, 2 over, 2 under, repeating 2 over/2 under

This book is for anyone interested in exploring psycho-emotional health. It is also for anyone involved in social justice work, and for therapists, bodyworkers, herbalists and other practitioners. I hope professionals in healthcare infrastructure and industries (for example psychologists and psychiatrists) can draw radical and transformative inspiration from the content. The book is creative commons and not-for-profit, please feel free to distribute it widely but please cite it as a source of reference and especially cite individuals' work referred to within it.

step 7 | repeating step 3; 2 over, 2 under, over 1, under 1, repeating

I hope you can just take what's useful, and leave, critique, augment or redefine areas based on your own knowledge and experience, and that in any case, it can be a springboard for or contribution to discussion: an addition to the polyphony already in dialogue about this terrain. I hope it can be part of fostering solidarity, deep interconnectivity, collective care, transformation and healing.

Content note, and taking care as you read

Part Two looks at some of the colonial violence that has been enacted by psych/iatry, and Part Three looks at embodied responses to and different forms of trauma. When we speak in detail about violence or trauma there is the possibility that it might bring up emotions and responses. It isn't always possible to know what might be triggering (cause strong emotion related to trauma) for us as individuals. What may feel benign to one person may be very activating for someone else and vice versa. This is an invitation to take care of yourself as you read, also to use practices to stay as grounded as possible (see the appendix which offers some simple embodied practices), and to call on friends or support if you need and can. Also to skip over anything that feels too much and come back to things when it feels like a better time.

Introduction References

1. I hyphenate the word re-source to point to an intention for the book that it also be a reference to amazing work and source material that's already available.

Part One - ‘Mental health’/Moving beyond

This chapter looks at the way global Northern culture, and in particular biomedicine, speaks about what gets called mental health. We are led to believe that our varied experiences of pain or distress, and consciousness in all its forms, are located in 'the mind' and increasingly in 'the brain', and that difficulties are due to imbalance, flaws or weakness in an *individual*. This book explores the way experiences aren't just in the brain, they are embodied and *relational*. We feel and are impacted on, through and in the body, and our experiences are responses and reactions – often coherent ones – to what we live in and as part of.

This chapter looks at the way biomedicine splits the mind from the body and soul, and at the way it separates us as atomised individuals from our social contexts and profounder interconnectivity with all of life. This chapter also critiques the drive to *destigmatise* 'mental health', because initiatives that do so mostly perpetuate dominant limiting and damaging ideas about 'mental health'. It begins a conversation that is a thread through the book, about more progressive ways we might speak about and approach consciousness, and experiences of distress and struggle.

Moving beyond the language and ideology of 'mental health'

I don't use the term 'mental health'. My feeling is that every time the term 'mental health', or worse, 'mental illness' is used, it suggests or continues to hammer home the very strong message we are given by bio-medicine (a knowledge system that emerged from the capitalist, patriarchal, imperialist culture of the global North). That message is that our various and very real experiences of distress, struggle, pain and/or (variable) consciousness are located in the mind or in the brain (*mental*), and are due to some kind of alleged faulty brain chemistry, or problematic inherited genetics (*illness*). The language and ideology of 'mental health', can also enforce an idea that there is a standard of normal (i.e. ways we should feel and think) that some people deviate from.

Mainstream institutions and health programmes drum home this story to us about individuated so-called 'mental health' and 'mental illness' in the language they use. Organisations commonly have titles like *Mental Health Matters, Mind, Health in Mind, Support in Mind, Moving Minds, Mainstreaming Mental Health, Rethink Mental Illness,* the *Mental Health Foundation* etc. The terminology and its implicit ideas have been adopted by mainstream culture and in common day to day speech; 'mental health' is sometimes even personalised and abbreviated to the initialism MH. '*My MH*' etc.

I tend to use the term *psycho-emotional health*, but could equally use a term like *psycho-social* or *psycho-spiritual* health to acknowledge the deep relational and contextual dimension to experience.

In his book *Toxic Psychiatry*, Peter Breggin writes:

I have chosen the word psychospiritual to denote the special awareness and concerns of people who get such diagnoses as schizophrenia, bi-polar or manic-depressive disorder, and major depression. The word is similar to 'psychological' before it acquired a more mechanical, pseudoscientific definition in modern times. The 1856 *Webster's Dictionary* defines psychology as the study of 'the human soul or the doctrine of man's spiritual nature'. By psychospiritual I mean pertaining to the self, identity, or personality of the individual, including his or her striving to lead a better more fulfilling or meaningful life.1

I use *psycho-emotional health* for a few reasons. I think it steers away from the dominating narratives we are given, that distress is caused by individual personal 'mental health' issues, which are located in the brain/mind. I think it describes what is usually being spoken about – i.e. how we *feel*, and that that *feeling* happens in the body and soul, not just the head, mind or brain. Psycho-emotional health acknowledges that

what we are *experiencing* is in our mindbodysoul. (I join these words together to point to the fact that they aren't separate, but profoundly interrelated). It acknowledges that we have somatic/ embodied sensations and emotional feelings in the contexts we live in, all of which is relevant when we are making sense of a situation where there is distress, considering ways we might foster support in that situation, and approaching transformation and healing.2 I also use it because it opens readily into exploring how experiences we have over the course of a lifetime are a result of a *confluence* of things:

– our unique constitutions (sensitivities/sensibilities/ natures/tendencies)
– our *embodied* personal, transgenerational, intergenerational and collective histories
– the current social/environmental contexts we live in
– the place and land we live in and on, and
– dominant cultural understandings of consciousness, and of the 'self '.

If we talk about *all* these interrelating factors, and about the experiences we have of pain, distress or disorientation – as opposed to talking about *individual illness* that should allegedly be fixed in an *individual mind* – I think we can get to the deeper conversation about what healing, or wholeness might really look like. That conversation can be part of how we mobilise for the social/structural changes needed *for* that healing to happen.

There's more analysis of the dominating stories we are given about faulty 'brain chemistry' later in Part One. Meantime, I wanted to name that when genetics are spoken about as being the cause of distress, it is often implied that there may be deviant, deficient or otherwise faulty genetics. We are told that someone or a family history may be predisposed to, for example, what gets called 'depression'. However someone, or their family, may actually be predisposed to sensitivity, creativity, or a contemplative consciousness which could manifest in all sorts of incredible ways, but in the context of intersecting oppressions, violences and lacks gets experienced as a feeling of sadness, frustration, meaninglessness etc.

Our genetic make up may predispose us to things, but how that shows up psycho-emotionally is shaped by social context. I like what the British psychologist Richard Marshall once said about the practice of attributing things *definitively* to genetics. He said, 'market capitalism is the dominant worldwide economic system but few people believe that there are uniformly distributed genes for capitalism'.3

It can feel like empowering solidarity to name that sadness, confusion, fear, grief, anger, feelings of lack of meaning, or (transient) shifts in consciousness aren't a result of personal faulty brain chemistry or faulty genetics. It can be empowering to speak of the way our unique energies and sensibilities, transgenerational, intergenerational and ancestral histories, and the constraint and

violence of current oppressions (like racism, classism, ageism, capitalism etc.) mean we may experience difficulty in particular ways. Even though figuring out new language can feel clunky, I feel like every time I use the term *psycho-emotional health* there's an opportunity to have some great conversation about it. There's the opportunity to

open up different ways to think, talk about and conceptualise our experiences together. There's the chance to shift language and reframe the conversation as part of making profound, life-affirming personal and collective choices and changes. It can feel like an interruption, and what comes, and can come from that

feels revolutionary.

The language and ideology of biomedicine #1

Claims to authority and truth

The term biomedicine is given to the dominant medicine of the global North. As a medicine system, it is primarily concerned with *biological processes*, and looks at symptoms rather than addressing their root causes. It is based on *reductionism*, where the smallest units are examined rather than considering and looking at the whole.

If we go to a biomedical doctor with a recurring sore throat for example, we will likely be told we have a *bacteria*, and be given *antibiotics*. The focus is typically, mostly at a microbial level. If we consult a holistic practitioner, they might inquire about our current stress levels, nutrition, explore whether there is unresolved grief or unexpressed emotion that can affect the throat, etc. To be *truly* holistic, there needs to also be consideration of systemic violence and the ways that can occur in the form of poverty, racism etc., and of the particular manifestations of that inequality and injustice like the reality of damp housing, having to work long hours without any time off, the experience of social isolation or threat of police aggression, etc. All these factors need to be taken into account, as well as the reality of intergenerational trauma, to really try and understand what might be going on, and address the many possible root causes of health issues.

Biomedicine uses language to centre itself and promote its alleged authority and the alleged 'truths' it tells us, by calling itself conventional or orthodox medicine. Traditional or holistic medicine knowledge systems are often called folk medicine, or complementary or alternative medicine, suggesting they are the 'poor cousin' of the 'real thing'! Biomedicine undermines the many global medicine traditions by claiming its knowledge system is scientific (i.e. 'proven' or 'real'), whereas Indigenous knowledge systems are often referenced as being beliefs (i.e. 'unproven' or 'less real').

I don't wish to set up a binary that suggests biomedicine is all bad and other approaches/knowledge systems are all progressive. Biomedicine, its language and approach, can be meaningful, useful and lifesaving. There are also so many amazing, caring people working within biomedicine as a system. Still, I mostly find its frameworks problematic and limiting, and hope that unpicking some of it can be part of a broad, shared conversation about what health and healing (that is more profoundly integrated and also less profit driven) could look like.

Stories,'splits' and 'systems'

Biomedicine offers us very particular stories as if they are truths: it generally splits the mind from the body as if they are separate entities, and splits the mindbody from the soul, from other people, social contexts, animals, ancestors and the earth/ cosmos, as if these were all entirely separate from each other, when we are profoundly interconnected. We are also most often told that the 'body' itself is divided into 'systems' (a digestive, cardiovascular, endocrine system etc.), even though the 'systems' of mindbody aren't really separate. They interrelate and interact in complex ways. In textbooks,
medical institutions and popular depictions we are usually shown these 'systems' as floating in an 'empty' body, and problematically, because of what gets visually represented as a norm or standard, that body is usually white and cis male.

Slowly there has been and continues to be increasing acknowledgment within biomedicine that these 'separate' systems *do* interrelate. There are medical branches now like neuro-immunology (which considers the interrelationship of the nervous and immune systems), and acknowledgment of the gut-mind connection, etc. However we are still mostly offered the biomedical story that 'systems' are distinct. This can stop us from intuiting that remedies for dis-ease which biomedicine locates in the 'nervous system', for example, might involve also tending to the muscular system (through relaxation and grounding practices), the digestive system (through choices of food and the way that affects us), etc. In that sense our experience, or dis-ease, is located in *all* those 'systems' or places, not just one system.

With solidarity and support, we can reintegrate the 'systems'; the dimensions of the self. We can also and especially reintegrate the mindbodysoul. If, for example, we feel stressed and anxious, we can engage the 'mind' *through* the body; we can stretch, ground, rest and connect in the body, and with others through the body (i.e. massage, movement, sound, etc.) We can also reintegrate the mindbodysoul within the greater whole of life through, for example, meditation and human, animal and nature connection. With solidarity and support we can also name what might be causing disease in our environments. With *all* of that in view we can tend to integrated personal and systemic healing.

Rae Johnson speaks about this interconnectedness in their book *Embodied Social Justice*. They write, 'our bodies and minds are functional aspects of the same whole that are always inextricably embedded in physical and relational environments'.4

Homeostasis and 'fixing' individuals

A prevailing idea that biomedicine also reinforces is a concept called *homeostasis*. Homeostasis can be defined as the stable state of an organism and of its internal environment; or the maintenance or regulation of a stable condition. This idea dominates

biomedicine and can be part of fostering an attitude and approach of 'fixing' the body/mind in isolation, or removed from external influences or the contexts it is part of and exists within. We are not sealed, individual units; and the ideology of homeostasis can sometimes be an obstacle to understanding how our health is *relational* to contexts, be they social, environmental, seasonal etc. Also that really tending to health (wholeness) and wellbeing involves engaging with and addressing everything that shapes, permeates, influences and affects us.

'Grappling with cure'

In *Brilliant Imperfection: Grappling with Cure*, Eli Clare speaks about the concept of 'cure', and how cure is often located within an individual bodymind. He acknowledges that it can be both sought after and valuable, and that it can be damaging and violent.

As an ideology seeped into every corner of white Western thought and culture, cure rides on the back of *normal* and *natural.* Insidious and pervasive, it impacts most of us. In response, we need neither a whole-hearted acceptance nor an outright rejection of cure, but rather a broad based grappling.

The *American Heritage Dictionary* defines cure as the 'restoration of health'. Those three words seem simple enough, but actually *health* is a mire. [...] I circle back to the ideology of cure. Framing it as a kind of restoration reveals the most obvious and essential tenets. First, cure requires damage, locating the harm entirely within individual human body-minds, operating as if each person were their own ecosystem. Second, it grounds itself in an original state of being, relying on a belief that what existed before is superior to what exists currently. And finally, it seeks to return what is damaged to that former state of being.5

I love what Clare speaks about above, generally and especially as it relates to psycho-emotional health. In particular that he points out one tenet of 'cure' which seeks a return – unquestioningly and without honouring potentially necessary transformation – to a 'former state of being'. Part Four also looks at and critiques this idea of 'recovery'. Clare expands on the concepts of 'normal' and 'natural' that are often at the heart of ideology around fixing and curing. He writes:

The standards called *normal* – sometimes in tandem with *natural* – are promoted as averages. They are posed as the most common and best states of being for body-minds. They are advertised as descriptions of who 'we' collectively are – a *we* who predictably is white, male, middleand upper-class, nondisabled, Christian, heterosexual, gender conforming, slender,

5. Eli Clare, 2017. *Brilliant Imperfection: Grappling with Cure*, Duke University Press, p.14/15 cisgender. And at the very same time, these standards, which supposedly reflect some sort of collective humanity, are sold back to us as goals and products. It makes no sense.6

Reintegration and deep interconnectivity

The splits and schisms of biomedicine spoken about above (that separate mind from body and soul, and examine people as separate from social, environmental and geographical context, and the unseen realms of spirit) are where so much damage has been done. It is exactly where the healing needs to happen. There's a need for profound reintegration of all dimensions of 'the self ' (bodymindsoul) and honouring of a deep interconnectivity between that 'self ' and other humans, and the land, the water, animals, plants, the moon, the planets and more.

Separating these aspects of our being forecloses ways we might respond to health on *all* levels in an *integrated* way, and so both heal dis-ease and live better. This *dis-integration* and *disconnection* emerged out of European culture which fractured mind from body, and all beings. It compartmentalised and classified things on the terms of what gets called 'the Enlightenment', also known as 'the Age of Reason'. This belief system, which many of us have been schooled to adopt, is rooted in that 'Enlightenment' philosophy (notably that of Descartes from the 17th century) which elevates the thinking mind over the felt sense of the body. Here patriarchy and whiteness imposed divisions and experiential hierarchies in order to maintain a gendered and racialised order of power: the mind and rationalism (which it elevated and associated with maleness and whiteness,) were divorced from and *deemed superior* to the body and the magical and sensual (which it denigrated and associated with femaleness and people of colour). These ideas were, and continue to be a global violence, and informed and inform colonial oppression that has suppressed and damaged global majority cultures and traditions. There is more about this, especially in terms of psychiatry, in Part Two.

Somatics and embodiment

To counter the splitting and compartmentalising that many of us have been shaped and damaged by, language and frameworks have been sought in the contemporary global North with which to speak of the *whole* of our being. *Somatics* is one of those terms. It speaks about the integration of the many aspects that constitute our being. The term *embodiment* has also come into use. It gives language to the fact that we are *shaped by, experience* the world and *feel, in and through* the body.

In their book *Embodied Social Justice*, Johnson tells us that the existential philosopher Thomas Hanna, 'founder of the field of somatics in the United States, defines the *soma* (after the Greek word meaning "living body") as the body as experienced from within'. Johnson summarises: 'An expanded definition of soma might be the body/ mind as experienced from within.'7

Staci Hains, founder of a US project called *generative somatics* (a project concerned with somatics – embodied transformation – as part of wider social and environmental justice transformation), talks about the concept of *soma*. Her definition speaks also to the kind of reintegration I've mentioned above. She writes: soma is the interconnected thinking, emotions, actions, relating, and worldview, embodied. All of this lives in, through and with the body. I tend to use the word *soma* instead of *body*, because body is generally defined in an objectified and utilitarian way. Body is mostly seen as a physicality and parts, separate from the self. It is seen as something to manage, steward, control, keep healthy, or feel ashamed about. Somatics, instead, holds the body as inseparable from the Self and how we live, act and relate.8

Hains talks in some more detail about the history of the separation that occurred in the global North between mind and body. She asks:

Where did this idea of Body as Object come from? We, in the West, have inherited a deeply rationalistic and objectifying view of the body, and therefore of ourselves and each other. It is an interpretation of the body as separate from the (more important) thinking mind. The body is seen as muscles, sinews, bones and a series of functions that move the mind or the 'Self ' around... We are taught to distance from sensations and the body, rather than live inside them.9

Hains speaks of the way that rationalistic separation 'puts us at odds with ourselves. As we learn to dismiss our lived experience, to be rational instead of "too emotional", we necessarily learn to numb, to dissociate, and to override the feelings of ourselves and others.'10

Rae Johnson also speaks about that culturally enforced disintegration, and the way they personally came to fear and mistrust their body: as an inferior aspect of [their]

identity. In the spirit of Thomas Edison, who insisted that 'the chief function of the body is to carry the brain around', I came to disown the corporeal reality of my body in favor of attending to, and presenting to others for approval and attention, my abstracted thoughts and ideas.11

Body-Mind psychotherapist Susan Aposhyan describes clearly the integration of body and mind; that the 'body reflects the mind and the mind reflects the body', and speaks about 'mutual feedback loops' where 'the state of the mind influences the body and the state of the body influences the mind'.12

In her book *Body-Mind Psychotherapy*, Aposhyan writes: 'The sort of human difficulties that bring an individual to therapy always have some connection with our cultural imbalances.' Speaking of the dominant culture of the global North she says:

Our culture is seriously disconnected from nature, spirit, and humanity. These disconnections are interrelated. This quality of disconnection is not inherent in every culture [...]. This fundamental sense of disconnection is nowhere more vivid than our disconnection with our own bodies.

Aposhyan then gives a definition of embodiment:

Embodiment is the moment to moment process by which human beings allow awareness to enhance the flow of thoughts, feelings, sensations, and energies through our bodily selves. Embodiment requires the creative ability to allow the life of the universe to move through our bodies, be colored by our unique perspectives, and move back out into the world. Embodiment also implies an unencumbered flow of life through us. Life comes into us as food, air, liquid, sights, sounds, and more organized experiences. Embodiment also implies the elegant and creative integration of these elements into the totality of our being. Embodiment means that these elements are thoroughly processed and expressed in our unique relationship with the world. The world comes in, we process it, and through the processing we find ourselves in a whole new relationship to the world. Embodiment, then, is a grounding and flowing relationship between ourselves and the rest of the world.13

The terms *soma* and *embodiment* speak to an integrated body/mind experienced *from within*, and experienced *within* and interrelated with our environmental contexts. They challenge and reconfigure the false and injurious ideas promoted by biomedicine, of the division of bodymindsoul and its separation from environmental, social and more universal contexts. Our experiences are both physical, emotional, and relational. Why is that so important? Because the fact that we are told there is something distinct called 'mental health', which is in the 'mind' or brain, deflects away from the myriad and multifaceted possibilities there are for healing (like touch, movement and sound that can facilitate deep (re)connection and (re)balancing, and spiritual practice that facilitates the dissolution of 'the 'self ' and enables a sense of union with the cosmos) which are *in* and *through* the body and soul. It also deflects away from healing (like mobilising for equality and justice) which addresses and engages the larger 'body', i.e. the social and economic contexts that the bodymindsoul exists within and as part of.

The field of Somatics – work for the kind of embodied reintegration spoken about above – is pretty broad. Some of it is marked by a striving for reintegration and connectivity that involves personal *and* systemic transformation. Some of it is partial and concerns itself with the individual and doesn't speak explicitly about social and historical context and necessary social change. Frustratingly, some work in this field is enmeshed with very problematic political ignorance that lacks an analysis of the way power has been configured historically, and can continue to be so. It should also be noted that lots of somatic practices, notably work developed by white people, has borrowed from Indigenous and global majority embodied practices (like Zen Buddhism, Aikido and Yoga, for example). It has involved cultural appropriation or assimilation, sometimes without direct acknowledgment of the lineage of practices being drawn from, or involving misuse of practices and traditions.

The emerging field of Cultural Somatics, in the work of people like Resmaa Menakem and Tada Hozumi, *explicitly* acknowledges the shaping and impact of *culture* on our soma, our being. It necessarily and overtly recognises how *everything* informs our being, including our cultural histories and the legacies of those histories, especially the legacy of colonisation and racism. That this exists and plays out in our embodied relations. There are more specific references and citations to some of this work in Part Three looking at reframing trauma. For now I want to cite Tada Hozumi who writes:

Cultural somatics, to me, has always been an emerging field of practice with an organic body of common knowledge and shared language – not a modality with a set approach that is tightly defined by a select group of teachers – that sees individual and collective change as inseparable, interconnected, and embodied processes.

He shares some of the terms and concepts that he has stewarded and which inform his involvement in the field. Such as: 'Cultural soma – The invisible sensing, feeling, and thinking body that emerges out of networks of complex relationships.'14

Cultural Somatics speaks to the complex interweaving of every aspect of culture in our being and relating, and of ways to honour that, and move towards profound integrated healing.

Constitutions: the Humoral tradition, the Doshas, the Five Elements

I mentioned constitutions above, when I was looking at the confluence of what I understand to be at play in terms of our psycho-emotional health. In many cultural and healing traditions there is an understanding that each person has a unique constitution. Their constitution suggests tendencies in their nature and in the kind of health imbalances they might be prone to. In the European context up until the 18th century, a knowledge system which was based on a conceptualisation of *the Humours* was used – it was a legacy of ancient Greek and Roman physicians via the work of the Persian polymath Avicenna, though its origins may lie in Ancient Egypt and Mesopotamia.

This knowledge system called *Humoralism*, or the *four tem- peraments theory*, came to associate four humours, temperaments or 'types', with the four elements. These four humours known as *sanguine, choleric, melancholic* and *phlegmatic* were associated with the elements *air, fire, earth* and *water* respectively. To which the corresponding energetics *warm and moist, warm and dry, cold and dry* and *cold and moist* were attributed respectively.

Imbalance of the humours in a person was thought to be the cause of ill health. One's personal humoural constitution, and any imbalance in one's humours, was the basis for deciding treatment approaches. If for example, there was excess in the *melancholic*, the humour of *cold and dry*, then warming and moistening herbs, food and relevant remedial practices to counter-balance humoral excess or imbalance would be used.

The Unani tradition practiced in Perso-Arabic countries and in India and Pakistan uses the humours as a fundamental part of its paradigm. While global traditions aren't comparable, and are too complex to understand without lengthy study of the social, philosophical and cosmological contexts they are located in, there are nonetheless some parallels in their consideration of honouring *ener-*

The knowledge system of Ayurvedic medicine assesses and defines people or 'types' constitutionally as having a combination of the three *Doshas* – which are known as *Vata, Pitta* and *Kapha*. These are constitutional descriptions that correspond to elements and energies (air & ether, fire, earth & water) and which are used to speak of someone's constitutional health and tendencies, and also determine appropriate approaches and treatments for any imbalances.

The knowledge system of Chinese Medicine speaks about people's constitutions in terms of the *Five Elements: Wood, Fire, Earth, Metal, Water.* These elements and energetic tendencies also speak

Textbox start « A »Textbox end of and lend themselves in a person's being to various constitutional health issues that might arise. They sit in relationship to changing seasonal patterns – as a way of understanding and approaching healing of the bodymindsoul situated within the cosmos that is always changing.

I don't mention these paradigms which acknowledge constitutions because they are all perfect healing models in and of themselves. Humoral medicine, for example, was used in quite invasive ways in the past, which involved sometimes drastic procedures. This kind of medicine, known as heroic medicine, could involve repeated bloodletting and applying harsh chemical blisters to induce sweating, etc. I mention them to point to ways we can acknowledge and honour everyone's uniqueness, as opposed to adopting blanket ideas about, and treatments of homogenised experiences and populations, which is what is mostly offered by biomedicine. 50,000 people, for example, will be offered the same drug without considering the unique health and contextual pictures they all have, and which might all require different remedial approaches.

Consciousness

I mentioned consciousness above, when I was looking at the confluence of what I understand to be at play in terms of our psycho-emotional health. Consciousness is a beautifully broad concept that can mean introspection, thought, imagination, feelings, perception, cognition, processing, volition (will), awareness and self awareness. The word is from the Latin *conscius* meaning 'knowing, aware', from *con* meaning 'with' + *scire* (also the root of the word science) meaning 'to know'.

Consciousness defies splits and binaries; it can be of the material, of the metaphysical and transcendent. It can be within one's own bodymind, and be within a greater body of people (collective consciousness), in plants and animals, and in the wider universe. It has a fluidity that can speak to both a feeling of something essential – how we move in the world, and something that has been *shaped* by the world. Consciousness is something that may be felt to be constant, variable/in flux, and alterable. It is also something that can change and evolve – my consciousness is different now to when I was 7, and will be different again when I am 70. It is of course also in common usage to mean awareness of issues and contexts, i.e. political consciousness.

Fractured Enlightenment thinking and reductive biomedicine have both claimed consciousness is located in the mind/brain. The British (of Welsh origin) physician Robert Fludd gave a depiction of consciousness in 1619 on the terms of the microcosm-macrocosm analogy: the microcosm of human life on earth and the macrocosm of the universe, which in his version included the spiritual realm of the Divine. His illustration centres that experience in the mind (see image on next page).

In 1945, French philosopher Merleau-Ponty wrote a book about phenomenology (the philosophical inquiry into consciousness and direct experience) called *Phenomenology of Perception*. He describes how 'consciousness, the world, and the human body are intricately interlinked and mutually engaged [...]. In essence, he argues that all consciousness is *embodied* (and therefore in and of the world), and the *body* is infused with consciousness [emphasis added].'15

A broad understanding of consciousness that is inhabited by many Indigenous cultures, and one like Merleau Ponty's above, defies the idea that our experiences are just located in the atomised 'self ', and centrally in the brain. This broad understanding points to how consciousness, and our experiences, are deeply embodied and interconnected. The way consciousness is understood by a culture plays a huge part in how psycho-emotional experiences are also understood. Part Four explores consciousness and what gets called the 'self ', and the implications those understandings might have for the shape of radical and collective healing.

In the global North the terms 'sanism' (coined by physician, advocate and lawyer Morton Birnbaum, in the 1960s) and 'mentalism' (coined by activist and psych/iatric survivor Judith Chamberlain, in the 1970s) critique normative standards that are enforced around consciousness and cognition. They speak to related prejudices and violence that can be upheld and experienced. The relatively new field of Mad Studies also has aspects that speak to the complexity of consciousness and resist the pathologising of so much human experience. Activist and Mad Studies scholar Lucy Decosta explains:

Mad Studies is an area of education, scholarship, and analysis about the experiences, history, culture, political organising, narratives, writings and most importantly, the PEOPLE who identify as: Mad; psychiatric survivors; consumers; service users; mentally ill; patients; neuro-diverse; inmates; disabled

– to name a few of the 'identity labels' our community may choose to use. Mad Studies has grown out of the long history of consumer/survivor movements organised both locally and internationally. [...] Together, *we can cultivate our own theories/ models/concepts/principles/hypotheses/values about how*

we understand ourselves, or our experiences in relationship to mental health system(s), research and politics. No one person, or school, or group owns Mad Studies or defines its borders. As explained in the book, *Mad Matters*, Mad Studies is a, 'project of inquiry, knowledge production and political action' [emphasis added].16

Like individual constitutions, there is such a huge range of consciousness we each inhabit and move through the world with. The Neurodiversity Paradigm speaks in part to this diversity of experience. Nick Walker, autistic scholar and educator, describes the genesis of the Neurodiversity Movement:

The Neurodiversity Movement has its origins in the Autistic Rights Movement that sprung up in the 1990s. The term neurodiversity was coined in 1998 by an autistic Australian sociologist named Judy Singer, and was quickly picked up and expanded upon within the autistic activist community. The focus of work within the neurodiversity paradigm has broadened beyond autism to encompass other forms of neurodivergence.17

Walker summarises:

There is no 'normal' or 'right' style of human brain or human mind, any more than there is one 'normal' or 'right' ethnicity, gender, or culture. The social dynamics that manifest in regard to neurodiversity are similar to the social dynamics that manifest in regard to other forms of human diversity (e.g. diversity of race, culture, gender, or sexual orientation). These dynamics include the dynamics of social power relations – the dynamics of social inequality, privilege, and oppression – as well as the dynamics by which diversity, when embraced, acts as a source of creative potential within a group or society.18

The Neurodiversity Paradigm honours, values and celebrates human diversity and names the way 'normative' social parameters impact on, limit and oppress that diversity of consciousness. I'm inspired by the way it is being used to name how 'normative'

infrastructure and institutions put many people at a disadvantage, and how it is being used as leverage to make spaces more accessible and inclusive, according to diverse needs. It seeks to make access to many avenues of support more possible without the usual language of pathology being iterated. The paradigm has generated and been a portal for a lot of important conversation, political mobilisation, and benefit.

There are questions, and I also have some reservations about some things about the paradigm. Like biomedicine it locates psychoemotional experience within a reductive framework, in this case that of 'neural' architecture and shaping. I think our experiences of consciousness are more complex and not purely located there. I think our processes, responses, feelings, sensibilities, intelligence, etc. are located in and informed also by the heart and the guts for example, also beyond the human body.

As Staci Hains writes:

In its current popularity, many people can assume that because we can explain what happens in the brain, we understand behaviour or how to change behaviour. Many also interpret the brain as the most important organ – if we understand the brain, we understand humans [...]. Interpretations of modern neuroscience can get caught in the same rationalistic tradition of objectifying the body as now merely carrying around the more important brain. [...] A somatic understanding of the body/self is radically different. It holds the body, self, thinking, emotions, action, and relating as an interconnected whole.19

The two identities that the Neurodiversity paradigm offers: 'neurotypical' or 'neurodivergent', are *not* in any way proposed as a narrative of 'normal' and 'not normal', but can still feel *akin* to that. Neurotypical or neurodivergent also has a tendency to suggest a binary; an either/or, rather than a more diffuse (and sometimes fluctuating) range or spectrum of experience.

I think leaning into the many critiques there are of normative standards that are set, and exploring broader, pre-industrial, pre-Enlightenment and Indigenous conceptualisations of consciousness, all opens out vital conversation. About what it means to be alive, and in relationship, within the particular social and spiritual frames that we live in. About how we might want to live, to shape our relationships and spiritual and social contexts, so that *everyone* can thrive within them?

Conversation that can delve into many questions. What is consciousness? What consciousness do we feel we have? How do we experience it? Is it a fairly constant experience or does it change? Is it cyclical; are there any recognisable cycles to our experiences of consciousness? What does it mean for us? How similar or different is it from each others'? What might it lend itself to? How can we engage spiritual practice to support that consciousness? How can we shape a world that enables, affirms and celebrates consciousness in all its variation and diversity?

19. Staci Hains, 2019. *The Politics of Trauma: Somatics, Healing, and Social Justice*, North Atlantic Books, p.42

The language and ideology of biomedicine #2

Stories about the 'Nervous System'

Biomedicine has a particular conceptualisation of what gets called the 'Nervous System'. It talks about this system comprising the brain, spinal chord, spinal fluid, nerve fibres, ganglia, synapses, axons, dendrites, etc. Stories about the nervous system have often involved replicating dominant cultural and social hierarchies; the brain will often be talked about in medical textbooks as being the '*control centre'* (see image).

The brain

Textbox start « p »Textbox endis the body's control center

The spinal cord carries messages between the brain and the body

The brain stem links the brain and the spinal cord

In actual fact, in the same way that we know that the mind and body aren't separate, and that the body isn't divided so neatly into distinct 'systems', we also know that even the so-called 'systems' themselves work in more of a complex, co-operative, feedback way rather than having a central origin ('control centre') of activity. Information travels in all directions back and forth and between things, within and through the body and brain. Biomedicine – though not entirely monolithic in its ideas – generally tells us the brain controls things in the body, when actually sensory input through the bodysoul also directly affects the brain. The interrelations between brain, body and beyond are more diffuse and complex.

Biomedicine's conceptualisation of this 'system' has changed through history and adopted different narratives. It's been spoken of in terms of movement of what were alleged to be 'animal spirits', or nervous fluids (more about this below), or once electricity had been discovered, as functioning like *electrical current*, and then also as involving *chemical transmission* once there had been an increase in the exploration of biochemistry.

Fritz Kahn, a German Jewish physician who published popular science books and is known for his illustrations, was working in the 1920s, a period of huge industrial and technological change. His illustration of the nervous system depicts it as a complex electronic signaling system, complete with buttons, charts and busy workers.

'The Heart stores the Spirit (Shen)'

Conceptualisations of experiences that involve emotional, spiritual or embodied distress vary culture to culture. Traditional Chinese Medicine (TCM) is a medicine system that homogenised and standardised many of the various and local healing modalities in China, which were thousands of years old. It was formulated under Chairman Mao in the 1960s. In TCM, there isn't a conceptualisation of the '*nervous system*' as such. There is, for example, an understanding of the five spirits, one of which Shen, '*resides in the heart*'. *Shen* can be translated in many ways including most
commonly as spirit, consciousness or mind. When there are disturbances of *Shen* there can be experiences of stammering, insomnia, agitation etc.

The Heart stores the Spirit (Shen). The Heart guarantees connection and stores the small Spirit component of the person's entire Spirit. The Heart Spirit ensures that whatever consciousness, intention, volition, thought, reflection, and self-awareness exist within the large composite Spirit intersects and 'clicks' with the world of time and space. The Heart is responsible for appropriate behaviour, timely interactions, and being suitable to the context. Being respectful, thoughtful, or emotional is only virtuous when the Heart's Spirit ensures the moment is right. The Heart's little Spirit makes sure that the big composite Spirit of the person is on target[...]

When the Heart Spirit is disturbed, one has symptoms such as insomnia, situational anxiety, and inappropriate or even bizarre behaviour. Discomfort with situations and people often has to do with the Heart, as do the somatic correlates of anxiety, such as sweating, blushing, being flustered, and palpitations. When the Heart Spirit is intact one connects with propriety and tact [...]

'The Heart opens into the tongue' [...]. The tradition also says 'the tongue is the sprout of the Heart'. The ability to choose words precisely, to convey meaning well, and to connect in dialogue belongs to the Heart Spirit's relation with the tongue [...] On a more physical level, the connection between the Heart and tongue means that pathological changes of the tongue such as ulceration and inflammation can often be treated by acupuncture or herbal therapy directed at the Heart. Stuttering is also linked to the Heart.20

20. Ted J Kaptchuck, 2000. *Chinese Medicine: The Web That Has No Weaver*, Rider, p.88/89

The section above shows the different ways the biomedical nervous system has been spoken about and understood, and the way experiences can be understood without *any* reference to something defined or spoken of as a nervous system. Both illustrate the way understandings can never be definitive or comprehensive, they are shaped by and located in historical and cultural factors. Below is some more detail of the history of understandings about the biomedical nervous system.

‘Neurologie’ and nerves

The conceptualisation of the nervous system as we now know it was significantly shaped by an English doctor, Thomas Willis (1621–75), who pioneered research into the anatomy of the brain and nervous tissue, and coined the term ‘neurologie’ to speak of this field. Willis identified features of the brain like the brain stem, the medulla, the cerebral cortex and the structure of the mid-brain. Based on a vast amount of experimentation and observation (which was possible because of advances in methods of preserving brains and tissue), he claimed that the anatomy of the nervous system had revealed ‘the true and genuine reasons for very many of the actions and passions that take place in our body, which otherwise seem most difficult to explain’.21

Willis’s work and the implication of the nervous system and the brain [...] marked the beginnings of a move away from the humoral explanations [...] His ideas were widely embraced by the society physicians who sought a lucrative new market in the treatment of ‘nervous’ patients.22

No longer was the explanation of pathology to be couched in terms of the humours. Instead the concept of

‘animal spirits’ that chased around the body, carrying messages to and from the brain, were what were said to be animating the human frame; and their derangement was the source of all manner of illness and pathology. This was a radical reconceptualisation of the role of ‘the Brain and Nervous Stock’.23

Pathologies that had been understood humorally were now conceived of as ‘disorders of the brain or the jangling of the nerves’.

In that medical world dominated by white cis men, another figure is cited as a contributing voice to the language that was being generated around ‘the nerves’. In 1733 a Scottish doctor George Cheyne coined the term *The English Malady*, describing various experiences of distress; a term that he felt was levied at ‘the Island’. Much like the 16th and 17th century vogue for Melancholia, the new disease was eagerly embraced. People could ‘proclaim that their nervous complaints elevated them into the ranks of the most refined and civilised of souls’.24 With this new term, Cheyne insisted experiences were ‘real diseases rooted in [...] the new animating principle of the human body, the nerves’.25

Through the language of ‘the nerves’, Cheyne and many of his contemporaries ‘constructed their claims about nervous illness, and legitimated their assertion that they were treating something real’.26 Although the language of the nerves might have been new, ‘the treatments it licensed were the old familiar [...] remedies [...] bleeding, purges, vomits and the like, along with attention to diet and regimen’.27

Willis, like many other physicians and asylums, had promoted violent, punitive and intimidating treatments for distress (called madness). Once his theories about the nervous system spread, they

23. Ibid. p.167

24. Ibid. p.171
25. Ibid. p.166
26. Ibid. p.168

were taken up by others. A Dutch physician, Herman Boerhaave, delivered over two hundred lectures about nervous diseases in the 1730s and was widely influential. Like Willis, he thought milder cases of something called 'nervous prostration' could be treated fairly gently, and like Willis recommended 'stronger' treatment for deeper distress.

Accompanying the new narrative about 'neurologie', both gentler and more brutalising treatments continued.

Meanwhile, there was much squabbling about whether the nervous system was a set of hollow tubes through which the animal spirits or nervous fluid found their way: or whether, on the contrary, it was a matter of nervous fibres, tense or lax, which provided the means by which the brain communicated with the other parts of *its dominion* [emphasis added].28

From the conceptualisation of 'animal spirits' or 'nervous fluids' in hollow tubes, to understandings of electrical current to chemical transmission, we can see how the 'nervous system' has been constructed through time, and cited to be the origin of our emotional and cognitive experiences. Not only is this just *one* way of describing what the seat of experience is, it is also a story that continues to be in flux. I've already pointed to the way there is growing recognition of systems interrelating (i.e. neuroimmunology, where nervous and immune systems are acknowledged as interconnected). Likely the stories about the nervous system will continue to change.

I wonder what would happen if some of the principles and theory of quantum physics were applied to and witnessed in the energy and matter of the 'nervous system'.

At a basic level, quantum physics predicts very strange things about how matter works [...]. Quantum particles can behave like particles, located in a single place; or they can act like waves, distributed all over space or in several places at once. How they appear seems to depend on how we choose to measure them, and before we measure they seem to have no definite properties at all – leading us to a fundamental conundrum about the nature of basic reality.29

I wonder, for example, what might be understood about the nervous system if the quantum concept of 'entanglement' were applied to it. In entanglement, two quantum particles (the smallest possible discrete units of any physical property, such as energy or matter) are observed as instantaneously interrelating, no matter how far apart they are. Something Einstein called 'Spooky action at a distance'.30

Entanglement has been described in the following way:

If you observe a particle in one place, another particle – even one light-years away – will instantly change its properties, as if the two are connected by a mysterious communication channel. Scientists have observed this phenomenon in tiny objects such as atoms and electrons. But in two new studies, researchers report seeing entanglement in devices nearly visible to the naked eye.31

What interconnections might be understood by *this* particular scientific paradigm, or by a myriad of global spiritual and healing paradigms which would disrupt the biomedical story of us having a discrete 'system' called the 'nervous system'? One which is perceived of being in us, as individual, homeostatic units?

29. Richard Webb, No date. 'Quantum physics'. *New Scientist.* Available from: www.newscientist.com/term/quantum-physics (Accessed 11.01.2021)

30. Ibid.

31. Gabriel Popkin, 2018. 'Einstein's 'spooky action at a distance' spotted in objects almost big enough to see'. April 25th. *Science Magazine.* Available from: www.sciencemag.org/news/2018/04/einstein-s-spooky-action-distance- spotted-objects-almost-big-enough-see (Accessed 11.01.2021)

'Lock and key' – stories about neurotransmitters and receptors

There's more about some of the physiology (workings) of the nervous system in Part Three. Meantime, I wanted to look at a concept that has been quite profoundly promoted in biomedical conversation around what it calls 'mental health'. That is strong narratives about neurotransmitters, using an analogy of a lock and key. We are told neurotransmitters, called chemical messengers, interrelate with electrical impulses between nerve cells (neurons) causing physiological changes to occur in the bodymind-soul.

Biomedicine claims that certain neurotransmitters (like seratonin, dopamine, oxytocin, etc) in the brain/nervous system are responsible for certain experiences in the 'mind'. One of the analogies and images we have been offered to explain how this works is that of a lock and key. We are told that particular biochemicals travel and attach to what are called 'receptors'. We are led to believe that the 'receptor sites' are like a *lock* and the neurotransmitters are like a *key.*

The analogy is accompanied by this kind of imagery (below and right).

In actual fact, receptors aren't like locks, they are *proteins* (made up of chains of amino acids) in cells, in this instance in neurons (nerve cells) that chemicals called *ligands* bind with. This binding, which we are told occurs when neurotransmitters travel across the synaptic cleft – a gap *between* the neurons – is believed to cause changes in the electrical activity in the cell. This causes resultant physiological processes. The lock and key analogy was first used by Emil Fischer in 1894.

One of the things I find problematic about the lock and key analogy is how it has been appropriated and promoted by the pharma industry, where it is highly suggestive that something *missing* needs to be joined together to enable 'correct' function. More specifically problematic is the suggestion in its marketing to consumers, that something

'missing' is needed to enable 'normal' functioning. The language is suggestive of a door being unlocked
and opened. Emotional distress is cast as an alleged chemical imbalance and the lock and key is strong iconography to support a narrative of *curing* personal chemical deficiency or imbalance. There is something seductive about the concept of some kind of alleged 'key' that is missing which can 'open' and 'fix'. In actual fact, what is occurring are complex chemical processes *and* electrochemical changes all over the body, and much of their exact behaviour and effect remains mysterious.

What also occurs is that we are *locked* by this narrative *inside* the individual body and brain. We are told that an imbalance in these 'keys' is the problem. Research has been carried out and then languaged to suggest that we can resolve emotional distress by fixing these 'internal' locks and keys. Not only is the neuroscientific focus a limited and very particular way to view and comprehend experience – we are shaped by so much more than just a single reductive chemical agent, our brain chemistry doesn't occur in a vacuum. It is affected by *external* events.

I'll come back to that idea below. Meantime, I think it's interesting to see the way the language and ideology of neuro-chemicals has totally permeated popular culture. A blog post about anxiety describes ways 'to increase our happiness', which suggests we increase chemical secretions in the brain, as if they are the *definitive* agents that cause happiness. We are told:

When you feel good, your brain is releasing one of the happiness chemicals. There are four happiness chemicals, which are known as DOSE:

1. Dopamine
2. Oxytocin
3. Serotonin
4. Endorphin

'By understanding how these chemicals work,' the blog tells us 'we can better improve our overall happiness by tapping into each of
the four happiness chemicals. Each chemical has a job to do and when your brain releases one of these chemicals, you feel good.'

The 'function' of each of the chemicals is described in turn, as are symptoms of their deficiency. We are told for example that: 'Oxytocin gives a feeling of trust, *it motivates you to build intimate relationships and sustain them* [emphasis added].'

We are told:

Low levels of oxytocin can result in signs and symptoms including but not limited to:

– feeling lonely
– stressed
– lack of motivation or enthusiasm
– low energy or fatigue
– a feeling of disconnect from your relationships
– feeling anxious

– insomnia

Suddenly it's as if all the social context that might cause loneliness or feeling of disconnect has been erased. We are being encouraged to generate the 'correct' amount of chemicals within our brains as the main locus of attention and remedy for profound social, spiritual and relational concerns.

The blog makes suggestions for increasing these 'happiness chemicals' by socialising, sharing cuddles, massage. It's true that if we build intimate relationships with people our physiological and chemical processes will likely be altered, but it seems hyper individuated to do so with the intention of personally increasing 'happiness chemicals'. I would argue that we need to generate a very different impulse, one that orients towards the embodied joy of collectively *feeling alive* and *interconnected* in all ways, as opposed to an emphasis being placed on raising our personal chemical secretions for the illusion of some kind of 'personal' healing. The emphasis needs to be on broader relational and societal healing, rather than a focus resting on personal biochemical levels, for greater transformative potential for wellness for everyone.32

It makes me think about how biomedicine and its reach into mainstream culture suggests that we now conceptualise *everything* reductively. Happiness, pleasure, joy, and the sensual world itself get reduced down to the biochemical.

A permaculture article, for example, tells us:

Did you know that there's a natural antidepressant in soil? It's true. Mycobacterium vaccae is the substance under study and has, indeed, been found to mirror the effect on neurons that drugs like Prozac provide. The bacterium is found in soil and may stimulate serotonin production, which makes you relaxed and happier.33

There it is again. Simplistic solutions. Soil Helps Depression we are told.

Individuated. Extractions.

Not just Mycobacterium vaccae; your studies injecting microbes into rats.

Not this reductive for what 'makes well'.

The soil that gives us sweetness, contact, moisture, life, connection, we inhale and exhale all of what it holds and bears forth.

You can keep your studies, suffocating variables. Talking about particles on particle terms. Water is not just H2O.

The benefits of soil rise up wider and richer than the microbes you claim to have distinguished.

That isn't the way the magic works.

32. Mind my Peelings, 2020. 'Daily Dose of Happiness Chemicals?' Available from: www.bananatreelog.com/blog/daily-dose-of-happiness-chemicals? (Accessed 11.01.2021)

33. Bonnie. L. Grant, no date. *Soil helps depression.* Available from: www. permaculture.co.uk/articles/soil-helps-depression (Accessed 11.01.2021)

It reminds me of the need for conceiving of medicine in terms that encourage us to *feel*, and therefore be able to *find* remedies through our *felt sense*, rather than reductively minimise life and take it out of the *felt sense.* That those felt experiences

(like contact with soil) may result in changes at the level of reductive components, but it isn't *solely* through them that we have, or know about the experience.34

What electrical and chemical shifting in music, song, vibration, dance?

Björk: I like your music very, very much because you give space to the listener. He can go inside and live there. But a lot of music over the past few centuries you just have to sit and listen.

Arvo Pärt: Maybe it's because I need space for myself – even if I am working. I think that sound is a very interesting phenomenon. You can ask why people are so influenced by music – they don't know how strong the influence of music can be on us – both good and bad. You can kill people with sound...and if you can kill, maybe there is the sound that is the opposite of killing. The distance between these two points is very big.35

34. Neurotheology, also called 'spiritual neuroscience' or the 'neuroscience of religion' is a relatively new field of study that attempts to map correlations between religious experience and the brain. While correlations can be of interest (for example there is correlation between magic mushrooms (psilocybin) and activation in the temporal lobe of the brain that simulates religious experience) it still feels like another version of the biomedical obsession to investigate experiences in terms of small components within the brain, when our experiences are also had in the whole body and the body within a greater whole.

35. 'Arvo Pärt interviewed by Björk': Modern Minimalists, no date. *bjork. fr.* Available from: www.bjork.fr/bjork-arvo-part-Modern-Minimalists- BBC-1997 (Accessed 11.01.2021)

What electrical and chemical shifting in our cells through a caress, a kiss?

What shift through making structural change, refusing violence, demanding justice?

How is the looking for, focused? What is the lens of inquiry?

I remember years ago reading that wolves who had subordinate social roles in the pack had particular neurochemical levels. It suggested social positioning correlated with or caused particular neurochemical activity to occur. Even though it is still the reductive lens of neuroscience speaking about neurochemicals, which I don't feel is the way experience can be defined or explained, I'm interested in what correlations there might be between what is *external* and contextual, and our *inner* territory. I'm interested in it, in order to flip the common argument – about our individual inner neurochemical territory being faulty and needing to be fixed, without addressing the contexts we exist in – on its head. I haven't been able to locate that research and findings in wolves, but found some about fish, and subsequently other research in direct reference to humans.

I'm very reluctant to engage with or cite studies that involve animal testing that may have harmed or disoriented living beings, but am going to reference a paper called *Serotonin Coordinates Responses to Social Stress – What We Can Learn from Fish* by Tobias Backström and Svante Winberg. They write, 'subordinate individuals are often subjected to chronic stress, which greatly affects both their behavior and

physiology'. Serotonin is a neurotransmitter, and serotonergic means pertaining to or affecting serotonin. A synapse is serotonergic if it uses serotonin as its neurotransmitter. Backström and Winberg continue, 'Social subordination results in a chronic activation of the brain serotonergic system and effect, which seems to be central in the subordinate phenotype.'

Backström and Winberg conclude, 'The social rank of an animal has large effects on its behavior, physiology and life history trajectory.' And they go on to make the point that, 'In general autonomic, endocrine and behavioral stress responses are well conserved and *similarities between mammals and teleost fish are striking* [emphasis added].'36

In terms of humans, I found reference to research called 'social neuroscience'.

In the mid 1970s, a young neuroscience researcher named John Cacioppo was listening to his professors – some of the best in the world – but there was something he just couldn't understand.

When they tried to explain why human emotions change, they seemed to focus only on one thing: what happens *inside* your brain. They didn't look at what was happening in your life, and ask whether that might be causing any of the changes in the brain they were discovering. It was as if they thought your brain is an island, cut off from the rest of the world and never interacting with it.

So John asked himself: What would happen if, instead of studying the brain as if it were an isolated island, we did it differently? What if we tried to study it as if it were an island connected by a hundred bridges to the outside world, where things are being carried on and off all the time as you receive signals from the world?

[...] John never forgot these questions. He puzzled over them for years, until one day, in the 1990s, he finally thought of a way he might begin to study them in more detail. If you want to figure out how your brain and your feelings change when you interact with the rest of the world you could start by looking at what happens in exactly the opposite situation – when you feel lonely and cut off from the world around you. Does that experience, he asked himself, change your brain? Does it change your body?

36. All quotes from Tobias Backström & Svante Winberg, 2017. 'Serotonin Coordinates Responses to Social Stress, What We Can Learn from Fish' 25th October. *Frontiers in Neuroscience*. Available from: www.frontiersin.org/ articles/10.3389/ fnins.2017.00595/full (Accessed 11.01.2021)

Back when John first started asking these questions in the 1970s, his professors had believed social factors were largely irrelevant (or too complex to study) if you wanted to figure out what happened in the brain as your mood and feelings changed. In the years since, John had proved conclusively that they can – on the contrary – be decisive. He pioneered a school of thinking differently about the brain, and it's come to be known as 'social neuroscience.' [...] He told me: 'This notion that the brain is static and fixed is not accurate. It changes. Being lonely will change your brain; and coming out of loneliness will change your brain

– so if you're not looking at both the brain *and* the social factors that change it, you cannot really understand what is going on.37

In popular culture, specifically the world of social media, we can see how neuroscience is being understood, and weaponised. In an article *Dopamine, Smartphones & You: A battle for your time*, Trevor Haynes documents how the former vice president of user growth at Facebook, Chamath Palihapitiya, admitted, 'I feel tremendous guilt...The short-term, dopamine-driven feedback loops that we have created are destroying how society works.' In Palihapitiya's talk, Haynes tells us, 'he highlighted something most of us know but few really appreciate: smartphones and the social media platforms they support are turning us into bona fide addicts'.38

That addiction serves advertising and corporate interest, and is part of what has been called surveillance capitalism. Our online habits are observed and we are manipulated to spend more and more time on our devices, on social media.

Corporate social media and the biomedical world layer up here – social media machinators admit to the fact that they work to 'consume as much of your time and conscious attention as

37. Johann Hari, 2018. *Lost Connections: Uncovering the Real Causes of Depression – And the Unexpected Solutions*, Bloomsbury USA, p.73 & 84

38. Trevor Haynes, 2018. 'Dopamine, Smartphones & You: A battle for your time'. *Harvard University.* Available from: sitn.hms.harvard.edu/flash/2018/ dopamine-smartphones-battle-time (Accessed 11.01.2021) possible', and claim the language and ideology of neuroscience as the way they believe they do this.

In an article *Has dopamine got us hooked on tech?*, Simon Parkin comments on the phenomenon. He writes:

Sean Parker, the 38-year-old founding president of Facebook, recently admitted that the social network was founded not to unite us, but to distract us. 'The thought process was: "How do we consume as much of your time and conscious attention as possible?" To achieve this goal, Facebook's architects exploited a 'vulnerability in human psychology' explained Parker, who resigned from the company in 2005. Whenever someone likes or comments on a post or photograph, he said, 'we [...] give you a little dopamine hit'.39

This dopamine science, presented as what drives addictive behaviour, and claimed to be shamelessly exploited by social media profiteers, feels like loops and layers of misguidance. Not only are we being strategically encouraged to spend all our time hooked into social media, but the industry perpetuates an idea that that behaviour is all dependent on certain neurochemical activity.

In an article titled *How evil is tech?*, David Brooks writes, 'Tech companies understand what causes dopamine surges in the brain and they lace their products with "hijacking techniques" that lure us in and create "compulsion loops".'40

I don't believe the 'hijacking techniques' seduce us purely because they cause some chemical high. We are offered (albeit

39. Simon Parkin, 2018. ‘Has dopamine got us hooked on tech?’ 4th March. *The Guardian.* Available from: www.theguardian.com/technology/2018/ mar/04/ has-dopamine-got-us-hooked-on-tech-facebook-apps-addiction (Accessed 11.01.2021)

40. David Brooks, 2017. ‘How evil is tech?’ Nov 20th. *New York Times.* Available from: www.nytimes.com/2017/11/20/opinion/how-evil-is-tech.html (Accessed 11.01.2021)

technologically mediated) connection, affirmation, interest, intellectual stimulation, stories, drama, excitement. We are offered both feeling, and the avoidance of feeling. The effect of all that in our bodymindsouls is embodied and somatic, not just neurochemical. I critique the premise of the Facebook/dopamine narrative, but cite it to show that if external events affect our ‘internal’ brain chemistry, then there *necessarily* needs to be consideration given to the way *everything* around us would surely do the same. We could ask what kind of brain chemistry patterns might be noticed that correlate with the experiences of oppression, violence, threat and stress, also with the experiences of justice, joy, community, and ecstatic divine commune? In this way we can challenge and redefine the stories and agendas that are often promoted in the pharma-medical-industrial complex; by naming biochemical levels, as potentially *mirrors* of life lived, not just *markers* of some

alleged personal chemical lack.

The language and ideology of biomedicine #3

The Myth of the Chemical Cure

I want to go into a bit more detail about the dominant messages we are given that 'mental health' or 'mental illness' is caused by imbalance in brain chemistry. There is a significant body of research and writing now that questions and challenges the validity of this argument, documented accessibly in books like *Cracked: Why Psychiatry is Doing More Harm Than Good* by James Davies, *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* by Robert Whitaker, and *Bad Pharma* by Ben Goldacre. British psychiatrist Joanna Moncrieff has set out a clear account of the pervasive narratives about brain chemistry, and the role of the pharmaceutical industry in promoting them. In her book *The Myth of the Chemical Cure*, Moncrieff charts some of the medical evolution of some now deeply ingrained ideas.

Moncrieff explains how with the rise of the early Eugenics movement, ideas about heredity became popular and influenced psychiatry, so that 'disorders came to be seen as primarily inherited and therefore incurable'.41

Eugenics

The Eugenics movement was mobilised by the ruling class in the global North in the late 19th century. The term eugenics was first formulated by Francis Gatton, the half cousin of Darwin, in 1883. The movement claimed that certain people perceived as being 'defective' or 'deviant' (which included disabled people, women who had children out of marriage, people who hadn't had access to education, and often those who were simply poor) were genetically and essentially of less human worth. A core agenda of the Eugenics movement was to prohibit groups of people from reproducing, in order to 'improve' the population. Its ideology was the basis for programmes of forced sterilisation of huge population groups, especially people who had been colonised, and was intrinsic to the Nazi holocaust where groups of people deemed 'degenerate' or 'unfit' were killed.

Moncrieff continues explaining the trajectory of the narrative about brain chemistry, saying that in 'contrast to the older humoral notion of disease as a general state of bodily imbalance, the modern scientific view [which] emerged during the late 19th and early 20th century' viewed a so-called disease as 'a collection of distinct symptoms caused by a biological mechanism, which could

41. Joanna Moncrieff, 2007. *The Myth of the Chemical Cure*, Palgrave Macmillan, p.2

be identified in anatomical or physiological terms'.42 She speaks about the way drugs increasingly came to be used in place of earlier treatment methods (which involved physical restraint or forceful impact on the bodymind like shock treatments), in what is commonly referred to as the Psychopharmaceutical Revolution. She writes: the new generation of drugs introduced into psychiatry from the 1950s onwards were greeted with immense enthusiasm verging on zeal. One contemporary observer noted disapprovingly that the atmosphere at conferences on the new drugs was akin to revivalist meetings.43

Moncrieff describes how the new drug-based psychiatric paradigm then metamorphosed from being a *drug-centred* model to a *disease-centred* one. Formerly, in the drug centred model, drugs were understood to simply have an action in the bodymind. They would, for example, sedate or stimulate. She explains that over time, and through the manufacture of narrative – which used selective, distorted and false evidence research – the story shifted from the observation simply of a drug's *action*, to a claim that a drug was now actually *treating an underlying pathology.*

Moncrieff discusses the two models in a bit more detail. In the drug-centred model, she says, the understanding is that therapeutic effects of drugs occur because of the 'impact of a drug-induced state on behavioural and emotional problems'. Under the now dominant disease-centred model, the understanding is that therapeutic effects of drugs occur because of 'their effects on presumed disease pathology'. Under the current disease-centred model for example, ' "antipsychotics" are thought to act specifically on the pathology of underlying psychosis, "antidepressants" are thought

42. Ibid. p.45 to act on the pathology of depression'.44 To cement this idea, the new model likens 'antidepressants' treating 'depression' to insulin treating diabetes.

In the drug-centred model

In the disease-centred model

Drugs affect the brain state, they could be said to create an 'abnormal' brain state.

Drugs are said to help correct an 'abnormal' brain state.

Therapeutic effects are said to be a result of the impact of the drug-induced state on behavioural and emotional problems.

Therapeutic effects of drugs are said to be a result of their effects on presumed underlying disease that they cure/correct.

Effects do not differ in people who take the drugs.

Effects may differ in people who take the drugs.

Outcomes are the state that is produced by taking the drug, and how this interacts with behaviours and experiences. It would be compared to: use of alcohol for feelings of social anxiety.

Outcomes are the effects of drugs on measures of the 'disease' and its manifestations or symptoms.

It would be compared to: use of insulin as a treatment for diabetes.

Above adapted from *The Myth of the Chemical Cure* by Joanna Moncrieff

The shift from the drug to the disease-centred model meant that drugs were alleged not to just have an *effect* in the bodymind, but to *cure* an underlying problem. This reconceptualisation generated the now widely promoted (and believed) story that complex, embodied, relational experiences of distress are due to faulty individual chemistry in the brain, which can be biochemically 'fixed',

often involving people remaining dependent on sustained, lifelong drug intake. The disease centred model, based on research that was sponsored and promoted by the pharmaceutical industry, has served that industry well. It has justified the sale of more drugs, generating huge profit margins for the companies that make them. Moncrieff cites in detail the spurious and selective ways in which the studies about drugs 'curing' alleged pathologies have been undertaken, and how papers have been written and ghost written (written by employees of the pharmaceutical industry but presented as being neutral or academic research), to promote what she describes as a myth, concluding, 'The institution of psychiatry, aided and abetted by the pharmaceutical industry and ultimately backed by the state, has constructed a system of false knowledge about the nature of

psychiatric drugs.'45

The corruption in 'research' steering the pharmaceutical industry has been documented in some of the books listed at the start of this section. Another voice, that of David Healy, professor of psychology at Bangor University, has also offered comment and critique:

According to Healy, drug companies first started ghostwriting scientific papers for university researchers in the 1950s. Back then it was seen as a marginally disreputable practice, and these papers usually appeared only in obscure journals with little prestige or influence. But by the 1970s the drug companies had taken control of funding the major randomised control studies, and by the mid 1990s, Healy estimates, over half of the studies in the most prestigious journals were being drafted not by the university researchers supposedly heading the studies but by medical-writing companies paid by the drug companies.46

45. Ibid. p.237

46. Ethan Watters, 2010. *Crazy Like Us: The Globalization of the American Psyche*, Simon & Schuster, p.260

... some time ago whilst in Canada I did three clinical trials to make some money quickly so I could take a show on a tour of fringe festivals

[...] things are set up in a way that means many symptoms don't get picked up on this is how it works

there is a set price you get for completing the whole study if you feel unwell or have any symptoms whilst on the study this will get logged and your involvement in the study will be stopped which means you don't get paid the full

amount now the people on these studies are not doing it for the furtherment of medical science they are doing it because they need the money[...] so everyone lies about getting symptoms including myself.47

Moncrieff writes:

People have become willing recipients of the idea that their problems emanate from a chemical imbalance in their brains. The idea has diffused into public consciousness, fundamentally changing the way we view ourselves and the nature of our experiences.48

I would argue people haven't just become 'willing recipients'. I think we are all doing the best we can to make sense of experiences we have in the context of the information we are offered. The messages we get from biomedicine (which have totally permeated

47. Lucy Hutson, 2018. *Everything in My Head at One Time in My Life*. Live Art Development Agency.

48. Joanna Moncrieff, 2007. *The Myth of the Chemical Cure*, Palgrave Macmillan, p.238 popular culture) to frame our experiences as 'biochemical' and 'mental' are *very* strong. This relates to the concept of hermeneutical injustice – what we *come to know* is dependent on what kind of information we have access to – which is explored ahead in Part Two.

Moncrieff devotes a whole chapter to the construction and hard sell of what are called 'antidepressants', which escalated in the 1990s. She shows how research about a group of drugs called monoamines, including serotonin and noradrenaline, was fabricated into a narrative which claimed their deficiency *causes*, and thus their prescription *cures*, depression. This 'disease process' was given the term 'endogenous depression' (endo – meaning within), as opposed to 'exogenous depression' (exo – meaning external/ outside).

She explains the way this new conceptualisation of endogenous, sometimes called 'vital' depression was defined. 'Endogenous replaced the idea of melancholia and referred to a state that was thought to originate from biological malfunction in contrast to "reactive" or "neurotic" depression that was thought to be a response to external events.'49 She writes, 'Although it is now little recognised, some of the first drugs that were later referred to as antidepressants were initially regarded as stimulants.'50 These drugs were initially described in terms of the action they caused, like 'a sensation approaching euphoric dynamism',51 or, as in 1957 where the idea of a drug as a '"psychic energiser" was elucidated by a group of American researchers'.52

Moncrieff continues:

Despite decades of research, there is no evidence to support the monoamine theory of depression. Studies of noradrenaline are inconsistent, with as many finding raised levels in people

49. Ibid. p.126

50. Ibid. p.119/120 with depression as those finding reduced levels. Evidence on serotonin is similarly inconsistent.53

When research couldn't prove that a *deficiency* of monoamines caused depression, it switched its focus to *receptors*. It reformulated a hypothesis about monoamine receptors and neurochemical uptake by these receptors. This led to massive research, selective documentation and heavy marketing of drugs called SSRIs (Selective Serotonin Reuptake Inhibitors).

Several campaigns to promote the concept of depression and 'antidepressants' were financed by pharmaceutical companies.

In the early 1990s, with the launch of the new range of antidepressants such as Prozac (fluoxetine), Lustral or Zoloft (sertraline) and Seroxat or Paxil (paroxetine), the pharmaceutical industry was involved in a number of [...] campaigns [...] the UK Defeat Depression Campaign run by the Royal College of Psychiatrists and General Practitioners but part-funded by Eli Lilly (makers of Prozac), is a good example [...] the campaign sought to persuade General Practitioners that they should diagnose more people as depressed and prescribe more antidepressants.

[...]Between 1992 and 2002 the number of prescriptions issued for antidepressants in the United Kingdom increased by 235% from 9.9 to 23.3 million.54

The pharmaceutical industry has actively appropriated and exploited popular culture to promote its messages. Art and artists have been assimilated indirectly and directly by pharmaceutical marketing campaigns to generate iconography which serves the narrative of personal turmoil/brain and biochemical malfunctioning that can

53. Ibid. p.132 54. Ibid. p.134/5 be fixed/alleviated with drugs. A reproduction of a Picasso illustration was placed alongside an image of a brain, to allude to the brain as being malfunctioning, to be fixed with drugs, in a 1961 advert for Largactyl (chlropromazine) in the British Medical Journal.

The pharmaceutical company Wallace Laboratories, which became famous for manufacturing a tranquilliser called Miltown (meprobamate), commissioned four works from the artist Salvador Dalí in 1958. Dalí was considered the ideal artist for the commission with his creative interest in the subconscious, and whose dreamlike and hallucinatory imagery lent itself to the theme of medication bringing the mind to a different state of reality. Dali was commissioned to depict a visualisation of the transition from mental turmoil to tranquility.

Dalí bought into the marketing campaign, titled the series of these four works *Crisalida*, and wrote about the series:

Crisalida paints tranquility. The outer structure of Miltown is that of a chrysalis, maximum symbol of the 'vital nirvana' which paves the way for the dazzling dawn of the butterfly, in its turn the symbol of the human soul.55

Drugs can have an effect that is useful, and in some cases vital, in both acute and long-term situations. They can however have long-term detrimental effects and generate more fundamental problems, because claims made about them being a 'cure' can

become internalised culturally and personally at the cost of seeking broader, holistic responses to experiences of distress. Can we open up the conversation? Are there desired effects in the bodymind that can be found from substances that are more holistic and harmless (and that aren't commercially driven by profit motivation)? And are there desired effects that can be found in practices, and from connection, support, solidarity, and from greater social change that we could mobilise and move towards?

Moncrieff concludes: the marketing of antidepressants has persuaded a large portion of the population of Western countries to take prescribed drugs to deal with the problems of living [...]. The message that drugs

55. Christie's Auction Lot 389: Dali, 2002. Available from: www.christies. com/en/lot/lot-3863326 (Accessed 11.01.2021) cure your problems has profound consequences. It encourages people to view themselves as powerless victims of their biology [...]. At another level it allows governments and institutions to ignore the social and political reasons why so many people feel discontented with their lives.56

When people are offered drugs, they are not offered a correlating blood test that could prove brain chemistry is deficient and a cause of experience. There is no chemical marker. This narrative, or 'system of false knowledge' is now taken as truth, and prescriptions are issued on that basis. Prescriptions are also often made, based not on deep experiential knowledge of the effect of a drug, but because of trends in very active marketing by pharmaceutical companies to medical professionals.

The 1990s obsession with brain chemistry and the brain can be seen in the demarcation of something in the USA that was called *The Decade of the Brain*. It was a 1990–1999 designation by president George W. Bush as part of a larger effort involving the National Institute of Mental Health, 'to enhance public awareness of the benefits to be derived from brain research'. It was part of an international trend. The Government of Japan invested $125 million into neuroscience research in 1997, leading to the development of the Brain Science Institute. The Government of India founded the National Brain Research Centre during the same year. In 1998, the Chinese Institute of Neuroscience was founded. It seems coherent that with the increased use of a hyper-individuated lens to situate and understand human experience, that there was not only something identified as 'The Century of the Self ', but at its close also 'The Decade of the Brain'. It is this narrowing of focus into the brain that has added to our experiences of perception, feeling, consciousness and cognition, as well as our very personhood, being (mis)located there. Although conversation about consciousness is broadening beyond the brain in global Northern scientific paradigms, it's not unusual to still find ideas, such as these in a *New Scientist* editorial titled *What's in Your Head?*:

The answers to the biggest questions of our existence – what is consciousness, what makes people behave the way they do, what is intelligence, and why do you sleep and dream – are all rooted in the 1.4 kilograms of soft stuff between your ears. These are

questions about what it means to be human, about *what makes you 'you'* [emphasis added].57

From the bio-psycho-social model to the bio-bio-bio model

The bio-psycho-social model was first proposed by George L. Engel and Jon Romano in 1977. Unlike the biomedical approach, it strived for a more holistic approach to understanding experiences of distress by recognising that each person has their own thoughts, feelings, history and social contexts.

In 2005, an article by psychiatrist Steven S. Sharfstein entitled *Big Pharma and American Psychiatry: The Good, the Bad, and the Ugly*, stated:

There is widespread concern at the over-medicalization of mental disorders and the overuse of medications. Financial incentives and managed care have contributed to the notion of a 'quick fix' by taking a pill and reducing the emphasis on psychotherapy and psychosocial treatments.58

In his article *The bio-bio-bio model of madness*, psychologist John Read comments on Sharfstein's words:

I admit to a barely suppressed 'Yes!' when I read Sharfstein's comment 'We must examine the fact that as a profession, we have allowed the bio-psycho-social model to become the biobio-bio model' [...]. The simple truths are that human misery is largely inflicted by other people and that the solutions are best based on human – rather than chemical or electrical – interventions. If mental health service users were involved in negotiating the final truce [...] the bio-bio-bio model would be history.59

The dominance of this shift in focus, from any broader analysis of social context to biochemical reductionism, is clear in so many mainstream approaches now. NHS packs and workbooks around

58. Steven S. Sharfstein, 2005. 'Big Pharma and American Psychiatry: The Good, the Bad, and the Ugly', *Psychiatric News.* Available from: psychnews. psychiatryonline.org/doi/10.1176/pn.40.16.00400003 (Accessed 11.01.2021)

59. John Read, 2005. 'The bio-bio-bio model of madness', in *The Psychologist*, 18(10), p.596–597. thepsychologist.bps.org.uk/volume-18/edition-10/bio-

'Mental Health First Aid for Young People' for example are revealing cultural documents because of the kind of narratives they centre. They tell us that 'Mental Health' means 'Mental Health problems' and 'Mental Wellbeing'. We are told that 'a young person with good mental health and wellbeing will feel *in control of their emotions* [...] and have [...] *positive interactions* with people around them [emphasis added]', seemingly with no examination of what their lived realities, or the oppression they might face might be. While this is followed by the recognition that 'socio-economic, environmental and cultural factors will affect a society's mental well being', there is

only a dilute reference to the fact that, ‘by making structural changes to economic, cultural and environmental conditions there *could* be a beneficial effect on society’s mental wellbeing [emphasis added]’. The rest of the manual and workbook are peppered with ideology that individualises the site of problems, and locates it back in personal biochemistry.

In the section called ‘What is depression?’ for example, while we are offered a list of ‘Other risk factors’, the *very first* factor we are offered is biochemical: ‘The symptoms of depression’ it tells us, ‘are thought to be due to changes in natural brain chemicals called neurotransmitters’. When a person becomes depressed we are told ‘the brain can have less of these chemical messengers’. The narrative about deficient or faulty brain chemistry is iterated and reiterated.60

Speaking about ‘mental health’ and destigmatising ‘mental health’

Compounding the language & ideology of ‘mental health’

Many mainstream voices and organisations talk about the necessity to both *speak about* and *destigmatise* ‘mental health’ and present this as a progressive step. One such project, Honest Open Proud,

60. NHS Scotland, 2013 & 2016. *Mental Health First Aid for Young People*. Packs and workbooks

for example, states its mission is to ‘erase the stigma of mental illness and improve the lives of those affected by mental illness by teaching people *safe* ways to talk about their experiences [emphasis added]’. Guidelines offered include: ‘Five ways to *come out*’ and ‘How to tell a *personally meaningful story* [emphasis added]’.61

There can be deep stigma and taboo around sharing experiences of vulnerability. It has often been buried, shamed and disallowed for years, and generations. The fear of the ill or sad person, or the dangerous lunatic, and the fear of the ‘Madhouse’ which has been generated historically in the global North also run deep in the cultural psyche. The problem however with saying that ‘mental health’ is *stigmatised* and should be *destigmatised*, is that it affirms dominant ideas about personal ‘mental health’ issues located in an atomised self. It is *this*, that we are being encouraged to speak about. So the language and ideology of ‘mental health’ is compounded.

I think what needs to be destigmatised is speaking rawly and honestly about how we all variously *feel* and *experience life*. Speaking about, for example, the impact of the alienation of most work structures and the division of labour, of class inequality, the injustice around economic and social resources, intergenerational trauma, structural racism, the violence and meaninglessness of consumer capitalism, the grief of environmental damage. Surely it’s *this* conversation that should be destigmatised. As long as there is primarily an interest in destigmatising a conceptualisation of something called ‘mental health’, we are limited in how we might view, name, discuss, analyse, approach and tend to our distinct and common experiences of distress.

How we name what is unbearable. Intolerable. How we name it together.

How we name breadth and curiosity.

61. ‘Open, Honest, Proud’, No date. *Mental Health Foundation*. Available from: www.mentalhealth.org.uk/projects/honest-open-proud (Accessed 12.1.2021)

How we hear each other. How we make connections.

Not self doubting our reactions. Not just the I me. Not internalised...

What we might stand strong in refusing together. What we might stand strong in demanding together.

Heads Together

Members of the Royal Family joined in promoting the narrative around ‘mental health’, launching a campaign in 2016 called *Heads Together*. At its onset it told us it is concerned with ‘workplace wellbeing, ‘mentally healthy schools’ and ‘military mental health’. In a promotional film – part of an #okaytosay campaign to promote ‘more conversation around mental health’ – Kate Middleton, Prince William and Prince Harry, described as ‘the royals having an honest chat’, are seen talking together in the grounds of Kensington Palace. Prince William determines that speaking about ‘mental health’ is ‘part of the healing process, part of sharing *your* problems, to halve them and *make them better with someone you trust*’. Kate Middleton says with this new initiative they want ‘to show people how to have those *simple conversations*’, that ‘j*ust having*

those conversations is like medicine’. At one point Kate, speaking in clipped English about the experience of becoming a parent, turns to William and says, ‘You often talk about the emotional changes that *even* you have gone through.’ She celebrates how close they are, and says ‘You know, some families *sadly aren’t as lucky as you’ve been.*’ Prince William agrees but adds, ‘You know, *even* Harry and I haven’t talked enough... [all emphases added]’. *Even...* It seems the irony of one interpretation of their charity’s name *Heads* Together is lost on them.62

what? What is it that people are being encouraged to speak about? What are the frames of reference for these ‘simple conversations’ people will be ‘shown how to have’. It’s so important for everyone to be able to say they are struggling or in pain, and not silence that. There is some good intention there, but this kind of narrow, individualised conversation (promoted by people who are part of maintaining *enormous* economic disparity and in positions of absurd privilege), which doesn’t directly and explicitly talk about some of the root contributing factors of distress, is a smoke screen for fundamental change which would be truly life affirming and *really* benefit everyone’s psycho-emotional health.

Who defines experience to whom? Who advises whom?

Who says how to speak, and when? Who says what conversation is healing?

In *Chav Solidarity*, D. Hunter comments on the impact of societal inequality and oppression on psycho-emotional health, and class based prejudice and privilege around what gets called mental health:

62. Heads Together, 2017. [Video]: Available from: www.youtube.com/ watch?v=45RqUmxDXiY&
7D4Y&index=3&t=0s (Accessed 12.1.2021)

[...] in the past year it was front page news that more young people than ever before are suffering from mental health issues. That this is part of the public discourse can only be a good thing, but refusal by society to ignore its own part in causing damage to people's mental health does, at times, terrify the life out of me.63

[...] prominence is given to the ways in which middle class people suffer from depression and anxiety. This is partly because the ways in which depression and anxiety of working class and poor people manifests itself is considered unpalatable and difficult, and is therefore more prone to being characterised and minimised as individual failings. And it's partly because white middle class people, whatever the state of their mental health, tend to place their narratives central in discussions around mental health, to the detriment of others.64

The introduction to *The Colour of Madness* speaks about the way racism impacts on what gets called mental health, and on negative experiences of services and institutional care:

[...] we acknowledge the collective disadvantage brought about by our racialisation and minoritisation with regards to our mental health... Recently, several commissions and audits have confirmed what many of us know from experience: people from BAME communities experience more negative interactions with mental health services than their white counterparts. The 2016 Royal College of Psychiatrists commission on acute adult psychiatric care, the 2016 Mental Health Taskforce Five Year Forward View for Mental Health, and the Prime Minister's 2017 race disparity audit revealed that people from BAME backgrounds continue to experience complex pathways into care, and, when compared with the majority white population,

63. D. Hunter, 2019. *Chav Solidarity*, theclassworkproject.com, p.42

64. Ibid. p.43 are more likely to be admitted to psychiatric hospitals, detained under the Mental Health Act, and experience poor treatment outcomes.65

'Destigmatising' campaigns that focus on 'simple conversations' at an interpersonal level, sideline, even eclipse essential conversation about oppression that affects us and causes psycho-emotional struggle. They deflect attention away from some of the root causes of distress, and so from these root causes really being addressed.

What's deeply cynical is that some destigmatising campaigns are funded by the pharmaceutical industry because the more we 'talk about mental health' on the terms set by the words 'mental health', the more window of opportunity there is for the pharma industry to promote, market and sell drugs. An example of this is the US project The National Alliance for the Mentally Ill (NAMI), who run destigmatising campaigns that are heavily funded by big pharmaceutical companies.

NAMI's leading donor is Eli Lilly and Company, maker of Prozac... In 1999 alone, Lilly will have delivered $1.1 million in quarterly installments, with the lion's share going to help fund NAMI's 'Campaign to End Discrimination' against the mentally ill.

As a matter of policy, NAMI does not reveal the amounts of specific donations. But spokesman Bob Carolla acknowledges that the group receives substantial funding

from drug firms, who provide 'most if not all' of the anti-discrimination campaign's $4 million annual budget.

Janet Foner, a co-coordinator of Support Coalition International, an activist organization of 'psychiatric survivors,' says NAMI does a good job in some areas, but argues that the group's corporate sponsors help shape its agenda. 'They appear to be a completely independent organization, but they parrot the line of the drug companies in saying that drugs are the essential thing.'66

In *How Pharma Uses the Charge of 'Stigma' To Sell Psychiatric Drugs*, Martha Rosenberg writes:

Another group yelling 'stigma' to sell psychiatric drugs is Active Minds which says it is 'the leading nonprofit organization that empowers students to speak openly about mental health in order to educate others and encourage help -seeking [...]. Through campus-wide events and national programs, Active Minds aims to remove the stigma that surrounds mental health issues, and create a comfortable environment for an open conversation about mental health issues on campuses nationwide. Active Minds calls itself a student group but when I went to the room in the student building at Northwestern University in Evanston, Illinois, where the organization was supposed to be headquartered, they were not there – nor had a desk clerk in the student union ever heard of them. Unlike student groups against climate change or for LGBT rights, Active Minds' fancy T-shirts and cagey PR apparatus hardly look 'grassroots'. In fact, the group gets financial support from Eli Lilly, one of the top makers of psychiatric drugs.67

Below are a handful of examples that illustrate how the ideology of 'mental health' and 'destigmatising' campaigns has permeated

66. Ken Silverstein, 1999. 'Prozac.org An influential mental health nonprofit finds its 'grassroots' watered by pharmaceutical millions'. *Mother Jones*. Available from: www.motherjones.com/politics/1999/11/prozacorg (Accessed 12.01.2021)

67. Martha Rosenberg, 2017. 'How Pharma Uses the Charge of 'Stigma' To Sell Psychiatric Drugs', *The Epoch Times*. Available from: www.theepochtimes. com/how-pharma-uses-the-charge-of-stigma-to-sell-psychiatricmainstream culture. It's followed by what I think are examples of more progressive ways of speaking about experience, and about distress, that move towards more profound transformation.

Real Talk

A project called *Real Talk (*Tagline: *Real people. Real stories. Real Talk. Storytelling For Mental Wellbeing)* invites people to speak about their personal experiences of 'mental health'. It has great intentions; people are supported to find creative processes and ways to share their experiences of personal struggle, and feel connection and esmpowerment in doing so. But what 'real' means is a construct. We are told that personal testimony – like the Christian confessional, private, therapeutic sharing, or

the telling-about-self that is solicited on TV talk shows – is somehow just plain and simply 'real'. It is authentic. But it is just one, individuated way of speaking. There's no emphasis on the 'real talk' of histories and social circumstances that affect and inform our psycho-emotional health. Within the context of neo-liberal* ideology, the emphasis on telling our personal, emotional stories is *very* strong, and strong for a reason. It deflects away from broader collective and contextualised storytelling, and social and political realisations that might come from doing that. Sharing personal stories can offer such a genuine celebration of individual strength and sensitivity, within which people can also find solidarity, the recognition that an experience of distress might be one that is felt by others, and engage the power of being witnessed and bearing witness, but it often stops there.

Liberalism and Neoliberalism

Liberalism was a movement in the Age of Enlightenment in the 18th century, popular among global Northern philosophers and economists. Liberalism challenged and strove to replace inherited privilege, state religion, absolute monarchy, the divine right of kings and traditional conservatism with representative democracy and secular law. It was a political and moral philosophy based on concepts of personal liberty and equal rights. Liberalism generally supports individual rights (including civil rights and human rights), capitalism (free markets), democracy, secularism, gender equality, racial equality, internationalism, freedom of speech, freedom of the press and freedom of religion.

Neo-liberalism is the 20th-century reconfiguration of 19th-century ideas associated with economic liberalism and capitalism. These ideas include economic liberalisation policies such as privatisation, austerity, deregulation, free trade and reductions in government spending in order to increase the role of the private sector and volunteer activity in the economy and society.

'... a tribute to our times'

A documentary called *Evelyn*, released in 2018, explores a family's loss and need for communication, 14 years after the director's sibling, Evelyn, took their own life. Family and friends make a walking journey together, on camera, and talk about what happened and how they have dealt, and also not dealt with it. The film is profoundly moving, in many ways generous, and opens up dialogue and connection between not only the family and friends but also passers-by on the walk. Once again though we see the dominant cultural messages about 'mental health' mirrored to us.

The film descriptor reads: 'EVELYN is an exposition of the *taboos of mental health* and male emotion, and *a tribute to our times* [emphasis added].' At the start of the

film Evelyn is described as having been a really sensitive person. Soon after that we are told that he was diagnosed with schizophrenia as a young man, after which we stay in the territory of 'mental health', as if that (some innate 'mental' malfunction) was the problem. In this sense the film is a 'tribute to our times', where conversation about distress is located in the individual, rather than there being an explicit examination of the individual situated within wider social, political and spiritual contexts.

On the film's website, under a menu heading 'Take Action' we are told: 'Despite increased public awareness, suicide and mental health problems still carry a huge stigma, which stops people from sharing their feelings or struggles.' It is suggested that, 'To reduce this stigma, and help to support those who may have been suffering in silence, there are some simple steps you can take.'

The suggestions that follow are well intentioned; to talk to someone, to watch the film, to spread the word and stay in touch. These suggestions occupy familiar turf to other destigmatising initiatives. The emphasis is on talking, and offering *interpersonal* support, rather than doing so combined with critical analysis of all the reasons *why* people might be struggling. Finally there is encouragement to volunteer on an all-volunteer run helpline. This suggestion fits with a right wing neoliberal 'Big Society' model, where systemic, structural institutional responsibility is supposed to be taken up by volunteer action.

'... if we want this situation to get better'

In a pamphlet, *Class Struggle and Mental Health*, there is also great intention to erase shame and guilt from feelings of struggle and pain. There is compassionate and useful advice for support during hard times and there are suggestions/tools that address the detrimental pressures that can be at play in political activist culture and organising. However, much of the mainstream ideology around 'mental health' is still being iterated.

Despite political awareness of the effects of oppression, and especially of the class system, some of the personal accounts claim:

'*Mental illness sometimes just happens. There may be no rhyme or reason to it. This isn't your fault. Could be genetics, could be fate, could be something in the water. Stay safe, smash the state, be good to yourself.*'68 Another contribution says, '*It's not you, it's chemicals in your brain temporarily disrupting your patterns.*'69 Another preludes a great analysis of the alienation and stress of capitalism, and the complex factors at play in our health with, '*As people with mental illness we need to tell people our stories and help normalise it [...] We all need to become mental health advocates who combat social stigma if we want this situation to get better.*'70 I don't think normalising the narrative about personal 'mental' distress is the answer to minimising that distress. I don't think normalising that will help things to 'get better'. I don't think we should

eclipse the effect of oppression and internalised oppression by speaking of individual pain on the terms offered by biomedicine.

How do we foster conversation that mobilises profound change?

How do we make that change based on the breadth of our experiences and needs...?

Ways of speaking, understanding and transforming

Below are four examples of ways of telling stories that feel more progressive and open up conversation that I feel is more useful in terms of understanding experiences and moving towards transformation. They are ones that ask about the *context* of our experiences, also about how experiences have been shaped and felt *in the body*. They transcend the individuated 'faulty' narrative and ask about what has affected us socially, politically and somatically, so that we

68. *Class Struggle and Mental Health*, by libcom.org/Freedom Press, p.13

69. Ibid. p.16

70. Ibid. p.27

can move beyond locating experience in the individual and in the individual brain.

An Emotional/Political Autobiography

The Emotional/Political Autobiography (EPA) is a tool devised by the project *generative somatic*s, who use group and individual movement practices, bodywork, and inquiries that are interwoven with work for social justice.

The EPA exercise involves writing, and then optionally sharing, something that is called your Emotional/Political Autobiography. The invitation is that you write down key things in your life that have shaped you and brought you into awareness of oppression or injustice, that have in some way politicised you or made you question the status quo and name a wish for change.

When you are reflecting on your Emotional/Political Autobiography, you can look to the major emotional and political (or politicizing) experiences that shaped who you are. This can include where you grew up, your class, race and gender experiences, the significant people in your life, as well as cultural and religious impacts. You can reflect on the difficult experiences as well as what got you through and what gave you resilience. Your E/PA can start with you or could begin with your ancestors, can be more of an individual or more of a collective story.

We ask that you write your E/PA as well. We suggest that you write 10–15 pages, or create some kind of documentation that makes sense to you. It may be written in chronological order or it may be grouped into categories of your choice. It is not about the events themselves, but about those times in your life that had a significant

emotional and/or politicizing impact. The events serve to contextualize the significant emotions, choices, ways of being, and your developing politics. Your E/PA is not a description or report of those events, but rather reveals the way those events affected your thoughts, perceptions, and actions. We suggest you write your E/PA as your present self. If you choose, you can bring copies of your E/PA to share with others.71

The Power Threat Meaning Framework

The Power Threat Meaning Framework (PTMF) was developed by psychologists and service user campaigners as an alternative to models based on psychiatric diagnosis. It's a framework with which to examine and speak about experience. The PTMF describes itself as a framework that is concerned with 'the role of various kinds of power in people's lives, the kinds of threat that misuse of power poses to us and the ways we have learnt to respond to those threats'. And that it 'applies not just to people who have been in contact with the mental health or criminal justice systems, but to all of us'.

The Power Threat Meaning Framework can be used as a way of helping people to create more hopeful narratives or stories about their lives and the difficulties they have faced or are still facing, instead of seeing themselves as blameworthy, weak, deficient or 'mentally ill'.

It highlights and clarifies the links between wider social factors such as poverty, discrimination and inequality, along with traumas such as abuse and violence, and the resulting emotional distress or troubled behaviour, whether it is confusion, fear, despair or troubled or troubling behaviour.

It also shows why those of us who do not have an obvious history of trauma or adversity can still struggle to find a sense of self-worth, meaning and identity.

71. *generative somatics*, 2014. EPA preparation, training document. generativesomatics.org

In traditional mental health practice, threat responses are sometimes called 'symptoms'.

The Framework instead looks at how we make sense of these experiences and how messages from wider society can increase our feelings of shame, self-blame, isolation, fear and guilt.

The approach of the Framework is summarised in four questions that can apply to individuals, families or social groups:

– What has happened to you? (How is power operating in your life?)

– How did it affect you? (What kind of threats does this pose?)

– What sense did you make of it? (What is the meaning of these situations and experiences to you?)

– What did you have to do to survive? (What kinds of threat response are you using?)

Two further questions help us think about what skills and resources people might have and how they might pull all these ideas and responses together into a personal narrative or story:

– What are your strengths? (What access to Power resources do you have?)

– What is your story? (How does all this fit together?).72

The PTMF suggests ways people might then respond – whether that is through therapy, creativity, medication, community activism, etc. The framework offers perspectives on distress beyond the individual and 'shows that we are all part of a wider struggle for a fairer society'. Additionally it offers

72. Introduction to the PTMF, no date. *The British Psychological Society*. Available from: www.bps.org.uk/power-threat-meaning-framework/ introduction-ptmf (Accessed 12.01.2021) a way of thinking about culturally-specific understandings of distress without seeing them through a Western diagnostic model. It encourages respect for the many creative and nonmedical ways of supporting people around the world, and the varied forms of narrative and healing practices that are used across cultures.73

I'd like to close with a quote from Lucy Johnstone, someone who has been part of developing the Power Threat Meaning Framework:

> A central aspect of the PTMF is the attempt to outline patterns in the ways people respond to the negative impacts of power – in other words, to go beyond a series of individual narratives and identify broader regularities in people's expressions and experiences of distress. From a PTMF viewpoint, the key difference between these 'General Patterns' and the patterns that support a medical diagnosis are that *they are organised by meaning, not by biology.*74

Our Embodied Stories

In their book *Embodied Social Justice*, Rae Johnson speaks about the way our bodies are formed and informed by the world. In research interviews conducted by Johnson, presented in the book, a series of questions inquire about the effect of oppression in the body, and how people felt they were/are shaped by oppression.

Some of the interview questions I asked included the following:

73. The Power Threat Meaning Framework: Summary, No date. Available from: www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20 Files/ PTM%20Summary.pdf (Accessed 12.01.2021)

74. Jo Watson, 2019. *Drop The Disorder! Challenging the culture of psychiatric diagnosis*, PCCS Books, p.20

1. What are some of your experiences of oppression?

2. How do you relate those experiences to social categories of oppression (for example, do you understand them as experiences of racism, sexism, or some other form of oppression?)

3. How have your experiences of oppression affected how you relate to your own body, how do you understand your body image, or the degree to which you experience a kinaesthetic awareness of your body?

4. How have your experiences of oppression affected how you believe others relate to (or read) your body?

5. How have your experiences affected how you related to (or read) the bodies of others?

6. What role has nonverbal communication – for example, the navigation of personal space, the use of gesture, touch, or eye contact – played in your experiences of oppression? For example are you aware of modifying your nonverbal communication according to whether or not you feel oppressed in a particular situation? What have you observed in the nonverbal communication of others in these situations?75

SOMA, an anarchist therapy

SOMA is an anarchist therapy that was developed in the 1970s by the Brazilian psychiatrist Roberto Freire, and which emerged out of the context of life under dictatorship in Brazil. It uses group therapy work, employing exercises that explore the relationship between the body and emotions, based on the theories of Wilhelm Reich; Capoeira (a martial art); and analysis that draws from anarchist politics (looking at the social contexts and power structures we live

75. Rae Johnson, 2017. *Embodied Social Justice*, Routledge, p.15

within) as its therapeutic modality to examine personal and collective patterns. The focus is not on *Why* do I feel like this, but on the question *How* did I come to feel/respond this way?

In the documentary film *Soma*, Goia, a somatherapist explains: with how, we can see what happened without judging. Without making a qualification if it is an illness or wellness, whether it is healthy or sick [...]. Unlike most traditional therapies, in *Soma* we don't work with the concept of the cure – that anyone will go from a state of sickness to a state of health. I think that vision that connects psychology to medicine is a vision that is extremely dangerous, because it judges what is healthy and it judges what is sick. From the moment it judges what can be healthy and sick it assigns political values. So in Soma we constantly reaffirm it is a process, a process of learning.76

In these four approaches and practices, the focus isn't just on *events or experiences* per se, but on what they might have made us aware of, or have motivated in us, or how they might have impacted on us in terms of embodying oppression with the effect that has on the bodymindsoul. I think they all offer important ways to reflect, make sense of, and share experience, and I would argue *all* of these approaches could equally, if

not more so, be described as ways of telling a 'personally meaningful story' (as *Honest, Open, Proud* encourage), or as being 'medicine' (that *Heads Together* speak of), or as a kind of '*Real Talk*'. Exploration of experience that is *contex- tual* (rather than focusing on the personal/confessional), can point to and be part of generating and honouring bodymindsoul healing modalities, and be part of shaping social change that profoundly affirms wellbeing.

76. Nick Cooper, Dir., 2006. [Video]. *SOMA: An Anarchist Therapy* documentary. Available from: youtube.com/watch?v=hMTk4QazKOA (Accessed 12.01.2021)

This conversation to share Urgent. These urgent things

I want to tell you I am listening That I hear you. Hold you. Hold me We'll hold each other

This far too much. This not enough The wounding and the weight

Power, grounding ours

Justice, vitality, connection, freedom ourss Joy, pleasure, peace ours

Conversation # 1

If useful, in pairs, threes or groups, begin by asking: ‘What does “mental health” mean to you?’

Brainstorm together on sheets of paper, listen well, and let conversation meander, note down all contributions.

Part 1 References

1. Peter Breggin, 1993. *Toxic Psychiatry*, HarperCollins, p.31

2. The word healing comes from the Germanic *heilen* meaning ‘to make whole’

3. Richard P. Bentall, 2003. *Madness Explained, Psychosis and Human Nature*, Penguin Books, p.124

4. Rae Johnson, 2017. *Embodied Social Justice*, Routledge, p.113

6. Ibid p.173

8. Staci Hains, 2019. *The Politics of Trauma*, North Atlantic Books, p.36

9. Ibid. p.38

10. Ibid. p.41

11. Rae Johnson, 2017. *Embodied Social Justice*, Routledge, p.44

12. Susan Aposhyan, 2004. *Body-Mind Psychotherapy: Principles, Techniques, and Practical Applications*, W. W. Norton & Company, p.12

15. Rae Johnson, 2017. *Embodied Social Justice*, Routledge, p.88

16. Lucy Costa, 2014. ‘Mad Studies – what it is and why you should care’. *Mad Studies Network*. Available from: madstudies2014.wordpress. com/2014/10/15/mad-studies-what-it-is-and-why-you-should-care-2 (Accessed 10.01.2021)

17. Nick Walker, no date. ‘The Neurodiversity Paradigm’. Available from: autloveaccept.files.wordpress.com/2015/08/finalneurodiversity.pdf (Accessed 10.01.2021)

18. Nick Walker, 2013. ‘Throw away the master’s tools, liberating ourselves from the pathology paradigm’. August 16th. *Neurocosmopolitan*. Available from: neurocosmopolitanism.com/throw-away-the-masters-tools-liberatingourselves-from-the-pathology-paradigm (Accessed 10.01.2021)

Part Two - Deconstructing psych/iatry, Decolonising ‘global mental health’

This chapter looks at the way *all* ideas about experience, including understandings about 'illness' are 'culture bound'. Culture bound is a term that describes how everything – ideas, frameworks and perspectives – emerge from and are shaped by a particular culture or cultures. This first section looks at the way the concept of everything being culture bound, and the practice of deconstruction can be useful in order to examine ideas that we are offered generally by the dominant/dominator cultures, and specifically by psych/iatry1 about experiences. They can be useful when we decide whether ideas are relevant, and in particular with which to challenge the premise of biomedicine that *it* offers the most valid perspectives.

This chapter looks briefly at some of the history of (colonial) psych/iatry. It gathers together some thinking and writing about the way the institution of psych/iatry has been, and continues to be used as a form of colonialism and colonial expansion. The chapter will look at some of the ways psych/iatry's ideas have been imposed and continue to be imposed globally, often suppressing Indigenous understandings of and healing approaches to experiences of distress and/or variable consciousness.

1. I've chosen to interrupt the word psych/iatry with an / for reasons explained below.

I'd like to start by looking at language again. I want to look briefly at a few terms that I think can be really helpful to consider and use as part of gaining insight and reframing ideas. They can be useful tools, like crowbars, to act as a kind of leverage; opening up and widening conversation about ways to unpick stories we are given, and with which to think about knowledge and power. The next handful of pages, before moving into the body of the chapter, will look at and briefly define four words and concepts: psych/iatry, deconstruction, epistemology, and decoloniality.

Psych/iatry

The term 'psychiatry' was first coined by the German physician Johann Christian Reil in 1808 and literally means the medical treatment of the soul, from the Ancient Greek *psykhē*; *psych*, meaning 'soul', and *iatry* meaning 'medical treatment', from the Greek *iātrikos*, from *iāsthai* 'to heal'.

It's interesting that the language suggests that psych/iatry was originally concerned with tending to/healing the psyche or soul. The term 'psychiatry' is rooted in a cultural framework emerging from an intellectual movement in 17thand 18th-century Europe: the Enlightenment (aka the 'Age of Reason'). Psych/iatry may have pointed linguistically to the treatment of the soul but has really always been concerned with treating the mind and one's 'reason' as separate from the body and soul, and from the wider social contexts and cosmos. I've chosen to write of this knowledge system as psych/iatry to reference what its linguistic roots spoke to and of, and to interrupt it and mark it as a product of medical, scientific 19th-century Europe.

Deconstruction

Deconstruction can be understood as the act of breaking something down in order to understand its meaning, especially when that new meaning is different from how something has previously been understood. It can also be the analytic examination of something, often in order to reveal its *inadequacy*, or show how it functions socially. It is a concept we can use to pick apart what we are being told by social and cultural institutions (like biomedicine and psych/iatry) in order to understand things in a new way. And with which to understand how things are functioning. Also in order to find understandings which feel more *adequate*, more meaningful. This possibility, to deconstruct, question, reframe and transform underpins some of what has already come in Part One and what follows in Parts Three and Four.

Epistemology

The term epistemology comes from the Greek *epistēmē* meaning ‘knowledge’, and *logos* meaning ‘reason’, and is sometimes called the theory of knowledge. It examines who produces knowledge, and how knowledge is held as belief or opinion in different contexts. I think epistemology is important to think about in terms of experiences of distress, to ask *whose* knowledge systems and healing models get validated and held up as central ones. In particular, whose knowledge is inferred to offer a kind of truth, or ultimate/ superior knowledge, that others are deemed inferior to, or invalid by.

Epistemic Injustice

When an injustice is done against someone in relation to their knowledge, or to them in ‘their capacity as a knower’,2 it is called epistemic injustice. It describes someone’s knowledge being

2. Miranda Fricker, 2007. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford University Press, p.1 doubted, called into question or challenged, often by someone who is in a position of power over them.

The term ‘epistemic injustice’ was coined in 2007 by British philosopher Miranda Fricker, but it’s been argued that AfricanAmerican Black liberation activists, Sojourner Truth and Anna Julia Cooper in the 1860s and1890s, had already named the concept in claiming that Black women are denied full and equal recognition as knowers.3 Gayatri Chakrovorty Spivak’s 1988 essay *Can the Subaltern Speak?* has been cited as another earlier naming of this power violation. Spivak describes what she calls *epistemic violence*, when subaltern persons (people who have been marginalised or oppressed) are prevented from speaking for themselves about their own interests because of others claiming to know what those interests are.4

In his 2013 essay *Overcoming the Epistemic Injustice of Colonialism*, Indian political theorist Rajeev Bhargava speaks explicitly about epistemic injustice as a colonial force. He writes:

I define epistemic injustice as a form of cultural injustice that occurs when the concepts and categories by which a people understand themselves and their world is replaced or adversely affected by the concepts and categories of the colonizers.5

3. Vivian M. May, 2013. ‘Speaking into the Void? Intersectionality, Critiques and Epistemic Backlash’. *Hypatia*. Available from: www.cambridge.org/core/ jour-

nals/hypatia/article/speaking-into-the-void-intersectionality-critiquesand-epistemic-backlash/66EBD2FA2567BBDA97FB90442161290C (Accessed 14.01.2021)

4. Gayatri Chakravorty Spivak, 1988, ‘Can the Subaltern Speak?’ *Marxism and the Interpretation of Culture*, Macmillan Education UK, pp. 271–313

5. Rajeev Bhargava, 2013. ‘Overcoming the Epistemic Injustice of Colonialism’. *Global Policy* 4(4) DOI: 10.1111/1758-5899.12093 Available from: www.researchgate.net/publication/259546123_Overcoming_the_ Epistemic_Injustice_of_Colonialism (Accessed 14.01.2021)

All these concepts inform this chapter where it is looking at the global imposition of the knowledge system of psychiatry.

While it’s a frustrating and common pattern for white academics to be given credit for ‘discoveries’ or ‘initiations’ of ideas and concepts, Fricker’s term *epistemic injustice* is a reference point with which we can look at two specific kinds of epistemic injustice she writes about: these are i) *testimonial injustice* and ii) *hermeneutical injustice*. I think these can be especially useful to think about in relation to the way individuals and whole cultures can be silenced and oppressed around their own ‘knowing’ about things.

i) Testimonial Injustice

This is an injustice that happens when someone’s word is mistrusted, or when they are ignored or not believed, often because of some aspect of their identity, within a context that holds prejudice about, or power over, that identity. This can be done by doubting, ignoring, or failing to take someone’s testimony seriously until it is corroborated by someone else.

There are many examples of this kind of violence occurring, for example, a woman’s experiences of sexual abuse being dismissed in court by a male judge/within a sexist legal system. Similarly, a person of colour’s experiences of racism in a workplace being dismissed by an all white board of trustees within the context of structural racism. In the context of what is being explored in this book, a strong sense of meaning that a person has of their experiences can be overridden by a doctor in the context of the psych/iatric system, and they may be told that actually they are sick and have an illness called X. On a larger global scale, biomedicine, and particularly here psych/iatry, can doubt, dismiss, ignore and attempt to erase Indigenous accounts and understandings of experiences.

ii) Hermeneutical Injustice

Hermeneutical is a word concerned with *interpretation*. Hermeneutical injustice is injustice related to how people *interpret* their experiences, in the context of how much

information is *avail- able* to them about the experience, that they can *interpret* those experiences *with*. Hermeneutical injustice happens when someone's experiences aren't understood – by themselves or by others, often because the experiences don't fit any *known* concepts. This can be because a dominant culture doesn't offer an interpretive framework for a particular experience. It can also happen as a result of the historic exclusion of some groups of people from activities like scholarship, journalism and other cultural knowledge production, that determine and shape *which concepts* become culturally well known.

In the 1960s in the UK for example, society didn't recognise sexual harassment, and the behaviour of harassers was typically tolerated or even excused. As a result, many women didn't always have a framework with which to make sense of experiences of harassment or violence and so were victimised and silenced. Following continuous feminist organising, an example of which is the recent

movement, women/people have more cultural frameworks to name experiences and be heard within.

In terms of psych/iatry, people might have complex psycho-emotional experiences that psych/iatry would define as illness. A lack of other frames of reference for understanding and interpreting which people could draw on to make sense of those experiences, means the dominant knowledge system might prevail. For example, someone might feel sad; the sadness might be about the way capitalism exploits them, but without support to name that capitalism does this, and that it is brutalising, they might just think of *themselves* as faulty, and the dominant knowledge system about personal 'depression' would prevail.

I think the concepts of testimonial and hermeneutical injustice are useful to hold in mind, in terms of how we might consider our experiences of distress or variable consciousness. They can be part of facilitating different understandings of those experiences, and so find approaches to negotiating them that differ from the dominant cultural and biomedical ones. I'll return to this at the very end of this chapter, and look at something called **hermeneutical *dissent***, which speaks about the fact that we *can* and *do* make meaning, on our own terms, outside of the dominant interpretations, and that this can be liberatory. A lot of this is explored more tangibly in Part Four.

The last of the four terms I wanted to explore before stepping more fully into this chapter is:

Decoloniality

A definition of *colonisation* could be that it is the subjugation of a people, by theft of land or suppression of culture and language or genocide, with all of these atrocities often happening simultaneously. In an essay about radical organising, Amara H. Pérez speaks about a group decision to adopt a systematic analysis of colonialism. She writes: 'As a political framework, we identified four core pillars in this system: taking the land, killing culture, use of force, and the control of mind, body, and spirit.'6

What can be understood by *decolonisation* is the end of a period of territorial domination of lands and suppression of culture and language, or genocide, occurring historically, and primarily in the global South perpetrated by global Northern/European forces: i.e. the struggles in the 20th century by people colonised in African territories, for liberation from domination by various European States. Colonisation occurred also *within* the global North, where

6. Amara H. Pérez, Sisters in Action for Power, 2017. 'Between Radical Theory and Community Praxis: Reflections on Organising and the NonProfit Industrial Complex'. *The Revolution Will Not Be Funded: Beyond the Non-Profit Industrial Complex*, Incite! Women of Color Against Violence, Duke University Press, p.91 brutal theft of land and violence to peoples was enacted by wealthy nation states over others, such as the Highland Clearances in Scotland.

Decoloniality is a term that has emerged from collective thinking in Latin America in the 1990s. It's not decolonisation. It speaks of *coloniality* as being the ideologies, social constructions, hierarchies, and violences of a historical period of colonisation. i.e the ideas and practices that underpinned colonisation. This coloniality was imposed globally, and enforced and determined many socioeconomic, racial, and knowledge value systems. There are big differences that exist in the histories, socioeconomics and geographies of colonisation in its various global manifestations. What happened in terms of colonialism in Peru was very different to what happened in South Africa, for example. However *Coloniality*, the ideologies, social constructions, hierarchies, and violences according to an *invented Eurocentric standard* was common to many instances of colonisation.

Coloniality didn't *disappear* with decolonisation. The theory of decoloniality names that coloniality is still being challenged, rebuked and decentered. *Decoloniality* in the form of challenges to these Eurocentric ideologies manifested in many places *before* they were decolonised. Activists like Gandhi in India, Fanon in Algeria, and the Zapatistas in Mexico are examples of *decolonial* projects that existed, and, in the case of the Zapatistas, currently exist before decolonisation. Decoloniality observes that whiteness

and Eurocentric mores and standards continue, and require being challenged, refused and reinvented. Decoloniality has also been called a form of 'epistemic disobedience',7 'epistemic de-linking'8 and 'epistemic reconstruction'.9 Decoloniality gives clear language

7. Walter D. Mignolo, 2011. *The Darker Side of Western Modernity*, Duke University Press, p.122–23

8. Walter D. Mignolo, 2007: 'Delinking: The rhetoric of modernity, the logic of coloniality and the grammar of de-coloniality, *Cultural Studies* 21(2–3): p.450

9. Aníbal Quijano, 2007. 'Coloniality and Modernity/Rationality', *Cultural Studies* 21(2–3): p.176 for the process of challenging and doing away with the myth that global Northern/European ideas and 'modes of thinking'10 are universal. It's a useful term to apply generally, and specifically to biomedicine, in particular to psych/iatry, to disrupt the power that it works to maintain everywhere.

Everything as ‘culture bound’, and ‘culturally bound syndromes’

I’d like to step more into this chapter by looking in more detail at the concept that *everything* we experience in life and the ways we have learned to think and feel about it is *culture bound*. That it emerges from the dominant culture, and some/oftentimes from a combination of cultures we are situated in. Another definition of the concept *culture bound*, is the understanding that everything is shaped, limited by or *sometimes valid only within a particular culture*.

This is essential and liberating because it encourages us to look at the stories, knowledge and value systems we are offered by and from a dominant culture and ask:

How have they come to be so?

How do ideas function in the dominant culture? How do we feel about them?

What relevance do they have?

What other ones might we either know, or want to define for ourselves?

Who do they serve? and

How might they be exported as power-over other cultures’ truths or knowledge systems?

10. Aníbal Quijano, 2000. ‘Coloniality of Power, Eurocentrism, and Latin America’, *Nepantla: Views from South* 1(3): p. 544

Using the concept that everything is *culture bound*, combined with *deconstruction* and *decoloniality*, offers a combination of lenses with which we can look critically at the narratives that are given or enforced about our experiences. Particularly we can examine psych/iatry in these ways. We can question and challenge alleged ‘truths’ that are offered, we can share conversation, and evolve understandings we might feel are more relevant, useful and life affirming. Again, there’s more tangible exploration of this in Part Four.

The DSM, and 'Cultural Concepts of Distress'

One of the most powerful productions of psych/iatric knowledge that has been manufactured in the global North is a huge medical volume called the *Diagnostic and Statistical Manual of Mental Disorders (DSM).* It is compiled and published by the The American Psychiatric Association (APA). The DSM, first published in 1952, and currently in its 5th edition, is used by doctors and psychiatrists as a reference manual in order to categorise people's experiences of distress or expanded, altered or variable consciousness. It includes a long list of experiences and groupings of experiences, and gives them diagnostic labels such as 'paranoid schizophrenia', 'bipolar disorder', 'anxiety disorder', etc. Many of the terms have now permeated deeply into popular culture and everyday language, defining parameters of experience. For example, '*He's a bit OCD*', '*She's got social anxiety disorder*', etc. An equivalent global reference manual used by the World Health Organisation is something called *The International Classification of Diseases (ICD).* I'll concentrate on the DSM as it has more dominant and mainstream reach, use and affect in terms of 'classifying' psycho-emotional health.

The DSM has a complex and disturbing history which has involved years of internal wrangling over the construction of diagnostic criteria, and lots of critique of that process, much of which is documented in Gary Greenberg's *The Book of Woe.*

A central motivation for the DSM's construction was so that psychiatrists could validate their profession as being equal to what gets called physical medicine, and *classify* people as being *ill*, thereby also justifying claims for treatment through people's health insurance providers. Because of this, increasing amounts of human experience has been classified as illness. This has been discussed in Frances Allen's book S*aving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM–5, Big Pharma, and the Medicalization of Ordinary Life*, where Allen looks at this increasing pathologising of human experience. The publication of the DSM, with tightly guarded copyrights, now makes APA over $5 million a year, historically totaling over $100 million.

There is more about the DSM and deconstructing of its criteria, and diagnoses in Part Four. For this chapter, what is especially significant is the way the DSM can present itself as a kind of central scripture about human experiences of distress. It says that 'other' (i.e. non-biomedical and non-psych/iatric) understandings of experience that don't fall under its criteria are 'culture bound syndromes', which it calls 'Cultural Concepts of Distress'.

Medical anthropology has coined the term 'culture bound syndromes' to look at particular health experiences that are defined and experienced in particular ways, within particular cultural contexts. Janis Hunter Jenkins, a psychological/medical anthropologist with an interest in culture and mental health writes about the way we are given ideas about and language for experiences that we have. She writes:

To be specific, a culture provides its members with an available repertoire of affective and behavioural responses to the human condition, including illness [...]. It offers models of how people should or might feel and act in response to the serious illness of a loved one. Individuals in a given place and time will react to illness similarly, in other words, because they share the limited repertoire of cultural scripts for how to play their part.11

In this instance, the DSM offers us scripts about what illness is, which we are supposed to understand our experiences through.

What is very significant is that buried away at the back of the DSM is a list of what it calls 'Cultural Concepts of Distress'. The introduction to the section reads:

Cultural concepts of distress refers to ways that cultural groups experience, understand, and communicate suffering, behavioural problems, or troubling thoughts and emotions. [...] *Cultural syndromes* are clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience.

11. Ethan Watters citing Janis Hunter Jenkins, 2010. *Crazy Like Us: The Globalization of the American Psyche*, Simon and Schuster, p.175

The text comes with an admission: that the DSM's own content is *also* culturally shaped: 'The current formulation' it confesses, 'acknowledges that all forms of distress are locally shaped, including the DSM disorders'.12

It feels very significant that this admission, 'that *all* forms of distress are locally shaped, *including the DSM disorders* [emphasis added]' isn't acknowledged in the DSM's introduction. Certain experiences listed at the very end of the manual are defined as 'Cultural Concepts of Distress', and *all* the other experiences of distress are just listed as 'diagnoses' in the core content of the DSM. In this sense the DSM is a classic colonial text which says it offers a standard/truth, but that truth is shaped by Euro-American biomedical conceptualisations of experience, while 'other' experiences are called 'cultural concepts'.

These 'Cultural Concepts of Distress' are often described by biomedical psych/iatry as 'other'. 'Othering', is the way one social group, often the dominator group, excludes or marginalises another group by pointing out what it believes makes them different. This can involve belittling strategies. Psych/iatry looks at 'other' cultural concepts and often gives what it claims is a reinterpretation of those experiences. It gives a biomedical 'explanation', or alleged comparative diagnosis, and related 'treatment' suggestions. The (mis)interpretation is deeply flawed because it outright eclipses the complex cultural understandings and contexts of those experiences.

An example of this is a slideshow on the website Medscape, called *20 More Rare and Unusual Psychiatric Syndromes*. In this slideshow, various so-called ‘rare’ and ‘unusual’ psychiatric syndromes are listed – along with alleged (mis)associated psych/iatric diagnostic correlations and treatments.

For example, the slideshow lists *Shin-byung*, which it calls a ‘folk diagnosis’, and follows that with a patronising and epistemologically violent ‘explanation’ of what people’s experience of ancestral spirits ‘actually’ is. It tells us:

Shin-byung (Spirit Sickness) Region/Culture: Korea

This folk diagnosis is characterized by anxiety and numerous somatic complaints, such as weakness, dizziness, and gastrointestinal symptoms. Patients often dissociate and attribute their state to possession by ancestral spirits. The condition can also be viewed as somatization of an underlying major depressive or anxiety disorder – or as an adjustment disorder – which is destigmatized by attributing this mental state to possession by a spirit. Shin-byung shares features of somatoform or dissociative disorders.13

Another example from that slideshow is *Susto*, an experience which is translated as a fright to the soul. Ironically the experience is speaking of the soul, the very territory that psych/iatry originally claimed to be concerned with. The slideshow tells us:

Susto

Region/Culture: United States, Latin America, South America

From the Spanish for ‘fright’, and common in certain Latino populations, susto refers to the soul leaving the body in response to a frightening experience. Symptoms can recur for years and are consistent with multiple DSM–5 diagnoses, including major depressive disorder, post traumatic stress disorder, and somatic symptoms and related disorders.14

13. Christoph U. Correll, MD; Bret S. Stetka, MD, 2014. *20 More Rare and Unusual Psychiatric Syndromes*. Medscape. Available from: www.medscape. com/features/slideshow/culture-synd (Accessed 14.02.2021)

In his book *Black Skin, White Coats*, Matthew M. Heaton equates the health knowledge production processes like the ones above to the ‘empiricist’ school of medical anthropology, which take biological and naturalistic understandings of disease entities grounded in Western scientific discourses as empirically ‘true’ and then adjudges the relative rationality or irrationality of non-Western health systems based on how closely they can be explained in terms of the Western norm.15

This is the epistemic violence that Spivak speaks about – in this instance people’s knowledge is eclipsed, reinterpreted and judged on terms set by the global Northern biomedical paradigm. Psych/iatry decides for example that an experience of ancestral possession can be viewed as ‘major depression’ or ‘anxiety’.

In her book *Decolonising Global Mental Health*, China Mills references the anti-psychiatry movement (discussed in more detail in Part Four). She speaks about a need to ‘map other ways of understanding distress that are not anti-psychiatry – they are simply not psychiatry’.16 She cites a project of ‘postpsychiatry’ which would ‘decentre,

deconstruct and defamiliarize psychiatry', and look to 'make visible alternatives to the hegemony17 of what might be called Western knowledge systems'.18

Some of the ways that psych/iatric ideology centres itself, and the ways that the pharmaceutical industry benefit from that, are examined and critiqued throughout the rest of this chapter. Before I get to that I want to include a brief look at some of the colonial history of psych/iatry.

15. Matthew M. Heaton, 2013. *Black Skin, White Coats*, Ohio University Press, p.12

16. China Mills, 2014. *Decolonising Global Mental Health*, Routledge, p.143

17. *hegemony*: leadership or dominance, especially by one state or social group over others.

18. China Mills, 2014. *Decolonising Global Mental Health*, Routledge, p.149

A look at some of the colonial history of psych/iatry

I think it's important to look at some of the history of the way psych/iatry has functioned as a colonial tool; the way that colonial violence has exported itself, and continues to do so, under the guise of psych/iatric 'care'. What follows is a very brief look at some of that trajectory; the racism and violence of colonial and comparative psych/iatry, and some of the shifts in perspective of crossand trans-cultural psych/iatry.

Colonial psych/iatry, which was enforced in colonised countries under colonial rule, adopted a 'racialised ethnopsychiatric knowledge'. Heaton, writing about what happened in Nigeria, says colonial psychiatry 'had constructed Africans as mentally and culturally inferior to Europeans'.19 It's this racialised knowledge and constructed inferiority that was used to legitimise colonialism, and has underpinned atrocities that have been carried out on black and brown bodies in the name of medical science, and continues to jeopardise the health of people of colour through medical misand maltreatments.20 Colonial psych/iatry was centered on incarceration and punishment. There was no therapeutic approach to distress.

19. Matthew M. Heaton, 2013. *Black Skin, White Coats*, Ohio University Press, p.51

20. For example, the medical experiment known as the Tuskagee Syphillis Experiment, which was carried out on 600 African American sharecroppers without their knowledge. As well as countless other violences, documented in books like *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* by Harriet A. Washington and *Reproductive Rights and Wrongs* by Betsy Hartman. Also in the continuing reality of medical misand maltreatment of Black bodies where, for example, it has been documented that pain medication given to Black people is often insufficient because of testimonial injustices and racist ideas held about Black bodies having higher pain thresholds. See *Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites* by Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver, 2016. *Proceedings of the National Academic Sciences of USA*. 2016, Apr 19; 113(16): 4296–4301.

Colonial asylums were places of containment, brutal violence and degradation, used as places of racist and oppressive confinement. Asylums were built under English colonial rule where none had ever been before, many were built in India for example, in

the 19th century. They were also built prolifically in Ireland under English colonial rule. Colonial psych/iatry controlled populations, including those who were dissenting colonial oppression, and local/indigenous understandings of and approaches to distress and healing were suppressed or dismissed as 'primitive' and invalid.

In the early 20th century, a branch of psych/iatry called comparative psych/iatry came into being. It was concerned with 'investigating' whether experiences of distress, classified in a European context, happened in the 'same way' elsewhere. It was highly problematic. It involved gazing with a colonial lens at 'others' to compare them on the terms set by that Eurocentric culture and the discipline of psych/iatry, in order to 'decide' if there were recognisable commonalities. Its origins are attributed to the German psych/ iatrist Emil Kraepelin. Kraepelin has been called the 'designer of modern psychiatric nosology'21. He believed the roots of distress to be in biological and genetic malfunction, and made psych/iatric classifications in a volume called the *Compendium of Psychiatry*, much of which – though discussed and debated – became the foundation stone for contemporary psych/iatric classifications and catalogues like the DSM.

In 1904 Kraepelin travelled to Java to 'observe' people there.

Kraepelin wanted to examine 'whether certain forms of insanity that provide the main content of our [European] institutions, occur in like manner and frequency as among us [Europeans] also under entirely different conditions of living and among different ethnicities'.22

21. *nosology*: the branch of medical science dealing with the classification of diseases

22. China Mills, 2014. *Decolonising Global Mental Health*, Routledge, p.53

He had planned several other trips elsewhere, which weren't possible because of the onset of WW1. His conclusions, based on his observations of Javanese people, also of Native and African Americans who he 'studied' in North America, were that the biological and genetic malfunction he claimed to be the root of distress was universal, but manifested differently depending on social context.

It is said despite Kraepelin's work locating experience in the biological and genetic and being the start point for pharmopsychology and subsequently pharmo-psychiatry, that there was a social dimension to his work. Kraepelin noted for example that Native Americans who had been exposed to disease and deprived of their culture had 'sunk into fatalistic apathy' [...] suggesting a link between distress and alienation from indigenous forms of life.23

His studies were colonial enactments, drawing universal conclusions about the human race, also enacting overt racism through familiar claims about so-called 'civilised' and 'primitive' societies. On the basis of his clinical observations, Kraepelin concluded that the normal Javanese mind was primitive, primarily emotional, childish, and highly suggestible. These conclusions corresponded with contemporary racist European anthropological thinking about 'the primitive mind'. Kraepelin was compounding com-

monplace contemporary racist ideology; a pseudo-scientific, fabricated categorisation of people which was used to legitimise colonialism.

Mills writes that when he was in Java, Kraepelin did not find severe deterioration in the Indonesians he studied, concluding, along with many prominent psychiatrists of the time, that Western civilisation had a negative effect on mental health. This was based on the assumption that those in poor countries lived *simple, contented* lives, and thus were less

23. Ibid. plagued by 'mental illness' and that it was the '*progress* inherent to Western civilization [that] was apt to produce mental derangement' [all emphases added].

In Java, Kraepelin along with many other psych/iatrists, enacted white supremacy and colonial arrogance, concluding that distress was the result of the 'progress' found in more sophisticated European cultures.24

Heaton talks about a version of this racist perception or fabrication that was imposed on African peoples. He writes:

In European history since the Renaissance, melancholy had frequently been romanticised as a disease of genius, likely to afflict the most intelligent and creative members of society. The preponderance of depression in Europeans became a marker of 'civilization', a by-product of a culture that had inculcated values of personal responsibility, self-improvement, and progress seeking through ambition, and, therefore, a disease of prestige. The perceived lack of depression in Africans became one more piece of 'evidence' indicating the relative inability of black cultures to produce highly insightful or intellectual individuals.25

It was during Kraepelin's travels in Java that he observed an experience called Amok. Amok, from the Malaysian/Indonesian word *meng-âmuk*, means 'furious attack' or 'rushing in a frenzy'.

According to Malay mythology, running amok was an involuntary behavior caused by the 'hantu belian', or evil tiger spirit entering a person's body and compelling him or her to behave violently without conscious awareness. Because of their

24. Ibid. p.52 spiritual beliefs, those in the Malay culture tolerated running amok despite its devastating effects.26

Kraepelin determined Amok through his Eurocentric psychiatric lens as a short episode of 'mania'. This is an early example of Eurocentric psych/iatry's assimilation of Indigenous experiences, and classifying them on psych/iatric terms. That colonial appropriation of language/experience and classification of Amok as a psychiatric disorder in 1849 has meant that the expression 'running amok' – (mis)meaning something that is simply wildly out of control or causing a frenzy – is now in common English language usage.

After WWII as part of a sweep of challenges to colonialism, and as part of reconfiguring post colonial landscapes, there was also a challenge to colonial and comparative psych/iatry. In this context something called transcultural psych/iatry emerged.

Transcultural psych/iatry was activity from the mid 1950s onwards generating international networks to develop a universal theory of human psychology based on the

ideas of racial and social equality. In a conference organised by the Nigerian psych/iatrist Thomas Adeoye Lambo, held in Nigeria in 1961, one of the many international contributors, the American academic Alexander H. Leighton, laid emphasis on 'the unity of mankind'. A comment by a UK scholar Aubrey Lewis similarly stated that 'the basic principles of psychiatry seem to me of universal application, and we have no grounds for supposing that there are fundamental psychological differences between people of different ethnic groups'.27

Many different voices shaped this emerging discipline. Thomas Adeoye Lambo contributed massively through his work in and alongside the Aro Mental Hospital near Abeokuta and the Aro

26. Manuel L. Saint Martin, 1999. 'Running Amok: A Modern Perspective on a Culture-Bound Syndrome', *Primary Care Companion.The Journal of Clinical Psychiatry.* 1(3): p. 66–70.

Village Scheme, to the 'deracialisation of psychiatric knowledge not only in Nigeria but globally'. John R. Rees founded the *World Federation for Mental Health*, and the psychiatry and anthropology departments in Montreal University founded a newsletter, which has since become the *Transcultural Psychiatric Research Review.*28

Heaton writes of this transcultural psych/iatry, that 'the politics of psychiatry served as a microcosm of the broader anticolonial, antiracist struggles that blacks and sympathetic non blacks were engaged in across the world in the mid-twentieth century'.29

And he continues:

The transcultural psychiatry of the 1950s and 1960s intended to reinforce the politics of anticolonial and civil rights activism in much the same way that colonial psychiatry had previously buttressed ideologies of racialised oppression. At the same time, however, it retained significant colonial legacies in its emergence from a psychiatric scientific trajectory with historical roots in the knowledge production processes of Western imperialist states. 30

What was problematic about transcultural psych/iatry was that the principles of psych/iatry were being used as the benchmark for speaking about experience. Heaton writes that transcultural psych/ iatry 'was divided from the very beginning about whether the primary goal should be to adapt Euro-American psychiatric theory and practice to non-Western cultures or to explore the influence of local cultures on mental health'.31

Transcultural psych/iatry wanted to affirm antiracist ideology, and was striving for a 'unity of mankind', but that 'mankind' was still centred on dominant Euro-American frameworks and premises. Those frameworks were also posited as being 'modern', suggesting a problematic narrative about the 'evolution' of ideas; ideas exclusively generated and developed by those in the global North.

Heaton notes there was 'sometimes a starkly racialised divide and tension between conceptualisations of what was being called "modern" and "progressive" '. He continues: 'For most African communities, Western biomedicine is merely a recent, and not

necessarily superior, addition to the cornucopia of healing options that patients have at their disposal at any given time.'32

He continues that it is 'impossible, or at least highly inaccurate, to conflate "modern" psychiatry with "Western" psychiatry in the postcolonial context'.33

Heaton also makes the important point which addresses any two-dimensional critique of what might get called a 'western' psych/iatric creep around the world, i.e. the spread of psych/iatric ideas traveling 'one-way' from the global North to the global South. While this coloniality *has* and *does* happen, there is also a more complex history of global psych/iatric knowledge production where Eurocentric ideas have met and meet with indigenous ones and vice versa. Heaton speaks about how this has happened in Nigeria, and critiques accounts like Ethan Watters' *Crazy Like Us: The Globalization of the Western Mind,* stating it 'reinforces the notion that Westerners are the only ones who produce and disseminate psychiatric knowledge, and that non-Westerners, with their "traditional" cultures, are simply the recipients of that knowledge, and to their own detriment at that'.34 Heaton refers to, 'the very significant roles that non-Westerners have played in the development of scientific thinking as well as specific scientific discoveries'.35

A shift occurred from the modalities of transcultural psych/ iatry to a new cross-cultural psych/iatry that critiqued the 'universalist theory' and acknowledged that experiences are unique to social, cultural and spiritual contexts. They are not available to be interpreted through 'western' colonial and scientific/diagnostic parameters.

Heaton tells us that by the late 1970s,

Cross-cultural psychiatrists and medical anthropologists began to question whether the universalist theory had, in fact, gone too far. They began to assail the idea that Western-based terminologies and definitions that were themselves culturally determined could account for the ways diverse cultures understood something as culturally embedded as mental illness.36

Heaton explains:

The new cross-cultural psychiatry was coming down on the position that while biological 'diseases' might affect human bodies in relatively universal ways, the ways that people expressed illness – whether biological or social – could indeed be fundamentally different across cultures and, as a result, were not likely to be better understood by force-fitting them into universal constructs.37

Some contemporary psych/iatric projects attempt to implement this awareness; that psych/iatric parameters can't be centred when understanding and addressing culturally situated experiences. A project that is a collaboration between the department of psych/ iatry at McGill University and Indigenous communities in Canada is an attempt to *co-construct* useful frameworks for addressing distress by bringing together different knowledge systems.

In a talk, *Co-constructing knowledge in Global Mental Health* by Laurence Kirmayer (professor and director of the Division of Social and Transcultural Psych/iatry, in the department of psych/ iatry at McGill University), he speaks about what he feels are

current progressive approaches to tending to distress and promoting wellbeing. Ones which draw on the awarenesses of transcultural psych/iatry and acknowledge how experience is culturally situated. He speaks about the necessity of naming structural oppression as impacting on psycho-emotional health, and of the necessity of honouring cultural knowledge systems. *Listening to One Another to Grow Strong*, describes itself as a community-driven and culturally-adapted programme for Indigenous youth and their families. It is a programme that explores models of care which are offered to a community, and – in consultation with the community and with elders – can be (re)shaped by them to be culturally relevant and coherent, strengthening cultural identity and tradition. A spokesperson for that work, Lauerence Kirmayer, references the Mi'kmaw term *Etuaptmumk* or in English – 'Two Eyed Seeing', offered as a way of understanding the integration of Indigenous and Western worldviews or forms of knowledge.

Etuaptmumk is an approach based on the teachings of the late spiritual leader, healer, and chief, Charles Labrador of Acadia First Nation, and brought forth in 2004 by Elders Albert and Murdena Marshall from the Eskasoni community [...] Chief Charles Labrador spoke about the intelligence and collaboration that exist in nature and explained how worthwhile it would be if we as humans followed this example with the practice of Etuaptmumk, 'Go into a forest, you see the birch, maple, pine. Look underground and all those trees are holding hands. We as people must do the same' [...] Etuaptmumk has been described as 'being the gift of multiple perspectives treasured by many aboriginal peoples' [...] 'learning to see from one eye with the strengths of Indigenous knowledges and ways of knowledges and ways of knowing', and bringing both eyes mindfully together, for the benefit of all. Elder Albert Marshall expands with more detail:

Two-Eyed Seeing adamantly, respectfully and passionately asks that we bring together our different ways of knowing to motivate people, Aboriginal and non-Aboriginal alike, to use all our understandings so that we can leave the world a better place and not compromise the opportunities for our youth (in the sense of seven generations) through our own inaction (Bartlett et al., 2012, p. 336).38

Some of the work Kirmayer speaks about feels in many ways respectful, thoughtful, and seems concerned with cross-cultural collaboration, not top-down knowledge imposition. It still feels however, heavily informed by global Northern eurocentric psych/iatric intervention. Even though the *Listening to One Another* programme is work that originates from collaboration between First Nations communities in British Columbia, Manitoba, Ontario and Quebec, and psych/iatric research teams in various Canadian universities, it still forefronts the same language as a Eurocentric paradigm. It is still saying it is concerned with something called 'mental health', even if what is actually being spoken to is the spiritual, the traditional, to community, and to structural inequity. While it says it isn't a mental health treatment but more a focus on wellbeing, it still says it is concerned with contributing to 'the overall objective of positive mental health'. This language and focus isn't a real *coming together* of cultural paradigms,

which *equally* examine and assess *each other*. It feels like one cultural paradigm is being offered (albeit with great intention and care) which can then be culturally adapted. This differs from a genuine 'Two eyed

38. Jenny L. Rowett, no date. '*Etuaptmumk*: A research approach and a way of being'. Available from: file:///Users/lis/Downloads/25740-Article%20Text1882519048-1-10-20180527.pdf (Accessed 14.01.2021) seeing' or simply honouring the wellbeing work of Indigenous elders, healers, and cultural workers, etc.39

Continuing violence in neocolonial psych/iatry

Whilst trans and cross-cultural psych/iatric projects have in part acknowledged the dangers of global Northern cultural dominance and the imposition of its paradigms, psych/iatry continues to impose its knowledge system and suppress Indigenous knowledges as a colonial tool. It exports both its psych/iatric conceptualisations and its treatments, selling its ideology and its drugs. It is widely promoted by the biomedical and pharmaceutical industry as well as by many global Northern NGOs.

Mills, writing about that heavy drive to export narratives about 'mental health' around the world says:

Currently the World Health Organisation (WHO) and the Movement for Global Mental Health (MGMH) are calling to 'scale up' psychiatric treatments, often specifically access to psychiatric medication, globally and particularly within the global South. Amid these calls others can be heard, from local and global movements of psychiatrized peoples in the global North and South, and from some critical and transcultural psychiatrists, to abolish psychiatric diagnostic systems and to acknowledge the harm caused by some medications.40

She writes that this 'Movement for Global Mental Health' aims 'to make mental health for all a reality', and that it implores institutions like the World Bank to join in this agenda, having a 'duty to make mental health a central theme of their strategies and financial

39. McGill University, no date. *Listening to One Another to Grow Strong (LTOA): Mental Health Promotion for Indigenous Youth.* Available from: www. mcgill.ca/mhp/ about (Accessed 14.01.2021)

40. China Mills, 2014. *Decolonising Global Mental Health*, Routledge, p.2

flows'.41 Mills also says that the MGMH and the WHO state that they 'need a "mental health literate" society in which basic knowledge and skills are more widely distributed'.42

Mills details activity of various NGOs (speaking notably about one called *Basic-Needs*) who work in the global South doing this kind of 'distribution of knowledge', by running 'mental health camps' in rural areas to, in their words, 'bring mental illness into the open and show people that mental illnesses are just like any other disease and are nothing to be feared. They are an important tool in the battle against stigma'.43

Mills describes these mental health campaigns engineered by the global North in the global South as 'medical imperialism, similar to the marginalisation of indigenous knowledge systems in the colonial era'. She names this kind of ideology as being an echo 'of colonialism's "civilizing mission" and its conversion of those of "heathen faiths" to Christianity'.44 She continues:

Western medicine and its emergent offshoot, psychiatry, lent themselves especially well to purposes of ideological legitimation. The attempt to impose a Western healing system and to discredit indigenous ones as uncivilized and superstitious became perceived of, and construed as, a noble part of the civilizing mission and as an expression of humanitarian concern.45

Finally, Mills concludes:

Biomedical psychiatry can be seen 'as a form of neo-colonialism; it involves the imposition of western values, customs and

41. Ibid. p.17 & 41

42. Ibid. p.57

43. Ibid. p.60

44. Ibid. p.67 practices on non-western cultures' [...]. To export psychiatry globally is to begin to reframe an enormous variety in expression of personal and social distress into an illness model, treatable by drugs.46

The following two sections illustrate some of the ways that this has happened.

>54

GlaxoSmithKline's marketing of 'depression' and 'antidepressants' in Japan

A significant example of the colonial exporting of psychiatric ideas can be seen in the case of GlaxoSmithKline's marketing of 'antidepressants' in Japan in the early 2000s. It refers back to Moncrieff's examination of the manufacture of narrative about 'antidepressants' in order to expand the pharmaceutical market in the global North, and shows how this has been aggressively marketed globally.

While Heaton has challenged two-dimensional stories about oneway knowledge production and dissemination from the global North to global South in books like *Crazy Like Us*, I nonetheless cite from one of that book's chapters, which describes the '*Mega-marketing of Depression in Japan*', as it exemplifies a stark pharmaceutical-driven colonial accumulation.

The pharmaceutical giant GlaxoSmithKline wanted to establish a market for antidepressants in Japan. They realised that in Japan, melancholy was considered an admirable trait; a signifier of concern about life and about one's community.

... *yuutsu* and other states of melancholy and sadness have been thought of as *jibyo*, that is, personal hardships that build character. Feelings that we might pathologise as depressive were often thought of in Japan as a source of moral meaning and self-understanding.47

Other Japanese terms like *utsusho; utsubyo; yuutsu; ki ga fusago* or *ki ga meiru* (referencing complex interaction between social forces, emotion and physiology; grief, also general gloominess of the body and spirit; blockages of energy; or leakage/loss of energy, respectively) weren't comparable to the biomedical/western concept of 'depression'. They refer to experiences that: do not exist only in the thoughts and emotions but encompass full-body sadness. As such the Japanese person who felt *yuutsu* or *ki ga fusago* was likely to describe it in terms of bodily sensations, such as having headaches or chest pains or feeling heavy in the head [...]. Not only did Japanese ideas of sadness include both the body and mind but, metaphorically at least, they sometimes existed beyond the self. The experience of *yuutsu* in particular contained connotations of the physical world and the weather. 48

Watters writes:

The psychiatric category of depression was not a widespread public concern, and the capacity to experience great sadness was considered not a burden but a mark of strength and distinction. That belief, combined with a suspicion of drugs that heightened moods or extroverted personality traits, made the market for SSRIs49 unpromising. Those public

47. Ethan Watters, 2010. *Crazy Like Us: The Globalization of the American Psyche*, Simon and Schuster, p.232

48. Ibid. p.229

49. SSRIs (Selective Serotonin Reuptake Inhibitors) are mentioned in Part One; biomedicine hypothesises about SSRIs as biochemical processes related to 'depression' which has been the basis for pharmaceutical intervention. perceptions, however, were soon to change.50

In light of cultural differences GlaxoSmithKline realised they had to find a way of convincing people to medicate emotions connected to sadness. They hired social anthropologists as part of their drive to work out how to create a market for antidepressant drugs in Japan. They generated a narrative, and even coined a descriptive phrase *kokoro no kaze* meaning 'cold of the soul', which they said was a condition that was treatable with their drugs. GlaxoSmithKline focused in on the fact that Japan was seeing an increase in levels of suicide. While Japan has a historical and cultural practice of honour suicide (an act carried out to atone for a wrongdoing or avoid dishonour or shame), the spike in suicide levels during the late 1990s financial crisis has been attributed in large part to economic insecurity, poverty and debt. In this psychosocial climate, GlaxoSmithKline promoted propaganda claiming that addressing this fabricated *kokoro no kaze* would be a way to minimise the increasing and distressing incidents of suicide.

The mega marketing campaign often came in disguised forms, such as patient advocacy groups that were actually created by the drug companies themselves. The website utu-net. which appeared to be a coalition of depressed patients and their advocates, was funded by GlaxoSmithKline, although visitors to this site would have no clue of the connection. What they would have found was a series of articles on depression driving home the key points of the campaign, including the idea that it was a common illness and that antidepressants bring the brain's natural chemistry back into balance.51

There is no doubt that the efforts of GlaxoSmithKline in Japan proved profitable. In just the first year on the market Paxil sales

50. Ethan Watters, 2010. *Crazy Like Us: The Globalization of the American Psyche*, Simon and Schuster, p.235

51. Ibid. p.249 brought in over 100 million dollars [...]. By 2008 sales of Paxil were over one billion dollars per year in Japan.

Prominent psychiatrist Dr. Tajima, who was involved in both the adoption of international diagnostic standards and the new marketed drugs, commented on the 'marginal effectiveness of the drugs [...]. "There are so many patients in Japan who

have not improved and not recovered [...]. Many ordinary people now have questions about these so-called magic drugs." '52

The social framed as the psych/ological and psych/iatric

This next section looks at some instances where pysch/ological53 or psych/iatric 'treatments' and pharmaceutical marketing have been absurd and atrocious responses to systemic injustices that have affected and continue to affect peoples' lives. The 'social' in this instance is shorthand for the violences and power abuses of capitalism, colonialism and other intersecting oppressions. One clear example of this individuation of what were complex colonial and corporate abuses can be seen enacted in a recent agrarian crisis in India. Farmers who had traditionally relied on indigenous seed from their crops were suddenly being forced to pay for hybridised seeds and pesticides they now had to use alongside them. The seeds and pesticides were sold to them by the global Northern corporation Monsanto. In order to sow seeds the farmers had to 'have access to cash or credit, usually borrowed from private money lenders. This reliance on credit put farmers in a precarious position, as they became particularly

52. Ibid. p.269

53. Psych/ology shares an etymological root with psych/iatry i.e being concerned with the soul, but is currently defined and practiced as the 'study of the mind'. I choose to / interrupt this as well to point again to that reductive focus.

vulnerabletocropfailureortopricefluctuationsofcropsintheworld market.'54

Vandana Shiva writes about the US company Monsanto (bought up since by the German pharmaceutical giant Bayer) in her essay, *The Seeds Of Suicide: How Monsanto Destroys Farming.* She writes: 'Monsanto's concentrated control over the seed sector in India as well as across the world is very worrying [...]. Through patents on seed, Monsanto has become the 'Life Lord' of our planet, collecting rents for life's renewal from farmers, the original breeders.'55

Mills speaks about the brutal effects of this corporate greed. She documents that: 'In 2007, more than 4000 farmers committed suicide in the state of Maharashtra.'56 Most suicides were the result of poverty. Many farmers killed themselves by drinking the pesticides they were now being forced to buy.

The state government of Maharashtra deflected away from the brutal realities and responded by providing ' "psychological healing sessions" for the farmers'. A study was also launched to 'investigate' a possible ' "genetic link to the spate of farmers' suicides in Vidarbha", exploring whether there is a "genetic factor which makes people in a particular community more prone to suicidal tendency" '.57 Mills describes: 'While

farmers write suicide letters to the Government telling of an unliveable life due to agricultural reforms, GMH [Global Mental Health] calls for increased access amongst farmers to antidepressants.'58

Shiva spoke about the 'promises Monsanto India's website makes, alongside pictures of smiling, prosperous farmers from the

54. China Mills, 2014. *Decolonising Global Mental Health*, Routledge, p.36

55. Dr. Vandana Shiva, 2013. 'The Seeds Of Suicide: How Monsanto Destroys Farming'. *Global Research, Centre for Research on Globalization*. Available from: www.globalresearch.ca/the-seeds-of-suicide-how-monsanto- destroys-farming/5329947 (Accessed 14.01.2021)

56. China Mills, 2014. *Decolonising Global Mental Health*, Routledge, p.36 state of Maharashtra'. And comments on the way this was a 'desperate attempt by Monsanto and its PR machinery to delink the epidemic of farmers' suicides in India from the company's growing control over cotton seed supply – 95 per cent of India's cotton seed is now controlled by Monsanto'.59

The individuating response to the Indian farmers' plight (which was the result of corporate and state forces) is a devastating example of economic greed and disparity and the intersect of capitalism and colonialism. Mills names how there is a need for analysis around the way 'certain phenomena come to be understood as psychological, or [...] psychiatric, and the rationales this may serve'.60 She names the way peoples' experiences are actually 'rational and resistant reactions to maladaptive environments'.61

Mills observes how it seems that 'society is much more comfortable dealing with poverty as a mental health problem rather than a social issue'. She cites the radical psychiatrist and political philosopher and activist Franz Fanon who was actively engaged with the psychopathology of colonisation. She writes, 'This is a psychologism that Fanon rallied against, for.' She quotes Fanon: 'the poor are plagued by poverty [...] blacks by exploitation [and psychology and psychiatry often deal] with all of these estranging afflictions as if they were [...] mere states of mind'.62

Fanon is a stark opponent of a colonial psychiatry that locates distress in brain structures, overlooking the socio-historical context in which that distress arises. Employing Fanon's socio-diagnostic psychiatry, one cannot understand psychological

59. Dr. Vandana Shiva, 2013. 'The Seeds Of Suicide: How Monsanto Destroys Farming'. *Global Research, Centre for Research on Globalization*. Available from: www.globalresearch.ca/the-seeds-of-suicide-how-monsanto- destroys-farming/5329947 (Accessed 14.01.2021)

60. China Mills, 2014. *Decolonising Global Mental Health*, Routledge, p.10
problems or distress outside of the conditions of oppression that lead to them.63

Fanon pioneered a psychiatry of liberation, and Bulhan's reading of his work summarises, 'The paramount tasks of psychology and psychiatry [should be] to unravel the

relation of the psyche to the social structure, to rehabilitate the alienated, and to help transform social structures that thwart human needs.'64

The Zapatistas, and Neoliberal Globalisation

Zapatista women take the stage to deliver their speeches collectively from each Caracol, or administrative centre. (WNV/Shirin Hess)65

In 1983, a group of indigenous peasants in Chiapas organized in secret, educating themselves politically and creating an entirely unique philosophy that insisted that 'another world is possible', one that focuses on collectivity, serving the Zapatista community and creating an autonomous social and economical environment for themselves within neoliberal and capitalist Mexico. Finally on January 1, 1994 the group went public, calling themselves the Zapatista National Liberation Army, named after the hero of the 1910 Mexican Revolution, Emiliano Zapata. That day, the EZLN [*Ejército Zapatista de Liberación Nacional*, the name of the Zapatista National Liberation Army] launched an armed uprising, occupied seven towns in Chiapas, including San Cristóbal, and declared war on the Mexican government.

During their brief occupation, followed by a 12-day battle, the EZLN criticized the effects of global capitalism on local farmers and indigenous land.66

In the Sixth Declaration of the Selva Lacandona, the Zapatista Army of National Liberation write:

And so the capitalism of today is not the same as before, when the rich were content with exploiting the workers in their own countries, but now they are on a path which is called Neoliberal Globalization. This globalization means that they no longer control the workers in one or several countries, but the capitalists are trying to dominate everything all over the world. And the world, or Planet Earth, is also called the 'globe', and that is why they say 'globalization', or the entire world.

And neoliberalism is the idea that capitalism is free to dominate the entire world, and so tough, you have to resign

66. Ibid. yourself and conform and not make a fuss, in other words, not rebel. So neoliberalism is like the theory, the plan, of capitalist globalization. And neoliberalism has its economic, political, military and cultural plans. All of those plans have to do with dominating everyone, and they repress or separate anyone who doesn't obey so that his rebellious ideas aren't passed on to others.

Then, in neoliberal globalization, the great capitalists who live in the countries which are powerful, like the United States, want the entire world to be made into a big business where merchandise is produced like a great market. A world market for buying and selling the entire world and for hiding all the exploitation from the world. Then the global capitalists insert themselves everywhere, in all the countries, in order to do their big business, their great exploitation.

Then they respect nothing, and they meddle wherever they wish. As if they were conquering other countries. That is why we Zapatistas say that neoliberal globalization is a war of conquest of the entire world, a world war, a war being waged by capitalism for global domination. Sometimes that conquest is by armies who invade a country and conquer it by force. But sometimes it is with the economy, in other words, the big capitalists put their money into another country or they lend it money, but on the condition that they obey what they tell them to do. And they also insert their ideas, with the capitalist culture which is the culture of merchandise, of profits, of the market.67

Another example of the individuation on psych/iatric terms of systemic oppression, is what happened in drought wrecked villages in

67. Zapatista Army of National Liberation. Mexico. (No date). *Sixth Declaration of the Selva Lacandona*. Available from: enlacezapatista.ezln.org. mx/sdsl-en (Accessed 14.01.2021)

Brazil in the 1960s. There, starvation – due to socioeconomic inequity – was capitalised on by the American pharmaceutical industry. People were hungry and a grotesque response was to import drugs as a personal 'treatment' for the situation. Mills tells us about the way the hunger had become so normalised that it was no longer a sign of nutritional deprivation but a mental pathology – 'delirio de fome', hunger madness – to be managed by tranquilizers and sleeping pills imported from the United States. Thus 'delirio de fome' became a 'national codeword for mental instability rather than a symptom of socioeconomic inequality'. [By locating the source of distress within the brain] 'psychiatry and epidemiology can be used as a tool to mute important issues that underlie social suffering'.68

Neoliberalism and inequity was incredibly cynically navigated by the drug company Gador who, like GlaxoSmithKline's marketing of antidepressants in Japan, also employed a great deal of strategy into its marketing campaigns for antidepressants in Argentina. The company knew they couldn't sell drugs marketed as they were in the US for 'personal illness'. So they relanguaged their propaganda to appeal to a population who were more conscious of the socio-political vectors in distress:

Aware of the dominance of psychodynamic and social explanations for the origins of distress in Argentina, Gador's 'lock and key' images of neurotransmitters and depression so popular in the United States were redundant. Gador's marketing campaign depicted globalization as a cause of anxiety, and the company's 'pharmaceuticals as a means to alleviate social suffering'... with the assumption that while

68. China Mills, 2014. *Decolonising Global Mental Health*, Routledge, pp.41–42 depression and anxiety may be caused by globalization they can still be intervened with at a biochemical level.69

Mills speaks about a promotional leaflet she came across in an outpatient clinic in India. The leaflet about a psychiatric drug made by the pharmaceutical giant Pfizer read: ' "Sertraline, power that speaks softly" and "Pfizer, working together for a healthier world".' Prompting Mills to ask, 'I wondered what constituted a "healthier world"?'70

Brute and Benevolent violence

'Global Mental Health' ideology, campaigns and projects are an example of a kind of 'benevolent' violence which researchers and scholars Chakrabati and Dhar have termed in their thinking about 'brute and benevolent violence': the two 'axes' along which violence, 'is afflicted on those in the global South'. Brute violence is inflicted through 'dislocation from place as well as from local forms of life, ways of living and understanding the world [...] Then there

is violence that is benevolent, that works through the "image of the destitute figure waiting to be rescued" ',71 in this instance by the 'often imported expertise of psychiatry and pharmaceuticals'.72 This 'benevolent violence' that occurs as part of Global Mental Health programmes, comes with many layers of colonial ideology which import and impose ideas on communities that are in conflict with cultural values they might hold. Mills talks about the way, for example, certain experiences which are termed 'mental illness', are

contextualised as being a 'burden'. She points out that:

In speaking of 'mental illness' as a burden, implied through increased dependency on others, the WHO forecloses the recognition of dependency as a mode of interconnectivity, present among all peoples and yet often covered over 'in the domain of western hegemony'.73

'Collectively interdependent'

The pressure to aspire to hyper-individuated independence, as opposed to nourishing interdependence and interconnectivity, has become ingrained in the global North. It is like a cultural pathology, a deep sickness. We are encouraged to live (materially and emotionally) in individual or small separate units. It is to some extent only possible in the global North because of a position of global economic privilege. The exploitation of labour and resources in the global South means lifestyles in the global North *can be* hyper individuated. It's important to name that individuated independence can also be inhabited or enforced because of a *lack*

71. China Mills, 2014. citing the work of researchers and scholars Chakrabati and Dhar in *Decolonising Global Mental Health*, Routledge, p.40

72. China Mills, 2014. Decolonising *Global Mental Health*, Routledge, p.41

73. Ibid. p.29

of economic and social privilege *within* the global North. Having no money, or being isolated because of estrangement from relational bonds resulting from the damage of transand intergenerational trauma, can necessitate having to make life work on your own. Sometimes a certain kind of independence is just what is possible or has to happen in the circumstances.

There's vital critique of this general neoliberal agenda of individuated independence, much of which has come from the Disability Justice movement. The Disability Justice movement adopts the social model of disability (i.e. naming the ways people are disabled by the limitations and oppressions of society) and calls for deeper analysis of structural oppressions, and profound transformation that is truly life-affirming for everyone. I cite Mia Mingus speaking about the 'myth of independence' in an article called *Interdependency*:

It is from being disabled that I have learned about the dangerous and privileged 'myth of independence' and embraced the power of interdependence. The myth of independence being of course, that somehow we can and should be able to do everything on our own without any help from anyone. This requires such a high level of privilege and even then, it is still a myth. Whose oppression and exploitation must exist for your 'independence?' [...].

We believe and swallow ableist notions that people should be 'independent,' that we would never want to have a nurse, or not be able to drive, or not be able to see, or hear. We believe that we should be able to do things on our own and push ourselves (and the law) hard to ensure that we can. We believe ableist heteronormative ideas that families should function as independent little spheres. That

I should just focus on MY family and make sure MY family is fed, clothed and provided for; that MY family inherits MY wealth; that families should not be dependent on the state or anyone else; that they should be 'able-bodied,' essentially [...].

[...] to be clear, I do not desire independence, as much of the disability rights movement rallies behind. I am not fighting for independence. I desire community and movements that are collectively interdependent.74

Decolonising healing

The globally exported biomedical psych/iatric knowledge system has historically deflected and continues to deflect from some of the profounder causes of distress and suffering. It has imposed limited and culture bound understandings about consciousness. It has also often been part of the suppression of Indigenous knowledge systems and healing modalities.

Mills speaks about Global Mental Health's rallying call to make '*Mental health a reality for all*'. She suggests, 'Perhaps labelling distress as 'mental illness' limits the mechanisms for responding to it solely within a medical register, eclipsing alternative non-medical intervention'. Also that the GMH agenda frames 'treatment that lies "outside" the formal health care system as ineffective and "irrational", something to be weeded out'.75

Traditional and indigenous healing modalities have remained both resilient and in usage, and are currently also being reclaimed. In *Decolonising Trauma Work*, Anishanabee scholar, health activist and educator Renee Linklater writes:

74. Mia. Mingus, no date. 'Interdependency' from her blog *Leaving Evidence*. Available from: leavingevidence.wordpress.com/2010/01/22/interdependencyexerpts-from-several-talks (Accessed 14.1.2021)

75. China Mills, 2014. *Decolonising Global Mental Health*, Routledge, p.34 (both)

Wellness philosophies are holistic approaches that consider equally the spiritual, emotional, mental and physical aspects of the person, and Western psychology generally focuses on the mind and behaviour [...]. Indigenous healing philosophies are based on a wellness model, while the medical model is based on illness [...] an Indigenous paradigm of mental health and healing is 'focused on restoring balance to the self through relationship with others and the environment'.76

A central theme of healing in non-biomedical global paradigms is seeking *relational* balance and a holistic integrated approach, as spoken about by Linklater above. Another is of *communal* response – in all senses of the word – to experiences of distress/pain/wounding. Andrew Solomon is a British writer who has spoken about his personal experiences of what gets called depression, and about his interest in cross-cultural approaches to tending to distress. He paraphrases a Rwandan person he spoke with following the violent post-colonial conflict of the Rwandan civil war, as saying:

We had a lot of trouble with western mental health workers who came here immediately after the genocide and we had to ask some of them to leave. They came and their practice did not involve being outside in the sun where you begin to feel better.

There was no music or drumming to get your blood flowing again. There was no sense that everyone had taken the day off so that the entire community could come together to try to lift you up and bring you back to joy. There was no acknowledgement of the depression as something invasive and external that could actually be cast out of you again. Instead they would take people one at a time into these dingy little rooms and have them sit around for an hour or so and talk

76. Renee Linklater, 2014. *Decolonising Trauma Work*, Fernwood Publishing Co Ltd, p.21

about bad things that had happened to them. We had to get them to leave the country.77 78

Malidoma Somé is a West African Elder and spiritual teacher from the Dagara of Burkina Faso. He facilitates workshops and Kontomble initiation and divination retreats. Somé is cited as acknowledging the meaning there may be in an experience of distress, about seeking balance; about the balance between the living, and the dead, and about opportunities for healing at a wider community level.

'The Western culture has consistently ignored the birth of the healer,' states Dr. Somé. 'Consequently, there will be a tendency from the other world to keep trying as many people as possible in an attempt to get somebody's attention. They have to try harder.' The spirits are drawn to people whose senses have not been anesthetized. 'The sensitivity is pretty much read as an invitation to come in,' he notes.

Those who develop so-called mental disorders are those who are sensitive, which is viewed in Western culture as oversensitivity. Indigenous cultures don't see it that way and, as a result, sensitive people don't experience themselves as overly sensitive. In the West, 'it is the overload of the culture they're in that is just wrecking them,' observes Dr. Somé. The frenetic pace, the bombardment of the senses, and the violent energy that characterize Western culture can overwhelm sensitive people. [...]

'Unless the relationship between the living and the dead is in balance, chaos ensues,' he says. 'The Dagara believe that, if

77. Anna Leach, 2015. 'Exporting trauma: can the talking cure do more harm than good?' *The Guardian*. Available from: theguardian.com/globaldevelopment-professionals-network/2015/feb/05/mental-health-aid-westerntalking-cure-harm-good-humanitarian-anthropologist (Accessed 14.01.2021)

78. Andrew. Solomon, no date. 'Notes on an Exorcism'. [Audio]. Available from: themoth.org/stories/notes-on-an-exorcism (Accessed 14.01.2021)

such an imbalance exists, it is the duty of the living to heal their ancestors. If these ancestors are not healed, their sick energy will haunt the souls and psyches of those who are responsible for helping them.' The rituals focus on healing the relationship with our ancestors, both specific issues of an individual ancestor and the larger cultural issues contained in our past. Dr. Somé has seen extraordinary healing occur at these rituals. Taking a sacred ritual approach to mental illness rather than regarding the person as a pathological case gives the person affected – and indeed the community

at large – the opportunity to begin looking at it from that vantage point too, which leads to ‘a whole plethora of opportunities and ritual initiative that

can be very, very beneficial to everyone present’.79

There is more reference to decolonising healing woven through Parts Three and Four.

Applying deconstruction and decoloniality *everywhere*

Deconstruction and decoloniality can be essential tools to look at how psych/iatry has come to function *everywhere*, including in the places from which it originated in the global North. Deconstruction and decoloniality investigate how ideas are *products* of the dominant culture that are used or imposed as a framework for the ways we are supposed to understand ourselves.

I think it's important to exercise caution around (mis)use of the terms colonisation and decolonisation. Some critical thinking speaks about generally 'decolonising mental health'. China Mills, for example, writes: 'Even when psychiatry is applied within the countries it originates from it has been criticised as being colonizing

79. Stephanie Marohn, featuring Malidoma Patrice Somé, 2003. *The Natural Medicine Guide to Schizophrenia*, Hampton Roads Publishing, pp.178–189

– naming people's experiences in alien and alienating, technical terms that deny personal or social meaningfulness.' I think it is important to avoid eclipsing the very *particular* histories and experiences of imperialist and white supremacist colonial violence, by using the term 'colonising' to describe *any* imposition of ideas, even if there are parallels. Decoloniality points more to *naming the ideologies* that have and continue to underpin colonial violence, and which have been detrimentally shaping culture and activity in many places, including in the places of their origin.80

Psych/iatry is a *construct*. It was, and still is, an imposition on Indigenous healing traditions in the European cultures from which many of its premises originally emerged and were formulated. In the absence of many of those Indigenous European traditions (resulting from historical destruction, like centuries of witch hunts that suppressed Indigenous pagan cosmologies and healing practices), psych/iatry has centred itself as a dominant framework. Using deconstruction, decoloniality and the concept of ideas being 'culture bound', we can apply critical lenses to psych/iatry *wherever* we live and *whatever* our heritages. As tools for analysis these words and ways of understanding can serve us in examining, questioning, reviewing, refusing and then reinventing things, wherever we reside or whatever culture we are from or find ourselves in.

Hermeneutical dissent; collective liberation

I want to loop back full circle to the start of this chapter, which looked at epistemic injustice; injustice that can happen around *knowledge*, and *whose knowledge* is validated. It looked specifically at something called hermeneutical injustice; injustice because people don't have access to information which would help them make sense of experience, and where they have their own understanding of experience called into question, or defined *for* them. I want to
touch in now on something that has been called **hermeneutical *dissent***, which acknowledges that we *do* find ways to understand and interpret our experiences. That people (especially marginalised people) don't just look to the mainstream to make sense of things, that we *can* and *do* interpret and build understanding on our own terms.

This is what researcher T.S. Goetze has termed hermeneutical dissent: 'where marginalized groups have produced their own interpretive tools for making sense of those experiences'. It might be difficult to interpret certain experiences on our own terms. It can definitely be difficult for *other people* to understand those interpretations. Goetze writes about the fact that even if we make sense of experiences, it might not be so easy for others who hold a more mainstream perspective to grasp. 'In these cases, the subject is not prevented from acquiring knowledge of her experience, but she is prevented from sharing that knowledge because others find her testimony unintelligible.'81

These are academic terms that speak to what many of us are doing all the time. I realise in hindsight for example, it is something I was doing decades ago around a particular set of experiences I was having of my menstrual cycle. As a young cis woman, I was trying to understand how I was feeling month by month, and how to navigate that. I wasn't offered a way to interpret my experiences by the dominant culture that made sense to me. So, based on my felt-sense, finding bits of feminist health information, talking with many friends, reading more, and running lots of workshops about it, I picked apart the dominant messages we are given about the menstrual cycle, and specifically the narrative of hormonal 'imbalance' and the concept of what gets called PMS, which is defined as a syndrome/sickness.

81. T.S Goetze, 2017. 'Hermeneutical Dissent and the Species of Hermeneutical Injustice'. *White Rose Research Online.* Available from: eprints.whiterose.ac.uk/115077/3/Hermeneutical%20Dissent%20

%28formatted%20for%20press%2C%20April%202017%29.pdf (Accessed 14.01.2021)

Biomedicine and mainstream culture tells the story about PMS

– hormone imbalance, depression, anxiety, sleep disturbance etc., as a syndrome, which is spoken of as being something 'faulty' in cyclical bodies assigned female at birth. I was exercising *hermeneu- tical dissent* by saying actually, how I understand my experiences is that I, along with the cosmos, am cyclical, and changeable. There are shifts in my embodiment at which point I can *feel* more deeply and intensely; my consciousness shifts, I wish to speak less, dream more, creativity can feel higher, channels can feel open. This energy feels powerful and rich. It is *conflicted* though by the linear and dissociative culture I live in, which demands constant and often emotionally deadening discipline and productivity. In that culture, (heightened) sensitivity and a thwarted need for solitude or spiritual depths for example, can manifest as irritability, sorrow and tiredness. In that culture of systemic gendered, racialised and imperial violence, (heightened) sensitivity can manifest as oceanic grief and rage. My feeling is that if we were to live differently, not bound by so many restrictions and such brutal injustice, that we would feel very differently. There could be room for the experiences of pre-menstrual energy to be felt not as struggle or 'sickness', but actually as part of affirming life very deeply. That the struggles we feel around the experiences, in the contexts we live in, can point to what kind of change is needed to make that possible (i.e. reconfiguring wealth, power and resource distribution, and recalibrating how we work, live, love, parent etc.).82

To promote hermeneutical justice, i.e. to honour ways we interpret our experiences, calls for many things: generating space, breadth and room for the interpretation of experience to be possible; learning from each other in different communities with different lived experiences; analysing the way power functions; honouring marginalised voices, and more.

This concept of hermeneutical dissent has definitely been at play in how I have been exploring psycho-emotional experience for

82. Collated by Lisa, 2009. *Threads*: threadsbook.org decades. It underpins Part Four, which looks at other ways to interpret, understand and find language for articulating psycho-emotional experience. Dissent is the opposite of consent. It is, in this instance, a refusal to accept psych/iatric framings of our experiences because of the limited lens that these offer on *consciousness* and *context*; because it is a legacy of fractured and reductive Eurocentric philosophy that doesn't speak to the whole of our contextual and relational existence. Part Four speaks explicitly to this kind of dissent; this freedom of interpretation, and its revolutionary possibility.

Psych/iatry tells a very powerful narrative backed by a huge set of vested (corporate and state) interests. That fact, coupled with structural disenfranchisement and obstacles to equality, means the struggle to redefine the narratives it gives us is a *real* one, and requires we support each other to do so. *Together* we can analyse how ideas we are offered might reflect the culture they come from. We can decide if ideas are

relevant, or of use. We can exercise the freedom to (re)interpret and (re)invent understandings, healing approaches and responses, personally, and collectively. These ideas feed into the following two chapters, which ask what reframing, relanguaging (and remedying) distress and our understandings of consciousness, on more radical terms together, might look like.

This conversation to share Urgent. These urgent things

I want to tell you I am listening That I hear you. Hold you. Hold me We'll hold each other

This far too much. This not enough The wounding and the weight

Power, grounding ours

Justice, vitality, connection, freedom ours Joy, pleasure, peace ours

Conversation # 2

If useful, consider the following questions in pairs, threes or groups:

1. Do you find the terms *decoloniality* and *deconstruction* useful? If yes, in what ways?

2. Do you find the term *culture bound* useful? If yes, in what ways?

3. Have you personally, or as a member of a (marginalised) group experienced *testimonial* or *hermeneutic injustice*?

Part 2 References

63. Ibid. p.132 & 136

64. Hussein Abdilahi Bulhan, 2004. *Frantz Fanon and the Psychology of Oppression*, Springer, p.195

65. Shirin. Hess, 2018. ‘Zapatista women inspire the fight against patriarchy’. *Waging Nonviolence*. Available from: wagingnonviolence.org/2018/04/

80. China Mills, 2014. *Decolonising Global Mental Health*, Routledge, p.6

Part Three - Reframing Trauma

Reframing Trauma

Trauma, from the Ancient Greek τραῦμα, meaning ‘wound’ or ‘damage’, can be defined as a distressing or disturbing experience or injury, and can be experienced in many ways over the course of a lifetime. Experience of woundings can be personal and systemic, and the two are almost always inter-related. Some kinds of trauma we might experience (listed and described further on in this section) can be specifically related to our social circumstances and heritages. Depending on these we can be subject to particular *woundings* in the form of oppressions, prejudices and inequalities (i.e. poverty and racism).

Trauma is now often defined in the global North not *just* as a distressing, disturbing or wounding experience, but as a *response* to a distressing, disturbing or wounding experience; one that overwhelms an ability to cope and leaves an imprint, a lasting pattern of feelings and behaviour. It is also spoken of as any *unresolved* response to a wounding.

One current definition of trauma from a key voice of global Northern trauma theory says, ‘Trauma occurs when an event creates an unresolved impact on an organism.’1
The concept of

1. Peter Levine with Ann Frederick, 1997. *Waking the Tiger: Healing Trauma – The Innate Capacity to Transform Overwhelming Experiences*, North Atlantic Books, U.S, pp.128–29

unresolved trauma is particularly significant to explore and address in a society where there is *so much* ‘unresolved’ impact on us. There is more about this ahead in the section that looks at some of the different forms of trauma.

This chapter gathers some ideas together in order to look at trauma, which is often spoken of in the global North in an individualised way, i.e. what get called the personal effects of trauma. This chapter reframes it in broader terms that go beyond the individual and name also collective and social trauma. The chapter also examines and critiques some of the current dominant understandings of trauma we are offered in the global North. In that sense, ‘reframing’ is also the intention to look at those ideas from different perspectives, and to search for alternate and progressive understandings and approaches.

Current biomedical and popular cultural understandings of the effects of trauma are located in what gets called the nervous system. There is now a sea of trauma theory, which is outside, alongside and/or attempting to influence biomedical practice and mainstream culture. I want to call that body of thinking and approach ‘alt-biomedical’ because it uses the same paradigm we are offered by biomedicine but suggests itself as

more alternative/progressive. In many ways it *is* more progressive, and I think lots of it is really useful. This chapter will look at some of those useful ideas and approaches. The alt-bio model remains however a very particular lens that often peers *inside* a sealed bodily 'unit', to look at the experience of distress and tend to it there. This chapter points also to concepts, thinking and approaches that go beyond that.

There has been a big upsurge in recent years in this 'altbiomedical' trauma conversation and advice, in the shape of books, courses, therapists and online forums, conferences, articles and resources. Like I said, I think lots of the information can be really useful as a reference point, but true to neoliberalism, it often stays *very* individuated. There can be a strong focus on 'transforming your life' and 'healing from trauma' which does not tend to come overtly interlinked with how we also need to transform and heal the relational *world* we live in. Of course tools and healing practices we can use and share personally are so profound, but they need to sit within wider practices of *collective* care, social change and systemic transformation for them to have (more/real) meaning and efficacy. A lot of the current information and/or therapeutic support also costs money; trauma in that sense has been commodified. You could say that there is now a kind of trauma-industrial-complex.2

These endless courses to tend to the 'self '. What self?

What transformation?

Thankfully there is also a swelling movement making the connections between personal, historical and collective trauma. Amazing work, writing and courses are being made accessible around politicised approaches to collective trauma, and addressing deeper and more profound healing for personal and collective transformation. In this chapter I've drawn from and point to just *some* of that inspirational work which I have come across.

This chapter starts by *centering* the 'alt-bio' paradigm to look at what can be *useful* about it. It then builds on ideas from Part Two, acknowledging that paradigm as being *culture bound*, and critiques and *decentres* it, i.e. challenges its centrality, and looks at *various* perspectives and paradigms related to healing trauma in the broadest sense.

The initial section below is about how the alt-bio model understands the nervous system, and the short and long-term effects

2. The concept of the trauma-industrial-complex borrows language from and refers to the existing industrial complexes like the military-industrialcomplex, the prison-industrial-complex and the wellness-industrial-complex; institutions and ideas that are totally enmeshed with the capitalist system of generating profit and economic growth. Money directs and motivates what occurs in these complexes to varying degrees of detriment to equity and social justice. of trauma. It will look at some of the current alt-bio approaches to addressing and resolving trauma which are useful, and then expand beyond these ideas to look at various perspectives on the bodymindsoul. Following that, there is a look at the different forms of trauma we can experience from single incidents to systemic and structural oppression and violence. In this chapter there is critique of some of the specific and reductive ideas of traumatology (a term now given

to the evaluation and treatment of trauma) to ask what is useful and relevant in them, and what is limiting or short sighted, and to stretch beyond them. The section closes with conversation about collective care, collective healing, and how we might shape that together in radical, compassionate, and embodied ways.

The anatomy and physiology of what gets called 'The Nervous System'

Part One looked at the way bio-medicine splits the mind from the body, and the mindbody from its social context and the earth/ cosmos. Also at the way it splits the body into 'systems'. It already looked at the way biomedicine conceptualises what gets called the 'Nervous System'. The next section looks at this 'system' in more detail, and at current understandings of how it functions.

The next section will briefly look at what biomedicine tells us about:

1. The Central and Peripheral Nervous System
2. The Somatic and Autonomic Nervous System
3. The Sympathetic, Parasympathetic, and Enteric Nervous System, and
4. The Hypothalamic–pituitary–adrenal axis.

1.The Central and Peripheral Nervous System

Biomedicine says our 'Nervous System' is divided into two parts; the Central Nervous System and Peripheral Nervous System. The **Central Nervous System** (CNS) is the brain and spinal cord, surrounded by fluid and protective membranous coverings called the meninges, and is housed in the skull and vertebrae of the spine. The **Peripheral Nervous System** (PNS) is the nervous tissue (nerves, ganglia, etc.) that is beyond the brain and spinal cord. We are told that the main function of the Peripheral Nervous System is to interconnect the Central Nervous System and the limbs and organs, essentially serving as a relay between the brain/spinal cord and the rest of the body. We are told they are separate systems, but in actual fact they interrelate.

Some people consider the retina and the optic nerve (cranial nerve II), which are involved with the sense of sight, and the olfactory nerves (cranial nerve I) involved with the sense of smell, as parts of the Central Nervous System. They synapse *directly* on brain tissue without intermediate ganglia. I find this significant as it in part explains the *deep* rest that comes from resting the eyes, and accounts for the way smell can affect us so directly and deeply. It points to the incredible ways we sense each other as humans, and our environments through smell. And it explains in part the immediate

profound and transformative effects of, for example, the scent of aromatic herbs and essential oils.

In her book *Conversations with Plants*, Nikki Darrell writes:

We smell through the left and right nostrils separately. Olfactory nerves are directly connected to the same side of the brain as the stimulus, and there are no synaptic junctions between the nerves and the brain. When aroma molecules are present in the air, we do not need to consciously perceive them in order to be affected by them. Sometimes molecules are present in parts per billion, and they affect us; whereas, they have to be present at parts per million in order for us to perceive them [...]. The olfactory bulb also connects closely with the hypothalamus.

Smell could therefore influence many of our bodily processes. There are amazing implications as to how this could initiate 'trickle down' effects on an emotional and physical level.3 4

3. Nikki Darrell, 2020. *Conversations with Plants*, Aeon Books, pp.12/13

4. Image: Rose: *Rosa damescena*; useful for fear, shock with emotional disconnection, or blocked or anxious heart, also grief. Anti-anxiety, antiinflammatory, aphrodisiac

2.The Somatic and Autonomic Nervous System

Biomedicine further divides the **Peripheral Nervous System** into two aspects:

1. The **Somatic Nervous System** (SNS) which we are told is associated with the voluntary control of body movements via skeletal muscles, i.e. moving our arms or turning our head.

2. The **Autonomic Nervous System** (ANS) which we are told connects with smooth muscle and glands, and so influences the function of internal organs, like heartbeat and digestion.

Biomedicine says that the Autonomic Nervous System is the 'control system' that acts largely 'unconsciously' and regulates bodily functions like heart rate, digestion, respiratory rate, pupillary response, urination. It is said to be the aspect of the nervous system responsible for the fight-flight or freeze (and related) threat responses.

We know however that the Autonomic Nervous System, which is said to be related to 'unconscious' processes, can *absolutely* be affected by conscious activity in what gets called the Somatic Nervous System. If we breathe deeply, practice meditation, rest the body, dance, receive and give pleasurable touch etc., our heart rate and digestion is affected. These systems are also interrelated, the binary that biomedical sets up between them isn't quite as clear cut.

3.The Sympathetic and Parasympathetic Nervous System

Biomedicine further divides the **Autonomic Nervous System** (this 'unconscious' 'reflex' activity) into two, some say three, aspects:

1. The **Sympathetic Nervous System**
2. The **Parasympathetic Nervous System** and
3. The **Enteric Nervous System**

4

Typical depiction of the sympathetic and parasympathetic, the two aspects of the autonomic nervous system.

We are told the **Sympathetic Nervous System** (*sympa* meaning *with* i.e. affected by or responding to the emotions) is concerned with mobilising the body for activity or arousal, and when it is under threat, causes what gets called the 'fight or flight' response. The **Parasympathetic Nervous System**, (*para* meaning *alongside/ apart from* the emotions) is where when we are at ease; digestion and sleep can take place, creativity can emerge, tissues in the body can heal. In this state it is known as 'rest and digest'. If we are under threat, however, a 'freeze' response (to which 'faint' and 'flop' have also been added as experiences) can occur in this aspect of our nervous systems. Those responses are said to *follow* initial fight-or-flight feelings if the threat we experience doesn't stop, or defence or fleeing aren't possible or effective. Biomedicine tells us we are 'wired' to respond to danger by running away or defending ourselves (fight or flight), or, if neither is possible, by freezing or fainting/numbing/feigning death to avoid being killed by predators, or feeling pain.

The relationship between the sympathetic and parasympathetic nervous systems is more complex; I don't think there's quite such a clear, definite binary. I think there are instances where *both* aspects of the autonomic nervous system, the sympathetic and the parasympathetic can be engaged at the same time, for example during certain physical intensity or ecstatic arousal.

Your heart pumping, you dance, yell, chant, and you rest deeply in yourself, at centre, connected, grounding through the wild riches. You ask what about that wild deep and still place? What about the long hours abandoned, chaotic ecstasy, dancing and dancing into trance... What of the cusp territory between distress and elevation... that proximity...

If you dive into cold water you can experience shock (engaging the sympathetic) and something that is called the 'diving reflex' (engaging the parasympathetic). The diving reflex is said to happen when the face is submerged and water fills the nostrils; receptors sensitive to wetness in the nasal cavity and other areas of the face cause a slowing of heart rate and concentration of blood flow in the heart–brain circuit allowing conservation of oxygen.

When both aspects of the autonomic nervous system are activated as in the above, biomedicine calls this autonomic conflict. The term autonomic

conflict is used in regards to research that has been done into irregular heartbeat that can occur in some peoples' bodies when they immerse in cold water.

I think it's interesting that as a result, biomedicine has chosen to define it just as a *conflict* between the aspects of the nervous system. Cold water immersion doesn't result in heartbeat irregularities in everyone, which suggests the two aspects can be activated and not in conflict. I imagine that in this instance, and in other instances of activation of both these two aspects of the autonomic nervous system (like during intense heat in a state of prayer for example), it could also be perceived as a complex and simultaneous *coexistence*, or *co-engagement*.

I think understanding the actions and effects of the sympathetic and the parasympathetic nervous systems is a useful way to understand important things that can occur in the bodymindsoul, especially where there has been/is trauma. It can be *one* way that we can make sense of the effects of trauma. I think the fact that there isn't always such a definite binary of these two 'systems' is important to consider though when we think about healing trauma. It can allow us more complex approaches to what we *feel* or *intuit* or want to explore that may be restorative and healing. I think there is room to feel our way with and inquire about understandings of this physiology, *and* choose healing approaches that maybe *complicate* the binary narratives we are given about the autonomic 'nervous system'.

Can your heart be pumping, you dance, yell, chant, and you rest deeply in yourself, at centre, connected, grounding through the wild riches. You ask what about that wild deep and still place? What about the long hours abandoned chaotic ecstasy, dancing and dancing into trance.

The Enteric Nervous System

The **Enteric Nervous System** (ENS) is the nervous system embedded in the lining of the guts; the gastrointestinal system, beginning in the oesophagus and extending down to the anus. Some biomedical sources call it a third main aspect of the autonomic nervous system. We are told it normally communicates with the central nervous system, through the parasympathetic and sympathetic nervous systems. Studies show though that it can operate autonomously and that when the vagus nerve (a core nerve of the parasympathetic nervous system which we will return to later in this chapter) is severed, the enteric nervous system continues to function. In neurochemical terms, chemicals it secretes (formerly believed to only occur in the brain) have an effect in the brain and elsewhere in the body.

The ENS is sometimes called the *second brain* – a term which comes as no surprise in this brain obsessed culture we live in. Really this centre of the body just has its own kind of knowing and responding: you could say it has its own *intelligence*. The

biomedical physiological explanation of the ENS supports what we often already speak of in popular/folk culture as having 'gut feelings' about things.5

And finally...

4.The Hypothalamic–pituitary–adrenal axis (HPA axis)

We know the 'nervous system', like all the 'systems' isn't a *separate* system that functions in isolation. It is interrelated with all the other systems, for example the muscular and cardio-vascular system. We may experience feelings of anxiety if the muscles are tense or the heartbeat is racing, and muscles will tense and the heartbeat might race if we are anxious. It is also interwoven with what gets called the endocrine system, a chemical

5. In his book *The Feeling Of What Happens: Body, Emotion and the Making of Consciousness*, Antonio Damasio articulates his 'somatic marker theory' which 'suggests the extent to which cortical functioning actually depends on the body's "gut feelings" in the operations of reasoning'. Barnaby B. Barratt, 2013. *The Emergence of Somatic Psychology and Bodymind Therapy*. Palgrave MacMillan, p.123

messenger system in the bodymind. Biomedicine is increasingly honouring that systems *do* interrelate, naming for example the 'new' disciplines of neuro-immunology and neuroendocrinology, etc. However this often replicates a colonial pattern, claiming that *science* has now *established* these links, i.e. made these 'discoveries', when actually many Indigenous traditions have *always* honoured interrelationships and not split and separated things in such a way.

The HPA axis is a major *neuroendocrine* system that plays a significant part in the stress response. It involves interactions between glands, hormones (what gets called the *endocrine* system), and parts of the brain (within what gets called the *nervous* system) which mediate stress. It is the name given to a set of feedback interactions between the hypothalamus (a portion of the brain), the pituitary gland (located just below the hypothalamus), and the adrenal glands (small, conical glands on top of the kidneys). It involves the secretion of various chemicals and hormones, like cortisol from the adrenal glands (see image). We are told that these chemicals are secreted as reactions to stress, and affect many body processes, including digestion, the immune system, mood and emotions, sexuality, and energy storage and expenditure. This understanding and depiction more explicitly acknowledges the *interconnectivity* of 'systems' in the body. Even though it depicts an image that suggests an 'internal' homeostatic feedback process, it acknowledges these are physiological effects (ones which can ravage the body) caused by responses to what is stressful, threatening or violent 'outside' the body.

The effects of trauma in the bodymind

As soon as we speak of the detail of trauma, there is the possibility that it might bring up challenging sensations or emotions, so I wanted to repeat the invitation that is in the introduction, which is that we take care of ourselves as we connect to some of these ideas about trauma, use practices to stay as grounded as possible, and call on friends or support if we need and can. Also to skip over anything that feels too much and come back to it if and when there's a better time.

Short-term effects of trauma

Biomedical and alt-bio models understand that trauma will activate our physiology into fight or flight (responses associated with activity in the *threatened* sympathetic nervous system) and, subsequently, maybe cause us to freeze, flop or faint (responses associated with activity in the *threatened* parasympathetic nervous system).

Under the influence of the sympathetic nervous system, the adrenal glands secrete adrenaline and cortisol, which causes raised heart rate and blood pressure, constriction of most blood vessels, a faster breathing rate, inhibited saliva production (dry mouth), and our digestive and generative organs will shut down their function. We might experience sweating, and our pupils will dilate.

Cortisol, sometimes called a primary 'stress hormone', increases sugars (glucose) in the bloodstream, enhances your brain's use of glucose and increases energy levels and the availability of substances
that repair tissues. Cortisol also curbs functions that would be nonessential in a fight or flight situation. It alters immune system responses and suppresses the digestive system, the reproductive system and growth processes.

Under the influence of the threatened parasympathetic nervous system, beyond the fight or flight response and into the freeze, faint, flop responses, we might experience constricted breathing, low heart rate, low blood pressure, numbing out, dissociation or immobilisation. Once an immediate stress or threat passes, we ideally return from the state of fight, flight or freeze responses, into the possibility to restore, in an unthreatened parasympathetic state (rest and digest).

The Threat/Stress Response Cycle

The alt-bio model explains how, once a threat has abated or gone, *releasing* that threat response from the body, by for example crying, shaking, laughing etc., allows the bodymind to return to a place that is not in threat mode. A place of relative ease or what can get called relative 'safety'. The stress/threat response cycle is *resolved*, and we can re-inhabit a relatively unthreatened state of being. This thinking has been shaped by observation of human behaviour but also from noting animal behaviour, and the way animals shake and release in the body after stressful encounters.

Long-term effects of trauma

If a specific stress doesn't subside, or a historical stress response cycle from trauma in the past wasn't/isn't resolved, or if we live in sustained/continuous/unresolved trauma and stress response cycles, we can stay in a threat response mode. We can be locked in either the sympathetic or parasympathetic nervous system threat responses. This can cause long-term effects like living in a constant
state of 'fight or flight' – *hyper-arousal*, being hyper-vigilant (meaning elevated levels of being on guard and cautious), having a raised base line of alertness to threat or danger, having increased startle responses, etc. We may also be stuck in *hypo-arousal* which can be experienced as a kind of 'freeze', a dissociative, constricted, numb state, and experience chronic fatigue, and chronic low mood. In both cases, *hyperor hypo-arousal*, we may experience various related psycho-emotional and physical health issues.

Unresolved trauma might result in triggers being experienced, where current incidents of relatively small stress can reactivate older, more significant experiences of stress or trauma. Unresolved trauma triggered by a smaller current experience can be reactivated and felt again with the same or similar intensity as if it were occurring in the present time. If something is triggering, it can awaken what can feel like a *disproportionately strong* threat response in the bodymind, which is a response to a deeper or older trauma.

Sometimes a current situation or event can trigger deep emotion that we might be able to recognise as being 'old', i.e. from the past. It's also the case that we might not always know *exactly* what happened to us in the past to have caused historical trauma; it may be pre-memory, or there may be amnesia around the wounding, which makes memories unclear or uncertain, but still gives rise to strong feelings. Triggers can sometimes also simply bring us into contact with deep *current* pain; with contemporary violations and oppressions that are *unbearable* that we contend with, and often have to disconnect from day to day.

We may feel 'old' trauma being reactivated whether we definitely know what caused that 'old' trauma, or not. We may feel intensely the weight of current continuous wounding. We may, through an incident, encounter also just the inherent vulnerability

of being human, of our and each other's mortality. I think there are times when it is likely that these can all intersect and overlap. That it may *all* be being felt at the *same time*. And that it may require specific, as well as general, release and social and spiritual remedy.

The long-term effects of trauma mean we might have less access to, or reduced memory day to day, or experience intrusive thoughts, emotional flashbacks, difficult dreams. Things that simply make us feel *uncomfortable*, can be disproportionately perceived as threatening or dangerous. We might be more likely to react to everyday experiences with stress, fear and/or feelings of overwhelm, and be more prone to catastrophising (thinking/anticipating the worst) because our base line of being is in a state of overwhelm.

We might experience trembling or feelings of heat or cold, or chronic neck, jaw or pelvic floor muscle tension, as we are still 'guarding' against perceived/potential threat in the body. We might experience intense shame, which includes feelings of self-loathing, exposure, mistrust, powerlessness or worthlessness, related to how we have been affected by woundings. We might get stuck in these feelings of shame, and we might also get stuck in shame spirals where, following an initial loss of self-control over something which makes us feel shame (being overdependent on an other, overeating, binge drinking, etc.), we repeat the action or behaviour (dependency, eating, drinking) out of feelings of more shame in this kind of loop. Feelings of self-degradation can repeat and be compounded.

Meg-John Barker has a great page on their website about shame as a pattern of response we can have as a result of trauma; the *ways* it can be experienced; and ways to tend to it through connecting to vulnerability, practicing compassion and empathy, and reparenting oneself to be the (emotional) parent we maybe never had, or giving ourselves the kindness and loving support we need. Barker references *Internal Family Systems Theory* (developed by psychotherapist Richard C. Schwartz) and neurobiology therapist Bonnie Badenoch's idea of 'internal community'. Barker concludes:

Both of these encourage befriending all parts of yourself – particularly those who are disowned or split off, and developing dialogue and compassion between different parts. It's vital that
we stop trying to eradicate shame-filled parts of ourselves, but instead learn how to turn towards them and befriend them.6 7

There are physical correlations with the long-term effects of trauma. Because we secrete adrenaline and cortisol when we are activated into fight or flight, we might be more at risk of the long-term effects of this such as raised blood pressure, increased inflammation, and related health issues in the bodymind such as auto-immune issues like arthritis and chronic pain, etc. Recent research shows that the bones are fundamentally involved in the stress/threat response as well. When danger is detected, the bloodstream is flooded with the bone-derived hormone osteocalcin, which is needed to turn on the fight or flight response. 'In bony vertebrates, the acute stress response is not possible without osteocalcin'[...]. The research revealed that the skeleton releases

osteocalcin, which travels through the bloodstream to affect the functions of the biology of the pancreas, the brain, muscles, and other organs.8

It makes me wonder about the relationship between stress, trauma and the current prevalence of osteoporosis and joint issues.

Other experiences resulting from the effects of trauma can include enacting forms of self-harm to both avoid painful feelings, or 'meet' the intensity of feelings, or in an effort to just *feel* if we are in a chronically numbed, frozen state. In *Trauma and Recovery*, Judith Herman names how: 'Many self-destructive behaviours can be understood as symbolic or literal re-enactments of the initial

6. Meg-John Barker, 2020. *Chronic Shame*. Available from: www.rewritingtherules.com/self/chronic-shame (Accessed 23.01.2021)

7. More ideas about connecting to and dialoguing with the different parts of the self can also be found at voicedialogueinternational.com

8. Columbia University Irving Medical Center. (2019). 'Bone, not adrenaline, drives fight or flight response'. *phys.org* Available from: phys.org/news/201909-bone-adrenaline-flight-response.html?fbclid=IwAR3uxuMPsJJaFwipo3S Jh-Jovi6_ZHplHas76BThJvDls1 (Accessed 23.01.2021) abuse. They serve the function of regulating intolerable feeling states, in the absence of more adaptive self-soothing strategies.'9

Trauma imprints can also result in being more inclined to risk taking behaviour, often as a way to try and resolve old trauma/threat response patterns (i.e. going to an edge with experiences to try and find a peak and then be able to release back into greater ease). Risk taking can also happen because we can be addicted to our own habitually raised adrenalin and seek familiar feelings from 'highs' or 'crises'. Resting and relaxing can also feel unusual or frightening, or be the states where original woundings may have occurred and so there is unease or guarding around reinhabiting those places.

Herman speaks about the way healing can occur when we are able to move through the way we have been shaped by trauma:

A survivor of childhood sexual abuse testifies about this change: 'I'm an intensity junkie. I feel let down whenever I come to the end of a particular cycle of intensity [...]. What am I going to cry and throw scenes about now? I see it as almost a chemical addiction. I became addicted to my own sense of drama and adrenaline. Letting go of the need for intensity has been a process of slowly weaning myself. I've gotton to a point where I've actually experienced bits of plain contentment.'10

'Risk taking behaviour' could be used to describe someone, or a group of people, who are putting themselves in what might get called questionable danger. It's often spoken of as involving substance use or what gets called risky sexual behaviour. In these instances 'risk taking behaviour' might actually be a coherent processing of, or response to pressure and trauma through *some* kind of activity. In that sense it isn't *just* risk-taking, or dangerous, it's a *response* that can be explored, understood and potentially transformed.

9. Judith Lewis Herman, 1997. *Trauma and recovery: the aftermath of violence*

– *from domestic abuse to political terror*. BasicBooks, p.203

10. Ibid.

There is often an invisible *morality* around what gets called 'risk taking' behaviour (same as there can be around what is considered *acceptable* 'self soothing'). In my experience it is often rooted in class-based prejudice, i.e. certain 'behaviours' are viewed as spiritually superior, they are perceived as tests of human capacity and endurance (for example free-climbing: climbing rock faces without any ropes or safety harnesses), while others (like high speed kart-racing) are deemed less so. There can be a fine line between potentially harmful risk-taking activity, and actively seeking intensity to connect to capacity, vitality and healing. We need collective, non-hierarchical conversation, all of us, about these two aspects of experience to explore what might be going on. To understand whether activity is damaging or serving some need, and how that might be navigated with the best sense, rather than specific people (often health or social work professionals) being in positions to make assessments or distinctions about others.

What can also happen is that trauma responses and unresolved trauma patterns shape behaviour and identity, and become *misper- ceived* as being aspects of our innate 'personality'. More about this and generally about the concept of the 'personality' in Part Four.

The long-term effects of trauma can disproportionately impact marginalised people where systemic oppression imprints trauma into the bodymindsoul. Explored in an article, *Scientists Start To Tease Out The Subtler Ways Racism Hurts Health*, Amani NuruJeter's work as a social epidemiologist researcher at the University of California, Berkeley is working to find out how, as she puts it, racism gets under the skin [...]. 'Prolonged elevation [and] circulation of the stress hormones in our bodies can be very toxic and compromise our body's ability to regulate key biological systems like our cardiovascular system, our inflammatory system, our neuroendocrine system [...]. It just gets us really out of whack and leaves us susceptible to a bunch of poor health outcomes.'

A number of small studies have documented similar stress reactions in response to racism, and even in response to the mere expectation of a racist encounter.

In studying black women, for example, she has found that chronic stress from frequent racist encounters is associated with chronic low-grade inflammation – a little like having a low fever all the time. Nuru-Jeter thinks it might be a sign that experiencing discrimination might dysregulate the body in a way that, over time, could put someone at a higher risk for a condition like heart disease.11

Fight, Flight, Freeze,Annihilate,

Please and Appease, and Tend and Befriend

Other responses have been named alongside the more commonly recognised trauma responses known as fight, flight and freeze. These are *annhilate*, *please and appease*, and *tend and befriend.*

Annihilate is a response recognised by Resmaa Menakem and other therapists. Menakem describes:

The lizard brain issues this command when it senses (accurately or inaccurately) that a threat is extreme and the body's total destruction is imminent. The *annihilate* command is a lastditch effort to survive. It usually looks like sudden, extreme rage or like the attack of a provoked animal. Some therapists see *annihilate* as just a variant of the fight response, but I classify it separately, because *annihilation* energy looks and feels quite different from *fighting* energy. It's the difference between a punch and a decapitation [...] in a therapy session, there are times when it is important for the therapist to note and

11. Rae Ellen Bichell, 2017. 'Scientists Start To Tease Out The Subtler Ways Racism Hurts Health'. *npr.* Available from: www.npr.org/sections/health- shots/2017/11/11/562623815/scientists-start-to-tease-out-the-subtler-waysracism-hurts-health (Accessed 23.01.2021) work with the unique energy of an *annihilate* response. [...] More generally, we would also be wise to recognize that much of what we call rage is actually unmetabolized annihilation energy.12

Please and Appease happens when people under threat enact behaviour that pleases or appeases the person or people who pose the threat, in order to manage the threat and guarantee safety. Children who grew up in disorientating or dangerous situations may use this adaptive behaviour, and it may shape a tendency in them to people-please throughout adult life for fear of reprimand or abandonment. Psychotherapist Peter Walker calls this *fawning* and has added it to the list as the fourth trauma response: fight, flight, freeze or fawn. I don't like the term fawning because I don't feel like it does justice to the *intense* negotiation many people are constantly in around danger and threat. In an online talk given by Resmaa Menakem about racialised trauma, he speaks about People of Culture13 'taking care of white bodies reflexively to stay safe'.14 He speaks to the danger that can exist for poc if white people feel discomfort. His is critical recognition of the way the trauma of racism can affect poc and necessitate relentless invisibilised emotional labour. And it relates to Amani Nuru-Jeter's work mentioned above, naming some of the physiological effects of the trauma of racism.

12. Resmaa Menakem, 2017. *My Grandmother's Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies*, Central Recovery Press, p.5

13. Resmaa Menakem is reinventing the term POC typically used to mean Person or People of Colour, to People of Culture:

Menakem: Well, I don't say bodies of 'color' anymore, because what I'm trying to do is, I'm trying to reclaim the idea that I'm actually a human.

Tippett: So you're saying that you're formed by the culture— Menakem: Bodies of culture. That's right.

Resmaa Menakem, 2020. ‘Notice the Rage; Notice the Silence’. *On Being*. Available from: onbeing.org/programs/resmaa-menakem-notice-the-ragenotice-the-silence (Accessed 23.01.2021)

14. Ibid.

Another named threat response has been called **Tend and Befriend**. It speaks about the way we might in some circumstances also seek proximity, connection and togetherness when threatened. There’s something powerful and beautiful in the potential of this impulse, and I wonder if it might be witnessed more often if we were encouraged to actively unlearn competition and prejudice, and actively practice solidarity and compassion. I don’t think ‘reflex’ responses just ‘occur’ without the complex influence of moral, social, political and spiritual frameworks. I think we can respond both situationally (i.e. depending on the specifics of a situation) and can also learn responses culturally.

Unfortunately claims about this behaviour to date have been problematic in the way they have been biologically essentialist. Research led by Dr. Shelley E. Taylor documented in papers like *Behavioural Responses to Stress in Females: Tend and Befriend, not Fight or Flight*, claims that tend and befriend behaviour occurs in cis women, allegedly driven by a hormonal interplay between oxytocin and estrogen. I don’t believe this essentialist sex-binary theory is true. I think the effect of hormones and physiology, and of socialisation, is much more complex in the way it occurs in *all* of our various sexed and gendered bodies and beings.

What I think is progressive is simply to *acknowledge* this behaviour as a possible and liberatory response. It makes me think again about the ‘cultural scripts’ we are given. The dominant ones we are given about our threat responses are that they involve *fight or flight*. A fairly common image we are offered is of a lone caveman in fight or flight mode as a result of a predator attack. The fact that *tend and befriend* is much less spoken of feels significant, located in a culture where we are constantly told life is dependent on the ‘survival of the fittest’, and also a culture which is predicated on conflict. I think it is noteworthy that the term *fight or flight* was first coined in 1915 by Walter Cannon who was a military physician in the First World War.

It makes me think about what I learned at school. I was taught that the ‘survival of the fittest’, as theorised by Social Darwinism, was the way all humans ‘naturally’ existed. It wasn’t until later in my life that I learned about not only the racist and eugenicist ideologies inherent in many of those theories, but also about global and Indigenous *co-operative* models of living. I remember also coming across the Russian anarchist and philosopher Kropotkin’s ideas about mutual aid. His understanding was that mutual aid and solidarity, not competition, have the most significant advantages for human and animal survival, and that it is this *mutuality* which is promoted through natural selection. I’m curious: what if we learned about *tend and befriend* as much as *fight or flight?* I think it’s possible that if it was more in our cultural currency, then we might *see it happen* (in all bodies, sexes and genders) more than we already do. That

in threat or crisis we might orient through our physiological responses *towards* each other for connection, safety and solidarity.

The concept of stress – from a stressor 'agent' to a 'state' of stress

The word stress is used in physics to refer to the distribution of a force exerted on a material body, resulting in strain. In the 1920s and '30s, biological and psychological circles occasionally used the term to refer to a mental strain, or to a harmful environmental agent, that could *cause* illness. The current usage of the word *stress* came from HungarianCanadian endocrinologist Hans Selye's work in the 1930s. Selye – called the 'father of stress' – started to use the term to refer not just to the *agent* that caused stress, but to the *state* of the organism as it responded and adapted to the environment.

Selye coined the term 'eustress' for positive stress, in contrast to distress. He situated 'eustress' in his argument that all people have a natural urge and need to work for their own benefit, a message that unsurprisingly found favour with capitalist industrialists and governments! He also coined the term *stressor* to refer to the *causative* event or stimulus, as opposed to the new idea of a resulting *state* of stress.

Selye was in contact with the tobacco industry from 1958 and they were undeclared allies in the promotion of the concept of stress. They clouded the link between smoking and cancer, portraying smoking as a 'diversion', or in Selye's language a 'deviation' from social stress.

I think it is essential to return to the pre-Selye usage of the term *stress*, in order that we name the real structural, systemic and social causes of pressure and distress; the *stressors*, so we can address and change them, more than just naming the *state* of stress we might find ourselves in that we are supposed to remedy within ourselves, often through (culturally/ mis) appropriated and assimilated 'relaxation' practices.

General Adaptation Syndrome and Allostatic load

Two other concepts, **General Adaptation Syndrome** and **Allostatic Load**, can be useful reference points in terms of thinking about and acknowledging the effects of stress(ors).

Selye was also responsible for coining the term **General Adaptation Syndrome** (GAS) in the 1920s to describe how he felt organisms respond to stress. He describes the General Adaptation Syndrome as being characterised by three phases:

– a stress that causes a mobilisation phase, which promotes sympathetic nervous system activity;

– a resistance phase, during which the organism makes efforts to cope with the threat;

– and an exhaustion phase, which occurs if the organism fails to overcome the threat and depletes its physiological resources.

Two neuroendocrinologists McEwen and Stellar coined the term **Allostatic Load** in 1993 to describe the physiological effects of wear and tear on the body which accumulated as an individual was exposed to repeated or chronic stress. This can include high blood pressure, cognitive dysfunction and depressed mood which can cause/accelerate systemic health issues, for example compromised immunity or thyroid function. The theory says a key component is the experience of *uncertainty*, and speaks about a need to reduce uncertainty. It says failure to resolve uncertainty results in the accumulation and ill effects of allostatic load. This raises profound questions about what healing actually means: about the need to mitigate the very *real* uncertainty of austerity capitalism, for example, and about how we navigate a more existential uncertainty; the fact that unexpected events happen in life, and that transience, change and the unknown are part of our human experience.

Depletion culture... Capitalism exhausting you. What's exhausting us?
Too much that is exhausting us. What are we adapting to?
And addicted to our (own?) adrenaline... What does release look like?
And what does rest look like? What does response look like?

Before moving on into sections about addressing and healing trauma, there are a few specific concepts in trauma theory I'd like to investigate. I want to look at some of the language and ideas that are in common usage; of 'self-regulation', 'co-regulation', also the language of 'safety', and the rhetoric of resilience, to consider more expansive and liberatory reframings.

The language of 'self-regulation'

Moving from the language of 'regulation' to the language of resonance?

A lot of the language of current alt-bio trauma theory and healing speaks about 'self-regulation'. On one hand this paradigm is useful. It is possible and necessary to find tools and practices to (re)access places of ease, connection, groundedness, vitality etc., within what we can say is 'oneself ', and where conditions around us allow a certain amount of safety to do that. Alt-bio trauma theory speaks about our emotional and physiological 'base line'. If we are traumatised, then our base line levels of arousal or alertness to potential threat or danger may be constantly, or quick to be raised. Our base lines may alternatively be constantly, or quick to be numbed and dissociated. Alt-bio theory speaks about ways we can 'down regulate' or 'up regulate' depending on what is needed. I understand how 'regulation' in this context means not being stuck in, or tipping into states of overwhelm or underwhelm, and being able to alter one's state of being through the power of connecting to the breath, movement, touch, sound, imagination, etc.

What is problematic is that it can be spoken about as if we are supposed to just *manage ourselves* emotionally, often without clear, simultaneous acknowledgement of wider systemic context; of structural oppressions, which are fundamentally damaging, wounding and traumatising. It suggests that we are to 'self-regulate' as distinct, separate units, when we are not. I personally don't want to regulate to the mania and violence of capitalism or standards of patriarchy or whiteness. We could ask who determines what a 'regulated' base line feels like in an often very rapid, restrictive and dissociating culture. Someone's consciousness and sensibility might mean that they need to 'self-regulate' a lot, simply because of how they feel, living in a very overstimulating world where there isn't time and space given that honours everyones' being and processes. What might understandings of a 'regulated' base line be across different cultures? The ways someone 'self-regulates', or feels well, grounded and alive in themself, also might not fit with culturally prescribed social norms about how that should feel and look. Certain global Northern culturally sanctioned embodiments (and presentations) of calm, for example, aren't how everyone inhabits wellness.

CAPITALISM IS A DISSOCIATIVE STATE

Within capitalism, for example, there can be a complicated kind of 'regulated'. We might pass as 'regulated' in the context of a working office day, but that feels contracted or dissociated, often involving shallow breathing and a lack of profound bodily ease. In this sense, many of our environments and given norms are themselves dysregulated and

dysregulating, which we are being asked to self-regulate within. We have been deeply shaped by a culturally sanctioned, systemic *dysregulation.* Many of us were made to sit still for long periods of time at school, engaging predominantly with our rational 'minds', when we might have had strong impulses to run/move/dream. We were also schooled with the *dysregulation* of constant competition, not cooperation. In that, and many other instances, self-regulation can mean going *against* the bodymindsoul to fit with social norms. I know that I regularly have to *dysregulate* to fit in to dominant ways of living; to meet deadlines, to sometimes speak too quickly, with too many people in order to arrange things, to get to places 'on time' as determined by mechanised clock time, etc., which I then have to recover from. That recovery involves accessing a feeling of coming home, a feeling of presence, where mind, body and soul can feel alignment, often out in nature. I try and move from dissonance back towards more life-affirming modes and rhythms, of resonance.

The word regulate means to adjust, also to bring order, method or uniformity, it suggests a sense of control. The idea of self-regulation can sometimes feel akin to a request for *self-control* in order to fit the requirements of productive capitalism, or the pressures of various social etiquettes and interaction. What if someone falls into a trance state, or a consciousness that is temporarily beyond their control/regulation? How does this global Northern trauma theory account for the diversity of those human experiences of consciousness?

Finally, what if we need to respond to injustice *as part of* 'self-regulating'? What if that response, i.e. channelling energy (which may be traumatised) into a project or activity that responds to injustice, is a significant part of how we come to connect to a base line of wellness or 'regulation'? Alt-bio trauma conceptualisations can be simultaneously useful and problematic. I'm interested in how we can draw from and critique them at the same time, to move towards profound healing. If we don't use the word regulating, what might we use? I wonder about moving from the language of self-regulating to the language of resonance. Where resonance can mean a clear, deep, strong sound, where it can mean a vibrational connectivity and relationship within ourselves and with each other as a social body, and with the rhythms of the earth, the moon, ancestral connection... where resonance challenges the idea of 'self ', of 'order' and of 'uniformity'.

Discipline, daily life and distress Deadener. Constraint constraining Even the things you love. Cramped 9-5. 10-6. Night shift. Graveyard. Dehydrated

Rushing to make it all in time

The collective memo. Next week at 4 Or 10.30

On the dot

No matter the weather Blizzard. Baking heat Bound. Binding

Q: Do you work part time or full time?

A: I'm not sure... I do things.

There is activity and there's rest... sometimes activity IS rest. I'm uncertain what of that is called work, or not work.

Some hours of it I get paid for.

Q: What is work?

A: Old English weorc, worc, 'something done, discreet act performed by someone, action (whether voluntary or required)'

Many hands make light work, from c. 1300

To work against 'attempt to subvert', from late 14th century To have (one's) work cut out for one, from 1610s

Work ethic recorded from 1959.

Q: How would you like to organise work?

A: They said £10 per hour. Units. Units per hour. Valuers. Value. Your distress a kind of truth speaking refusal. Speaking truth to power. £100 per hour. Some hours of it I get paid for. It might take three hours. Or more. Or less. I'm not sure. Who knows?

Q: Is there anything else you would like to say?

A: I see you. I see you, and you are not alone. Saying you can't fit yourself into this.

And me saying I can't either. That I can't and won't either.

That this is the violence of everyday life.

Q: How would you like to organise time?

A: Wind. Sun. Migration of birds. Human. Beings. Together.

Q: Pain/painkiller. Go to the source.

A: Sorry. Can you repeat that? What was the question?

The language of ‘co-regulation’

Moving from the language of ‘regulation’ to the language of (re)connection?

In 1994 behavioural neuroscientist Stephen Porges put forward his Polyvagal theory, which has become a cornerstone of contemporary, global Northern trauma theory, informing therapeutic approaches. Polyvagal theory is concerned with the vagus nerve, a long nerve that travels right through the body (from the cranial nerves near the skull right down to the digestive and generative organs in the abdomen). The vagus nerve is considered a part of the parasympathetic nervous system, typically credited with reestablishing calm and restoration after we have been in fight or flight. Polyvagal theory (*poly*: meaning many) claims that there are two aspects to the vagus nerve: a more primitive, and a more developed one. The theory says that these two branches of the vagus nerve serve different evolutionary stress responses in mammals: the more primitive branch causes immobilisation behaviours (e.g. freezing and feigning death), whereas the more evolved branch is associated with soothing behaviour that comes about through social communication. This is the part of the vagus nerve involved in what Porges calls the ‘social engagement system’.

Porges says that this social engagement system functions because of connections the more evolved branch of the vagus nerve facilitates between people’s eyes, larynx, muscles of the face that govern expression, and digestive and cardiac activity. Porges says a smile, a melodic tone of voice, a kind facial gesture from someone reassures our ‘nervous systems’ through this vagal activation that we can be at ease, that we are ‘safe’. The theory determines that we can ‘co-regulate’ as humans using these interpersonal feedback loops.

His work is much heralded in ‘alt-bio’ trauma thinking.

Psychiatrist and researcher Bessel van der Kolk says:

The Polyvagal Theory provided us with a more sophisticated understanding of the biology of safety and danger, one based on the subtle interplay between the visceral experiences of our own bodies and the voices and faces of the people around us. It explains why a kind face or a soothing tone of voice can dramatically alter the way we feel. It clarifies why knowing that we are seen and heard by the important people in our lives can make us feel calm and safe, and why being ignored or dismissed can precipitate rage reactions or mental collapse. It helped us understand why attuning with another person can shift us out of disorganized and fearful states. In short, Porges’s theory makes us look beyond the effects of fight or flight and put social relationships front and centre in our understanding of trauma. It also suggested new approaches to healing that focus on strengthening the body’s system for regulating arousal.15

There's no doubt that warm, grounded human connection, mediated by sound, facial expression and the nervous system can have this effect, but the scientific conceptualisation falls short for me for a couple of reasons. It feels to me culture bound to a particular normative *global Northern* lens, and certainly culture bound to a *homocentric* (a *human* focused) one.

Porges talks about visual and oral cues that we give each other through eye contact, smiling and tone of voice, which he says causes co-regulation. He especially focuses on something called prosody (the sonic patterns of stress or intonation in a language, how the voice moves up and down in a range of frequency). But these aren't *universal* human experiences. Different individual people and different cultures speak with different intonation, make different amounts of eye contact, and adhere to different cultural norms around displaying emotion, i.e. these 'cues'.

15. Bessel van der Kolk, 2015. *The Body Keeps Score*, Penguin, p. 78

Smiling lessons #1

To talk about smiling, as a sales technique

An article, *Smiling lessons end service with a scowl in Greenland*, points to the cultural differences there are in terms of facial and verbal communication, and documents an example of the way colonial social etiquette is being imposed as a standard.

'We don't have a tradition of smiling. We don't say hello or goodbye much either', said Leif Louring, president of Greenlandic Co-operative, one of Greenland's largest supermarket chains. But as the service industry becomes more competitive, managers have concluded that sullenness may be losing them business. In an attempt to win custom, they are introducing the smile into their shops, and even 'have a nice day' for good measure. Greenlandic Co-operative is currently sending the 'highest achievers' from its 275-strong staff to Arctic Co-operatives in Winnipeg, Canada, to train in North American service techniques, including pleasantries and smiling.

The instructors say it is not about trying to change an ancient culture, but in supermarkets a smiling shop assistant can encourage customers to return. So far, the training appears to have produced results. At Greenlandic Co-operative, employees are smiling much more than they ever used to, and service standards have improved. But some shop assistants have been unable to adapt to the new happy regime. Some are too shy and others claim the American manner is too chatty, loud and insincere [...]. Mr Louring concedes: 'We allow an employee to smile in his or her own way.'

Not to be left behind, Pisiffik, the main competitor to Greenlandic Co-operative, is also tackling the smiling issue. But instead of sending employees abroad, Pisiffik has made an instruction video on how to smile, which it is showing to staff throughout the chain's 100 stores. In the video, two popular Greenlandic actors demonstrate different types of service: firstly the smiling new style and then the semi-hostile, unhelpful service regularly encountered in Greenland's shops. The employees usually find the video so funny they fall about laughing. 'We're trying to Europeanise the way of doing things,' said Steen MontgomeryAnderson, Pisiffik's chief financial officer.16

To talk about smiling and selling your feelings

The Greenland smiling lessons remind me of the fact that the fast food coffee shop chain Pret A Manger require that their staff sell feelings as part of the job. This selling of emotion is called affective labour.

And it has to be real. 'The authenticity of being happy is important,' [...] 'customers pick up on that.'[...].

To guard against the possibility of Pret workers allowing themselves to behave even for a moment as if they were 'just here for the money', the company maintains a panoptical17 regime of surveillance and assessment. Not only do workers watch each other, chivvying, cajoling, competing, high-fiving; they are also watched. Mystery shoppers visit every branch of Pret A Manger every week. If their reports are positive – more than 80 per cent of them are – the entire staff gets a bonus

16. Lucy Jones, 1999. 'Smiling lessons end service with a scowl in Greenland'. *The Guardian.* Available from: www.theguardian.com/world/1999/oct/23/7 (Accessed 24.01.21)

17. The Panopticon was a surveillance model designed by Jeremy Bentham in the 18th century; a central watchtower in a prison allowed guards to see into every prison cell but didn't allow prisoners to see into the tower so no one knew if they were being watched. that week. Workers cited for 'going the extra mile' get a further £50 in cash, which they have to distribute among their colleagues. But if the mystery shopper happens to be served by someone momentarily off their game, who may be named and shamed in the report, no one gets rewarded. 18

Porges also makes what feel like gender essentialist claims about prosody. He says that higher pitched, modulated female voices create more 'co-regulation'. Porges talks about this concept of female tonality as '*Motherease*'. 'Fathers are good with their dogs', Porges tells us, 'not so good with their kids, because fathers' voices tend to go into lower frequency bands and lose the prosody or the melodic aspects'.19 This feels like it abides by a sexist model where cis women with alleged 'higher frequency voices', are perceived as the ultimate biological caregivers, and as being the axis and containers of emotional support (regulation). Voice pitches vary across genders, and across cultures. Surely *all* timbres of voice have the possibility of being calming, soothing, reassuring, or 'co-regulating' if they are inhabited with a feeling of care and connection. The sound of *any* consistent loving caregiver could soothe an infant. Other vocalisations can also profoundly 'co-regulate', like for example, the low durational, often fairly unmodulated chanting of various monastic traditions. I believe our sense and felt-sense perceptions of authenticity and connection, goes deeper than this particular prescribed notion of pitch and tone. Porges has made computer generated music at the frequency he calls 'Motherease' which is marketed as a therapeutic tool 'designed to reduce stress and auditory sensitivity while enhancing social

18. Paul Myerscough, 2013. 'The Pret Buzz'. *London Review of Books.* Available from: www.lrb.co.uk/the-paper/v35/n01/paul-myerscough/short- cuts (Accessed 24.01.21)

19. Stephen. Porges, 2019. Therapists Uncensored # 93: 'Polyvagal Theory in Action – The Practice of Body Regulation'. *Therapists Uncensored.* Available from: therapistuncensored.com/episodes/tu93-polyvagal-theory-in-action-thepractice-of-body-regulation-with-dr-stephen-porges (Accessed 24.01.2021)

engagement and resilience'.20 Porges' work genuinely feels like it seeks to serve connectivity, and heal trauma and isolation, and feels useful in many ways. There's no question we can co-regulate as humans, but I intuit that it is in more complex ways than his theory proposes. Porges' work is in some ways an example of the way white cis men working in and from a global Northern scientific context can make reductive generalising theories. In this instance there is also yet another example of the way everything, even the essence of something as fundamental as voice tone, can be made into a commodity. Porges' theory places a heavy emphasis on what feels like normative *global Northern* and *gendered* social cues. His focus is also a *homocen- tric* one. It is primarily concerned with human-to-human exchange. While that connectivity21 is fundamental, it feels unsurprising that

– emerging from a dominant culture which is so dislocated from *all* the myriad relations there are in life – this theory doesn't research or reference them. What about the effect of the non-human world through the senses, the colour of dark green pine trees, the movement of cherry blossom, the sound of birdsong, looking up at the night sky, and how that might affect the 'vagus nerve'?

Spring, hearing the Chiff Chaffs' returning repetition clearing the air, the Blackbird calling the coming rain, one lone note down the wire Greenfinch heal you, reset, soon from far off the Cuckoo will soften the landscape again with its two notes like a wooden recorder, high Swifts will be sickling and screeching, screeching the heat to us, we stop, close in the Robin pouring liquid into the air, into us.

20. Ibid.

21. Mirror neurons are proposed to be single neurons in various parts of the brain that are activated when we both act and observe/mirror the same action in other people. Some theorists say they are implicated in how we learn, especially in our capacity to learn language, how we understand and anticipate behaviour in others and in our empathic responses. There is still some controversy over mirror neurons, and a lot of the research has involved hideous testing on monkeys. It is of course also another very reductive conceptualisation of human experience. I mention it in relation to the polyvagal theory only to point to another biomedically framed investigation into how profoundly physiologically interconnected we are.

It feels so important and opens such vast possibility for healing to honour deep human connection *and* consider also a wider sense of re-connection (and belonging). One that honours *all* relationships: animals, plants, the weather, the planets, spirit...

One that hasn't been 'scientifically' theorised about but is evidently profound. I cherish, and am absolutely held, calmed, soothed and grounded by human connection. I know that wider interconnectivity in times of dis-ease or feelings of threat or reactivation, likewise, otherwise and sometimes more so hold, calm, soothe and ground.

We lie, belly to earth, skin to skin

like deep newborn slumber, rest absolute maybe the best sleep I have in months the rutting stags bellowing bovine

and great whales through our dreams

To the ground, gratitude

have the ground sleep you, restore you

until the sunrise comes to bless the hillsides again

I am beating the bounds22

to know what lies to the north, east, south, west

fostering relationship with land, with space with distance

visitations, to tread and retread gaining perspective

know you lime lichen covered birch tree know you, shiny magpie

know you, red volcanic rock know you grey mist I know you

released from bound cognition, wide into the whole soul of the world

knowing the water courses the rises in the land

where the tide goes out and comes in

22. Beating the bounds is an ancient tradition in areas of the UK, continuing in some places today, where a community walks the boundaries of a parish to share the knowledge of where they lie and to pray for protection and blessings for the lands.

seeing back to where you have been feeling the surround frame to wherever home is –

Put a pin in the map draw a circle

an eight mile radius

and come to know all its inhabitants in every season

You step out to step in

make small pilgrimages again and again travels that become mind maps

and compass

'Walk as if you are kissing the Earth with your feet.'23

23. Thich Nhat Hanh, 1991. *Peace Is Every Step: The Path of Mindfulness in Everyday Life*, Rider

Sitting by the same tree, sitting at the same bit of water Every day

Every day for a week or a month, or a year Observing

*Nothing mo*re

Let us sit down here, all of us, on the open prairie, where we can't see a highway or a fence. Let's have no blankets to sit on, but feel the ground with our bodies, the earth, the yielding shrubs. Let's have the grass for a mattress, experiencing its sharpness and softness. Let us become like stones, plants, and trees. Let us be animals, think and feel like animals.

Listen to the air. You can hear it, feel it, smell it, taste it. *Woniya waken* – the holy air – which renews by all its breath. *Woniya, woniya waken* – spirit, life, breath, renewal – it means all that. *Woniya* – we sit together, don't touch, but something is there; we feel it between us, as a presence. A good way to start thinking about nature, talk about it. Rather talk to it, talk to the rivers, to the lakes, to the winds as to our relatives.24

You climb the rise make the slow 360
turn
take it all in
this is where you are you belong here longing and belonging

... most of all after hours of steady walking, with the long rhythm of motion sustained until motion is felt, not merely known by the brain, as the 'still centre' of being [...]. Walking thus, hour after hour, the senses keyed, one walks the flesh transparent. But no metaphor, *transparent*, or *light as air*, is adequate. The body is not made negligible, but paramount. Flesh is not annihilated but fulfilled. One is not bodiless but essential body. It is therefore when the body is keyed to its highest potential and controlled to a profound harmony deepening into something that resembles trance, that I discover most nearly what it is *to be*. I have walked out of the body and into the mountain.25

The language of 'safety'

In trauma theory there is often talk of the concept of 'safety'; that we might aspire to feelings of safety, and return to feelings of safety after an experience of threat. One of Porges' books has the title *The Pocket Guide to the Polyvagal Theory: The Transformative Power of Feeling Safe*. Of course feelings of ease, peace, connection, joy are life affirming and aspired to for everyone, and after a particular threat the ideal to return to a sense of safety seems self-evident. Frustratingly the *concept* of safety, as it is used in this way, can lack a breadth of analysis. It begs the question *who* defines what *safety* is? Many peoples' lives are *constantly* under threat: working class people living in poverty, people of colour living in structural racism, people in prison, trans women, etc. Safety is experienced in different ways and for different durations by different people. Just talking about safety as a blanket concept can deflect away from this reality.

Trauma theorists and therapists speak about the way people's bodies have responded to trauma. Porges for example says: 'their body has done something to protect them from something in their

25. Nan Shepherd, 2011. *The Living Mountain*, Canongate Books Ltd, p.106 lives, and the real issue is are those features still in their worlds, so in a sense [...] are they living a life that's filled with *faulty neurocep- tion* [emphasis added]'.26

This narrative about trauma imprints, and responses occurring because of historical trauma that is now no longer needed, underpins lots of the treatment approaches. Some of these approaches focus on reestablishing a felt sense of safety and not responding to situations *now*, with patterning that might have been learned or useful in the past. It's true that some experiences of trauma *are* in the past, they have happened and are over, and we no longer need to deal with them or respond with the same coping mechanisms. Porges says:

...we can be mobilised, we can fight, and at various, unfortunate times we can shut down and disappear, but we have to now restructure the narrative and see these adaptive reactions as life saving or protecting us, and not see it that something's wrong with us, we can say that our bodies got into this state to save us, but it's not so easy for our bodies to get out of those states [...] can we in a way *convince* our body that the *world's safe enough*, and that's what therapy, that's what relationships are [...] *the neural exercises that enable the body not to go into states of defence* [emphasis added].27

In many cases this *is* relevant, and with support we can look to alter trauma patternings because the wounding that caused them initially *is* no longer present. But what

does this mean for the fact that many of the wounding conditions still exist/continue, from brutal transphobia, to relentless racialised aggressions and microaggressions, to the violence of everyday life under a profit-driven, dehumanising economic system?

26. Stephen. Porges, 2019. Therapists Uncensored # 93: ‘Polyvagal Theory in Action – The Practice of Body Regulation’. *Therapists Uncensored.* Available from: therapistuncensored.com/episodes/tu93-polyvagal-theory-in-action-thepractice-of-body-regulation-with-dr-stephen-porges (Accessed 24.01.2021)

27. Ibid.

To really address the realities of healing trauma and knowing safety, we need an explicitly integrated approach. One where we can make incredible healing practices available and accessible (massage, movement, counselling, plant medicine, ritual, etc.) *and* transform destructive social systems. But this is rarely fore fronted, or explicitly articulated in mainstream trauma theory. Neuroscience lingers its fascination and gaze on inner neural workings, and at interpersonal ‘co-regulation’, and a state of ‘safety’ we are supposed to be able to personally inhabit. There often only seems to be reference sideways or as an afterthought to the surrounding contexts that may be profoundly unsafe.

Alt bio trauma theory can mirror dominant narratives about ‘safety’. From the onset of the Coronavirus pandemic for example, it was spoken about as if we had moved from ‘safety’ into a time that was ‘suddenly unsafe’. But capitalism and racism weren’t a safe place that was disrupted, and that we might hope to return to. It’s essential we are clear about what safety really needs to look like for everyone, and move towards that in our healing.

The rhetoric of ‘resilience’

Resilience is such a beautiful term. It references capacity, power, joy, resourcefulness, strength, care and more. It is for sure something to build and share. Unsurprisingly it has been hijacked by neoliberalism which can encourage developing a kind of resilience that gives people strength to continue to function, or function better in conditions that are brutalising. This neoliberal framing of resilience doesn’t encourage all the beautiful aspects of resilience *whilst* transforming our social conditions, together. Below are some critical voices speaking about resilience that I’ve found important.

In an essay *Resilience in psychology: A critical analysis of the con- cept*, scholar Silke Schwarz writes:

In line with the neoliberal paradigm, public health focuses on how individuals can become resilient and maintain their resilience. Timimi (2017) uses the term ‘commodification’ in order to describe a process by which goods, ideas, etc. are instilled with a commercial value that can be sold and bought. Resilience and mental health may be considered as commodities in a neoliberal culture. Buying or having these things promises a better life.

It lies within the responsibility of the individual to take on an attitude and behave in ways that are influential and lead to satisfactory performance. It links with Western over-emphasis on person-centred constructs and on a goalbased human nature linked to ideas of self-regulation, conscious control over agency, and rational calculation. In Europe, an autonomous, independent self that aims at individual enhancements and the conquest of new domains is highly valued. The person is considered to be in charge of his or her life course.

According to Kirmayer et al. (2011), communities strengthen resilience through political activism and empowerment. If active engagement is successful, this not only brings material gains but enhances the collective as well as individual self-esteem, which in turn is associated with better communal as well as person-centred mental health. 28

28. Silke Schwarz, 2018. ‘Resilience in psychology: A critical analysis of the concept’. *Theory and Psychology.* Available from: journals.sagepub.com/doi/ abs/10.1177/ 0959354318783584 (Accessed 24.01.2021)

In an article, *The conservative turn in person-centered therapy*, psychotherapist Manu Bazzano illustrates the way ideas about resilience have been co-opted into both military and international economic arenas. He writes:

The Comprehensive Soldier Fitness program, established in 2009, was aimed at 'creating more resilient soldiers by helping them with the necessary psychological adjustments'. To this purpose, Seligman devised a method for measuring resilience, the Global Assessment Tool. One of the results of his efforts was that 'in 2010, the University of Pennsylvania's Positive Psychology Center (founded by Seligman) was awarded a $31 million contract by the Department Of Defense'. The notion of resilience was met with great enthusiasm by other psychologists who came up with creative variations on the theme. Professor Michael Matthews promptly supplied the notion of 'adaptive killing': a set of cognitive and behavioral techniques 'focus[ed] on eliminating irrational thoughts and beliefs [...] on changing a soldier's belief structure regarding killing'. As he sees it, 'these interventions could be integrated into immersive simulations to promote the conviction that adaptive killing is permissible' (Matthews, 2014, p. 187).

Bazzano continues:

Resilience has effectively become a new fetish in contemporary psychology useful in fostering the neoliberal agenda at a time of heightened security and financial austerity. Unsurprisingly, it has found applications in several areas. The International Monetary Fund's website has over 2000 documents discussing the topic and similar emphasis is found within the World Bank (which has created a 'Social Resilience' group) and the World Economic Forum with its focus on 'systemic financial resilience'.29

29. Manu Bazzano, 2016. 'The conservative turn in person-centered therapy' in *Person-Centered and Experiential Psychotherapies* 15(4):1–17

In her essay *As the world becomes trauma–informed, work to do*, Kathryn A. Becker-Blease also concludes:

Just as Dr. King vowed to remain 'creatively maladjusted' rather than numb as long there was discrimination, bigotry, income inequality, militarism, and violence, so might everyone reject those trauma-informed practices that leave individuals well adjusted but inactive in the face of oppression and trauma of all kinds while the individuals and systems that give rise to trauma and oppression operate as usual.30

I am interested in other ways of languaging and relating to experience that can move us towards deeper interconnectivity, and in the social change that is needed for that to be more possible.

Mindfulness

Trauma theory suggests many useful embodied practices to address and heal trauma and support wellbeing including touch, movement, meditation, etc. These practices can however often be co-opted by global Northern culture into propping up the situations and systems that are oppressive and traumatising. Mindfulness can be used this way.

On the NHS website page about Mindfulness, Professor Mark Williams, former director of the Oxford Mindfulness Centre is quoted as saying:

It's easy to stop noticing the world around us. It's also easy to lose touch with the way our bodies are feeling and to end up living 'in our heads' – caught up in our thoughts without stopping to notice how those thoughts are driving our emotions and behaviour [...]. An important part of mindfulness is reconnecting with our bodies and the sensations they experience. This means waking up to the sights, sounds, smells and tastes of the present moment. That might be something as simple as the feel of a banister as we walk upstairs.

Another important part of mindfulness,' he says, 'is an awareness of our thoughts and feelings as they happen moment to moment. It's about allowing ourselves to see the present moment clearly. *When we do that, it can positively change the way we see ourselves and our lives* (emphasis added).31

A friend commented on the value placed on *presence*, as offered in this global Northern version of Mindfulness, which has simultaneously a strange contextually blind focus on time. While presence is powerful, what about relationships to presence that also honour what has come before and will follow, like the Haudenosaunee (the North American Indigenous Tribal Confederacy), who hold an awareness of seven future generations in terms of decisions and choices that are being made. The 'present moment' does not need to be divorced from other consciousness of time that can anchor and ground us. A workshop participant also spoke about the way this current global Northern Mindfulness practice is cultural appropriation of ancient Buddhist practice, which has been taken out of context, and stripped of its profound spiritual meaning and intent.

Practices that can ground, connect and bring us into awareness are useful and can be such essential and powerful ways to support/alleviate distress, as well as to simply hold us *being* in the world. But practices like Mindfulness can be depoliticising and derail political focus on social change that is needed to not just 'change the way we see ourselves and our lives', but actually change the world. Publicity for a book called McMindfulness by Ronald Purser speaks about the way:

Mindfulness is now all the rage. From celebrity endorsements to monks, neuroscientists and meditation coaches rubbing shoulders with CEOs at the World Economic

Forum in Davos, it is clear that mindfulness has gone mainstream. Some have even called it a revolution.

But what if, instead of changing the world, mindfulness has become a banal form of capitalist spirituality that mindlessly avoids social and political transformation, reinforcing the neoliberal status quo?

[...] corporations, schools, governments and the military have co-opted it as a technique for social control and self-pacification. A lively and razor-sharp critique, Purser busts the myths its salesmen rely on, challenging the narrative that stress is self-imposed and mindfulness is the cure-all.32

Mindfulness and Its Discontents: Education, Self, and Social Transformation by David Forbes offers further perspectives:

Mindfulness, a way to alleviate suffering by realizing the impermanence of the self and our interdependence with others, has been severed from its Buddhist roots. In the late-stage-capitalist, neoliberal, solipsistic West, it becomes McMindfulness, a practice that instead shores up the privatized self, and is corporatized and repackaged as a strategy to cope with our stressful society through an emphasis on self-responsibility and self-promotion.

32. Ronald Purser, 2019. *McMindfulness*, Repeater Books, promotional text

Rather than a way to promote human development and social justice, McMindfulness covertly reinforces neoliberalism and capitalism, the very self-promoting systems that worsen our suffering. [...] education curricula across North America employ mindfulness: to help students learn to succeed in a neoliberal society by enhancing the ego through emphasizing individualistic skills and the selfregulation of anger and stress. [...] mindfulness educators instead should uncover and resist the sources of stress and distress that stem from an inequitable, racist, individualistic, market-based (neoliberal) society, and show how school mindfulness programs can help bring about a society that is more transformative, compassionate and just.33

Mindfulness has been co-opted by corporations, like Tesco where it props up unjust divisions of and repetitive labour. '...the session was wonderful. When I came back I went straight into a 1–1 and my manager could really notice the difference in my mood.'34

Similarly practices like Transcendental Meditation, which of course *can* be used in a radical and genuinely powerful way, have been co-opted. TM was given lots of US government funding because it can be easily assimilated into the culture. In her book *New Age and Armageddon*, Monica Sjoo writes:

It is no surprise that the US government has funded Transcendental Meditation (TM) teachings and research programmes [...]. Transcendental Meditation functions as a non chemical tranquilliser to 'cool out' 'anti-social behaviour', and is used by both those who make the laws

33. David Forbes, 2021. *Mindfulness and Its Discontents: Education, Self, and Social Transformation.* Fernwood Publishing Co Ltd, promotional text

34. The moment is now, no date. *In-house mindfulness session attendees, Tesco Bank*. Available from: www.momentisnow.co.uk/become-mindful/ mindfulness-workplace (Accessed 24.01.2021) as well as those who are punished by them. TM helps to make us placidly accept the iron bars of our lives and keeps people 'out of trouble'. It pacifies inmates of prisons and 'self-actualises' workers to become more committed to the company they work for.35

I'm inspired by the ways it's possible to engage with groundedness, deep connection and access feelings of relative ease through embodied practices which are not appropriated, and do so while we also apply critical (as in *critique* and as in *necessary*) analysis of our conditions. That we can combine both, to connect to, nourish, to reconfigure the way power functions, and transform oppression and injustice.

Addressing and resolving trauma in the bodymind

Alt-bio trauma theory acknowledges the way trauma can be held in the bodymind (for example in the muscles and somatic habits). It observes that resolving trauma requires it be *released* and/ or *resolved* in *embodied* ways. Following trauma, the bodymind typically releases shock to re/connect to and foster a sense of ease/safety/connection and feelings of rest. Peter Levine in his book *Waking the Tiger: Healing Trauma – The Innate Capacity to Transform Overwhelming Experiences* has been a primary global Northern voice, putting forward some of this theory based on his observation of animals who can be seen to 'shake' trauma out of their bodies after being under threat. He says that we need to find ways to somatically *release* trauma from the body, and in some cases come into the felt sense of the body again which we may have become dissociated from as a coping mechanism.

35. Monica Sjoo, 1992. *New Age and Armageddon*, The Women's Press Ltd, p.41

As mentioned in the 'language of safety', conceptualising trauma as 'historical' and 'resolvable' can be problematic. Not only do racism and capitalism mean that threat remains as a surround frame, but the experience of single incidents of trauma may anyway be something to negotiate (with strength and capacity) for a lifetime, and are also not necessarily 'resolvable'. Resolving trauma can't be oversimplified. Below looks at some practices and approaches that can support both negotiating and resolving and healing trauma.

There are various somatic approaches which encourage release, or reconnection to grounded relative ease in the body including specialist practices, again from within a global Northern context. Trauma Releasing Exercises (TRE) for example, are a set of simple positions/holds that micro-stress muscle groups, and encourage a gentle, sometimes stronger tremoring which can release tension, fear, anger and other emotion that is held in the body, or that the body remembers.

The Psoas muscle is a strong muscle in the centre of the body that connects the lumbar spine to the pelvis and provides core stability in the body. It is especially activated when we are in fight-or-flight (related to a capacity to run/flee) and release in the Psoas following trauma is understood to be especially profound.

Release can happen generally in the body (and specifically in the Psoas) in many ways through movement, shaking, crying, laughing, trembling etc. Breathwork, the practice of controlled and sometimes very dynamic breathing can engender similar release and reconnection.

The term *pandiculation* means the stretching and extending of the torso and extremities in the way animals do. We often do it
when we wake up or if we are fatigued or under pressure, and it's often accompanied by yawning. These physical actions are useful in terms of opening and releasing the body.

Pandiculated movement is said to be our innate way to prepare the nervous system/ body for action. It is nature's way of resetting the body mind and equipping us for movement. We 'remind' our muscles that they don't have to stay in one constricted state, it sends internal signals to improve proprioception (how we sense ourselves) and re-sets the signals that tell us our muscle length. Instead of staying short and contracted we can stretch and elongate.

Observe your cat. You may have noticed that the first thing it does as it wakes is stretch, arch the back, lengthen their legs, elongate the neck. Instead of going to the gym your cat will automatically do this type of movement up to 40 times a day and correspondingly its body will be ready to leap up onto a high wall without friction or effort.36

Alongside practices that enable general physical release of stored trauma like TRE (above) or breathwork (see online re-sources), there are others that support working intentionally with particular unresolved trauma. Somatic Experiencing is one such therapeutic approach. In Somatic Experiencing, gestures and movements can be explored (like pushing unwanted aggression or threat *away* from the body), which allows the body to enact an embodied response that may not have been possible at the time of a trauma occurring.

36. Kate Munden, 2019. 'More than just stretching...' Available from: katemunden.com/advanced-tre-more-than-just-stretching (Accessed 24.01.2021)

It can be a powerful way of resolving the threat response cycle in a very felt sense, by employing appropriate and empowering embodiments which can speak to trauma by establishing new imprints in the bodymindsoul.

Overwhelm and underwhelm

Trauma responses of overwhelm or underwhelm; feelings of for example deep fear or of numbness, can be reactivated when working therapeutically with trauma. There is an acknowledgement in the field of traumatology that it can be wise to be slow and gentle, so as not to reactivate or re-inhabit those places again. Gwynnie Hale, a trauma informed herbalist in the US, also points to the fact that for people holding trauma, or what she languages as 'neuro-emotional dysregulation [...] beginning to come into the present means feeling all the things that we have been protected from through the dysregulation, thus, there are often further signs of dysregulation and/or struggle that make themselves apparent'.37 If there are strong feelings of fear, triggering, or emotional flashbacks, where there is overwhelming feeling, or hyper-arousal, it's often suggested to look to grounding or self-soothing practices. Self-soothing will look different for each of us: Being held. Being alone. Watching films. Eating grounding food. Eating junk food. Journaling. Connecting with nature. Grounding embodied practices, etc. Self-soothing here is simply defined as things that can make us feel better, and they can be things that might not immediately be *the best things* for us, sometimes they are just how we can cope in that moment. It's important not to *judge* self-soothing measures as not being 'good enough'. At times it's also important to honour that just temporary distraction or consumption works to help bring us into a place of greater ease or capacity. We might have ways of self-soothing that will *do for now*, and we can find others

37. Trauma workshop notes by herbalist Gwynnie Hale

we prefer or that support our health more, in the longer term. If the way we self-soothe causes harm, or doesn't feel life affirming, then, in moments where we are *not* in overwhelm we could look to support ourselves/each other to explore other self-soothing practices that we might feel able to turn to next time we need to.

Working with trauma can also reactivate feelings of hypo-arousal or what you could call underwhelm. This can be experienced or expressed as feelings of frozenness, numbness, dissociation, etc. In this case it can be useful to engage the body through movement, either gently moving the body, or dynamic movement or exercise, or connect to music, creativity, to use our senses, be outside in nature, have physical contact, etc., to tend to those feelings.

I've found some of somatic psychologist Pat Ogden's work called Sensorimotor Psychotherapy (SP) useful for taking care of overwhelm. Ogden's somatics has various approaches. I mention one she suggests in particular to support staying within what has been called a person's *window of tolerance*, a term coined by psych/ iatrist and

Mindfulness educator Dan Siegel to describe staying within what feels like an 'optimal arousal zone' and avoiding going into hyperor hypo arousal. Ogden encourages observing body *sensations* as opposed to emotions as a way to stay present, but avoid overwhelm. Sensorimotor Psychotherapy speaks about turning attention to sensation and disregarding emotion until arousal has subsided. We can come into the felt sense: i.e the *feeling of shak- iness, tightness, dullness*, etc., as opposed to evaluating or assessing it emotionally, i.e. *I feel scared, sad*, etc. That invitation can be really useful in many instances to be able to stay with feelings but help avoid tipping into overwhelm caused by the impact of woundings, when processing trauma. Ogden explains:

SP uses a three-phase treatment approach to gently guide the client through the therapeutic process – Safety and Stabilization, Processing, and Integration [...]. It is thought that SP strengthens instinctual capacities for survival and assists clients to reinstate or develop resources which were unavailable or missing at the time the trauma or wounding occurred. Once resources are developed and in place, the traumatic event can be processed with the aid of resources.38

In *Trauma and Recovery*, Judith Herman speaks about three steps of recovery which include the need to:

38. Sensorimotorpsychotherapy website homepage, no date. Available from: sensorimotorpsychotherapy.org/about (Accessed 24.01.2021)

1. foster feelings of *safety*, go through a process of

2. *remembrance and mourning*, expanding the capacity to *be with* difficult feelings and memories and grieve/ process them, and then

3. move towards *re/connection* in life.

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She acknowledges how this process might not be *linear*, it might be more of a *spiral.* A process in which you might return to or revisit steps (i.e. need to foster feelings of safety again, or return to mourn and remember), but each time from a place of greater insight and capacity, or 'from a higher level of integration'.39

I've found all of the above incredibly useful. At the same time you could say this approach, like everything else, is culture bound. There can be a sort of 'management' of the body, attention and emotions that is often highly individuated, i.e. you managing your emotions, on your own, at best with one other person therapeutically supporting you. Alt-bio theory also speaks of the bodymind but not the bodymindsoul. Many cultures' traditional practices involve communally supported spaces to *actively* encounter intensity, what might get experienced as a kind of supported and spiritually contextualised 'overwhelm', as a way to connect, or engage, to clear or heal imbalance, disturbance and/or distress.

In *Decolonising Trauma Work*, Renee Linklater cites Native scholars Duran & Duran who observe how

'in Native American healing the factor that is of importance is intensity, not passage of time'. My Cree friend, Lloyd Martin, concurs with these thoughts and expresses 'that is the reason for all the effort, the drumming, the rattling' [...] Indigenous healing ceremonies often incite a powerful presence of spiritual

39. Judith Lewis Herman citing therapist S. SgroI, 1992. *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*, BasicBooks, p.155

activity that is generated to provoke healing in the person requiring assistance.40

Additionally Yvon Lamarche, a Métis person with an Anishinaabe background and Wendat, Scottish and French ancestry, and a registered nurse with a postgraduate training in psychiatric nursing, also points to the *multiplicity* of ways to heal, some of which involve physicality and intensity: He points out that: It is important for people to have access to skills, to be able to grieve in a healthy way "through song, through ceremony, through the seven natural ways of healing: talking, sweating, yawning, sighing, crying, shaking and laughing".'41

Maybe it's about knowing *what* is useful *when*? Maybe it's about being well held either way by *others*, in feelings of gentle inquiry and safety that don't take us too far into distress, or being supported by the human and beyond human so we can go deep into emotion/energy and it be transformed? I know I have appreciated the power of really carefully and sensitively being supported to feel my emotions and not feel overwhelmed, *and* the power of quite deep catharsis through for example, creativity, bodywork and/or spiritual practice. Like bringing the soul home in a solitary context and/or in communal space.

Dance dance this Exhausted.
More alive than I have ever felt Twist and turn.
Belie your deathly discipline Stay up for the dawn
More alive than I have ever felt Stronger than ever

40. Renee Linklater, 2014. *Decolonising Trauma Work*, Fernwood Publishing Ltd, p.30

Exhausted
More alive than I have ever felt Stronger than ever
I settle into the body
Learning anew how to settle into the body Feel the body now
Breathe the bones
Sitting at the centre of the circle

I'm interested in how we can access processes of being both gently supported, *and* dynamically transformed. Both approaches, avoiding activating overwhelm that we don't have the capacity to hold or process, *and* actively seeking intensity for connection or transformation, seem to be coherent responses. I think both approaches can and need to inform our explorations, choices and intuitions at any given time, for ways to engage with and tend to woundings/trauma.

It puts me in mind of a couple of things. Firstly of reading about an experience of cold water swimming in Orkney Scotland, done in part to process loss, grief and change. In her book *Swimming with Seals*, Victoria Whitworth speaks about the healing intensity of that encounter.

The second time I put my head under the water it is just as cold, just as shocking. I surface and gasp, perfectly timed for a rogue wavelet to smack me in the face, dousing eyes, nose and mouth with brine. My sinuses flood, and I choke and splutter, very glad I am still close to shore, only just out of my depth. The physiological response to sudden immersion in cold water is very like that of a panic attack, in which your heart pounds, your breath shortens, you are hyper-aware of perceived threat. There are doctors who recommend cold water swimming as a therapy for patients who present with depression or anxiety. Replicating symptoms of a panic attack in cold water is a valuable step towards taking back control [...]

[...] my system is coursing with joy, crackling with energy. I feel every little electrical jolt as my nerves high-five across the synapses. The cold-water plunge brings me so close to the pleasure/pain boundary that my body reacts with the painkillers it keeps stowed away for crisis: dopamine, serotonin, endorphins. [...] the word that comes to mind for this sensation is *Jouissance*. Enjoyment, joy, rapture, orgasm. [...] It gets left in French because there is no English word that takes pleasure so close to the edge of the unbearable.42

Intense sensation can itself lead to being overwhelmed and sinking into oblivion, sensation so powerful that it shorts out, like a shock. *Oblivion* is a fascinating word: its disputed etymology may come from *lividus*, giving us dark, blue-black memory, one that has sunk into night [...]. I think of sinking down through the layers of the sea [...]. Cold water swimming is the obliteration of the self [...]. This very annihilation is addictive [...]. In the water there is only *Now*.43

Secondly is the inspiration I found in Bob Flanagan's life and work. Flanagan was an American performance artist, comic, poet and writer who explored deep intensities of BDSM practice (bondage, discipline, domination, submission, sadism and masochism), in part as a way to live with and negotiate his experience of cystic fibrosis. Some of the practices problematically appropriate from Indigenous culture – for example the BDSM practice of piercing flesh and hanging in pierced suspension, which appropriates from the various North American, First Nations' complex four-day ritual, the Sun Dance. While I am critical of that, I mention Flanagan because of the way he immersed in intensity as a place of power, healing, refusal, determination, and transformation.

Excerpts from Flanagan's poem *Why?*

42. Victoria Whitworth, 2017. *Swimming with Seals*, Head of Zeus, p.199

43. Ibid. p.91

Because it feels good; because it gives me an erection; because it makes me come; because I'm sick; because there was so much sickness; because I say fuck the sickness; because I like the attention; because I was alone a lot; because I was different; because kids beat me up on the way to school; because I was humiliated by nuns; because of

Christ and the crucifixion; [...] because my parents loved me even more when I was suffering; because I was born into a world of suffering; because surrender is sweet; because I'm attracted to it; because I'm addicted to it; because endorphins in the brain are like a natural kind of heroin; because I learned to take my medicine; because I was a big boy for taking it; because I can take it like a man; because, as someone once said, he's got more balls than I do; because it is an act of courage; because it does take guts; because I'm proud of it; because I can't climb mountains; because I'm terrible at sports; because no pain, no gain; because spare the rod and spoil the child;

BECAUSE YOU ALWAYS HURT THE ONE YOU LOVE.44

44. Excerpts from Bob Flanagan, 1985. *Why?* featured in the 1997 documentary film *Sick: The Life and Death of Bob Flanagan, Supermasochist*, 1997, directed by Kirby Dick

Trauma and Recovery

In Herman's work she describes the *breadth* of what *recovery* or *reconnection* can mean. She writes:

The best indices of resolution are the survivor's restored capacity to take pleasure in her life and to engage fully in relationships with others. She has become more interested in the present and the future than in the past, more apt to approach the world with praise and awe than with fear.45

However Herman doesn't stop there. She writes that the first principle of recovery is the empowerment of the survivor, and comments on how recovery can also involve having agency to act upon the world to address and change the conditions that *cause* trauma. In this sense her focus is not individuated, she is explicitly concerned with tending not just to the *wound*, but to preventing the acts and institutions that are *(the) wounding*.

Herman writes, while most survivors seek the resolution of their traumatic experience within the confines of their personal lives [...] a significant minority, as a result of the trauma, feel called upon to engage in a wider world. These survivors recognise a political or religious dimension in their misfortune and discover that they can transform the meaning of their personal tragedy by making it the basis for social action.46

Herman shares with us the historical example of Anna O., who was one of the physician Breuer's 'patients' that he studied whilst theorising about 'hysteria'. Herman writes:

45. Judith Lewis Herman, 1992. *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*, BasicBooks, p.212

After Breuer abandoned her, she apparently remained ill for several years. And then she recovered. The mute hysteric who had invented the 'talking cure' found her voice, and her sanity, in the women's liberation movement. Under a pseudonym, Paul Berthold, she translated into German the classic treatise by Mary Wollstonecroft, *A Vindication of the Rights of Women*, and authored a play *Women's Rights*. Under her own name, Bertha Pappenheim became a prominent feminist social worker, intellectual, and organiser.47

If we were all *encouraged* to transform the meaning of tragedy into the 'basis for social action' (and if we weren't so atomised tending to what gets called 'personal' trauma), I imagine there would be great mobilisation to explore deeper collective models of healing together. I imagine also that trauma theory and practitioners would also all be more *explicitly* concerned with healing embodied trauma as it entirely *interrelates* with social justice.

Judith Herman's work around trauma in the early 1990s was groundbreaking and radical in approach in the global North. On the back cover of Herman's book we are told, 'This is a book about restoring connections: between the public and private worlds, between the individual and community', that 'proposes a groundbreaking recovery programme which favours a process of re-integration to one of catharsis'. Herman worked closely with other scholars and researchers in the field, notably Bessel van der Kolk, author of *The Body Keeps the Score*. It seems significant to me that van der Kolk's book, in the current sea of trauma (self-help) advice has gained such popularity. While I think it is a really useful, insightful, caring and concerned book, he is a white global Northern cis male putting the weight of 'science' (thus being validated in dominant cultural terms) behind his inquiry. The framing of his attention throughout most of the book also leans towards individuated therapeutic treatments, which fit in with more of an individuated cultural status quo.

The cover of van der Kolk's book in comparison to Judith Herman's tells us, 'Here one of the *world's experts* [emphasis added] on traumatic stress offers a bold new paradigm for treatment, moving away from the standard talking therapies toward an alternative approach that heals mind, brain, body.' It feels unsurprising under imperial patriarchy that van der Kolk is promoted as one of the 'world's experts'. And that under neoliberalism his bestseller forefronts individual recovery even though he speaks of the contexts that trauma occurs within.

In his book, van der Kolk explains current trauma theory based on his experience of investigating it through a focus on brain development, physiology and function. An early chapter speaks about *Looking into the Brain: The Neuroscience Revolution*. While he fully addresses the need for embodied therapeutic approaches like mindfulness, yoga, etc. a very strong locus of attention for therapeutic intervention and transformation is in the individual body and in the brain.

He tells us about brain function; that the amygdala (a part of what gets called the 'older brain', the limbic system) functions as the 'smoke alarm'; warning and activating us very quickly – before we are conscious of it – of potential threat. He speaks of the prefrontal cortex, (a part of what gets called the 'newer brain', the neocortex) functioning as the 'watchtower'; having overview, discernment, and deciding about the *actual* nature/context of the threat which then mediates appropriate embodied responses.

Trauma can present as an over activation of the amygdala (because of previous danger we have experienced that has left us with a higher habituated threat response). It can also be a disorientation between the amygdala and nearby hippocampus (which locates memory in time) around *when* a threat has occurred, meaning that a high level of threat from a past incident can be perceived as if occurring (triggered) in the present moment. It can also be an imbalance between the amygdala and physiology it activates, and the ability of the prefrontal cortex to mediate that activation. This might point to a need for someone to foster more capacity to have overview and

intervene in physiological threat responses as they get activated, and to do this both cognitively; through being able to pause and assess and use thought processes and self speak, and somatically; by working in and through the body with the breath (slowing it down) and touch, sound, movement and connection with others to release/ shift through a threat response, and feel grounded and steady in the body in the present.

Van der Kolk's book, though using various embodied therapeutic approaches, is heavily focused on a sense of individual 'rewiring' of the brain (a later chapter title speaks about *Rewiring the Brain: Neurofeedback*). He talks about neuroplasticity: the capacity, in neuroscientific terms, to change pathways in the brain which in turn reconfigure our responses and behaviours.

Neuroplasticity

Neuroplasticity is the ability of the brain to change continuously throughout an individual's life. Brain activity associated with a particular task function can be transferred to a different location, for example if that brain area is damaged. Neuron synapses – neural pathways in the brain – can be strengthened or weakened depending on our daily activity.

The idea that the brain and its function are not fixed throughout adulthood was proposed in 1890 by William James in *The Principles of Psychology*, though the idea was largely neglected. He was the first person to be credited with using the term plasticity. The term neuroplasticity was coined by the Polish neurophysiologist Jerzy Konorski (1903–1973), whose work built on the work of Russian physiologist Ivan Pavlov around conditioning responses (i.e. Pavlov's dogs). So while it is a relatively new field of scientific research, the ideas have been around for a while.

Neuroplasticity affirms change is *possible*. It speaks to the potential of liberatory transformation, albeit on reductive neural terms, following trauma. That we can renew and restore as described, at this neural level (even though that isn't the *only* place that we renew and restore). This location of change being situated in *individual* brain patternings however does two things. It over-emphasises the *brain*, reiterating a perception of it as being the 'control centre'. In actual fact we can reshape following trauma through the tone and use of muscles, through posture, the depth of our breathing etc., and this is where we might much more markedly *feel* the effects of healing. It also over-emphasises the *individual* as the *site of change*.

On positivepsychology.com for example, we are given a very particular narrative about neural plasticity. The website claims: 'Those billions of pathways in your brain light up every time you think, feel, or do something. So if you want new habits to become ingrained in your daily life, then it is a matter of building and strengthening certain pathways while not reinforcing others.'

This is just another example of individuating healing or 'cure'. Yes, changing habits and patterns can occur in a profound way at a personal level. But what about the effect of *context* on *how* habits become 'ingrained in daily life'? We develop habits (and associated neural pathways) often in response to oppressive systems. If they weren't impacting on us, our habits (and neural territory) would *necessarily* be different. If for example, we weren't schooled to be competitive and awarded worth through achievement, then our habits, our neural pathways that 'light up', wouldn't be ingrained around prescribed standards of 'success' or 'failure'. If we want 'new habits' then I think it is also a 'matter of building and strengthening' a more just, life-affirming so-

cial frame, so that our habits and consequently our neural pathways are shaped by, and reflect that.

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For all the wealth of tools and insight in van der Kolk's book, it is, tucked away in the back pages of the Epilogue, that he says:

When I give presentations on trauma and trauma treatment, participants sometimes ask me to leave out the politics and confine myself to talking about neuroscience and therapy. I wish I could separate trauma from politics, but as long as we continue to live in denial and treat only trauma while ignoring its origins, we are bound to fail.48

I wish this could be named more *explicitly* in the field of trauma theory, and stated in *introductions* and explicitly *woven through* the work. Van der Kolk goes on to name social change that would support health and mitigate trauma to some extent, but there is still a lack of critique of economic and power structures that underpin a lot of the inequality that he describes.

In his closing paragraphs, where he does refer to trauma as having the potential to be a mobilising source for social change, he iterates a lack of analysis by uncritically holding up as inspiration a mainstream neoliberal voice. He writes, 'Most instigators of social change have intimate personal knowledge of trauma. Oprah Winfrey comes to mind.'49 While Oprah comes from the hardship of a childhood in poverty, and the experience of oppression as a black woman living in structural racism in America, her story complies with the American dream of rags to riches and doesn't put its weight behind challenging the disparity of current economic systems. Oprah's wealth amounts to a net worth of 2.7 billion dollars.

48. Bessel van der Kolk, 2015. *The Body Keeps the Score*, Penguin, p.348

49. Ibid. p.356

Cultural Icon for the Neoliberal Era

While there is a whole catalogue of neoliberal celebrities offering self-help, Oprah stands out as an immensely influential one. The introduction to an interview with Janice Peck, author of *The Age of Oprah, Cultural Icon for the Neoliberal Era,* on *The Black Agenda Report* says:

If you work hard enough, if you prepare long enough, if you visualise astutely and pray on it resolutely, it really can happen for you. At least that's the way it works in the world of Oprah Winfrey. In the Age of Oprah [...] there's no such thing as collective problem-solving; there are only individual, market-driven and spirit-centered solutions. Water polluted? Buy it bottled. Dissatisfied with your kids' school? Find a private one or homeschool. Dead-end job with no respect and no benefits? Polish that resume and assume an attitude of gratitude, or get ready to start your own business. House falling down? Maybe you can qualify for an extreme makeover. Is the world view of Oprah really uplifting after all? Or does it disempower individuals and disarm communities?50

The brain/neuroscientific framing in much of the global Northern conversation about trauma is such a familiar Zeitgeist now. It is frequently reproduced and popu-

larised. In a graphic book, *Trauma is Really Strange*, we are inundated with 'brain' images. While the book definitely does focus on transforming *embodied* reactions to historical trauma, it still effectively adheres to a dominant narrative that we are to be centrally concerned with 'fixing the brain'.

50. Bruce A. Dixon, 2008.'The Age of Oprah, Cultural Icon for the Neoliberal Era'. *The Black Agenda Report*. Available from: www. blackagendareport.com/content/age-oprah-cultural-icon-neoliberal-era (Accessed 24.01.2021)

Images from Steve Haines, 2015.

Trauma is Really Strange, *Singing Dragon*

If we speak of the effects of trauma in terms of 'the body', we need to move beyond the focus which is so heavily centred on the brain and neuroendocrinal aspects. Healing in the bodymindsoul does not only or centrally happen there. It can happen also in the heart, in the guts, in the muscles, in the breath, and in our relational connections. I think centering the brain can compromise our intuition and knowing about what we might *feel* we need in order to heal, that is *through* the bodymindsoul. I think it can also compromise our intuition about what healing might be needed 'beyond' the individual body in the collective body of humanity/ community, the body of ancestors, and within the greater body of the earth and cosmos...

Also in the body

Also, from the Old English *eallswa* meaning 'just as, even as, as if, so as, **likewise**'. Originally an emphatic form of so. The sense of '**wholly so**'.

Below are experiences, understandings and knowledge systems woven together and layered up, that 'likewise' and 'wholly so' look at ways trauma impacts on both individual and larger collective bodies. They speak 'wholly so' to what might be needed in terms of personal and collective healing.

Also in the body...

Broken-heart syndrome

A biomedical condition called **Takotsubo cardiomyopathy**, also called **broken-heart syndrome** is one where, following shock or bereavement, the left ventricle of the heart balloons and compromises heart function. It is named after the Japanese word for an octopus trap (tako-tsubo) which the heart is said to resemble.

On the cardiomyopathy.org website we are told:

Although the exact cause of the condition is not known, it is commonly brought on by an extremely stressful emotion (such as bereavement) or physical event (such as an illness or extreme pain). As it is often caused by stress, it is also known as 'broken-heart syndrome' or 'stress-induced cardiomyopathy'. It is possible that events causing great positive emotions may also cause the condition in some people.

Research at Harvard health education claims that:

Years of gender-based research have shown that in matters of the heart, sex differences abound. One striking example is the temporary heart condition known as takotsubo cardiomyopathy, also known as broken-heart syndrome, first described in 1990 in Japan. More than 90% of reported cases are in women ages 58 to 75.51

It is unclear if this research understands physiological/hormonal correlations between this heart condition and the bodies of people who were assigned female at birth to be factors, or whether they believe socialised/gendered experience is a factor for all women. I suspect they base their research on cis women and deem takotsubo to be a condition that older post menopausal cis women experience. The complexities of sex and gender (and how research might be conducted around that) aside, what's interesting is the insight into the way the *heart* responds to shock and trauma. We feel the effects

51. Harvard Health, 2010. *Takotsubo cardiomyopathy* (broken-heart syndrome). Available from: www.health.harvard.edu/heart-health/takotsubo- cardiomyopathy-broken-heart-syndrome (Accessed 24.01.2021)
of trauma in the heart (and the guts and lungs and so many other sites and centres of the body), not just the brain. All of these places can also be sites of healing within the body.52

Also in the body...

If *Schizo Phrenos* is a broken soul

The radical psych/iatrist R.D. Laing, associated with the antipsych/iatry movement, spoke about schizophrenia in *The Politics of Experience*, and asked:

Perhaps we can still retain the [...] name, and read into it its etymological meaning: *Schiz* – broken; *Phrenos* – 'soul' *or* 'heart'.54

Phren from Greek phreno can mean 'mind', also 'diaphragm' *or* 'the muscle which parts the abdomen from the thorax'. In Homer the meaning was extended to 'parts around the heart'.

52. Biomedicine is in some ways *slowly* catching up with Indigenous knowledge systems, reintegrating the body (by not fixating on the brain). It is acknowledging (even on its own terms) that: '*Consciousness isn't your brain: The body shapes your sense of self*'.53 In this article in the *New Scientist*, for example, the work of Sarah Garfinkel (professor of neuroscience and psych/iatry at the University of Sussex) is being cited, which looks at the whole body's responses and signalling activity as regards trauma.

Electrical signals coming from your heart and other organs influence how you perceive the world, the decisions you take, your sense of who you are and consciousness itself. 'It seemed to me that what [...] bodies were doing was meaningful, but I was just scanning [...] brains,' she says [...]. 'Our thoughts, feelings and behaviours are shaped in part by the internal signals that arise from our body,' she says. But it goes beyond that. It is leading her and others to a surprising conclusion: that the body helps to generate our sense of self and is a key part of consciousness.

53. Spinney, Laura, 2020. 'Consciousness isn't just the brain: The body shapes your sense of self '. Available from: www.newscientist.com/article/ mg24632881-300-consciousness-isnt-just-the-brain-the-body-shapes-yoursense-of-self (Accessed 24.01.2021)

54. R.D. Laing, 1967. *The Politics of Experience and The Bird of Paradise*, Penguin, p.107

I think it's important to acknowledge and consider the ways the soul and heart can be 'broken' by a world that can be fracturing and violent. Our souls and hearts are wounded, not just our minds/ brains, and our souls and hearts need healing. We may need to tend more *directly* to the heart in trauma with medicine, herbs, embodied

practices, within the context of healing the wider social and spiritual fractures and violences that cause harm and wounding.

Also in the body...

Lomi Lomi, and the soul

Hawaiian traditional massage is called Lomi Lomi. In the Hawaiian and Samoan language, the word *lomi* used traditionally means to rub, press, squeeze, crush, mash, knead, massage, rub out; to work in and out.

Traditionally in Hawaii, Lomi Lomi was practiced in four contexts:

– As a healing practice of native healers – kahuna;

– For pleasure and also as an aid to digestion, especially by the ruling chiefs;

– As restorative massage within the family;

– By masters of the Hawaiian martial arts.

After American missionaries arrived in Hawaii in 1820, colonial laws prohibited Native Hawaiian healing practices. This caused Lomi Lomi to go underground, although it remained popular among Hawaiians, and foreign residents and visitors as well. It wasn't until 1947 that the Hawaiian Board of Massage was established to regulate Lomi Lomi and massage therapies.

When traditional Hawaiian massage was practiced by Kahuna healers, they were regarded as the keepers of specialised knowledge and wisdom, and would be chosen from a young age, as early as 5 years old, based on factors like weather events, birthmarks and behaviour. They would undergo years of training and as part of

their role they performed 'bodywork', a rite of passage intended to help people connect with themselves and the world around them. The underlying philosophy of Lomi Lomi is 'Huna Wisdom'.

Huna believes that the primary desire of all living beings is to find contentment. It particularly promotes the concept of 'aloha', which means 'unification', 'love' and 'breath'. Like all traditional endeavours in Hawaii, Lomi Lomi was conducted with prayer and intention. Hawaiian kupuna (elder) Auntie Margaret Machado describes Lomi Lomi as 'praying work'.55

Lomi Lomi includes and gives particular attention to abdominal massage. There are many thoughts as to why this area of the body is concentrated on. One is that Hawaiian tradition understands the Hawaiian term *Na'au* to mean both the guts/small intestines/ colon, and the seat of thought, the affections, the heart, and the place where the soul resides.

The following are from records of the Hawaiian knowledge system that speak to the significance of the breath, diaphragm, heart and soul.

Breath – deep, powerful breath beginning in the diaphragm, at the solar plexus, the space between the lungs and stomach

– is where the power to heal comes through. The connection to grace comes through the diaphragm. The diaphragm is the basket of emotion where the Unihipili (Low Self, your friendly unconscious) can create a will with the Uhane [middle/ mediating self] to heal then empower the Au'makua, your High Self. That's what healing is. And that's where you get your facilitation [...]. So the breath begins and gathers power in the diaphragm, echoes as it moves through the heart, then into the throat where it becomes a spoken chant.

So you will hear the kahuna chant *A ki mele ahua a pu'u* when a session begins. *A ki mele ahua a pu'u*: 'I connect with you in the song of my heart, the master of my soul.' *A ki mele*

55. Makana Risser Chai, 2005. *Na Mo'olelo Lomilomi: The Traditions of Hawaiian Massage and Healing*, Bishop Museum Press, p.39

ahua a pu'u: 'I connect with you in the song of my heart, the master of my soul.'

This is the way emotional language, the language that heals, moves. The diaphragm is like a drum. The diaphragm is a vacuum. Breath activates the emotional language, beats it like the drum. Then the real breath movement flows with emotion when the kahuna gives voice to the healing. The chant is the en-chant-ment.56

Older records about Lomi Lomi speak about the soul being returned to the chest and heart:

Even when death had occurred and the spirit had taken its flight from the body, it was possible for a man of psychic skill to catch and bring back the escaped soul and reintroduce it into the body. One class of kahuna in Hawaii was supposed to be able to catch an escaped soul and to force it into the body by raising the big toenail and introducing it there, then urging it (by massage) up to the ankle, then up the leg, and so on until it was lodged in its right place in the man's chest.57

In spirit restoration, such massage was done upward, toward the heart. Observation of recoveries may have led to the interpretation that the spirit works up through the body.58

Also in the body...

Healing Whiteness and Cultural Somatics

In an article '*The Key to Healing Whiteness is Understanding Cultural Somatic Context*', somatic practitioner and educator Tada

56. Garnette Arledge and Kahuna Harry Uhane Jim, 2007. *Wise Secrets of Aloha: Learn and Live the Sacred Art of Lomilomi*, Red Wheel/Weiser, p.64

57. Makana Risser Chai, 2005. *Na Mo'olelo Lomilomi: The Traditions of Hawaiian Massage and Healing*, Bishop Museum Press, p.96

58. Ibid. p.97

Hozumi speaks of the impact of whiteness (the centring of northern European bodies, culture and false notions of supremacy) on *all* bodies. They write, 'Whiteness, like all

other oppressions, is trauma itself held in our collective cultural body. And because of this, embodied spiritual practice is absolutely necessary for healing whiteness in a lasting and sustainable way.' They caution against *just* doing intellectual work. They also guard against the phenomena of culturally appropriating spiritual practices from people of colour, especially speaking about the way bodies and practices are inhabited *within* a cultural context which profoundly frames both the physicality of a practice and the tradition.

Hozumi references a predominant white, European, Christian locus of attention which is in the heart and head areas.

To me, white culture is defined by its disconnected relationship to the body, particularly to the abdomen, pelvis, and lower limbs. If you look closely, awareness of the body below the belly is almost completely missing in white culture.

Hozumi speaks about the potential healing to be accessed by inhabiting the abdomen and lower body, to know wisdom that comes from the lower body and not just the head. In support, Hozumi shares a Hara breathing practice.

They explain:

Hara is the Japanese word for the spiritual centre in our abdomen-pelvis. It has many other names from around the world. Yes in Kabbalah, Kath in Sufism, The Cauldron of Warming in Celtic magick, The Lower Dantien in Qigong, The Root and Sacral chakras in Yoga, and often simply the womb or navel point. Modern neuroscience calls Hara the gut-brain.

In my work, I use Hara as a kind of internal North Star – a guiding light in our body that helps us orient ourselves in the journey of healing from whiteness. We know we are going in the right direction when our Hara is restoring.59

I love how this speaks of ways to reinhabit and restore connection to the lower body as part of healing cultural trauma. It also decentres global Northern ideas in trauma theory that are fixating on the brain and head.

Also in the body...

'Call me back'

In her book *Woman Warrior*, Michelle Hong Kingston speaks of experiences in the body. She describes her mother's intense experiences with a ghost while she was studying at medical school. It's worth mentioning that Chairman Mao (after initially abolishing it as provincial and backwards) *standardised* Chinese Medicine in the 1960s into what is now called TCM. As an authoritarian Marxist, he stripped out some of its more spiritual dimensions. In the early Chinese Medicine texts and schools, dating back to the 7th century, significant attention was given to spirit possession and the issue of ghosts and exorcism. In *Woman Warrior*, a detailed passage which narrates Michelle's mother's intense interaction with a ghost concludes:

She then ignored the ghost on her chest and chanted her lessons for the next day's classes. The moon moved from one window to the other, and as the dawn came, the thing scurried off, climbing quickly down the foot of the bed.

Hong Kingston writes about the need, following deep fear, for the soul to be called back to the body. She tells us that her mother

59. Hozumi, Tada. 2019. 'The key to healing whiteness is understanding cultural somatic context'. Available from: selfishactivist.com/the-key-tohealing-whiteness-is-understanding-cultural-somatic-context (Accessed 24.01.2021) awoke when the students came tumbling into the room. 'What happened?' they asked, getting under the quilt to keep warm. 'Did anything happen?'

'Take my earlobes, please,' said my mother, 'and pull them back and forth. In case I lost any of myself, I want you to call me back. I was afraid, and fear may have driven me out of my body and mind.'[...]. Two friends clasped her hands while a third held her head and took each earlobe between thumb and forefinger, wiggling them and chanting, 'Come home, come home, Brave Orchid, who has fought ghosts and won. Return to Keung School, Kwangtung City, Kwangtung Province. Your classmates are waiting here for you, scholarly Brave Orchid. Come home. Come home. Come back and help us with our lessons. School is starting soon. Come for breakfast. Return, daughter of New Society Village, Kwangtung Province. Your brother and sisters call you. Your friends call you. We need you. Return to us. Return to us at the To Keung School. There's work to do. Come back, Doctor Brave Orchid, be unafraid. Be unafraid. You are safe now in the To Keung School. All is safe. Return.'

Abundant comfort in long restoring waves warmed my mother. Her soul returned fully to her and nestled happily inside her skin.60

Also in the body...

'The Otherworld'

Malidoma Somé of the Dagara, from Burkina Faso, speaks about the wider body of the ancestors, with whom connection through ritual is necessary for wellbeing and healing.

60. Michelle Hong Kingston, 1989. *Woman Warrior: Memoirs of a Girlhood among Ghosts*, Vintage Books, p.69

For the Dagara, ritual is, above all else, the yardstick by which people measure their state of connection within the hidden ancestral realm, with which the entire community is genetically connected. In a way, the Dagara think of themselves as a projection of the spirit world. It is composed of the world of ancestors, the place where the dead go to rest, the world of spirits where non-human entities in charge of the order of nature dwell.

Somé continues:

The abandonment of ritual can be devastating [...]. The young ones are the future of the old ones. To allow this future to happen, the old ones must work with the Otherworld. When an elder fails to perform his work with respect to the spiritual, the future of this elder is threatened, not the present. Where ritual is absent, the young ones are restless or violent, there are no real elders, and grown-ups are bewildered. The future is dim.61

There are *multiple* ways that healing is conceptualised and understood, in the individual and collective body. These are well established in various global majority lineages and traditions. These ways are also being reinvented through critical and intuitive inquiry through the bodymindsoul. In the section ahead; Collective Care, Collective Healing, there is the invitation to explore what breadth of healing modalities and approaches we might (re)connect to and (re)imagine.

61. Malidoma Somé, 1997. *Ritual: Power, Healing, and Community*, Penguin Books, p.12

Forms of Trauma

Below is a list of some different forms of trauma. These are just tiny windows into huge experiences. Naming them here, sometimes even just in referential ways, is not to explore them in depth, but one way to name and validate experiences we might have. It's also a list that can inform ways we might move towards healing responses and remedies, in specific personal, interpersonal and very broad collective relational, and societal ways together.

I want to reiterate, just once more here, that we take care of ourselves as we connect to some of these ideas that speak about some forms of trauma, use practices to stay as grounded as possible, and call on friends or support if we need and can. Also to skip over anything that feels too much and come back to it if and when there's a better time.

This list of experiences below all potentially interrelate and intersect. Several might be experienced at the same time, or over the course of a lifetime. Likely there are *many* other forms of wounding that could be given name to. I have listed some forms of trauma here that are commonly spoken of, others that I think are less so. I've referenced some people's work around trauma that I've found inspiring, all of which I can only recommend seeking out and supporting. I've languaged some forms of trauma myself, in an attempt to add to the many voices that are reframing trauma in wider systemic, structural and social terms.

The list is, as everything, also culture bound: i.e., it is categorised from a predominantly contemporary global Northern perspective. Later in this section, and in this section that follows, there is information and thinking about the fact that the *way we respond* to trauma doesn't happen in a vacuum. It is dependent on our cultural heritages and lineages, and on our inherited and current circumstances, and is *also* culture bound. It is shaped by belief systems, spiritual traditions, practices and cultural habits.

Developmental trauma

In the first years of life, infants and toddlers require safe, predictable, accessible, and loving caregivers for healthy development. A neurobiological understanding is that in this environment the brain is able to develop in a healthy sequence of growth. The lower (or older, more reflexive, sometimes called reptilian) part of the brain develops first, which is responsible for functions dedicated to ensuring survival and responding

to threat. Upper parts (or newer parts: the limbic and neocortex) of the brain are responsible for executive functions, like making sense of what you are experiencing or exercising moral judgement.

The **reptilian** brain controls the body's vital functions like heart rate, breathing, body temperature and balance. Our reptilian brain includes the main structures found in a reptile's brain: the brainstem and the cerebellum.

The **limbic** system is a set of structures in the brain – the hippocampus, the amygdala, and the hypothalamus – that deal with emotions and memory. It regulates autonomic or endocrine function in response to emotional stimuli, including stress, and is also involved in reinforcing behaviour.

The **neocortex** with its two large cerebral hemispheres, is the part of the mammalian brain involved in brain functions such as sensory perception, cognition, generation of motor commands, spatial reasoning, abstract thought and language.

Biomedicine says development of the 'upper parts' of the brain depends upon prior development of the 'lower parts'. In other words the brain is meant to develop like a ladder, from the bottom-up. When stress responses (typically due to consistent neglect or abuse) are repeatedly activated over an extended period as an infant or toddler, this development of the brain can be disturbed. It is said the ladder develops, but foundational steps are either missing or over-activated, and many developmental stages and experiences that can follow are affected.

Developmental trauma can manifest in a variety of ways in children, including cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions), speech delay, learning disabilities, and later in adulthood as a wide variety of experiences of emotional disorientation, and of what gets called PTSD (see below).

I want to add in something around attachment here because it relates to the concept of developmental trauma. I think it is a useful reference point in many ways, as we try and figure out how we might have been shaped and what we might need in terms of awareness, care and healing. I'll look a bit at psychological attachment theory, and then broaden beyond that to other discussions of attachment including cultural attachment theory.

Attachment theories

Psych/ological attachment theory

This was formulated in the 1950s and '60s by British psych/ iatrist, psych/ologist and psycho/analyst John Bowlby and

American-Canadian developmental psych/ologist Mary Ainsworth. It says that our early experiences from primary caregivers affect how we socially develop and move in the world, and that early experiences with caregivers give rise to a system of thoughts,

memories, beliefs, expectations, emotions, and behaviours about the self and others that shape how we experience others and life.

Attachment theory suggests that there are four attachment classifications, sometimes called attachment styles that have been identified in children:

Secure attachment occurs when caregivers are sensitive and consistent, and children feel they can rely on their caregivers to attend to their needs, emotional support and protection. In this context it's said children tend to appear explorative and generally happy/at ease.

Anxious-avoidant attachment occurs when caregivers are distant or disengaged and children feel their needs probably won't get met. Children may avoid exploration, connection and be more emotionally distant.

Anxious-ambivalent attachment occurs when caregivers are sometimes present and sensitive, sometimes absent or neglectful. Children may respond to that inconsistency by feeling anxious, insecure and angry, and feel separation anxiety when separated from the caregiver and not feel reassured when the caregiver returns.

Disorganised attachment occurs when caregiving has been extremely erratic, and children feel frightened or abused. Children may be unresponsive/depressed and passive, or angry and anxious. There may be lots of confusion and no strategy to get needs met.

Attachment theory says that as children we will have responded to caregivers and may have learned patterns of attachment and relating that kept us or siblings safe. Those attachment patterns will likely have served an important role. These patterns then affect how we relate to people in our lives. They translate into corresponding adult attachment patterns that we may have a tendency to enact. These are classified respectively as:

– secure attachment
– anxious-preoccupied attachment
– dismissive-avoidant attachment
– fearful-avoidant attachment.

These attachment 'styles' can be considered as either distinct, or on a spectrum (see images over page).

Early attachment styles don't have to dictate how we continue to relate. We can *reconfigure* our attachment and relating patterns later in life if they no longer serve us, through awareness about our learned attachments, compassionate interpersonal communication, and exploration of somatic/ spiritual practices to support transformation. This can happen through therapeutic relationships and support, and also when we form different close bonds with people later in life where the connection, communication and circumstances can allow healing of wounds and patterns we might have grown up with.

As well as these attachment patterns influencing some of the way we move in the world, we are also given an emotional *range of permission* from our primary carers, which can shape our responses. If we live with parents/carers who are very anxious, we

may learn to have anxious responses to situations. If we grow up in a family system that has shame or rigidity around sexual energy, intimacy and pleasure, we may learn to be absent from that part of ourselves/connection. Our emotional ranges of permissions are micro; occurring within family units, and macro; under wider social and cultural influences.

Reframing attachment theory

Like everything, psychological attachment theory is culture bound. While I think it has genuine value as a language for understanding in part what has shaped us, it emerges out of the global North with its tendency towards referencing and emphasising (small nuclear) human family systems, and dwelling especially on parental care (often particularly maternal). It also emerges from a culture that deflects from the *wider* social/cultural attachment we have to each other as humans, by foregrounding one area – the smaller demarcated 'family unit'. It also emerges from a culture that lays *great* emphasis on interactions that are centrally in the human realm. What about attachment we learn (or don't) to animals, birds, plants, spirit, ancestors, land? What profound holding might be there, that teaches and re-situates attachment, potentially at a young age through rites of passage, to a greater sense of family and interconnectivity? Which even has the capacity to mitigate interpersonal attachment wounds.

In a chapter, *Safety Belonging and Dignity*, Staci Hains broadens out thinking about attachment:

Attachment is not just to our primary caregivers or our family and children – while it is key there. We also need to belong within our communities. Our communities need to belong to the broader social fabric. There is a broader circle of belonging that also affects attachment, a sense of security, and real choices for connection and interdependence.

[...] Let's consider this: What happens to people within a community who are regularly targeted by the police, where children have typically been detained by the age of eleven? What is happening to their attachments and belonging? This is regularly happening in poor Black and Brown communities in the United States. How does this environment allow for secure attachment, even if a child has it at home?62

Buddhist psych/ology and attachment

In an article by Baljinder K. Sahdra & Phillip R. Shaver, *Comparing Attachment Theory and Buddhist Psychology*, the authors focus on some similarities and differences between the two. The article suggests both systems highlight the importance of giving and receiving love and of minimising anxious clinging or avoidant aloofness. However the two theories differ in their conception of security in adulthood. The authors write:

Attachment theory suggests that security is rooted in mental representations of a self that has been reliably loved and cared for in close relationships. In Buddhist

psychology, security is conceptualized as freedom from static or rigid views of self and others, and is cultivated by countering, often through formal meditation practices, our habitual tendencies of reifying or solidifying aspects of our ever-changing phenomenal experience. 'Non-attachment' or release from mental fixations is a key construct in this process. It is empirically distinct from its Western counterpart of *felt security* [emphasis added].63

I've found it useful to consider interpersonal relational patterns. I've also been inspired by existential questions about

62. Staci Hains, 2019. *The Politics of Trauma: Somatics, Healing, and Social Justice*, North Atlantic Books, p.143

63. Baljinder K. Sahdra & Phillip R. Shaver, 2013. 'Comparing Attachment Theory and Buddhist Psychology'. *International Journal for the Psychology of Religion*. Available from: www.tandfonline.com/doi/abs/10.1080/10508619.2 013.795821 (Accessed 24.01.2021) attachment; how we relate to impermanence, change, and where we locate feelings of security – in Hains' words 'safety and belonging'. That they can be located in fostering secure relationships with land, with practices to support us in the face of flux and the unknown of life. That we need it all, secure attachment with individual humans, secure and life affirming social fabric, secure relations with the places on earth we inhabit, and with practices to anchor us to navigate the greater spiritual realms.

Cultural attachment theory

Estelle Simard is an Anishinaabe scholar and executive director of the Institute for Culturally Restorative Practices. She has written extensively about the concept of Cultural attachment. She explains:

Cultural attachment is a philosophy, which encapsulates how an individual bonds to his or her culture. Cultural attachment creates a direct spiritual force, where the bond begins, develops, and evolves for the individual. In Anishinaabemowin, cultural attachment is expressed as *wiidamaagowiziwinan*. This means the deep connection between the individual and their spiritual connection to their Creator through his or her access to cultural structure. Cultural attachment is a life-giving philosophy, as it instills life force energy into an individual.

Simard concludes:

Cultural attachment has remained in Aboriginal worldview because as Aboriginal people there exists the genetic memory of the ancestors, this is called *gichi Anishinaabe aadizokaan(an)/gagiikwewewin(an)*.

This genetic memory is the spirit of Aboriginal people. Cultural attachment is built on the principle that cultural memory is carried in an Aboriginal's DNA. This cultural memory becomes active or alive, and inspires connection to the spirit. Many people feared that historical effect and colonization has eroded the cultural memory of the Aboriginal people, but they cannot be further from the truth. The truth is that cultural

memory, connection to that memory, and its subsequent cultural attachment has never left the people, it has only waited to be awakened.64

Cultural Attachment Theory is a profound and vital naming of the impact of colonisation. It affirms the need for, and power of, reconnection with cultural memory. It can particularly relate to the effects of trans-generational, intergenerational and ancestral trauma which are mentioned below.

Adverse Childhood Experiences (ACEs)

I want to add in some thoughts about Adverse Childhood Experiences (ACEs). ACEs theory is profoundly related to developmental trauma (and to continuous systemic and structural trauma described in the list of forms of trauma that continues below). ACEs are a list of childhood experiences of abuse or neglect from which researchers have made causal links to developmental trauma and compromised wellbeing and health in later life.

There are ten recognised ACEs, which were identified in a US study undertaken by the private health insurance

64. Estelle Simard, 2011. 'Developing a Culturally Restorative Approach to Aboriginal Child and Youth Development: Transitions to Adulthood'. Available from: culturalattachmenttheory.blogspot.com/2011/06/culturalattachment-theory.html (Accessed 24.01.2021)

company Kaiser Permanente in the late 1990s. They include physical, sexual, and verbal abuse; emotional and physical neglect; growing up in a household where there are adults with alcohol and drug use problems; where there are adults with mental health problems; where there is domestic violence; where there are adults who have spent time in prison; or where parents have separated. A pyramid has been generated of the effects researchers attribute to those ACEs, over a lifespan.

The ACEs framework has permeated a lot of child welfare work. Children are assessed and point-scored according to the ACEs criteria, and adults can also self-assess on websites like acestoohigh.com. While ACEs acknowledge some of the effect of childhood adversity and of abuse and neglect, it is a *limited* paradigm because it focuses on *specific* childhood experiences (i.e. having a caregiver who is an alcoholic, or who is in prison), but doesn't acknowledge more continuous, structural violence and neglect like the effects of racism, the fact of a prison system, capitalism, poverty, etc.

In Professor Morag Treanor's article *ACEs – repackaging old problems in shiny new (Emperor's) clothes*, she comments:

... parents are being encouraged to nurture their children better to alleviate the negative impacts of systemic inequalities, such as poverty, rather than society tackling the systemic inequalities in the first place (Hartas, 2019). This risks promoting policies that do not increase and, in fact, may decrease income to families facing poverty and inequality, such as we have seen in this past decade of austerity.

Treanor continues: instead of shedding light on an emerging social problem, old problems are repackaged and the thinking becomes ossified. The idea of ACEs is simple, simplistic and intuitive, which is why it has caught the political and public imagination. It offers a simple solution to complex problems. However, it very much lacks scrutiny through a critical lens and has been adopted without question. Furthermore, it blames those it purports to help. This is problematic.65

Since the initial individuated ACEs model, social researchers have acknowledged more fundamental root factors that cause immediate and long-term distress and damage. In something called *The Pair of Aces* (image on p.221) both adverse experiences and adverse community environments have been named.

But *even here*, the root causes seem to hang in a contextual vacuum. Violence and discrimination are depicted,

65. Professor Morag Treanor, 2019. 'ACEs – repackaging old problems in shiny new (Emperor's) clothes'. Available from: blogs.ed.ac.uk/ CRFRresilience/2019/08/ 01/repackaging-old-problems (Accessed 24.01.2021) but some of the structural *root causes of* that violence and discrimination, for example white supremacy and capitalism are not named. I wonder, if the actual root causes *were* to be named in this particular imagery of tree and root, whether they would need to be depicted as the soil? If what fosters root causes of adverse community environments was named, *it* could be addressed and transformed. There would be explicit focus on naming the abuse and neglect of racism and capitalism for example – and efforts made for transformation of these systems of oppression.

[image]

The Pair of ACEs by Dr. Wendy Ellis, The Milken Institute School f Public Health.66

Following the concept of developmental trauma, this section continues to look at other woundings that can shape us and require remedy.

Single-incident trauma

Single-incident trauma can be understood as a single painful, violent or otherwise injurious event that happens, like a car crash, or the experience of a distinct physical assault which can leave an imprint of trauma in the bodymindsoul. Most often 'single incidents', like sexual violence are manifestations of wider systemic trauma, like the violence of patriarchy.

Sexual trauma

Sexual trauma can be a distinct boundary or consent violation or physical assault, or repeated sexual violence. It can be the palpable experiences of abuse in the body. It

can also be what could be called cultural molestation, where we are adversely affected in our sexuality by things like objectification and the fear of violence.

Medical trauma and/or re-traumatisation

Medical trauma and/or re-traumatisation names any experience of objectification, disrespect, being ignored, dehumanised, aggressive or abusive interpersonal communication, the experience of repeated, unnecessary, or frightening medical procedures or intervention, or forced hospital detention, that cause trauma responses and imprints.

Birth trauma

Birth trauma names both the experience of a violent or distressing entry into the world for a child, or one that involves medical intervention and/or separation/isolation. Birth trauma also applies to any person who has given birth, if that experience was disempowering, overwhelming, violating or violent.

Betrayal Trauma

American researcher Jennifer J. Freyd coined this term, and has written: 'Betrayal trauma occurs when the people or institutions on which a person depends for survival significantly violate that person's trust or well-being.'67 When psychological trauma involves betrayal, the person experiencing it may be less aware of, or less able to recall the traumatic experience, because to do so will likely lead to confrontation or withdrawal by the betraying caregiver. This potential confrontation or withdrawal may threaten a necessary relationship and thus the person's survival.

She writes about Institutional Betrayal, which 'refers to wrongdoings perpetrated by an institution upon individuals dependent on that institution, including failure to prevent or respond supportively to wrongdoings by individuals'.68 I've found the concept really significant to think about in the way it might function both interpersonally and institutionally. It's a useful tool to name what can occur as a result of state violence (see below). The concept of betrayal trauma validates the incredible disorientation and difficulty there can be in naming some experiences of trauma which may be enmeshed with a social fabric or support system we might depend on.

Post-Traumatic Stress Disorder (PTSD)

PTSD is a term used to describe the experience of particular recurring physiological and emotional response patterns that follow on from trauma. Many of those embodied experiences have been described in

49. Jennifer J. Freyd, PhD, no date. 'What is a Betrayal Trauma? What is Betrayal Trauma Theory?' Available from: dynamic.uoregon.edu/jjf/defineBT. html (Accessed 24.01.2021)

50. Jennifer J. Freyd, PhD, no date. 'Institutional Betrayal and Institutional Courage'. Available from: dynamic.uoregon.edu/jjf/institutionalbetrayal/ index.html (Accessed 24.01.2021) the section about the long-term effects of trauma. PTSD acknowledges that trauma can cause those long-term effects, and can be reactivated and triggered by things. A sudden loud noise for a survivor of military conflict for example, could trigger an embodied flash back to a past experience of an exploding bomb. Given that a lot of the experiences of post traumatic stress can be *understandable* responses to what has been experienced, I would argue a more progressive term might actually be **Post Traumatic Stress *Response* (PTSR)**.

What was really interesting for me to find out was that the movement to recognise PTSD began as a *political* as much as a psych/iatric one: 'Originally called post-Vietnam syndrome, the idea came out of the hothouse of roundtable discussions held by Vietnam Veterans Against the War and supervised by anti-war psychoanalysts.' Dr. Chaim Shatan at New York University, one of the first to help find the professional volunteers to participate in the discussions, circulated a memo to colleagues in which his politics were clear: 'This is an opportunity to apply our professional expertise and anti-war sentiments to help some of those Americans who have suffered most from the war.'

Ethan Watters documents:

According to Shatan, these veterans felt upset because they had been 'deceived, used and betrayed' by both the military and society at large. Although Shatan did mention that these veterans experienced 'rage', he did not link this or any psychological reaction to particular traumatic battlefield experiences. Instead the rage, as Shatan described it 'follows naturally from the awareness of being duped and manipulated' by the military and US government. It was the moral ambiguity of the Vietnam War and deceitfulness of the US government and military, not the trauma of battle, that damaged the psyche of the soldier.69

51. Ethan Watters, 2010. *Crazy Like Us: The Globalization of the American Psyche*, Simon & Schuster, p.127

This relates directly to Jennifer J. Freyd's work around 'betrayal trauma' and is a good example of people finding ways to name the violation of trust that happens at an institutional level. It could be applied to so many other aspects of our lives governed by states and policy makers that we don't trust and can feel betrayed by. It gives

language to a broad sense of dis-ease felt living under governmental systems concerned with maintaining power and with perpetuating economic profit.

The history of PTSD unfolded as follows:

In their push to gain official diagnostic status in the *DSM*, the advocates for recognition of post-Vietnam syndrome found it necessary to cede some ground. Despite the early arguments intent on carving out a disorder specific to the experience of Vietnam veterans it proved expedient to make alliances with other researchers and clinicians who wanted to extend the concept to include those who suffered psychologically after surviving horrors, including fires, natural disasters and accidents. The earlier argument that the psychological trauma suffered by Vietnam veterans was utterly specific was put aside and then forgotten [...]. As the diagnosis expanded in the West, encompassing more and more experiences, there grew a market for those claiming to have the latest techniques for treating the condition. These techniques, in turn, began to shape our cultural expectations and understandings of how trauma *affects the mind* [emphasis added).70

...as it evolved into its modern clinical form, PTSD left behind [...] quests for social meaning[...]. In contrast to those angry but socially engaged Vietnam veterans, the personal accounts of current-day soldiers returning from Afghanistan and Iraq often seem pigeonholed into a PTSD diagnosis that is tied to a particularly modern style of lonely hyper-introspection.71

Judith Herman's analysis and approach to trauma, which is explicitly feminist offers another perspective on the concept of PTSD. A lot of trauma theory references Vietnam veterans, or WW1 soldiers and shell shock, as being the conditions where the original concept of PTSD was acknowledged. Herman locates its earlier acknowledgement in what was called 'Hysteria' in women. She cites the investigations of male doctors like Janet, Breuer and Freud, all of whom she says arrived at strikingly similar formulations: hysteria was a condition caused by psychological trauma. Unbearable emotional reactions to traumatic events produced an altered state of consciousness, which in turn induced the hysterical symptoms. Janet called this alteration in consciousness 'dissociation', Breuer and Freud called it 'double consciousness' [...]. By the mid 1890s these investigators had also discovered that 'hysterical symptoms' could be alleviated when the traumatic memories, as well as the intense feelings that accompanied them, were recovered and put into words. This method of treatment became the basis of modern psychotherapy.72

Hysteria as trauma manifesting

'If it's hysterical, it's historical.'73

In 1896 Freud published a book acknowledging sexual abuse as causative of trauma. In *The Aetiology of Hysteria*, he wrote:

I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences

72. Judith Lewis Herman, 1992. *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*, BasicBooks, p.12

73. Sarah Schulman, 2017. *Conflict is not Abuse: Overstating Harm,* of premature sexual experience, occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psycho-analysis in spite of the intervening decades.74

Freud received huge criticism for this work from peers, and 'within a year he had privately repudiated the traumatic theory in the origins of hysteria'. Herman tells us:

His correspondence makes clear that he was increasingly troubled by the radical social implications of his hypothesis. Hysteria was so common among women that if his patients' stories were true, and if his theory were correct, he would be forced to conclude that what he called 'perverted acts against children' were endemic. The idea was simply unacceptable. It was beyond credibility [...]. Faced with this dilemma, Freud stopped listening to his female patients.

The turning point is documented in the famous case of Dora, one of Freud's 'case studies', 'whose father had essentially offered her to his friends as a sexual toy'. While Freud still acknowledged the reality of his patient's experience, he refused 'to validate Dora's feelings of outrage and humiliation. Instead he insisted on exploring her feelings of erotic excitement, as if the exploitative situation were a fulfilment of her desire.'

Herman explains how:

Out of the ruins of the traumatic theory of hysteria, Freud created psycho-analysis. The dominant psychological theory for the next century was founded in the denial of womens' reality. Sexuality remained the central focus of inquiry [...].

74. Judith Lewis Herman, 1992. *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*, BasicBooks, p.13

Freud had concluded that his hysterical patients' accounts of childhood sexual abuse were untrue: 'I was obliged to recognise that these scenes of seduction had never taken place, and that they were only fantasies which my patients had made up.'75

Conflict and War trauma

I place conflict and war trauma here because it is often associated with the term PTSD and I wanted to mention that there has been critique of the use of the term PTSD as an umbrella term for experiences particularly in relation to the diverse experiences of war and conflict cross-culturally.

In an article *Palestine's head of mental health services says PTSD is a western concept*, Samah Jabr, chair of the mental health unit at the Palestinian Ministry of Health, one of just 32 psychiatrists in the Palestinian territories, says clinical definitions of post-traumatic stress disorder do not apply to the experiences of Palestinians.

‘PTSD better describes the experiences of an American soldier who goes to Iraq to bomb and goes back to the safety of the United States. He’s having nightmares and fears related to the battlefield and his fears are imaginary. Whereas for a Palestinian in Gaza whose home was bombarded, the threat of having another bombardment is a very real one. It’s not imaginary,’ says Jabr. ‘There is no “post” because the trauma is repetitive and ongoing and continuous. I think we need to be authentic about our experiences and not to try to impose on ourselves experiences that are not ours.’

Jabr says people in Palestine who face continual trauma are more susceptible to shifts in personality, and express a variety of symptoms

75. Ibid. p.14

where their emotional stress manifests in physical reactions. In the face of chronic conflict, Jabr says she has come up with her own measures of what constitutes good mental health in Palestine: ‘ “To be able to have critical thinking, to maintain your capacity to empathize.” ’ The article explains:

She’s not denying other symptoms of trauma or stress used in alternative definitions, but her primary goal in working with patients is to help cultivate these two mental faculties. ‘It’s important to develop your own mental health standards,’ she says. ‘It’s not just the definition of the World Health Organization.’ 76

Transgenerational, Intergenerational and Ancestral trauma

Transgenerational, Intergenerational and Ancestral trauma describe trauma that has been experienced by and across preceding generations which affects the generations that follow. It speaks about the ways trauma can travel down physically and psychologically. How we can inherit embodied patterns (response and reactions) from our predecessors and *learn* behaviours that our ancestors might have adopted in challenging situations, which have been passed on. These responses and behavioural patterns can be destructive. We can also inherit life-affirming patterns (see vicarious resilience below!). The legacy of historical violence, suppression, genocide, poverty and displacement can present as distress in our bodymindsouls in the present.

Psychotherapist Dr. Aileen Alleyne has differentiated between:

76. Olivia Goldhill, 2019. ‘Palestine’s head of mental health services says PTSD is a western concept’. *Quartz*. Available from: qz.com/1521806/ palestines-head-of-mental-health-services-says-ptsd-is-a-western-concept (Accessed 24.01.2021)

Intergenerational trauma – between and across familial generations, manifesting as recurring patterns across the generations; a generation is around 30 years in length.

Transgenerational trauma – impacting *multiple* generations over *centuries* and is the impact of violences like colonisation, slavery, wars...77

In her book *Post Traumatic Slave Syndrome: America's legacy of enduring injury and healing*, Dr. Joy DeGruy defines what she names as Post Traumatic Slave Syndrome, and speaks of the various shapes of necessary healing. She writes:

Post Traumatic Slave Syndrome is a condition that exists when a population has experienced multigenerational trauma resulting from centuries of slavery and continues to experience oppression and institutionalised racism today. Added to this condition is a belief (real or imagined) that the benefits of the society in which they live are not accessible to them.78

DeGruy looks to healing through self-efficacy and building self-esteem, through challenging racial socialisation, telling the truth about the world, through food, and more.

In Christina Sharpe's *In the Wake, On Blackness and Being*, she writes about life in the wake of the Transatlantic Slave Trade. She speaks to the continuing wound of anti-Blackness and the fact that some trauma is apparently endless, asking: 'How does one mourn the interminable event?' In that reality she is asking, 'How can we think (and rethink and rethink) care laterally [...] in a different relation than

77. Dr. Aileen Alleyne, 2019. [Video]. Speaking at the conference: 'PostSlavery Syndrome: Exploring The Clinical Impact Of The Trans-Atlantic Slave Trade'. *Confer*. Available from: confer.uk.com/module/module-slavery. html (Accessed 25.01.21)

78. Dr. Joy DeGruy, 2017. *Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing*, Joy Degruy Publications Inc, p.136

that of the violence of the state?' In an endnote she adds that despite/in the face of state violence, 'I want to find a way to hold on to something like care as a way to feel and to feel for and with, a way to tend to the living and the dying.'79

Epigenetics

The scientific enquiry called epigenetics says we can *carry* ancestral experiences in our inherited DNA and be affected by it. Epigenetics tells us that life experiences modify the activation of certain genes, but not the genetic code sequence of DNA. This modification can cause genetic activation or silencing. Genes can get switched on and off depending on our experiences and circumstances. Those changes are preserved when cells divide. Most epigenetic changes occur within the course of one individual organism's lifetime, but these epigenetic changes can be transmitted to offspring through a process called transgenerational epigenetic inheritance.

Staci Hains cites Matt Ridley, the author of *Genome: The Autobiography of a Species in 23 Chapters*:

'On chromosome 10, there's a gene which makes an enzyme which creates cortisol from cholesterol. Cortisol is the body's stress hormone. When you feel very stressed, it's caused by having cortisol in your blood system. Cortisol goes round switching on and off genes and that changes your behaviour and your sensations. This means that

external events in your life, which change the stress you're under, can actually change your genes. It can switch on

79. Christina Sharpe, 2016. *In the Wake, On Blackness and Being*, Duke University Press, p. 19/20 & endnote chapter 1, #28

some genes and switch off others. So our genes are at the mercy of our behaviour, as well as our behaviour being at the mercy of our genes.'

Hains cites Ridley on the specificity of what occurs epigenetically:

... he discusses that when the stress gene is 'turned on' in the pregnant mother, the infant will be born with it turned on as well. That blew my mind, thinking about intergenerational trauma. The good news is that our behaviour, healing, and practices can also switch the stress gene 'off'.80

Resmaa Menakem, author of *My Grandmother's Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies* has developed something which he calls HIPP theory to speak of the *intersection* of trauma. He names the intersection of Historical, Intergenerational, Persistent Institutional and Personal trauma, and the effect that has on people/communities. He speaks about the way *all* factors need to be taken into account, and that it isn't always possible to tell the difference – he speaks about the way there may be stuck energy, or rage, dissociation, or a feeling of a presence of a *lot*, or *lack*, of energy around an experience that relates to historical/ layered trauma. He speaks about the need to address historical, racialised trauma as black/ people of colour and as white people, at an embodied level to prevent it being reenacted, working with something called cultural somatics. Menakem and others use the concept of cultural somatics to speak about the way we all have embodied – in the soma – historical legacies and cultural conditions. In order to challenge injustice and transform our relations, it is necessary to work somatically, with both intellect, intent and through the felt sense in the body. Menakem gives clear practical examples of how we can work this way; feeling, being with and sensing with the bodymindsoul.

In *The Four Bodies: A Holistic Toolkit for Coping With Racial Trauma*, Jacquelyn Ogorchukwu lays out a paradigm for tending to racial trauma that is explicitly holistic. She writes:

As a society, we often talk about racism, but rarely ever do we talk about how it affects the health of our people. I call racism 'the multifaceted abuser' because it has emotional, physical, mental and spiritual effects on our community. Research shows that racism can lead to anxiety, depression, hypervigilance, chronic stress, chronic fatigue, bodily inflammation, internalized racism and symptoms similar to post traumatic stress disorder. This is called *racial trauma*.

[...] Our ancestors knew that our health was more than just about the physical, that our bodies are made up of four distinct parts: the mental body, the emotional body, the physical body and the spiritual body. Trauma can be stored in these different parts of our being, and so by working with our four bodies, we remind ourselves of our full humanity.81

Ogorchukwu gives practical suggestions for tending and responding to each 'body'.

The concept of Ancestral trauma is referenced in the following terms by Rene Linklater in *Decolonizing Trauma Work*: ‘In Indigenous thought, “blood memory” is the occurrence of an experience of those that have gone before us being embedded in our physical and psychological being.’82

81. Jacquelyn Ogorchukwu, 2020. ‘The Four Bodies: A Holistic Toolkit for Coping With Racial Trauma’. Available from: medium.com/nappyhead-club/the-four-bodies-a-holistic-toolkit-for-coping-with-racial-trauma8d15aa55ae06 (Accessed 25.01.21)

82. Renee Linklater, 2104. *Decolonizing Trauma Work: Indigenous Stories and*

Colonial trauma response

Linklater speaks about the concept of a **Colonial trauma response**; the impact of historical colonisation, and the relationship between that experience and current trauma. She writes:

The concepts of historical trauma and cumulative trauma have [...] become a useful framework for health care practitioners who provide services to Indigenous peoples. Importantly, the construction of historical trauma was generated to address the inadequacies of psychiatric diagnostic criteria [...]. EvansCampbell and Walters propose a ‘colonial trauma response’ that explores ‘the interaction of historical and current trauma’.

Ethnostress

Linklater also references the concept of **Ethnostress**. ‘Ethnostress refers to “confusion and disruption that people were experiencing inside of their world” (Hill, 1992: 1).’ Linklater notes that:

Robert Antone (Oneida), Diane Hill (Mohawk) and Brian Myers (Seneca) identified this stress as being specific to the disruption of Aboriginal identity and sought to understand the impact of this disruption on the individual and community. The connection ethnostress makes between political history and current social realities places it well within Indigenous trauma theory. Essentially, ethnostress is a response to colonial trauma and is consistent with the notion that Indigenous peoples have been injured, oppressed and dehumanized by colonization: ‘Their reactions surface as response patterns, feelings of powerlessness and hopelessness that work to disrupt the life of the individual, family, community and nation’.

Linklater continues, ‘Hill identifies the effects of ethnostress as the loss of faith and belief, the hostage syndrome, the narrowing of culture, the idea of culture being under glass, tribal isolation, internalised stereotypes and the adopting of survivalist behaviours.’83

83. Ibid. p.32/33

There are many Indigenous practitioners, psych/ologists, theorists, community health workers and social workers languaging and generating practice to tend to the historical legacy of colonial trauma in their communities. Maria Yellow Horse Brave Heart (Lakota) speaks about Historical Trauma and Unresolved Grief. She defines historical trauma as, 'cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma'. She names the way historical unresolved grief accompanies that trauma:

...historical trauma response (HTR) is a constellation of features in reaction to massive group trauma. This response is observed among Lakota and other Native populations, Jewish Holocaust survivors and descendants, Japanese American internment camp survivors and descendants.

Brave Heart speaks about working with the Lakota community through naming trauma, honouring history and connecting to ceremony. Ceremonies that can facilitate the cathartic release of emotions, which she also describes in neurobiological terms; speaking about the way ceremonies may help in the healing process, change brain chemistry, and calm a traumatised brain. There is a focus on connecting to the sacred path – the strengths in traditional culture, like the Traditional Protective Factors: Woope Sakowin (7 Laws of the Lakota); with psychoeducation; narratives and trauma testimony.84

Karina Walters (Choctaw Nation) also speaks about historical trauma, as a non-pathologising way of understanding the effect of historical trauma on communities, and of finding ways to tend to it. Walters speaks about working with

84. Notes taken from Maria Yellow Horse Brave Heart, no date. 'The Return to the Sacred Path: Reflections on the Development of Historical Trauma Healing presentation'. Available from: www.ihs.gov/sites/telebehavioral/ themes/responsive2017/ display_objects/documents/slides//historicaltrauma/ htreturnsacredpath0513.pdf (Accessed 26.01.2021) models that really build on our sovereignty, on our [...] ancient teachings and ancient knowledges, that focuses on restoring relational ways of being in the world because that's what colonisation does, it disrupts our relational ways of being, and narrative transformation, you know, really thinking about how we talk about ourselves, how we treat each other, how that really matters.85

Decolonising 'mental health'/Decolonising Therapy

Jennifer Mullan, an author, academic, clinical psychologist and founder of Decolonizing Therapy in New Jersey says:

I feel like so much of the depression, of the anxiety, of the constant state of trauma that we are going through, this complex, developmental trauma, this concept of fight, flight, freeze response that we're in are due to systems of oppression – are due to these overt and covert acts of racism and colonization and the effects of colonization on our minds, bodies and spirits.

Mullan describes working towards a decolonised mental health system, where healing for all people should come in more forms than just individualised therapy and medication. 'I really believe that our understanding of therapy needs to shift out of it only being a problem, an issue, with the brain,' says Mullan. 'I also believe that Indigenous work and spirit work needs to be more included as a form of therapy, that it shouldn't be considered that only one-on-one therapy in an office with a licensed person is therapeutic work.'

85. Karina Walters 2018. [Video]. *Speaking about Historical Trauma Research*, Smith College School for Social Work. Available from: youtube.com/ watch?v=OxilPSnbU9I (Accessed 26.01.2021)

Mullan honours that some people need individual therapy and medication in order to thrive. However, she would like to see more collective, holistic healing approaches to mental health as options – the way they were done, and successfully worked, before colonization. 'I do think that we continue to blame ourselves or our brain or our trauma histories – and not that they do not have a major impact – but we are not continuing to look at and hold these systems of oppression accountable.'

Mim Khúc, a writer, scholar and teacher in the Washington, D.C. area who specialises in Asian American mental health makes the point:

I think that decolonization practice has to come out of communities of colour but the idea is that it benefits everybody because it takes mental health and puts it back in the hands of communities. All communities would benefit from it being in their hands and not in the hands of so-called experts.

Khúc stresses this work is important for everyone – not just people of colour.86

Recognition trauma

Recognition trauma has been articulated by Dr. Isha McKenzieMavinga and speaks about the feelings that can arise in people when they emerge from being silenced about racism. In her article *The concept of Recognition Trauma and emerging from the hurt of racism* she writes:

86. Karina Zapata, 2020. 'Decolonizing mental health: The importance of an oppression-focused mental health system'. Available from: calgaryjournal.ca/ more/calgaryvoices/4982-decolonizing-mental-health-the-importance-of-anoppression-focused-mental-health-system.html (Accessed 26.01.2021)

Following on from the concept of 'Ancestral baggage', I have introduced the concept of 'recognition trauma'. This concept identifies the process that both black and white people go through when emerging from being silenced about racism. It describes the awakening of hurtful experiences, which sometimes evokes feelings of guilt, shame, hurt and anger. Symptoms of recognition trauma emanate in a similar way to the awakening of powerful feelings related to the impact of sexism and heterosexism.87

The trauma of State Violence

State Violence enacts trauma in many ways. Harassment by the police, arrest, the court system, prison, detention and experience of the immigration system can all result in trauma with lasting effects. It can include traumatic experiences in state care or through related social work interventions.

Naming state violence as traumatic again points towards necessary systemic transformation and healing, for example by defunding the police and striving for more progressive ways to negotiate community safety. By addressing the root structural causes of lack, need and conflict. By mobilising for prison abolition,88 etc.

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87. Dr. Isha Mckenzie-Mavinga, 2011. *The concept of Recognition Trauma and emerging from the hurt of racism.* Available from: www.baatn.org.uk/wp-content/uploads/The-concept-of-Recognition-Trauma-and-emerging-fromthe-hurt-of-racim-Paper-1-1.pdf (Accessed 26.01.2021)

88. Prison abolition is the global movement to dismantle the prisonindustrial-complex, where profit is made from incarcerating people. Incarceration is deeply racialised, with disproportionate amounts of people of colour imprisoned. It is a movement that seeks *transformative* justice; demanding structural change that addresses the causes of violence or what gets called crime.

The trauma of Natural Disasters

Trauma can result from the tragedy of sudden and great loss of life, homes or livelihood through natural disasters. What is significant, through a wider analysis of trauma, is the way economic and racist systems are often responsible for *generating* and escalating trauma in conditions of natural disaster. Hurricane Katrina, which affected New Orleans in America in 2005 where over 1,800 people were killed, and which left significant areas flood damaged at a cost of

$125 billion, is a clear example of this. Negligence and racialised prejudice meant that the disaster, which could have been prevented through sufficient engineering on the flood barriers, wasn't. The emergency response was also delayed and inadequate. This connects back to the realities of institutional betrayal.

Disaster Anticipation trauma

I'm using this as a term to speak about threats like climate change, nuclear disaster, health epidemics and pandemics, disaster capitalism where abuses of power and profit will be engineered on the back of a crisis, or *any* experience where we anticipate grave

consequences but can't yet completely predict or entirely feel their effects. I also coin it in reference to the concept of anticipatory grief (used to speak of a feeling of grief occurring before an impending loss, though typically, the impending loss is the death of someone close due to illness). I use it also in relation to writing that I found in Cindy Milstein's' book *Rebellious Mourning: Collective Work of Grief.* A passage in that book is about a particular experience following the Chernobyl nuclear disaster of 1986. It's found in a chapter which features an interview between Sabu Kohso and Mari Matsumotu about the 2011 Fukushima nuclear disaster:

Sabu: How would you describe the situation people face in Japan after Fukushima?

Mari: A phrase from the book *Voices from Chernobyl* by Alexievitch Svetlana speaks to it well:

Something occurred for which we do not yet have a conceptualisation, or analogies or experience, something to which our vision and hearing, even our vocabulary, is not adapted.

*Our entire instrument is tuned to see, hear or touch. But none of that is possible. In order to comprehend this, humanity must go outside its own limits. A new history of feeling has begun.*89

In *Grievous Bodily Harm*, poets Karen McCarthy Woolf and Dominic Bury talk about climate change, grief and decolonising ecopoetics.

DB: The problem is that, unlike normal grief, environmental grief isn't processed by the body. It's too amorphous, too conceptual to be worked through properly. With climate change there's no closure or catharsis; grief goes on whirling around in the body [...] once the connection between the body and the environment is re-established, e.g. through nature connection work, then acts against the environment become intolerable, because they are felt as a violence towards the self.

KMW: We can't really formulate a post/humanist ecopoetics without a commitment to decolonising the patriarchal space from which we interact with nature – until we see it not as 'other' or remote from the self, but as an interbiotic system to which we contribute and belong.90

89. Cindy Milstein, 2017. *Rebellious Mourning: Collective Work of Grief.* AK Press, p.149

90. Karen McCarthy Woolf & Dominic Bury, 2018. 'Grievous Bodily Harm – Karen McCarthy Woolf and Dominic Bury talk climate change, grief and decolonising ecopoetics'. Frears, Ella. & Scott, Richard eds. *Magma #73.*

Changeling, Magma Poetry Journal. p.20

Yarning; land and climate change

Yarning is an Australian Aboriginal practice described as 'a conversational process that involves the sharing of stories and the development of knowledge. It prioritizes

indigenous ways of communicating, in that it is culturally prescribed, cooperative, and respectful'.91

I've distilled out some paragraphs from an article, *'If the land is sick, you are sick': An Aboriginal approach to mental health in times of drought.* The article speaks about Yarning in relation to the land and climate change. It also speaks about the ways Yarning is being honoured as a practice in clinical/community health settings. While that honouring is progressive, it occurs within the legacy of colonial violence that is still being enacted on Aboriginal communities. I refer to the article despite some reservations about its analysis, because of the way it celebrates an Indigenous practice that de-centres biomedical approaches to trauma and psycho-emotional distress, and the way it names relationship to land and the felt sense of current and anticipated environmental pain.

'If the land is sick, you are sick,' says Fiona Livingstone, who manages a suicide prevention programme at the University of Newcastle's Centre for Rural and Remote Mental Health.

She explains that the traditional Aboriginal concept of health is much broader than that of conventional

91. Melissa Walker & Bronwyn Fredericks & Kyly Mills & Debra Anderson, 2013. 'Yarning' as a Method for Community-Based Health Research With Indigenous Women: The Indigenous Women's Wellness Research Program'. *Healthcare for Women International.* Available from: www.tandfonline.com/ doi/bs/10.1080/ 07399332.2013.815754?mobileUi=0&journalCode=uhcw20 (Accessed 26.01.2021)

Western medicine. Aboriginal people, she says, are deeply connected to 'country', the place with which they have spiritual ties. The personal, social and ecological are closely interconnected: 'health' is the state in which they are all in balance.

A strong sense of responsibility to the land, of being 'custodians of the land we live on', is intrinsic to Australian Aboriginal culture. It means looking after the water and the land for the next generation. But climate change has made the weather chaotic, with drier winters and erratic or failing rains, especially in the south and east. No one can remember it being so dry, so little water in the dams and creeks. Many of Australia's iconic gum trees have failed to flower.

Water is a symbol of knowledge in at least one Aboriginal culture. In languages of the Northern Territory, the word ganma means a place where saltwater and freshwater meet. It is used as a metaphor for different people coming together to share knowledge and reach mutual understanding. It's also the basis of what Aboriginal people call yarning – sitting in a circle on the ground, sharing stories.

These old ways of thinking are being used by some psychologists to counter the colonial connotations of the Western style of psychology. Consultations based on yarning involve history, storytelling and finding common ground through skin ties, a complex system of inter-family connections. It can take weeks or months – the comparative directness of a Western-style consultation is seen as rude in Aboriginal culture.

Yarning has become the basis of many remote health programmes [...]. Mental health workers are building on this idea, yarning with older Aboriginal people in remote areas to understand their specific health needs, with the effects of the drought now foremost in everyone's minds.[...].

Ecological pain has been the subject of a growing body of academic study. The environmental philosopher Glenn Albrecht coined the word solastalgia to describe it while he worked at the University of Newcastle in NSW. Specifically, solastalgia is the feeling of distress associated with environmental change close to your home. The concept can be found in clinical psychology and health policy in Australia, as well as being used by researchers in the US looking into the effects of wildfires in California.92

Storytelling *'Poems are our guns too'*

Following the excerpts above about the practice of Yarning, and in referring back to Samah Jabr's words about the Palestinian context and the need to find Indigenous critical processes, I want to mention inspiration I drew from a talk by scholar and activist Ayesha Ahmad (St George's, University of London). In her talk *Approaches and Responses to Psychological Sufferings from Conflict: Clearing the debris of western-centred traumatisations*, she spoke about the power of storytelling, based on work she has been involved in with women in Afghanistan and elsewhere, around gender based violence (GBV). She cited Derek Summerfield: 'Current concepts of trauma are in line with the tradition in Western biomedicine and psychology to regard the singular human being as the basic unit of study and to prescribe technical solutions (Summerfield, 2000).'

In documentation of a period of time working with women in safe houses in Afghanistan, as part of the

92. Georgina Kenyon, 2019. 'If the land is sick, you are sick': An Aboriginal approach to mental health in times of drought'. *Scroll.in.* Available from: scroll.in/pulse/921558/if-the-land-is-sick-you-are-sick-an-aboriginalapproach-to-mental-health-in-times-of-drought? (Accessed 26.01.2021) project *SHAER: Storytelling for Healing, Acknowledgement, Expression and Recovery*, she describes how:

All participants described how they felt after telling their story to others in a similar way: they often used the word *subic*, which is used to refer to relief from suffering, and is best translated as 'being empty after having been full'. The release achieved through telling one's story was described as an embodied, cathartic experience:

Today I told you my whole story. I cry and it helps me. Now I am a bit relaxed. [P16: age 20, 1 year in the safe house].

Ahmad explains:

The positive benefits of storytelling were not from the telling alone, but as a result of being heard by another individual. The women described how the listener plays a supportive role in the storytelling by showing interest in their story. Also how people

can maintain a sense of identity and honour a sense of capacity through reappraisals of trauma that can happen in the process of storytelling. The speaking of not just the trauma itself that has happened but how one coped, managed, even thrived. She also comments on the *communal* aspect of the experience, of *sharing* stories:

People tell their story to reduce their pain. I am here in the safe house, and here I have met many women and girls who have suffered. Sometimes we tell our story to each other and cry together. Then we feel as if something is coming out of our bodies. We talk about our pain just to share it with each other and it helps us. So, I think people tell stories to share

their sadness and happiness.[P5: age 19, 1.2 years in the safe house].

Ahmad recognises that one of the ways in which storytelling accomplishes positive support for womens' psycho-emotional health is also through offering a space for the storyteller to imagine a 'hoped for' future and providing a space for healing from trauma through this process of imagining (Toyosaki, 2007). However, imagining a potential future within a therapeutic encounter requires not only a re-construction of the traumatic event itself, but also a process of situating the trauma in a wider life narrative. In our study, the women living in the safe houses expressed a clear desire to contextualise their trauma.

[...] As a potential alternative to biomedical approaches to trauma, our findings point to the importance of the interpersonal and social process of storytelling, which moves beyond the limited focus on symptoms of mental illness to offer a means for women experiencing GBV [Gender Based Violence] to formulate ways of seeing the world that support a positive social identity.93

Ahmad notes that:

The Afghan adage 'sorrow makes me a story-teller' reveals the strong symbolism between suffering and the telling of stories. Given the chronic nature of the conflict and the structural violence towards women who have experienced GBV, stories of suffering are continuing; there are no closed stories of violence. This requires a shift in the aims and expectations of trauma therapeutic interventions in

93. Jenevieve Mannell, Lida Ahmad, Ayesha Ahmad, 2018. 'Narrative storytelling as mental health support for women experiencing gender-based violence in Afghanistan'. *Social Science & Medicine*. Available from: www. sciencedirect.com/science/article/abs/pii/S0277953618304350?via%3Dihub (Accessed 26.01.2021)

Afghanistan to ensure that any impact is sustained, not nullified. To achieve this, there also needs to be a shift in the way narratives are conceptualised [...] to take on board cultural nuances in the meaning and purpose of a story, as well as different forms of narrative. Poetry can be used to express resistance in Afghanistan, including in response to GBV and conflict, through depicting literary representations of lived experiences and raising awareness of the human rights violations Afghan women face. Traditional story-telling, then, has the potential for therapeutic benefits through enabling the participants to challenge their prescribed narratives. As our local researcher says, 'poems are our guns too'.94

Complex trauma

Complex trauma is an overarching term for a response to prolonged, repeated experience of trauma in a context in which an individual has little or no chance of the situation changing, or of escape. Complex trauma can also be defined as exposure to multiple traumas. It is a term associated with chronic sexual and psychological abuse, and physical abuse and neglect, chronic intimate partner violence, or prolonged workplace or school bullying.

It is also associated with the experience of kidnapping and hostage situations, indentured service, slavery and human trafficking, also the experience of prisoners of war, concentration camp survivors, residential school survivors, etc.

It can occur at any stage of life, whether that is developmentally, during youth, or as a result of sustained adult experiences of violence, in the community, e.g. domestic and family violence, civil unrest, war or genocide, the experience of being a refugee or asylum seeker.

94. Ibid.

Complex trauma can occur as a result of extreme experiences of violence or injurious behaviour or circumstance. It can also occur as a result of what can get called small 't' trauma. Small 't' trauma can occur where sustained surrounding context has involved neglect, emotional disorientation or confusing emotional communication, and/or sustained micro stresses that accumulate. This kind of trauma can often be minimised by people who have experienced it because it can be rationalised as being not worthy of note in comparison to other more overtly traumatic experiences. It can also be perceived as being a common experience and therefore be normalised and disregarded, when it absolutely has had an impact and merits care, empathy, support and remedy.

Continuous systemic and structural trauma

The trauma of structural racism, sexism, homophobia, transphobia, capitalism, poverty, ableism and all the *many* oppressions, could be called continuous systemic and structural trauma. They are current and constant woundings. Naming that explicitly, raises essential questions about how power is configured, and points to where and how deep healing needs to, and can, occur. It speaks to the fact that we are all experiencing durational trauma in current social systems.

It asks the questions: What does it mean that we might be in various kinds of constant fight, flight or freeze states if what causes those responses is continuous? How do we move out of a kind of state of social 'freeze' to *mobilise collectively* for liberation, love and justice? How can we best generate cultures of care, and rest, while we lend our energies and capacities to challenging structural racism, cancelling world debt, paying reparations, redistributing wealth, collectivising labour, reinventing and reinvigorating social housing, building infrastructure through co-ops, collectives, coali-

tions, sharing childcare, sharing radical education and resources, dismantling fossil fuel corruption and nuclear technology, reducing consumption, transitioning to sustainable energy sources, making spaces accessible, fostering meaning and spiritual context and on and on... revolutions...

Vicarious trauma

Vicarious trauma is trauma that is witnessed or experienced *indi- rectly* which affects us. Naming this experience can encourage the practice of navigating and minimising embodying trauma that we might be directly or indirectly alongside. In her book *Trauma Stewardship*, Laura Van Dernoot Lipsky talks about the concept of the Trauma Exposure Response, and describes both how we can come to be affected being alongside trauma, and ways to tend to/ minimise that. She speaks about finding inner compasses to navigate care and wellbeing, about building compassion and community support and what it might mean to find balance that nourishes us and supports deep interconnectivity in the face of what can feel intolerable.

Therapist Charles Figley uses the term Compassion Fatigue to describe feelings of emotional and physical exhaustion leading to a diminished ability to empathise or feel compassion for others. It is sometimes also referred to as secondary traumatic stress (STS). This can be experienced in specific situations and/or places of work supporting folks who have experienced trauma.

Therapist and educator Vikki Reynolds addresses this concern through what she calls working in '*The Zone of Fabulousness*', i.e. in circumstances where we are neither enmeshed with someone's trauma nor distanced from them, and where we are providing support within networks of support, accountability and solidarity.

Trauma therapist Babette Rothschild also speaks about the potential dangers of empathy, and ways to minimise vicarious trauma through practicing boundaries and bringing more awareness and agency to how much we see and feel of another's trauma while still being very present alongside it. Rothschild also speaks

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of a need to be aware of whether someone else's trauma might be activating our own experience of a trauma, making us more susceptible to a heightened trauma response.

In an article, *The connection between heart-centredness, burnout and colonization*, Tada Hozumi has written about how an emphasis on heart-centred empathy can be destabilising, and can result in over-amplifying empathic embodiment; feeling too much of someone else's experience. They speak of it as a colonial legacy, and look at a precedent in the history of Christianity and whiteness, for upper body/heart inhabitation. They compare this to various cultures pre-colonisation holding more significant connection to and 'awareness of their lower bodies'. Hozumi speaks of the need for compassion that is inhabited lower in the body. And how this can support and foster capacity to

‘recognise our emotional resonance with another’, *and* be able to separate and ground in our own system, distinctly from anothers’ to avoid enmeshment and burnout.95

Vicarious trauma is applicable interpersonally, and to the wider sense of global suffering and trauma we *all* witness and navigate. Some of the suggestions around taking care to minimise, negotiate and tend to what might feel like more immediate vicarious trauma also feel relevant in that wider context.

Vicarious *resilience!*

As well as vicarious trauma – what we experience of, and how we are affected by others’ wounds – is the experience of vicarious *resilience*! When we share life, and within that the specificity of our personal and collective woundings, we can also get to share how we have all found/are finding resilience, ways to cope, ways to thrive,

95. Tada Hozumi, 2017. ‘The connection between heart-centredness, burnout and colonization’. Available from: selfishactivist.com/the-connection-betweenheart-centredness-empathy-burnout-and-colonization (Accessed 26.01.2021) oftentimes against the odds. We can be inspired by and inspire each other directly in sharing that resilience, and can be inspired indirectly as we witness each other engage capacity, joy, knowledge, empowerment, vulnerability, interdependence, spiritual practice and political resistance. We are also shaped by the resilience of our ancestors, who got us here. We can actively pool all this power, strength etc., by refusing the alienation and isolation of many of the social paradigms, and sometimes social etiquette (which suppresses really honest critical conversation), that we are supposed to abide by. We can speak of our experiences and of our capacity and build collective momentum for healing.

I’ve already critiqued what is problematic about the rhetoric of resilience under neoliberalism, which encourages finding ways to adapt and survive in contexts that don’t support wellbeing and actually need to be transformed. Here I celebrate the concept of resilience, particularly vicarious resilience, where sometimes *because* of our woundings we get to inherit and share with each other incredible strengths and wisdoms. Which we can (and do) use for profound personal and collective healing.

The Politics of Trauma speaks to this idea of resilience in the context of social justice. Hains asks:

When we are organising for social and environmental justice we can engage this question of resilience. What resilience is already present within a community, group, or organisation? Are there other resilience factors we can introduce that help to make the group more hopeful, connected and powerful? How can building resilience be a purposeful aspect of our strategy or campaign? We can keep asking:

– How would our communities, organizations, and our work be different if we oriented to cultivate resilience? Our own, and that of other people and communities?

– How can we purposefully support each other’s resilience and practice collectively?

– In times of increased stress, how can we both let ourselves feel the impact of it, and also return to practices of resilience?96

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Much of the conversation and activity around sharing resources, ideas, energy and radical resilience has been modelled by the disability justice movement. In their book *Care Work*, Leah Lakshmi Piepzna-Samarasinha records the way webs of care have been mobilised for a long long time by disabled people, where there has been a reinventing of culture that looks to respond to *everyone's* needs. They ask: 'How do we learn to do this love work of collective care that lifts us instead of abandons us, that grapples with all the deep ways in which care is complicated?' *Care Work* gives testimony to the multiple and complex ways that this reinvention of culture, centred on access and care, has happened and can happen. The book celebrates the necessity, and the love and power to be found in *all* of us doing that work.97

Trauma responses also culture bound

The alt-bio trauma model suggests we have innate, reflex physiological responses to trauma (fight, flight, freeze, etc.), and that these are universal, i.e. experienced in the same way in all humans. The way we respond to trauma however doesn't happen in a vacuum. It is also culture bound. Our physiology is *mediated* by spiritual frameworks and traditions, and by social and cultural habits and value systems that we have been shaped by.

In a chapter of *Crazy like Us*, Watters documents and critiques the way thousands of 'trauma experts' from the global North descended on Sri Lanka following the Tsunami there in 2004. He

96. Staci Hains, 2019. *The Politics of Trauma: Somatics, Healing, and Social Justice*, North Atlantic Books, p. 204

97. Leah Lakshmi Piepzna-Samarasinha, 2018. *Care Work; Dreaming Disability Justice*, Arsenal Pulp Press, p.33

details how problematic and colonial these 'trauma experts' were, presuming they offered better (or even, according to some of them, any) ways of dealing with what had occurred, over and above anything Sri Lankan people already used in their own communities.

A memo was emailed out by faculty members from the University of Colombo in Sri Lanka, critical of this mass arrival of 'trauma experts'. Watters says faculty members made an argument that fundamentally undercut the certainty that Western ideas about trauma are universal. 'A victim processes a traumatic event as a function of what it means' they wrote. 'This meaning is drawn from their society and culture and this shapes how they seek help and the expectation of their recovery.' Trauma reactions aren't automatic physiological reactions inside the brain, they suggested, but rather cultural communications.98

The response above is a clear example of decolonising, and a challenge to the way that global Northern frameworks seek to centre themselves. There is no one universal way that trauma is experienced or processed, much as the alt-bio model suggests there is.

Watters documents various cross-cultural and historical responses to trauma, to illustrate that physiological experience is also *shaped* by the way a culture, at a given time, speaks about distress and ascribes meaning to it. Watters speaks about Salvadoran women refugees who had endured a protracted civil war often experiencing

'something called *calorias*, a feeling of intense heat in their bodies. Although these women did experience sleep disturbances, which is a symptom of PTSD, they did not, for the most part, report increased startle responses or physical reactions when re-exposed to symbols of trauma'. He also speaks about the experience of Cambodian refugees, where the significant 'impact of trauma was being visited by vengeful spirits and the accompanying

98. Ethan Watters, 2010. *Crazy Like Us: The Globalization of the American Psyche*, Simon & Schuster, p.83

feeling of intense distress that, in escaping from the country, they had not been able to perform rituals for the dead'.

Watters concludes that, 'By isolating trauma as a malfunction of the mind that can be connected to discrete symptoms and targeted with new and specialised treatments [...], cultural narratives and beliefs that might otherwise give meaning to suffering' are erased. Watters speaks of the fallacy and danger of being 'value-neutral' to cultural beliefs. Someone may understand that the tragic loss of a child is God's plan, someone who lost a limb in battle may understand that they have served their community well. The context and meaning will affect what levels of trauma are experienced, and any generic 'value-neutral' appraisal can eclipse meaning, solace and strength that inform how people situate experiences and respond to them.99

Watters cites the difference in responses to war trauma found in several historical contexts. He tells us about British soldiers in the Boer War who spoke of joint and muscle pain – a condition doctors called 'debility syndrome'. He tells us about the experiences of soldiers in the American Civil War who spoke of aching on the left side of the chest and a feeling of having a weak heartbeat – a condition labelled 'da Costa's syndrome'. He tells about soldiers in WW1 with shell shock experienced as nervous ticks, muteness and paralysis. All these war situations were different, fought in different climates, and used different military technology, so the effect in terms of trauma would likely therefore *anyway* be different. The differences in experiences and responses however may also point to ways we are in part culturally *permitted* and given *experiential frameworks and language* to feel things in and with.

Trauma responses are also shaped by our heritages and lineages; and approaches and capacities that they may, or may not offer. Patrick Bracken, a researcher at Bradford University's Department of Health Studies, argues that the emergence of PTSD is a symptom of a troubled global Northern post-modern world: ' "In most

Western societies there has been a move away from religious and other belief systems which offered individuals stable pathways through life, and meaningful frameworks with which to encounter suffering and death." ' Watters, referencing Bracken, points to the fact that: 'Although we might be able to ignore the absence of these belief systems during our normal day-to-day lives, truly traumatic events have the power to startle us into awareness of a heart-stopping emptiness.'100

I disagree with Bracken's premise that PTSD is just a symptom of a world that has lost meaningful frameworks. I think PTSD (or better PTSR) is a very real experience. People/we are ricocheting about, navigating very real traumas, oppressions and violations and their sometimes huge and sustained impact on us. I take encouragement from Bracken's quote however, and the cross-cultural experiences above, to focus not just on trauma in terms of imprints and the effects (on alt-bio trauma physiology terms), but on the fact that the *ways* we place and respond to trauma are also contingent on frameworks we may or may not have been given for living. I agree with Watters conclusion, that traumatic events have the power to startle us into an 'awareness of a heart-stopping emptiness'. Consumer capitalism for example is such a political and spiritual wasteland. I'm interested in how we can collectively tend to this 'emptiness'. I think this emptiness, and an awareness that the frameworks we live in affect how we respond to crisis or woundings, can encourage us to reconnect to or reinvent frameworks and tools together *with which* we might navigate and respond to trauma. For example, exploring embodied meditative practices with which we can *observe* our physiological responses, so we can have more agency over the effect they have, on us and others. For example, speaking together about the socio-political meaning of our experiences of trauma and acting to change what is unjust and brutalising, together. For example, speaking about how we navigate uncertainty, when uncertainty in neocolonial and austerity capitalism is *very* real
and can be prevented, *and* when uncertainty is simultaneously also a fact of life; events in life can be unexpected and unpredictable. For example, going deeper (alongside that political analysis and mobilising for social justice) into conversation and exploration of feelings we have about the realm of spirit, the mystery of life and death, and the fact of both our agency and sometimes non-agency in some of life's unfoldings.

I'm inspired by the ways we can *tend to* some of the effects and impacts of trauma, work to *mitigate* the causes of trauma, also engage frameworks with which to *respond to and make meaning* of trauma, together. All of this interwoven exploration feeds into collective care and collective healing.

Collective Care, Collective Healing: practices, remedies, strategies

In workshops I've facilitated we've explored gathering any and all approaches; practices, remedies and strategies we use, or think might be useful, for resolving or tending to trauma. That conversation frame is outlined below. It might be useful to share as a model in different groups – in friendship circles, in organising collectives, with co-workers.

The invitation to share uses some of the 'alt-bio' conceptualisation of the effects of trauma and unresolved trauma physiology in the body/soma as a starting point. The conversation however invites *decentering* that alt-bio model, to consider the broadest understandings and feelings we might have about the questions below which make up Collective Care, Collective Healing Conversation # 1.

The conversation asks for the sharing of practices, remedies and strategies for healing.

Practices, remedies, strategies

Practice is a term for repeated activity that sustains and deepens. Practice can be activity for healing and transformation that we support each other to integrate daily, weekly, monthly, etc. I've been inspired by the project *generative somatics*' thinking and work on practice:

The Transformative Power of Practice

What is practice?

A central component of any change process – personal change or organizational change – is the concept of practice. But what is practice and why is it so important?

Practice is simply the act of doing something, whether that something is as complicated as doing a piano solo or as simple as washing the dishes. We call it practice when the act becomes a repeated behavior.

Default Practices

Default practices are the deeply rooted behaviors that we do automatically, consistently, and unconsciously in response to any given situation. By automatic we mean that it is the primary reaction that is triggered in us when we are in a particular situation; consistent means that it is the reaction that we engage in more often than not; and unconscious means that we do it without being consciously aware that there are probably other responses that we could choose in the situation.

Default practices are learned behaviors and reactions that are inherited through our life experiences. Our families, cultures and the social conditions in which we live invite and at times demand certain ways of being.

The good news is that we can learn to observe our default practices, instead of reacting out of them immediately. We can learn other ways to take care of what they were taking care of – other ways to deal with conflict, power, our own and others' emotions and need for safety.

Intentional Practices

Intentional practices are those that we choose to do to transform the way we show up in the world. Through new practices we increase choice and alignment with our values.

When we begin to look at our own practices and then practice on purpose, the first thing we want to ask ourselves is: 'What matters to me?', 'What do I care about?', 'What am I committed to?'. The answers to these questions become the guide for taking on new practices.

We are what we practice.

Are we practicing what is most aligned with our vision for the world, for justice? This is where we want to continue to hone ourselves, organizations and work.101

In their book *Rituals; Simple and radical practices for enchantment in times of crisis*, Yarrow Magdalena speaks about integrating practice, and about making changes

to patterns and habits. They are speaking about this in the context of engaging with regular ritual practice as a space of support, sustenance and connection. I think what they write applies to engaging with any transformative practice, and I love how they frame it as practice that can move from being *discipline* to *devotion*, a term of engagement that can mean love, loyalty, profound commitment,

101. Excerpts from Ng'ethe Maina & Staci Hains, 2019. 'The Transformative Power of Practice'. *generative somatics*. Available from: generativesomatics.org/ wp-content/ uploads/2019/10/Transformative-Power-of-Practice.pdf (Accessed 26.01.2021) steadfastness, faithfulness, enthusiasm, celebration, care and caring:

I'd like to say a few more things about habits and change that I hope might be useful. I am someone who has taken an incredibly long time, many years in fact, to really make ritual practice a central part of my life. I have always known, since I was little, that I love ritualised creativity and play and that I need these things to be okay on the most basic level. And yet I have spent many years chasing other goals and resisting confronting my feelings as hard as I could.

It just takes time. It takes time to change things and many of us have to fight hard for small pockets of privacy and headspace and energy to make something just for ourselves. I am in love with the idea that sometimes over time discipline becomes devotion. A friend once asked me how to tell the difference between discipline as self-care and discipline as self-harm and honestly I thought that was one of the best questions I've ever heard. It's pretty hard to answer yet so important to lean into. The more you practice the more you'll develop your discernment and be able to tell how much structure you need in your life at any point in time, at least that is my experience.102

I use the word **remedies** as it speaks to re-healing; of re-wholing:

remedy comes from the Latin *remedium* meaning medicine, antidote, that which restores health, from *re-* meaning again and *mederi* '**to heal**', from root *med* meaning **to take appro- priate measures**.

102. Yarrow Magdalena, 2020. *Rituals; Simple and radical practices for enchantment in times of crisis*, Yarrow Magdalena, p.137

heal comes from the Old English *hælan* meaning **make whole**, sound and well, from the German *heilen*, meaning to heal, literally '**to make whole**'.

I use the word **strategies** (subverting its original military meaning) as it speaks to plans of action designed to achieve a long-term or overall aim. Civil rights organiser Marshall Ganz defines strategy as 'how we turn what we have into what we need to get what we want'.103 How can we have *strategy* be part of our broader healing? In her book *Emergent Strategy, Shaping Change, Changing Worlds*, adrienne maree brown takes the idea of strategy into really broad, holistic terrain. She shares that the evolution and layerings of what has fed into her conceptualisation of Emergent Strategies, includes inspiration from Black science fiction writers like Octavia Butler, from activism, from biomimicry and permaculture, etc. She concludes: and now it's like [...] ways for humans to practice being in right relationship to our home and each other,

to practice complexity, and grow a compelling future together through relatively simple interactions. Emergent strategy is how we intentionally change in ways that grow our capacity to embody the just and liberated worlds we long for. And maybe, if I'm honest, it's a philosophy for how to be in harmony and love, in and with the world.104

I'm inspired by the principles of Emergent Strategy such as embodying 'the just and liberated worlds we long for' and how they might be part of shaping conversation around

103. Marshall Ganz, 2009. *Why David Sometimes Wins: Leadership, Organization, and Strategy in the California Farm Worker Movement*, Oxford University Press, p.8

104. adrienne maree brown, 2017. *Emergent Strategy, Shaping Change, Changing Worlds*, AK Press, p.23/24 collective care and collective healing, both here in Part Three, and when the conversation is revisited in Part Four.

Collective Care, Collective Healing Conversation # 1

Sharing practices, remedies, strategies to
1. *release*;
2. *rest, restore and renew*; *reconnect and reassociate*;
3. *respond and reimagine...*

Below are just *some* examples of the collective care and healing related to trauma that was pooled in workshop groups and shared on big sheets of paper... It's *not* definitive, that's the whole point, we need to speak about it in our different contexts and communities, from the positions and perspectives of our various heritages, life histories and social co-ordinates, and choose what feels relevant, appropriate, and where and when it may do so. All the questions that are prompts for group conversation could be (re)phrased by each grouping of people. It is outlined below as an exercise in three parts, but could be changed in any way that feels useful or more coherent.

The three parts or steps below demarcate areas for consideration, even though they all interrelate. As we spoke in groups it was clear for example that 'distinct' healing approaches for the bodymindsoul as asked about in step 1 and step 2 overlapped and intersected. Some things that were a *release* were also how we *rested* deeply, and/ or were also how we *reconnected*. Nonetheless it was a useful *way in*, and the questions then just became a portal for sharing thoughts, experiences, ideas and for opening into more fluid dialogue. Take time with each of the three steps or questions. It might be useful to read them out a couple of times, and have them written at the top of sheets of large paper to be able to refer back to.

1. How do we release?

Begin by asking, writing down and responding to reflective questions:

– How do we *release* trauma that might be held in the bodymindsoul?

– How do we release feelings of being stuck in, even addicted to states (fight, flight) associated with the (threatened) sympathetic nervous system?

– How do we access vitality, association and excitement if we have felt stuck in states (freeze) associated with the (threatened) parasympathetic nervous system?

– How do we access vitality, association and excitement if we have felt stuck in the (threatened) sympathetic nervous system state, and vitality, association and excitement can now feel *akin* to fight, flight, and so feel frightening or overwhelming?

Exercise – especially that raises heart beat and takes us to a feeling of peak exertion/capacity: running, swimming, weights, kick boxing, etc., followed by rest and grounding.

Sweating – saunas, exertion, sex – amongst other profound physiological and spiritual effects we actually release adrenaline when we sweat.

Expressing emotion – crying, shouting, singing, shaking, trembling, making sounds, laughing, dancing, etc., yelling at demos...

Bodywork – any kind of safe touch or movement practice to release tension stored in the body and notice patterns we hold, in a safe space.

TRE – a series of exercises that assist the body in releasing deep muscular patterns of stress, tension and trauma. The exercises safely activate a natural reflex mechanism of shaking or vibrating that releases muscular tension, calming down the nervous system.

Breathwork – a specific breathing practice that can release deep holding patterns and emotion.

Making sound – singing, chanting, toning, yelling

Drinking enough water – dehydration can cause tension in the body and keep us in the activated sympathetic or frozen parasympathetic nervous system.

Intensity – going to an edge with a physical or sexual, emotional, creative or spiritual experience; the experiences of alternating hot and cold, like hot and cold showers; performance; fairground rides, kart racing. Then grounding.

2. How do we rest, restore, renew, reconnect, reassociate?

Then ask, write down and respond to reflective questions:

– How do we regularly access deep *rest*?

– How do we *restore* and *renew* what gets called the (unthreatened) parasympathetic nervous system?

– How do we reconnect and reassociate?

Slowing breathing in and out – and making the exhalation slightly longer. Current trauma theory references the understanding that long exhalations stimulate the vagal nerve and engage the parasympathetic nervous system, so are calming.

Relaxing the eyes – palming the eyes: rests the alert activity of the sympathetic nervous system.

Touching the lips – has parasympathetic activation through nerves there.

Stimulating the cervix – (in bodies assigned female at birth) which is connected to the vagus nerve.

Movement practices together – martial arts, dance, etc.

Pleasurable touch – solo or exchanged on the body, massage, etc.
Also heat – saunas, dancing, steam, smoke.
Sexual pleasure – with self or others, in all its shapes and forms.
Creativity – losing oneself in flow states, altered consciousness, etc.
Nature connection – time with the land, weather, animals... lakes, the sea....
Meditation – yoga/tai chi/prayer/bodyscans/ guided meditations, etc.
Tending to spiritual and ancestral connection.
Ritual practice – to tend to ancestral connection, seasonal connection and marking, planetary movement, etc.
Tending to altars
Singing, sounding, drumming....
Plant allies – making relationships with and using herbs to connect, ground, calm, soothe etc.
How do you release? How do you rest deeply? Reservoir. Resource
In your body where the places of pain may be In the body of the earth
rested back, supported
Look around you, look locate yourself, here
Stack the bones, stand Soil, peat, moss, grasses Rock and stone Muscle, fascia, skin
To push, To be still To undo To sound To dance To fuck To sorrow To weep To rage To laugh

3. How do we respond and reimagine?

As well as pooling embodied practices and tools for transformation, through group conversation we shared questions, ideas and action to ***respond and reimagine***. Judith Herman's work which speaks of recovery as also potentially involving *responding* to the world, and mitigating the causes of trauma, invites further questions here like:

– How do we transform what causes trauma, and find ways to *respond* to, *reimagine*, and orient to a world that is more life affirming for all beings?

– What might response-ability mean for us personally and collectively?

– How do we foster resilience that supports us as complex beings, *at the same time* as we are in processes of addressing and mitigating what is traumatising in the world?

Of the responses for each of the questions above, determine what you might take away and implement personally and collectively.

Creating and holding the conversation space

The three steps above are just *one* approach, or invitation for dialogue and solidarity.

Whatever way the conversation is structured, it can be useful to set an intention for a level of *respect* and *care* that is desired whilst sharing conversation. And an intention for the focus and spirit of the conversation, i.e. that there is a desire for it to be non-reductive and liberatory.

It can be useful to create some ground rules together that support safety in the group space and conversation. It can be helpful to write them up on a sheet so that they can be referred to if needed. They might be agreements like:

– Respecting confidentiality and anonymity – that what is shared in the space remains in the space, that if something shared is referenced outside the space it doesn't disclose anyone personally, i.e. *we spoke about the need for..., not X person said they needed...*

– Listening well, and deep listening – where you just *receive* what has been said, and don't offer any reflection, and that that kind of listening can be requested by people when they speak.

– Honouring difference of opinion

– Turning off mobile phones

– Agreeing on the length of the conversation and on timings for comfort breaks

– Making sure everyone feels free to take a break from the space if they need.

It can be useful to honour that the smallest personal remedies and the largest structural ones are *all* welcome! That there is space to focus in on what may seem small and/or intimate needs and remedies, and on dreaming big.

It can be useful to agree on a way to close the space together when the time has come to an end. For example a closing circle where everyone says what they particularly valued in the exchange, or anything they would like to revisit in a second conversation, or what could be reshaped or improved for future conversations.

Models of Care

There are some great models that can be templates to use and adapt, in order to generate groups, networks and circles of care, for sharing conversation and support and solidarity. I just point to *some* here...

T-MAPS:Transformative Mutual Aid Practices

Developed by Jacks McNamara and Sascha Altman Debrul as part of the Icarus Project: T-MAPS are a set of tools that provide space for building a personal 'map' of wellness strategies, resilience practices, unique stories, and community resources. Creating a T-MAP will inspire you to connect your struggle to collective struggles. When we make and share our T-MAPs with others they become potent tools for healing and liberation. Your

T-MAP is a guide for navigating challenging times, figuring out what you care about, and communicating with the important people in your life.

tmapscommunity.net

Pods and Podmapping

Developed by the Bay Area Transformative Justice Collective:

During the spring of 2014 the Bay Area Transformative Justice Collective (BATJC) began using the term 'pod' to refer to a specific type of relationship within transformative justice (TJ) work. We needed a term to describe the kind of relationship between people who would turn to each other for support around violent, harmful and abusive experiences, whether as survivors, bystanders or people who have harmed. These would be the people in our lives that we would call on to support us with things such as our immediate and on-going safety, accountability and transformation of behaviors, or individual and collective healing and resiliency.

batjc.wordpress.com/pods-and-pod-mapping-worksheet

The Hologram

Developed by Cassie Thornton, inspired by infrastructure explored at the solidarity clinics in Athens, Greece, the

Hologram is: a feminist social health-care project that aims to provide accountability, attention and solidarity as a source of long-term care. This project aims to serve anyone falling between the widening cracks of highly regulated, financedriven police states, regardless of where they live. This viral care system functions to empower small groups of people to focus rigorously on the medical, emotional and social health of one person at a time. By looking at all three dimensions, the idea is that the person and their health become a hologram, instead of a financial instrument for the medical industry. The goal of this project is to find a semi-systematic way that we can attend to and track the health of people around us through regular conversations (in person and virtual), close observation, and good documentation. **feministeconomicsdepartment.com/hologram**

Regular 'cleansing and purification'; clearing and connecting

The idea of regular practice, ceremony or ritual to clear and (re) connect feels relevant given the many intersecting woundings and trauma imprints that might be layered up and impact us. Also as part of engaging with just the fact of our existence; of human vulnerability and of mortality. This feels in keeping with many global traditions that engage with regular release and reconnection in the many shapes and forms that can take.

The language of cleansing and purification may be familiar to us. It can however come laden with problematic meanings of cleansing 'sin' or 'evil', or even echo colonial narratives about cleanness and purity that are deeply racialised. The dictionary definition of purification reads: 'Purification rites are required whenever there has been some kind of polluting contact. In addition, cultures may institutionalize regular, periodic purification rituals on the general principle that pollution occurs all the time.'105 We could use a very broad, metaphorical definition of the term 'pollution' as the presence of something which has harmful or poisonous effects. The words clearing and connection, (or several others) might feel more appropriate.

We have a choice about the language, felt sense and intention of any kind of regular practice, ceremony or ritual we might devise. Practice, ceremony or ritual which has an embodied *intent to heal*, based on whatever energy we feel may be stuck, agitated, absent, numb, etc., in ourselves, and/or in the collective body of the human or non-human world.

We might root in to or base that on our own cultural heritages. If we lack or have lost practices in our own heritages, and are *feeling our way* towards/with them, it feels essential not to generate them based on cultural appropriation, but more so on the *felt sense* of what might be needed for healing to occur. We can let that kind of knowing and intuition shape the practices. We might know, feel, or intuit that regular practices of hours of massage, or being in or making very loud sound, dancing uninterrupted for long periods, sitting in prayer (whatever that means for us) around fire through the night, or walking in very remote places in silence, either in solitude or communally might be healing, for example.

I reference Yarrow Magdelena's book again where they speak about ritual practices we can lean into, especially in times of challenge. They describe the common ritual process; involving a separation from daily life and consciousness, a period of liminality, and then (re)integration.

I draw inspiration from Malidoma Somé's writing on ritual and healing, and especially ritual as an 'anti-machine'. He writes: 'ritual is called for because our soul communicates things to us that the body translates as need, or want, or absence. So we enter into ritual in order to respond to the call of the soul.'106

105. www.britannica.com/topic/purification-rite

106.Malidoma Somé 1997. *Ritual: Power, Healing and Community.* Penguin, p.24

Ritual in a way is an anti-machine, even though the industrial world is not totally devoid of the practice of ritual [...] *Ritual is not compatible with the rapid rhythm that industrialism has injected into life.* So whenever ritual happens in a place commanded by or dominated by a machine, ritual becomes a statement against the very rhythm that feeds the needs of that machine. It makes no difference whether it is a political machine or otherwise.107

Let us make time, space

old pain, fear, old sorrow, stored, and resurfacing sometimes the pain of this morning, today

of last month of world sorrow

sometimes mortality come blunt look you in the face

Immense strength, immense fragility here we all are, wounded, healing and looking death in the face

travel in this body that will come to pass how we seek ways to contemplate the mystery steep in it

honour it

May we rest back into hands that listen and listen and listen, undoing to the depths of ourselves, in connection, absolute, breath to breath, supported, through the body, the ground holding our total shape, arms wide, surrender, warm hands, warm roots, warm moss, warm grasses...

Let us be sounded, base lines reverberating in the belly, crying and laughing, we are side to side, side by side, long hours til the sunrise,

107. Ibid. p.19

see the dawn come, let us sleep deeper than we ever did wrapped in blankets we have woven for each other...

Let us be running and rolling, and sweating, and wrestling, to an edge, push, the vital challenge, to our limit, then deep in breaths, deep breaths out, our hearts beating, settling, clearance, in the cold wind, by the river, by the water's edge...

Let us roll and run the streets, know ourselves, agents in the infrastructure, spinning, pounding, pulsing, our lungs dragging in the air in great tides of clarity before the city starts...

Do you need to come up and out, then down? Do you need to sink and settle deeper in?

When to rise high.

When to drop to the base of yourself, your own mountain.

Let us engage lineage, open to the land, the wind, calling with the crows, opening the palms of our hands, face up to the falling rain, through the fire smoke...

Let us dream up and build better. Mobilise for that together.

Asking. Anchoring.

This conversation to share Urgent. This urgent things

I want to tell you I am listening That I hear you. Hold you. Hold me We'll hold each other

This far too much. This not enough The wounding and the weight

Power, grounding ours

Justice, vitality, connection, freedom ours Joy, pleasure, peace ours

Part 3 References

66. W. Ellis, & W. Dietz, 2017. A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. *Academic Pediatrics*, 17 (2017) pp. S86-S93. DOI

Part Four - The Politics of Experience

The Politics of Experience

This chapter looks in more detail at the way consciousness and experiences of distress can be pathologised. It considers ways we might understand and speak about those experiences on our own non-biomedical terms, with analysis and dialogue about social and spiritual context.

The section begins by looking at psych/iatric diagnosis – referencing a little more of the history of how diagnoses have been constructed, and how much of that construction has been deeply problematic, and both systematic and arbitrary. It acknowledges and honours the *uses* of diagnoses, but, building on Part Two, critiques diagnosis as a way of classifying experiences of consciousness or distress, and the way these can be interrelated.

This chapter examines the ideas that are promoted within psych/iatry by the words 'disorder' and 'recovery'; it also looks at the concept of the personality and the 'self '; and considers experience, or what psych/iatry might call symptoms, as a protest against oppression, like the conditions of global Northern neoliberalism and whiteness.

This chapter explores what it could mean to lay aside diagnostic labels and concepts that we are commonly offered, and *relanguage* (i.e. find broader, more accurate, useful language and understanding of) experiences together. It considers how we might do this

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through the sharing of expansive conversation about what we *feel*, what we *experience*, what that might point to in terms of *root causes and correlations*, and what *remedies and responses* that may suggest/ call for. I think *reconceptualising* our experiences of being human, consciousness, and specific experiences of distress collectively, and finding language for it, can be part of movement towards remedies and responses that are truly life affirming, that create space, possibility and healing in the broadest sense. This chapter returns to and builds on the Collective Care, Collective Healing conversation begun in Part Three – considering how we might share practices, remedies and strategies, as part of resourcing ourselves and each other, and mobilising for a better world for everyone.

The chapter title *The Politics of Experience* is borrowed from the title of a book by the radical psych/iatrist R.D. Laing who was a key figure in the anti-psychiatry movement. I remember coming across Laing and that movement when I was young and drawing a lot of inspiration from it. The emergence of anti-psychiatry in the 1960s occurred in the UK, with activity that I know of also in Italy and Latin America. It

had a desire to explore *experience* in the context and critique of the social, and in connection to the spiritual. People were asking what has shaped and is shaping us, rather than just talking about experiences as if they are located in one's 'personhood', occurring in some kind of contextual vacuum.

While Laing's analysis of oppression was lacking in terms of race and gender, he nonetheless named systemic alienation and violence that impacts on us as part of the conversation needed to be had around psycho-emotional health.

Our alienation goes to the roots. The realization of this is the essential springboard for any serious reflection on any aspect of present inter-human life [...]. We are bemused and crazed creatures, strangers to our true selves, to one another, and to the spiritual and material world – mad, even, from an ideal standpoint we can glimpse but not adopt [...] [we] are in an alienated state, and this state is not simply a natural system. Alienation as our present destiny is achieved only by outrageous violence perpetrated by human beings on human beings.1

Laing was a co-founder of Kingsley Hall, an experimental community (1965–1970) established in the east end of London by the Philadelphia Association (which Laing co-founded with radical psych/ iatrists and psychotherapists David Cooper, Joseph Berke and others). The aim of the community was to generate space where people could inhabit psycho-emotional healing processes, and explore their states of being away from conventional understandings or prescriptions about consciousness and distress. It was also a place that attempted to break down some of the doctor/patient model; people experiencing distress or exploring states of consciousness that they were inhabiting lived and explored there together with therapists. While not without problematic aspects, the Kingsley Hall community was a landmark in exploration moving away from only pathologising, or attempting to mute or fix experiences of distress. Mary Barnes became the most famous participant, whose experience of navigating through what might get called psychosis is documented in her autobiography *Mary Barnes: Two Accounts of a Journey through Madness*, co-authored with Joseph Berke, a therapist who supported her in that journey.

David Cooper, a South African psych/iatrist working in Britain, co-founder of the Philadelphia Association, coined the term anti-psychiatry in 1967 to describe opposition and alternative approaches to the orthodox psych/iatry of the time. A Marxist revolutionary, he argued that the political context of psych/iatry and its patients had to be highlighted and radically challenged, and warned that the 'fog of individualized therapeutic language' could take away people's ability to see and challenge the bigger social picture. He spoke of having a goal of 'non-psychiatry' as well as anti-psychiatry.

1. R.D. Laing, 1967. *The Politics of Experience and The Bird of Paradise*, Penguin, p.12

Cooper coordinated the *Congress on the Dialectics of Liberation*, which was a gathering held in London in 1967. Participants included R. D. Laing, poet Allen Ginsberg, philosopher Herbert Marcuse, Buddhist monk Thich Nat Han and Black Panther mem-

ber Stokely Carmichael. The two week congress was generated as 'a unique gathering to demystify human violence in all its forms'. What's interesting, inspiring and energising to me is the way a focus was placed on addressing wider violence in all its *intersecting* forms, of which psych/iatry was named as being one.

Diagnoses as culturally produced *Homosexuality, 'Drapetomania' and the Bereavement exclusion*

Part Two already looked at some of the history of the construction of psych/iatric diagnoses that are listed in the DSM (*Diagnostic and Statistical Manual of Mental Disorders*). That history has involved questionable processes, whereby complex experiences have come to be defined by medical professionals as distinct illnesses or disorders. Part Two spoke about the concept of *culture bound syndromes*, and how that of course includes all the 'syndromes' that are listed in the DSM. They emerge from and are shaped by a particular biomedical global Northern culture, even though the DSM centres itself as a catalogue of human experience.

Diagnostic classifications are clear examples of the way ideas *emerge from a culture*, are *constructed*, and then shift and *change*. In this next section I want to give some examples of how that has happened, and look at the way prejudice and profit can motivate decisions about what is deemed pathological. What follows shows how diagnoses are *very* subjective, and most often determined by people in positions of power. I think these very problematic examples can help throw open for question and discussion *all* the dominant diagnostic classifications that have been made.

One example that demonstrates the way prejudice has motivated diagnostic classification, and how changeable diagnoses can be, is the classification of homosexuality as a pathology. Homosexuality used to be classified as mental illness and people were put through brutal processes of 'hetero-normalising treatments' often involving drugs and hormones. In 1952, the American Psychiatric Association (APA) listed homosexuality in the DSM as a sociopathic personality disturbance, and it remained in the DSM until May 1974.

Gay rights activists, including the Gay Liberation Front, protested against the APA at its conventions in San Francisco in 1970 and 1971, disrupting the conferences, interrupting speakers and shouting down psych/iatrists who defined homosexuality as a mental disorder.

In 1974, the diagnosis was replaced with the category of 'sexual orientation disturbance', later 'ego-dystonic homosexuality', which was only *finally* deleted in 1987. Homophobia and related violence is of course sadly not just a thing of the past. The legacy of that kind of prejudice can still be seen here in the UK. It can also be seen

in colonial laws imposed in former colonised territories, laws which often usurped existing, more liberatory pre-colonial attitudes to (and legislation around) expressions of sexuality and gender.

The manufacture of 'mental illness' by those in positions of power and prejudice, and the ways it has been deeply racialised and violently racist, is evidenced by another example of a former diagnostic criteria. In 1850, in the context of the Transatlantic Slave Trade, a white American physician Samuel Cartwright claimed he had discovered a new 'disease'. ' "In noticing a disease hertofore classed among the long list of maladies that man is subject to", he told the Medical Association of Louisiana, "it was necessary to have a new term to express it".' He called this 'disease' *drapetomania*, taking two words from the Greek *drapetes*, meaning runaway enslaved person and *mania*, meaning madness, frenzy – defining it as 'the disease causing Negroes to run away'. This grotesque racism heralded as a new disease claimed to have 'had one diagnostic symptom – "absconding from service" and a few secondary ones, including sulkiness and dissatisfaction'2 which were said to appear just prior to the enslaved person's flight. While Cartwright was mocked in the North, he was reprinted in the South. And as late as 1914, the legacy of the diagnosis was uncritically continued in the third edition of Thomas Lathrop Stedman's *Practical Medical Dictionary* which included an entry for drapetomania, by then defined as 'Vagabondage, dromomania; an uncontrollable or insane impulsion to wander'.3

Gary Greenberg suggests Drapetomania could equally have been included in the DSM:

Drapetomania was never considered for the *Diagnostic and Statistical Manual of Mental Disorders*, the American Psychiatric Association's compendium of mental illness, but that may be only because there was no such book in 1850. (Indeed, the Association of Superintendents of American Institutions for the Insane, the organisation that would eventually become the APA, was only six at the time, and the word *psychiatry* had just come into use). Certainly it met many of the criteria for inclusion.4

Prior to Cartwright's violently racist claims, we can see how the early classification of people into categories in the US was also racialised and racist. The 1840 census included a single category in its data criteria: idiocy/insanity. Three years later, the American Statistical Association made an official protest to the U.S. House of Representatives about that census, stating that significant errors had been found about the people of the nation, pointing out that in many towns African-Americans had all been marked as insane.

While this contestation was acknowledged, the dangerous lenses of that kind of social mapping continued. The census expanded

3. Thomas Lathrop Stedman's, no date. *Practical Medical Dictionary.* Available from: archive.org/stream/stedmansmedical00unkngoog#page/n282/ mode/2up (Accessed 9.02.2021)

to 2 volumes in 1870, and to 25 volumes in 1880. Frederick H. Wines was appointed to write a 582 page volume based on findings from that census called *Report on the*

Defective, Dependent, and Delinquent Classes of the Population of the United States, which was published in 1888. 'Deficient' and 'delinquent' classes were being mapped out by those in power along racial and economic lines of prejudice. In that sense one of the functions of the census was to support the way power and control could be maintained by the ruling classes.

This pattern of deeply racialised and racist diagnoses continued. Eli Clare documents two white psych/iatrists Walter Bromberg and Frank Simon, who in 1968 coined the diagnosis 'protest psychosis' to speak about African-American resistance and revolution as illness. They alleged:

The stress of asserting civil rights now in the United States these past ten years and the corresponding nationalistic fervour of African-American nations [...] has stimulated specific reactive psychoses in American Negroes [...]. The particular symptomotology we have observed, for which the term 'protest psychosis' is suggested, is influenced by [...] the Civil Rights Movement [...] and is colored by a denial of Caucasian values [...]. This protest psychosis among prisoners is virtually a repudiation of 'white civilisation'.

Eli Clare writes:

In coining this new diagnosis 'protest psychosis', cousin to schizophrenia, and declaring it widespread among Blacks who defied white supremacy, they, like Cartwright, framed resistance as pathology. They used [a constructed notion of] defectiveness yet again to justify violence – this time the locking up of Black men in prisons and psychiatric facilities and drugging them with antipsychotic meds.

Clare also exemplifies the grotesque racism in the marketing of some of the psych/iatric drugs at that time, detailing how Haldol was 'marketed to psychiatrists in the 1970s as a treatment for Black schizophrenia'. He continues: 'One ad leads with the tagline "Assaultive and belligerent" and pictures a caricature of an angry Black man with his left hand balled into a fist. It claims "Cooperation often begins with Haldol".'5

In an article *Whiteness in Psychiatry: the Madness of European Misdiagnosis*, survivor, activist, trainer and researcher Colin King writes about the continuing colonialism of psych/iatry, and the whiteness in specific diagnostic categorisation of the mid 19th century up to current times. He writes:

The diagnostic classifications of *ICD* and *DSM* represent how African men are perceived in the eyes of a psychiatric system that enacts the cultural reality of whiteness. Consequently my own diagnosis as a schizophrenic can be located in the cultural reality of European psychiatry that has no representation of me as normal. Eurocentric theories impose on my life a set of beliefs and diagnostic tools that are intrusive features of a classification system that fails to see these patterns of whiteness. *DSM* and *ICD* must be understood philosophically as modern versions of drapetomania as they are linked to the trauma of slavery and the experiences of African men exposed to values that bear no resemblance to their cultural world.6

A final example illustrating how constructed, arbitrary and alienated diagnoses can be, is seen through something in the history of the DSM called the 'bereavement

exclusion'. The bereavement exclusion is a period of time following a death, within which you are excluded

5. Eli Clare, 2017. *Brilliant Imperfection. Grappling with Cure*, Duke University Press, p.24 & p. 12

6. Colin King, 2016. 'Whiteness in Psychiatry: the Madness of European Misdiagnosis' in *Searching for a Rose Garden: Challenging psychiatry, fostering Mad Studies*, PCCS Books, p. 72 from being given a diagnosis (i.e. depression) for what you are feeling. The APA decided they would 'allow' a certain amount of time for grieving to occur, after which point if the 'symptoms' of grief continued, it would be classified as a (mental) disorder. The initial permitted time frame for grief in the DSM–lV (1994) was two months, but it was reduced in the DSM–V (2013) to two weeks.7

Classifying experience in this way regulates and transforms everyday human experiences into a pathology which is 'treatable' in a profit driven system. Doctors in the USA are only able to claim health insurance coverage for something classified as a disorder, and advocate drug treatments which consequently feed the profit of the pharma-industrial complex. In that context there is a strong impetus from psych/iatry and the pharma industry to define more and more experiences as pathologies.

Frances Allen (a psych/iatrist who chaired the task force that produced the fourth revision of the DSM–IV) writes critically about the DSM–V revisions, and the way psych/iatry becomes more and more the 'business of manufacturing mental disorders'. He has spoken out about the way lowered thresholds, new diagnoses and revamped criteria would create diagnostic epidemics. 'The result would be a wholesale imperial medicalisation of normality [...] a bonanza for the pharmaceutical industry but at huge cost to the new patients caught in the excessively wide DSM–V net.'8

In *The Loss of Sadness*, Wakefield and his co-author, sociologist Allan Horowitz, make it clear that more is at stake than the bereavement exclusion. 'Even if we accept the inescapable fuzziness of psychiatric diagnoses,' they argued, 'still a nosology must have some kind of integrity, lest the DSM define every undesirable consequence of sadness as a disorder'.9

7. Silke Schwarz, 2018. 'Resilience in psychology: A critical analysis of the concept'. *Theory and Psychology.* Available from: https://doi. org/10.1177/0959354318783584 (Accessed 9.01.2021)

8. Gary Greenberg, 2013. *The Book of Woe, The DSM and the Unmaking of Psychiatry*, Scribe Publications Ltd, p.106

9. Ibid. p.160

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I remember when Princess Diana died. The streets were lined with grieving people, and apart from feeling critical of so many people mourning a celebrity member of a wealthy royal family, I had the realisation that this was a culturally sanctioned moment which *allowed* people to grieve, and to grieve *collectively.* I sensed the grief to be in

relation to lots of things; it felt like it gave permission to connect to loss and mortality in general. It also seemed like an unnamed portal for mourning the conditions we live in that can both alienate us from the fact of death, and from the fullness of life.

The ‘bereavement exclusion’ and the general pathologising of sadness has profound consequences. It has the power to profoundly compromise the space we have to express specific griefs, and the experience of wider contextual and continuing grief. In the introduction to her book *Rebellious Mourning: The Collective Work of Grief*, Cindy Milstein writes:

We are, at present, swimming in a sea of grief [...] in a time marked globally by rising fascism and authoritarianism, the largest displacement of people in human history, and the greatest structural devastation of the very basis of life, the ecosystem as a whole.

She speaks about one of the cruelest affronts being that pain should be hidden away, buried, privatised – a lie manufactured so as to mask and uphold the social order that produces our many, unnecessary losses. When we instead open ourselves to the bonds of loss and pain, we lessen what debilitates us; we reassert life and its beauty. We open ourselves to the bonds of love, expansively understood. Crucially, we have a way, together, to at once grieve more qualitatively and struggle to undo the deadening and deadly structures intent on destroying us.10

10. Cindy Milstein, 2017. *Rebellious Mourning. The Collective Work of Grief*, AK Press, p.4

From ‘Madness’ and ‘Lunacy’ to ‘Mental Health’: language and law

Changing perceptions and classifications of experience though time have seen various legal and institutional structures mandated to confine, control, punish, treat and care for people.

In the late 13th century the term mad was used to mean demented or insane. The term demented came from the Latin *demantare* meaning ‘away from one’s mind’, and insane meant something that was unsound or unhealthy, from an inversion of the Latin *sanus*, meaning healthy.

In the 13th century the word lunatic, from the Latin *lunaticus* meaning moon-struck, from the Latin root *luna* meaning moon, referred to intermittent periods of ‘insanity’ correlating with changes in the moon’s cycle, usually when it was at full moon. The Old English equivalent was *monaðseocnes* meaning month-sickness, or *monseoc*; literally moon-sick. The term and experience also has a relationship to the New Testament Greek *seleniazomai* meaning epileptic, from *selene* meaning moon. As is well known the moon has an effect on the water of the planet, on the volume of the tides, and so can be understood to affect us even just at this level (Iet alone the effect of its light and more magical consciousness altering energetics), as human bodies are on average 60% water. Research has looked at the moon in terms of the menstrual cycle and fertility, showing that moonlight stimulates ovulation and influences bodily cycles.11 The police even accumulate this knowledge for the purposes of enforcing state control, recently acknowledging some contemporary effects of the full moon. In Sussex there was a decision to deploy more senior officers around the full moon ‘to counter trouble

they believe is linked to the lunar cycle'. A Sussex police spokeswoman said, ' "Research carried out by us has shown a correlation between violent incidents and full moons." '12

The original use of 'lunacy' referred to the way we are affected by lunar cycles; the cycle of the dark moon to full moon and back to the dark again. I imagine historically (and know from my own experience) that the effect of lunar cycles could have been and can be experienced in all sorts of profound and life affirming ways, giving insight and both ecstatic depth and elevated experience. My experience of profound cyclical changes in being and consciousness related to my menstrual cycle and the moon cycles motivated workshops I facilitated and what I then gathered together into a book called *Threads*. With the shift through the Enlightenment to an emphasis on rationalism and reason, and then into more linear, mechanised, industrial ways of living, it has become harder and actively disallowed to inhabit energies of diffuse and elevated consciousness and flux. I think this has resulted in cyclical agitation, distress, confusion. Changeable, cyclical, lunar influenced consciousness, experienced by all sexes and genders, has come to be denigrated. In later legal use, the term lunatic came to mean 'of unsound mind' sufficient to render someone incapable of transactions or the management of their affairs, which informed psych/iatric legislation (see below).

By the mid 18th century, the common method in the UK for dealing with people deemed mad, insane or lunatics, was either to keep them in the family home or put them in a 'madhouse'; private houses where proprietors were paid

12. Fred Attewill, 2007. 'Police link full moon to aggression'. *The Guardian*. Available from: www.theguardian.com/uk/2007/jun/05/ukcrime (Accessed to detain their residents, and run them as a commercial concern with little or no medical involvement. This led to two forms of abuse; the first was keeping people deemed mad or insane in atrocious conditions, and the second was the detention of people who were falsely claimed to be mad or insane – in effect, private imprisonment.

The Madhouses Act 1774 was an Act of the Parliament of Great Britain, which set out a legal framework for regulating 'madhouses'. The Act required that all madhouses be licensed by a committee of the Royal College of Physicians. A license permitted the holder to maintain a single house for accommodating people deemed 'mad', and would have to be renewed each year. All madhouses were to be inspected at least once per year by the committee, who would also keep a central register of everyone who was confined so that people could locate them. It required that people admitted be examined and certified insane by a doctor. Penalty fines were set for concealing or confining more than one person without a license or for taking in a patient without an order from a doctor. A series of Madhouse Acts followed in 1828 and 1832 to try and make the Act more effectual.

The County Asylums Act 1808 established *public* asylums in Britain, the first of which opened in Northampton in 1811. The Act intersected with the wider policing and confinement of poor people, permitting but not compelling Justices of the Peace to provide establishments for the care of what were called pauper lunatics, so that they

could be removed from workhouses and prisons. By 1827 however, only nine county asylums had opened. As a consequence of this slow progress, the Lunacy Act 1845 created the Lunacy Commission to focus on lunacy legislation.

As psych/iatry was forging its ground in the UK, it was under pressure to establish itself as an institution worthy of credit, comparable to physical medicine. Acts were introduced to give credence (and power) to it as medical territory.

The Lunacy Act 1845 had a significant agenda; to change the status of those deemed 'mentally ill people' to *patients*. The Lunacy Act 1890, which placed an obligation on local authorities to maintain institutions for the 'mentally ill', formed the basis of mental health law in England and Wales right up until 1959.

In 1886 **The Idiots Act** was intended to provide facilities for the care, education, and training of people deemed 'idiots' and 'imbeciles'. In the House of Commons in February 1911, Winston Churchill spoke about ideas to introduce compulsory labour camps for 'mental defectives'. A bill that was the *precursor* for the coming **Mental Deficiency Act** was passed in 1913 with only three MPs voting against it. One of them was Josiah Wedgwood, who said of it, 'It is a spirit of the Horrible Eugenic Society which is setting out to breed up the working class as though they were cattle.' The Idiots Act was repealed by the Mental Deficiency Act 1913. It established a Board of Control for Lunacy and Mental Deficiency to oversee the care and *management* of people, now classified as either idiots, imbeciles, additionally feeble-minded persons or moral imbeciles, all of which were open to very wide and very problematic interpretation. The act remained in effect until it was repealed by the Mental Health Act 1959.13

The Mental Health Act 1959 had an aim to abolish the distinction between psychiatric hospitals and other hospitals, and to de-institutionalise people and promote community care. One of the changes introduced by the Act was the abolishment of the category of 'moral imbecile'.

13. Jayne Woodhouse, 2006. 'Eugenics and the feeble-minded: the Parliamentary debates of 1912–14'. *Journal of the History of Education Society.* 11: 2, 133

That category had been defined in such vague terms that it had meant that mothers of 'illegitimate' children, especially in case of multiple births out of wedlock, had been placed in institutions for 'defectives', or under often very spurious 'guardianship'.

Some thoughts on diagnosis; uses and dangers

There can be very real uses and benefits of diagnoses, and diagnoses can have meaning. They can affirm that pain and distress being felt are *real* and help create space for responses or approaches to be found to support or address experiences. They can be part of acknowledging that experiences of struggle, or variable consciousness, are unique but also *common* to *many* people. They can be part of generating communities of shared experiences and support and help in accessing resources (like medication, therapy, or wider support). They can be used as leverage to refuse to live in prescribed ways, and so afford more freedoms. They can be of use and sometimes essential in benefit (welfare) and asylum claims, and in certain legal cases. And can be useful for securing/sustaining funding for resources or projects that support particular experiences that fall within a diagnostic classification.

I honour the fact that for many people diagnosis can be the first time that distress or difficulty has been given acknowledgement, and taken seriously, and that diagnosis can be a basis from which to make further, broader and empowering personal, relational and political realisations. I also honour the way many people find meaning and use in a diagnosis *and* simultaneously *deconstruct* it on their own terms. A non-binary approach exercising hermeneutical dissent. Tiffany Sostar and collective, for example, have put together a document about experiences, and reinterpretations of experience, that can be listed under the diagnostic classification of Borderline Personality Disorder (BPD). In their document *BPD Superpowers: What the Borderline makes possible*, they give information and advice

about support that might be useful or welcomed by people given or choosing this diagnosis. At the same time they contextualise, critique and complicate mainstream diagnostic narratives. They cite from Rebecca Lester's essay *Lessons from the Borderline: Anthropology, psychiatry, and the risks of being human*:

In my view, BPD does not reside within the individual person; a person stranded alone on a desert island cannot have BPD. Nor does it reside within diagnostic taxa; if we eliminated BPD from the DSM, people would still struggle with the cluster of issues captured in the diagnosis. Rather, BPD resides – and only resides – in relationship. BPD is a disorder of relationship, not of personality. And it is only a 'disorder' because [...] it extends an entirely adaptive skill set into contexts where those skills are less adaptive and may cause a great deal of difficulty. Yet due to the contexts

in which the skills were developed, the person has a great deal of trouble amending them (Linehan, 1993). Since BPD resides in relationship, BPD can also be attenuated through relationship: it is not a life-sentence, and it is not even necessarily problematic if managed constructively.14

While I absolutely honour that diagnoses can have meaning and uses, I feel that diagnoses are in essence problematic, limiting and/ or dangerous. Below are some aspects of diagnoses that enact this problematic limitation or danger.

In most cases a diagnosis:

Looks at symptoms – If someone is experiencing insomnia, anxiety, sadness or unusual beliefs, *these* experiences or 'symptoms' will most often be focused on as the things that need to be 'treated' or 'fixed',

14. Rebecca Lester, 2013. 'Lessons from the Borderline: Anthropology, psychiatry, and the risks of being human'. *Feminism and Psycholog*y 23(1): 70–77 rather than understanding that they are expressions, and asking what the root causes or meaning of the experiences may be: Why is someone not sleeping, or feeling frightened? Why does someone feel deep sorrow, or numbness? What might the meaning be in someone's experiences or current beliefs?

Enacts the mind/body/soul split – Psych/iatric diagnoses look at emotional or cognitive 'symptoms'. They most often disregard what is felt in the body related to experiences of emotional distress (where and how, for example, are things felt in the body?). And disregard what might be embodied symptoms that occur simultaneously to the distress, like nausea or physical heaviness or feelings of heat or cold, all of which give information and might point towards remedial approaches. They most often disregard profound relational and spiritual contexts and concerns.

Defines – Someone, usually in a position of power, defines and categorises someone else's experiences for/to them. People's agency is often taken away, there is little or no room for someone to understand, define or give language to their experience in a way that is meaningful for them, and might point towards remedy. Experiences are also classified individually and/or classified in groupings ('symptom clusters') that suggest they are distinct. Actually there is often much more fluid overlap between experiences, and groupings of experiences.

Pathologises – Diagnoses suggest or insist that what someone is feeling or experiencing is something 'bad/sick' that needs to be changed, treated, cured or fixed, when there may be personal/ collective insight or meaning that is possible to understand from/ within the experience. It is predicated on a deficit rather than a strength based model; the problems are focused on, often eclipsing possibility and potential. While experiences (called symptoms) can be painful, frightening and debilitating, they can be *messengers* and guide us towards change. In this sense they can be perceived

as useful or as a source of information about our personal and collective circumstances. It's interesting to draw from an early 15th century definition of the word *crisis* as a vitally important or decisive state of things, and a point at which change must come, for better or worse. The Latinised form of Greek *krisis* means 'to separate,

decide, judge, from root *krei* meaning ‘to sieve, discriminate, distinguish’. Even if an experience is very difficult it can shed light on what might be needed, and in that sense can be an opportunity.

Says there is a ‘normal’ – Diagnoses suggest there is a ‘normal’ that others deviate from. We can ask what is normal? Who sets that definition of normal?

Individualises – Diagnoses suggest that what is being experienced is located *within* the individual, and needs to be treated on an *indi- vidual* level. It apportions individual responsibility, defectiveness and blame and suggests that the individual person needs to be made ‘better’. There is often little or no recognition of the social context people are living in or their personal/intergenerational history, or personal constitution and consciousness that has unique sensibilities, capacities and needs within those contexts. It doesn’t look at what experiences might tell us or reveal about our *collective* human social condition that could be addressed or made sense of *communally.*

Also paradoxically *de-individualises* – A diagnosis denies the fact that we all have unique and different constitutions, consciousnesses and personal and intergenerational histories, and often promotes a homogenised one-treatment-fits-all plan for everyone instead of engaging a personal and socially contextualised, therapeutic approach.

‘Fixes’ – Diagnoses often suggest or insist that what someone experiences is essentially part of who they are, and will be something/

an ‘illness’ they will live with ‘for life’. It doesn’t honour trauma wounds that might be healed. It doesn’t honour consciousness that appears ‘other’ to a dominant idea of normal as determined by the dominant culture. It doesn’t honour that things can shift and change, or that we may come to an understanding of experience and foster tools, practices and resources to navigate life ahead with more power, capacity and pleasure. It also encourages people to *identify* with a diagnosis – and the ideology that a diagnosis comes with as listed above (*I am schizophrenic, I have Bipolar*, etc.) as a fundamental part of who they are.

Naming and meaning

Maori scholar Linda Tuhiwai Smith speaks about the power of naming. She writes that naming 'is about retaining as much control over meanings as possible. By naming the world people name their realities'.15 Tuhiwai Smith says this in the context of the legacy of colonialism. I think the fact that naming is such an important way to retain control over meaning can apply where there is *any* dominant ideology imposed on experience. Experience which may have historically been, or could currently be conceived of and named differently, and not on those dominant terms.

In *Names matter, language matters, truth matters*, Jaqui Dillon writes: decolonise the medicalised language of human experience [...]. And if you are the person that has to use services and their diagnoses for whatever reason – because you need the support, you need the welfare benefits, you need the passport of diagnosis to open certain doors – fine, but don't buy their version of your reality.

15. Linda Tuhiwai Smith, 2012. *Decolonising Methodologies. Research and Indigenous Peoples*, Zed Books Ltd, p.159

Don't buy the bullshit. Know your own truth. Define your own reality.

Do not let anyone else define your reality for you.16

'How we feel about how we feel'

The way we perceive experiences is intimately bound in with the ideas and language we are given to perceive them *with*. We interpret our emotional responses through current *cultural* understandings and ideas about them. In a talk, *The History of Human Emotions*, historian Tiffany Watt Smith describes how: 'Today we celebrate happiness. Happiness is supposed to make us better workers and partners and parents. It's supposed to make us live longer.'17 But Watt Smith tells us that in 16th century Europe, *sadness* was thought to do most of those things. That sorrow and melancholy were held in high esteem, to serve connection and commitment to work and love and family.

The way embodied responses are experienced, like sadness and grief for example, is shaped by what the culture says about them. Whether they are allowed or disallowed, whether they are considered meaningful and profound, or a sign of weakness or personal faultiness.

This fact that emotional responses can have particular meaning ascribed to them in different contexts makes me think of some of the medieval female mystics, whose perception of their experience was shaped by a religious devotional frame. Margery Kempe for example, a

16. Jo Watson, ed. 2019. *Drop the Disorder: Challenging the culture of psychiatric diagnosis*, PCCS Books, p.221

17. Tiffany Watt Smith, 2017. [Video]. 'The History of Human Emotions'. *TED Talk*. Available from: https://www.ted.com/talks/tiffany_watt_smith_the_history_of_human_emotions?language=en (Accessed 9.02.2021) pilgrimaging mystic in England in the early 15th century, experienced long periods of sobbing. Following a pilgrimage to Rome, she also experienced howling. She referred to those experiences, the 'affective movement of her soul',18 as gifts. She spoke of them as the gift of crying, and the gift of howling. Her strong emotions were validated and ascribed meaning.

Sometimes when I cry it's an expression of anger, pain, struggle, it's a release. Often it's because I've been moved incredibly deeply. In the crying I can feel connected to (my) humanity, love, wonder, joy. There is such an alive richness to the tears. Since I came across Margery Kempe's words, they have become quite a reference point. I joke/serious comment now if I am in those kinds of tears that it's 'the gift of crying'. It defies the cultural norms I grew up with and internalised, that crying is weak or something to be ashamed of. It points to transcendence and awe, sometimes of being spiritually and emotionally consumed, as part of the human experience.

There are many emotional experiences and experiences of consciousness that have been interpreted differently throughout time. We now think yawning means tiredness but in the 12th century some troubadours believed it to be a symbol of the deepest love. Boredom, as we speak of it now, Watt Smith says was conceptualised by the Victorians in relation to new ideas about leisure time, stimulus and self-improvement. I realised that often when I experience what we are told is boredom it is actually feelings of disconnection or restlessness. The feeling (that could be boredom) doesn't always mean I want to *do* things, it sometimes just means I need different ways to *be*, or to know myself as part of the larger interconnected human, and beyond human world. Sometimes it means I am hungry for intellectual

18. Andrea Janelle Dickens, 2009. *The Female Mystic: Great Women Thinkers of the Middle Ages*, I B Tauris & Co Ltd, p.171 stimulation, sometimes for pleasure and touch, sometimes for time within the greater natural world, sometimes for rest, sometimes I just feel stuck in the discipline of capitalism and need to feel more flux and variation.

Watt Smith speaks about the fact that when language changes, our emotions do too, and that there have been dramatic shifts in emotions 'in response to new cultural expectations or religious beliefs'. She says there is a 'historicity to emotions'.19

An example of a change in language related to experience can be seen in the way the term 'Nostalgia' has been used and changed over time. In 1688 a Swiss medical student Johanes Hofer coined a diagnostic term: *Nostalgia* (*Nostos*: homecoming, *Algos*: pain), which could be fatal. He coined it after he heard of the case of a young man who appeared to be fatally ill and wanted to return home to die. The closer he got to his home village the more he recovered his health, and when he got home he regained his full health. Nostalgia was also coined based on accounts of Swiss mercenaries who were pining for their native mountain landscapes. Symptoms included fainting, high fever, indigestion, stomach pain and death.

The last person to officially die from that diagnosis of *Nostalgia* was an American Soldier fighting in France in WW1. Watt Smith looks at the way homesickness has since been downgraded. It isn't believed to kill people anymore. And the term nostalgia now means a yearning for things past, for a particular time, not specifically a place. She asks if this accounts for the fact that in the global North we maybe no longer feel it as acutely today? Through this example she

19. Tiffany Watt Smith, 2017. [Video]. 'The History of Human Emotions'. *TED Talk*. Available from: https://www.ted.com/talks/tiffany_watt_smith_the_history_of_human_emotions?language=en (Accessed 9.02.2021) illustrates how large historical shifts affect, as she puts it, 'how we feel about how we feel'.20

Concepts and words shape 'how we feel about how we feel', i.e. inform how we both *look for* and *understand* experiences. The actual feelings and sensations in the body are interpreted and given meaning.

Watt Smith discusses the way emotions don't just 'happen', they are embodied physiology meeting with cultural frameworks and understandings. She explains that the most recent developments in cognitive science show that emotions are not simple

reflexes, but immensely complex, elastic systems that respond both to the biologies we've inherited and to the cultures that we live in now. They are cognitive phenomena, they are shaped not just by our bodies but by our thoughts, our concepts, our language.

She tells us how neuroscientist Lisa Feldman Barrett suggests that in a dynamic relationship between words and emotions, 'when we learn a new *word* for an emotion, new *feelings* are sure to follow'.21

Feldman Barrett continues:

It may feel to you like your emotions are just hardwired and they just trigger and happen *to* you, but they don't [...], no brain on this planet contains emotion circuits [...], so what are emotions really? [...] emotions are not built into your brain at birth, they are just *built* [....], you interpret a physical sensation and give it meaning.22

20. Ibid.

21. Ibid.

22. Lisa Feldman Barrett, 2017. [Video]. 'You Aren't at the Mercy of your Emotions: Your Brain Creates Them'. *TED Talk*. Available from: www.ted.com/talks/lisa_feldman_barrett_you_aren_t_at_the_mercy_of_your_emotions_your_brain_creates_them/transcript?language=en (Accessed 9.02.2021)

This has huge implications for how we come to understand our psycho-emotional states, consciousness, and distress.

Watt Smith suggests that in order to be truly emotionally intelligent we need to look at where the meaning of words have come from 'and what ideas about how we ought to live and behave they are smuggling along with them'. I think this is a key concept, especially in terms of diagnostic labels, and also feeds into how we might language experiences more on our own terms.

The language of ‘disorder’ and ‘recovery’

A lot of the language of diagnosis centres the notion of ‘disorder’. It suggests we either experience *disorders*, or we are personally *disor- dered*. Lots of things we experience aren’t disorders, they just don’t fit into given social norms, or are expressions of pain that are founded in our realities. We might feel *distress*, or consciousness that doesn’t fit into a rational, capitalist, functioning mode. Often responses might be totally *in order* given our circumstances and legacies.

In his 1966 Ware Lecture, *Don’t Sleep Through the Revolution*, Dr. Martin Luther King, Jr. said:

There are some things in our nation and in our world to which I’m proud to be maladjusted [...]. I never intend to adjust myself to segregation and discrimination. I never intend to become adjusted to religious bigotry. I never intend to adjust myself to economic conditions that will take necessities from the many to give luxuries to the few, and leave millions of people perishing on a lonely island of poverty in the midst of a vast ocean of prosperity. I never intend to adjust myself to the madness of militarism, and to the self-defeating effects of physical violence [...].

And I call upon you to be maladjusted to these things until the good society is realized [...].

Yes, I must confess that I believe firmly that our world is in dire need of a new organization – the International Association for the Advancement of Creative Maladjustment [...]. Through such maladjustment we will be able to emerge from the bleak and desolate midnight of man’s inhumanity to man, into the bright and glittering daybreak of freedom and justice.23

Many contemporary voices highlight and challenge this idea of ‘disorder’, including projects like *Drop the Disorder, Recovery in the Bin* and *Personality Disorder in the Bin*. In the anthology *Drop the Disorder*, for example, Jo Watson writes:

The language of ‘diagnosis and disorder’ has replaced the everyday language we once used to describe emotional states, and the acronyms of psychiatry are now part of our everyday conversations [...]. As long as individual illness is accepted as being the primary cause of distress, the real causes go unnamed, and those responsible for them are effectively let off the hook.24

Disability justice activist Eli Clare writes:

Disorder doesn’t allow for voices and visions to be common

– connected to our daydreams or spiritual experiences, the channeling and writing of fictional characters or the terrifying aftermath of trauma. *Disorder* dictates specific ways of understanding our body-minds and excludes others.

I wonder what we would know about ourselves and each other if diagnosis projected acceptance rather than disorder onto our body-minds. Inside this imagined projection, pain

23. Dr. Martin Luther King, Jr., 1966. 'Don't Sleep Through the Revolution'. *Ware Lecture* at the Unitarian Universalist Association General Assembly, Hollywood, Florida'. May 18th. Available from: www.uua.org/ga/past/1966/ ware (Accessed 10.2.2021)

24. Jo Watson, ed., 2019. *Drop the Disorder: Challenging the culture of psychiatric diagnosis*, PCCS Books, p.226/228

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and death might become familiar parts of our life cycle rather than markers of disorder to dread and avoid.25

As well as dominant psych/iatric and cultural ideas about disorder, is the idea we are given that everyone can 'recover'. The group *Recovery in the Bin* offers great critique of the idea of 'recovery'. They question the idea of a recovery that fits people back into damaging and lacking social systems, and they also name the way the concept of 'recovery' has been co-opted. Recovery began as a grassroots term which people experiencing distress coined to speak about healing journeys. The term has been assimilated by medical and social institutions to mean 'getting better' and also as a way to shift responsibility from supportive service provision to a notion of personal recovery and 'independence' that absolves provision of support. *Recovery in the Bin* have coined the term *neo-recovery* to describe this new agenda.

We are a User Led group for MH Survivors and Supporters who are fed up with the way co-opted 'recovery' is being used to discipline and control those who are trying to find a place in the world, to live as they wish, trying to deal with the very real mental distress they encounter on a daily basis. We believe in human rights and social justice! We want a robust 'Social Model of Madness, Distress & Confusion', placing mental health within the context of social justice and the wider class struggle.

We recognise that the growing development of MH 'Recovery' in the UK/US during the past decade or so has been corrupted by neoliberalism, and capitalism is the crisis! Some of us will never feel 'Recovered' living under these intolerable and inhumane social pressures.26

25. Eli Clare, 2017. *Brilliant Imperfection. Grappling with Cure*, Duke University Press, p.43

26. Recovery in the Bin. A critical theorist and activist collective, 2016. *The Unrecovery Star.* Available from: recoveryinthebin.org/unrecovery-star-2 (Accessed 10.2.2021)

The social framed as the psych/ological

In Part Two, a section with a similar heading drew together examples of the way injustice and oppression (in India, Brazil and Argentina) were deflected from and reframed as individual, psych/ological distress. I revisit that here with an example of an insidious kind of reframing that happened near me when I was living in South London. A South London council decided to demolish a social housing estate called the Heygate, destroying a community and socially cleansing the neighbourhood to make way for private housing which priced everyone out of the area. It was met with righteous resistance and frustration. The council ignored community outrage, and in 2009 something called 'The Happiness Project' was contracted in, to offer residents counselling and workshops. Residents were offered 'coping with change stress busters' and 'success intelligence' coaching to mute unease and frustration, in place of people having actual agency over their own housing and social situation. The involvement of the Happiness Project with its motto 'Success is a state of mind; happiness is a way of travelling; love is your true power' is another *classic* example of individuating what is *systemic* corporate and State injustice; of quieting dissent to abuses of power with suggestions of 'personal improvement'. One resident, Ernest, said 'I'm happy enough. I've got two lovely children, I've got four grandchildren [...] I love my life [...] if they hadn't have come along and said we're going to move you out, force

you out, I'd have been happy for the next 30 years hopefully.'27

Toxic Positivity

While happiness is important, it can't be solicited in the face of very real oppression, like the Heygate above, and it's anyway

27. Interview on a web page titled *Broken Promises*, no date. Available from: heygatewashome.org/displacement.html (Accessed 10.2.2021) problematic to centre happiness or positivity over all other emotions. In Barbara Ehrenreich's book *Smile or Die, How Positive Thinking Fooled America & the World*, she gives a disturbing insight into the history of positive thinking, how it emerged through the rise of the New Thought movement in the US, a precursor to self-help culture. She documents and tracks the way it permeated popular culture, and business and corporate life.

She tells us about sociologist Robin Leidner who underwent sales training at a company called Combined Insurance. The first day of class began with trainees standing up and chanting:

'I FEEL HEALTHY, I FEEL HAPPY, I FEEL TERRIFIC!' while throwing 'the winning punch' [...] this was part of the 'Positive Mental Attitude' philosophy developed by the company's founder, W. Clement Stone – a major Republican donor and coauthor, with Napoleon Hill, of *Success Through a Positive Mental Attitude*. Slogans flashed at sales trainees on video included: 'I dare you to develop a winning personality'. And Leidner comments, 'As that last slogan makes clear, trainees were encouraged to regard their personalities as something to be worked on and adjusted to promote success.'28

Ehrenreich shows how the ideology of positivity and personal improvement has moved intractably into the mainstream. She reflects on the way positive psychology publishes mass market books with 'you' or 'your' in the title – a telltale sign of the self-help genre – like Seligman's *What You Can Change... and What You Can't* and *Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfillment*.29

28. Barbara Ehrenreich, 2009. *Smile or Die. How Positive Thinking Fooled America and the World*. Granta Books. p.104

29. Ibid. p.149

Ehrenreich explains how positive psychology advocates like Seligman went into the life-coaching business 'providing life-coaching conference calls to hundreds of people at a time for $2000 per each. He also developed a cash-generating Web [sic] site, reflectivehappiness.com, promoting "monthly exercises intended to increase happiness" ',30 which included an authentic happiness inventory to self test with. When Ehrenreich met Seligman she says:

I mentioned the possibilities of species wide disasters like extinction and barbarism, but he just looked at me intently and said that if I could 'learn' optimism, as in his earlier book *Learned Optimism: How to Change Your Mind and Your Life*, which shows the reader how to program his or her thoughts in a more optimistical direction, my productivity as a writer would soar.31

The Happiness Project, brought in to ameliorate the violence happening in the clearance of the Heygate community was just another incarnation in the line of New Thought/Positive Thinking lineage. The Happiness Project's website references the inspiration from American New Age affirmation guru Louise Hay. Hay, who herself drew inspiration from the church of New Thought, tapped into the complex territory and power of prayer and intent; coopting it into the neoliberal agenda. Her work ballooned into what is now a multimillion dollar corporate enterprise, marketing individuated 'personal growth' and publishing a stream of books like *Love Yourself, Heal Your Life Workbook* and *The Power Is Within You*, etc.

30. Ibid.

31. Ibid. p.156

‘Personality’, the ‘self’, personality tests, and ‘personality disorders’

Personality, the ‘self’

The idea of disorder often gets located in an individual and an idea of someone’s personality. Part Three already looked in some detail at the way trauma and our environments can shape us, and then be superficially perceived as being part of what gets called our ‘personality’. We might have coped with pain, by keeping very busy and talking constantly, which could be misperceived as having an outgoing personality. We might actually crave stillness and solitude but it is too frightening to access. Distress patterns can be attributed in this way to an external idea of ‘who we are’.

[...] the trauma response can look like part of the person’s personality. As years and decades pass, reflexive trauma responses can lose context. A person may forget that something happened to him or her – and then internalise the trauma responses. These responses are typically viewed by others, and often by the person, as a personality defect. When this same strategy gets internalized and passed down over generations within a particular group, it can start to look like culture. Therapists call this a *traumatic retention*.32

The Merriam Webster dictionary defines personality as ‘the totality of an individual’s behavioural and emotional characteristics’, and as ‘a set of distinctive *traits* and *characteristics*’. The Cambridge dictionary defines personality as ‘*the type of person you are*, shown by the way you behave, feel and think [emphasis added]’. While many contemporary conceptions of personality acknowledge

32. Resmaa Menakem, 2017. *My Grandmother’s Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies*, Central Recovery Press, p.9 environmental influences, this sense of personality nonetheless being the ‘type of person you are’ and viewed as something that is relatively stable, can erase and shut down vital conversation about what has shaped us, and how we might want to change some of those things that shape us.

In the English speaking global North there has been a shift from an idea of *character* to a focus on *personality*. The ancient Greek term *kharaktēr* meant mark or defining symbol. The meaning was extended in Hellenistic times by metaphor to mean a defining quality, individual feature. In English, from the1640s, the meaning of character was

'sum of qualities that define a person or thing and distinguish it from another'. In 1712, character meant the 'moral qualities assigned to a person by repute'.33

'Character' tends to reference some sense of virtue within a person, which might be held in high esteem and lend itself to the collective good. It typically sits within a shared communal moral/ spiritual framework. The idea of having 'good character' would have been in order to be of service to a community, i.e. situated within a whole.

The term 'personality' has been recorded as being in use since the late 14th century, however the first recorded use of it, meaning 'person whose character *stands out from that of others* [emphasis added]' is from 1889. It follows the beginning of the use of the term 'personhood' in 1878 as a quality or condition of being an *individual person*, drawing directly from the Latin *persona*, 'human being, person, personage; a part in a drama, assumed character) + hood (state or condition of being)'.34

This shift from *character* to *personality*, an individuated 'self ', feels in keeping with the context of greater economic and cultural shifts that occurred at the end of the 19th century. A shift away from more communal relations into the belly of industrialisation,

33. Online Etymological Dictionary etymology of 'character', no date. Available from: etymonline.com/word/character (Accessed 10.2.2021)

34. Online Etymological Dictionary etymology of 'personality', no date. Available from: etymonline.com/word/personality (Accessed 10.2.2021)

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and increasing atomisation and individualisation. Where 'character' showed us defining qualities/virtues (within a wider whole), 'personality' speaks more of defining 'traits' that *stand out* from (and increasingly compete with) those of others.

I think it's also possible to find ways to speak of *layers* or *aspects* of personhood or 'self '. We might identify core aspects of who we are in what can get called our 'essential' 'nature'. (Of course that conversation about any kind of essential nature is complicated and needs to be so.) For the purposes of this section it refers back to Part One, which spoke of what our individual *constitutions* might be. Maybe we have a tendency to heat or cold, to faster energy, to humour, to melancholy, etc. We might also identify aspects of ourselves which have been inherited (genetically and/or epigenetically). We can also identify aspects of ourselves that are shaped by oppression and/or privilege.

Not only is the conceptualisation of 'personality' a construct, but so is the whole notion of 'the 'self '. In the global North we are told the self is a person's essential individual being (which distinguishes them from others). Aside from all the circumstances and inheritances already mentioned that might shape the 'self ', there can be multiple *understandings* and *sites* of this conceptualisation of the 'self ' or person/ality. We might, for example, also understand the 'self ' through an astrological lens, which understands how we each uniquely embody energies and qualities which are synchronous with planetary ones. And how that, within the unfolding emergence of the

Universe, informs who we are and how we walk through life. In *Threads*, I referenced the Walpiri; Aboriginal people who live north and west of what is now called Alice Springs, Australia, whose experience of the self and of Ancestors is very permeable.35

Like the Warlpiri experience of permeability of self and ancestors, there are so many wider notions of 'the self ' that acknowledge

35. Collated by Lisa, 2009. *Threads*, Active Publishing, p.37 also at threadsbook.org profound, also non or beyond human, interconnectivity. In Navajo cosmology for example, the air is understood to be continuous between what a Eurocentric conceptualisation might speak of as the 'interior' self, one's psyche, and the greater element of Air and of the land. This particular understanding of a continuous innerouter/self-beyond self is spoken of as being 'the Winds within us'.

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For the Navajo then the Air – particularly in its capacity to provide awareness, thought, speech – has properties that European, alphabetic civilization has traditionally ascribed to an interior, individual 'mind' or 'psyche.' Yet by attributing these powers to the Air, and by insisting that the 'Winds within us' are thoroughly continuous with the Wind at large

– with the invisible medium in which we are immersed – the Navajo elders suggest that that which we call the 'mind' *is not ours*, is not a human possession. Rather, mind as Wind is a property of the encompassing world, in which humans – like all other beings – participate. One's individual awareness, the sense of a relatively personal self or psyche, is simply part of the enveloping Air that circulates within, through, and around one's particular body; hence one's own intelligence is assumed from the start, to be entirely participant with the swirling psyche of the land. Any undue harm that befalls the land is readily felt within the awareness of all who dwell within that land. And thus the health, balance, and well-being of each person is inseparable from the health and well-being of the enveloping earthly terrain.36

The psychotherapeutic model called Internal Family Systems (IFS) holds a conceptualisation of 'Self ' as the 'seat of consciousness'. A higher, divine Self, it is likened to other spiritual traditions'

36. David Abram, 1996. *The Spell of the Sensuous: Perception and Language in a More-Than-Human World, drawing on James Kale Mcneley, Holy Wind and Navajo Philosophy*, Vintage Books, p. 235 conceptualisations such as the Quakers' *Inner Light*, Buddhism's *Rigga*, Hinduism's *Atman*, etc. 'The Self has been known and named in spiritual traditions all around the world for centuries and most of us can remember at least a few spacious moments of inner peace that denote the Self.' IFS speaks of the many parts of us, that inform how we move and act. It suggests we can be motivated (and held hostage) by parts of ourselves more than others, and that we can explore our 'parts' by connecting to the 'Self ' from which we have overview, understanding and capacity for balancing those 'parts'. IFS suggests that, 'Throughout the day all of

us pass from one personality to the next',37 our inner community, an internal family system, which the 'Self ' ideally mediates.

In an interview about decolonising psych/ology, psych/ologist Sunhil Bhatia speaks about Indian conceptualisations of the self as being interconnected and relational as opposed to the hyperindividuated neoliberal self:

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In the Indian context, the self is always thought about as embedded within the family, the community, and the neighborhood. The distinctions between self and other are slippery; this is a kind of slippery subjectivity. It cannot be encased within the individual.

Psychology's understanding of self is based on the individual as self-contained, as atomic – a self which fashions itself as separate from the other. That concept did not exist in the Indian context, which focuses on the connection of self to the world, a relational concept. Philosophically, the transcendence of self was important.

In postcolonial times, after the British left but colonialism remained in India, new and powerful ideas about the self came about. In the '70s, with the unleashing of

37. Richard C. Schwarz & Martha Sweezy, 2019. *Internal Family Systems Therapy*, Guilford Press, p. 43/44/11

modern globalization and privatization, and with the decline in social safety nets and access to public goods, came neoliberalism. Within neoliberalism, the idea emerges that social structures are not going to guarantee the maintenance of self. You have to rely on your biography, your strength, your family, your education, your credibility, your degree. You become an entrepreneur – managing your 'self ' and making it presentable becomes critical, as Gauri Pathak says.

Being presentable involves acquiring new skills, whether it is meditation, new degrees, or other ways to look attractive and market yourself [...]. These psychological ways of thinking tie well-being to your productivity. This is the neoliberal shift, and it reflects the neoliberal economy and culture.38

'Personality' and the 'self ' have become exploitable, as written about by Ehrenreich above in relation to toxic positivity and the corporate world, and in Bhatia's analysis of the neoliberal self. The biomedical lens views 'personality' as something that can be deemed 'deviant', in need of being fixed, in isolation from the many and various contexts a person exists within. Before we look at the ways personality has come to be viewed as disordered, I'd like to briefly look at the way personality came to be something that could be *assessed*, and in particular so that it could be fitted into corporate productivity.

Personality tests

The first modern personality test, the Woodworth Personal Data Sheet, was developed by Robert S. Woodworth during World War I for the United States Army. It was designed to help the US

38. Ayurdhi Dhar, 2015.'When Psychology Speaks for You, Without You: Sunil Bhatia on Decolonizing Psychology'. *Mad in America*. Available from: www.madinamerica.com/2020/05/sunil-bhatia-on-decolonizing-psychology (Accessed 10.2.2021)

Army screen out recruits who might be susceptible to shell shock, but wasn't completed in time to be used for that purpose. Instead it became widely used in psych/ological research and led to the development of many other personality tests. It's been described as the ancestor of all subsequent personality inventories and questionnaires.

There was a surge in uptake of the use of personality tests once they had been assimilated into corporate use. The idea was that employers could reduce their turnover rates and prevent economic losses by avoiding employing people who personality tests deemed inappropriate for the job. It was the personality test called the Myers-Briggs indicator that rocketed personality tests into corporate and popular culture. In the book, *The Capitalist Origins of the Myers-Briggs Personality Test*, Merve Emre describes some of the history of this mother-daughter team who, with no particular foundation other than an interest in Jungian archetypes, developed a test to assess personality 'types'.

Emre tells us the original system Myers developed 'never really caught on until her daughter, Isabel Briggs Myers, developed it' into a 117-question marketable indicator and then sold this indicator of 'types' to Edward N. Hay: a family friend and one of the first personnel consultants in the United States. With the rise of the labor force during and after World War II, newly established consultancies like Hay's were warming to the idea of using cheap, standardized tests to fit workers to the jobs that were 'right for them,' a match made under the watchful eyes of executives eager to keep both profits and morale high.39

39. Merve Emre, 2018. 'The Capitalist Origins of the Myers-Briggs Personality Test: The pseudoscientific tool was a popular, and powerful, force in corporations across the United States'. *Forge*. Available from: forge. medium.com/the-capitalist-origins-of-the-myers-briggs-personality-test309187757d4e (Accessed 10.2.2021)

Personality tests were also promoted to support the 'work-life balance'. The work-life balance in its original usage wasn't speaking about the balance between work and leisure or 'free' time as it does today. In its original usage it was talking about achieving congruence between the moral values we aligned with and the work we did day to day. A congruence that personality tests were deemed to be able to mediate.

In an article *Your Type? The Myers-Briggs Test and the Rise of the Personality Quiz*, Kate Knibbs writes:

Isabel's strongest conceptual ally was a client Hay introduced her to, named Oliver Arthur Ohmann, assistant to the vice president of the Standard Oil company and head of its industrial relations department. Ohmann was also one of the first management theorists to formulate the now-ubiquitous idea of 'work-life balance', although this meant something very different to him than what it does today.

'How can we preserve the wholeness of personality if we are expected to worship God on Sundays and holidays and mammon on Mondays through Fridays?' The conflict between work and life was not a simple matter of time allocation. It required preserving one's spiritual and psychological integrity across the domains of labor and leisure, the workplace and the home. It required keeping one's personality intact.

The Myers-Briggs Type Indicator, which Ohmann purchased from Hay in 1949, offered him the perfect solution for preserving the 'wholeness of personality' – a way of introducing people to their true selves and convincing them that the work they were doing was a natural extension of how God had created them. The fact that it might also help enhance productivity seemed, to Ohmann, the ideal marriage of 'higher and more enduring spiritual values' to the material realities of work. In its primordial form, the idea of 'work-life balance' was a bargain struck between God and mammon; a bargain brokered by the Myers-Briggs Type Indicator, Ohmann informed Hay and Isabel.40

'Personality disorders'

Psych/iatry places a big emphasis on groupings of behavioural patterns that it calls personality 'disorders'. 'Personality disorders' are diagnosed in 40–60% of psychiatric patients, making them the most frequent of psychiatric diagnoses. Psych/iatric lists of 'personality disorders' include for example Narcissistic Personality Disorder (NPD), and Borderline Personality Disorder (BPD), which insist medically defined *disordered* behaviour is the problem. In the case of 'Narcissistic Personality Disorder', we might ask why people have come to endlessly centre and elevate themselves, and lack empathetic connection, often at the cost of/harm to others. What damaging familial, social and spiritual frameworks might generate and compound that kind of behaviour? What patterns might have been shaped and inherited intergenerationally? Global Northern culture also teaches us to attach strongly to a sense of self, the ego, and doesn't encourage us to contemplate our being within the greater Cosmos. Perhaps the combination of deep insecurity felt by a lack of affirming familial and social relations, and lack of a more profound sense of spiritual belonging beyond the self, manifest as self-absorption, strong need for recognition, lack of

empathic connection and/or exerting control over others.

Contextual examination of behaviour doesn't mitigate the damage that behaviour can cause to others, but seeks wider conversation about perspectives we might have of that 'behaviour', and what we might want to move towards in the way of healing or remedy. In this case, loving circles of support for everyone, where everyone

40. Kate Knibbs, 2018.'What's Your Type? The Myers-Briggs Test and the Rise of the Personality Quiz'. *The Ringer.* Available from: www.theringer. com/2018/8/31/ 17800414/myers-briggs-personality-brokers-merve-emrebook (Accessed 10.2.2021)
is seen, heard and celebrated; social justice that allows everyone to flourish and lend their energies to the collective good; spiritual practice that 'reminds' us of our place within deep interconnection and interdependence.

The diagnosis 'Borderline Personality Disorder' feels like an especially unnerving and dangerous diagnosis because many of the criteria ('symptoms') which it is an umbrella term for, is behaviour that copes, refuses, resists and revolts, in response to violence, lack, woundings, inequality, etc. – responses which get classified as 'personal' disorder.

The NHS tells us:

Borderline personality disorder (BPD) can cause a wide range of symptoms, which can be broadly grouped into 4 main areas.

The 4 areas are: emotional instability disturbed patterns of thinking or perception impulsive behaviour intense but unstable relationships with others.

Each of these areas is then described in more detail i.e. about emotional instability we are told:

If you have BPD, you may experience a range of often intense negative emotions, such as: rage sorrow shame panic terror long-term feelings of emptiness and loneliness

You may have severe mood swings over a short space of time...

All this located in your personhood... 'Your' negative emotions

Rage, sorrow, emptiness, loneliness... All this...

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In the anthology *Drop the Disorder*, Lucy Johnstone writes: the problems that are called 'symptoms' in psychiatry are actually forms of thinking, feeling and behaving [...] there are no universally agreed standards for deciding on 'normal' ways of thinking, feeling and behaving, because these judgements are subjective and depend on context. In fact adding in the context often makes the experiences understandable. For example, 'the intense anger or difficulty controlling anger' that is said to be a 'symptom' of 'borderline personality disorder' may be an entirely reasonable response if you have been abused or abandoned, as many people with this label have.41

It's no coincidence that there is a high amount of Personality Disorder diagnoses given to folk who are in prison. Borderline Personality Disorder is common along with something called Antisocial Personality Disorder. In a carceral system, individual people are deemed personally disordered instead of investigating the social contexts that shape us. The narrative of the 'disordered personality' (as opposed to social injustice and inequality) being the cause of what gets called crime paves the way for dangerous speculation/claims like those in a 2016 *Daily Mail* article titled *Is there a criminal gene?*, which claims:

Up to 70% of jail inmates have a disorder

41. Jo Watson, ed., 2019. *Drop the Disorder: Challenging the culture of psychiatric diagnosis*, PCCS Books, p.11

Antisocial Personality Disorder is found in 40–70% of prison populations

However, it is only observed in 1–3% of the general population

Researchers have discovered genes that are linked to this criminal trait.42

‘Symptoms’ as protest, and idioms of distress

‘*It is precisely the unsayable and the unspeakable that must be expressed in the mad and poetic discourse.*’43

I think many experiences can be understood as *communal* expressions of distress that are shaped by, responding to, refusing, and/or resisting wider social conditions. If we look at the way experiences might be a *collective* response to, even protest against circumstances, it means we necessarily need to examine *those circumstances,* and decide together how they should/could be changed. In this sense distress and struggle can be sites of collective insight and potential revolutionary transformation.

Below are two examples from European history that have been (in part) read by scholars and historians as mass and communal expressions of distress and protest.

The Dancing Plagues

In July and August of 1572 there was an outbreak of dancing in

42. Stacy Liberatore, 2016. ‘Is there a criminal gene? Up to 70% of jail inmates have disorder also seen in serial killer Jeffrey Dahmer – and it could be in their DNA’. *Daily Mail.* Available from: dailymail.co.uk/sciencetech/ article-3787469/Does-DNA-predict-end-jail-Scientists-closer-finding-geneticroots-crime-reveal-40-inmates-disorder-seen-serial-killer-Jeffrey-Dahmer.html (Accessed 10.2.2021)

43. Jane. M. Ussher, 1991. *Women’s Madness: Misogyny or Mental Illness?*

Pearson Education Limited, citing David Cooper, p. 149

Strasbourg. It was a particularly intense example of what have been called the Dancing Plagues that spanned the 1300s to the mid 1500s. A woman called Frau Troffea began to dance without pausing, and hundreds of other people followed, dancing in the heat for days and days until their feet bled. Many people died of exhaustion.

The dancing can be understood on multiple levels, both as ecstatic transcendent experience, and in *A Time to Die, a Time to Dance*, John Waller suggests that the Dancing Plagues have been understood in part as a communal response by working class people to economic disparity and the resulting anxiety and uncertainty. He suggests that dancing as the mode of *expression* or *protest* was in keeping with complex cultural, medical and religious paradigms of the time. In this sense it occupies the kind of cusp territory (that I speak about more in a section ahead); where expressions of distress and the inhabitation of transcendent consciousness can overlap and coexist.

Waller explains:

By early August 1518, the epidemic had begun to spread at an alarming rate. The numbers of afflicted rose each passing day so that soon at least 100 citizens were dancing with crazed abandon. Within a month, according to one chronicle, as many as 400 people had experienced the madness [...]. Exactly how many fell dead we cannot know, though one chronicle suggests that (at least for a time) fifteen were dying each day as they danced in the punishing summer heat, seldom pausing to eat, drink or rest. Only in late August or early September 1518 did the epidemic finally subside, leaving many people bereaved and thousands more, in the city and beyond, fearful and bewildered.44

44. John Waller, 2008. *A Time to Dance, a Time to Die: The Extraordinary Story of the Dancing Plague of 1518*, Icon Books, p.3/4

Fugues

Another more recent account of a communal and temporally specific experience, which has in part been read as an expression of distress, was identified in France in 1887. It described mostly men who were called *Fugeurs*, who were following an impulse to compulsively travel without purpose or destination (a Fugue), sometimes in 'states of obscured consciousness' and without memory of the episodes. In his book *Mad Travellers*, Ian Hacking writes about the way this complex experience was classified as a new diagnosis: 'Fugue became a medical disorder in its own right, with earthly labels like *Wandertrieb* and suitable Latinate or Greeksounding ones such as *automatisme, ambulatoire, determinismo ambulatorio, dromomania*, and *poriomanie.*'45 Like the diagnoses of *Nostalgia*, this experience was given a diagnostic label of *Fugues/ Fuguers* because a student doctor became interested in it, gave it a name, and published a thesis about it for his degree. It shows, like the construction of the DSM, how diagnoses have been dependent on a select few people deciding which experience to define as a personal pathology.

Hacking talks about influencing factors; 'vectors' that might have been an aspect of this experience and led to it becoming a diagnosable condition. One vector that Hacking speculates is the fact of *release*, that in the case of the Fugeurs, men were breaking free from the restraint of daily life.

Social psychologist Erving Goffman has written: 'If you rob people of all customary means of expressing anger and alienation and put them in a situation where they have never had better reason for having these emotions, the natural recourse will be to seize on what remains – situational improprieties.'46

By 'situational improprieties', Goffman means things that appear inappropriate in a given situation. I am inclined to insert '*what*

45. Ian Hacking, 1998. *Mad Travellers: Reflections on the Reality of Transient Mental Illnesses*, Harvard University Press, p.82

46. Erving Goffman, 1961. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, Anchor Books/Doubleday, p.135

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appear to be' situational improprieties into the end of Goffman's quote. I think we need to look *into* and *beneath* experiences to try and understand, in context, what might be occurring, or what meaning – whether analytical or mysterious, whether distress or transcendence – there is to be found in them. I think this applies to all expressions, or idioms of distress, wherever we live, and in current times.

In an article *Idioms of Distress*, (the term idiom meaning a form of expression in a language, person, or group of people), Geetha Desai and Santosh K. Chaturvedi, writing about their perspective on idioms of distress in India, speak about the ways:

Idioms of distress are alternative modes of expressing distress and indicate manifestations of distress in relation to personal and cultural meaning. Distress may arise out of interpersonal conflicts, economic difficulties, and cultural conflicts [...]

Idioms of distress are considered as adaptive responses in circumstances where other modes of expression fail to communicate distress adequately or provide appropriate coping strategies.47

I've often thought about the way current mass experiences of distress, for example wide scale 'symptoms' of what gets called depression and anxiety, could be read as a mass, communal psycho-emotional response to psycho-social conditions. In that sense they are a response and a protest. Then I came across Johanna Hedva's work *Sick Woman Theory*, which explicitly speaks about sickness in social and historical context. She begins by referencing the work of Ann Cvetkovich, who has written a book called *Depression, a public feeling.* Hedva says:

47. Geetha Desai and Santosh K. Chaturvedi, 2017. 'Idioms of Distress'. *Journal of Neurosciences in Rural Practice.* Available from: www.ncbi.nlm.nih. gov/pmc/articles/ PMC5602270/ (Accessed 10.2.2021)

Ann Cvetkovich writes: 'What if depression, in the Americas, at least, could be traced to histories of colonialism, genocide, slavery, legal exclusion, and everyday segregation and isolation that haunt all of our lives, rather than to be biochemical imbalances?' I'd like to change the word 'depression' here to be all mental illnesses.48

To which I would add, that I'd like to change the word 'mental illness' to psycho-emotional health.

Hedva continues:

Sick Woman Theory is an insistence that most modes of political protest are internalized, lived, embodied, suffering, and no doubt invisible [...]. Sick Woman Theory maintains that the body and mind are sensitive and reactive to regimes of oppression – particularly our current regime of neoliberal, white-supremacist, imperial-capitalist, cis-hetero-patriarchy. It is that all of our bodies and minds carry the historical trauma of this, that it is the world itself that is making and keeping us sick.49

Both Hedva and Cvetkovich's work remind me of the SPK – The Socialist Patients' Kollective. The SPK was a patients' collective founded in West Germany in1970. The kernel of the SPK's ideological programme is encapsulated in its slogan, *Turn illness*

into a weapon, which is also the title of one of its most widely known texts. On an SPK archival website we are told:

The SPK collective produced information leaflets, held teach-ins and established a 'free space' for 'political therapy', re-framing illness as a contradiction created by capitalism which could be

48. Johanna Hedva, 2020. *Sick Woman Theory.* Available from: johannahedva. com/ SickWomanTheory_Hedva_2020.pdf (Accessed 10.2.2021)

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embraced to bring an end to the system which gave it life. They believed that the sick formed a revolutionary class of dispossessed people who could be radicalized to struggle against oppression. Organizing by sickness instead of socioeconomic class allowed middle-class student leftists to articulate their own feelings of psychic and political oppression and to struggle against the status quo in their own right in solidarity with other oppressed groups. Additionally, according to the SPK sickness had the advantage of being familiar to everyone, hence everyone was a potential revolutionary so long as they disavowed the medical establishment.50

Hedva closes her writing about Sick Woman Theory with the beautiful and transformative call for care. And speaks of *care* as protest:

The most anti-capitalist protest is to care for another and to care for yourself. To take on the historically feminized and therefore invisible practice of nursing, nurturing, caring. To take seriously each other's vulnerability and fragility and precarity, and to support it, honor it, empower it. To protect each other, to enact and practice community. A radical kinship, an interdependent sociality, a politics of care.51

50. *Proposal for a text for international use concerning SPK.* Available from: www.spkpfh.de/ProposalSPKtext.htm (Accessed 10.2.2021)

51. Johanna Hedva, 2020. *Sick Woman Theory.* Available from: johannahedva. com/ SickWomanTheory_Hedva_2020.pdf (Accessed 10.2.2021)

I've drawn huge inspiration also from therapist, writer and educator Guilaine Kinouani. In her foreword to *The Colour of Madness: Exploring BAME mental health in the UK*, she writes about the possibility in struggle for care that turns inwards, to then also turn outwards for systemic change:

In a world that orders you to keep strong and, to take the bricks of oppression thrown at you with a smile, our tears are political. Our tears are victories. Being vulnerable is revolutionary. It is deeply humanising. And saying we are hurting is also often giving ourselves permission to start to centre our psychological needs. To turn inwards. But, only momentarily; to better turn outwards and organise.52

Naming and identity

In *Decolonising Trauma Work* Renee Linklater writes: 'The impact of diagnosis on identity is a particularly important issue given the loss of identity for many Indigenous people.' She continues:

In the absence of cultural frameworks, many people did not have the opportunity to develop strong Indigenous identities, and as such, many of the identity-forming customs became replaced by external beliefs and practices. Duran refers to the diagnostic procedure as a naming ceremony and asserts that this results in 'an identity of pathology'.53

Linklater's quotes are vital when thinking about the dangers of diagnoses that define and pathologise. Like Tuhiwai Smith's words

52. Samara Linton, Rianna Walcott, eds., 2018. *The Colour of Madness: Exploring BAME mental health in the UK*, Skiddaw Book, p.i, by Guilaine Kinouani.

53. Renee Linklater, 2014. *Decolonising Trauma Work: Indigenous Stories and Strategies*, Fernwood Publishing Co Ltd, p110 & p113

about naming and meaning, the words speak specifically about experience in the context of the legacy of colonialism. As with Tuhiwai Smith's words, I feel Linklater's can be applied, to an extent, also in global Northern contexts, where dominator psych/iatric ideology can replace a more profound sense of identity, one that would exist within a more coherent cultural whole. If there was more room to inhabit depth, and spiritual practice communally, someone might not, for example, perceive themselves as having social anxiety disorder. The social realm would have more possibility and allow more of a breadth of connection. Someone's timing, quietness, contemplation might have more place, not pathology.

Some of the fracturing and violent legacies of the Enlightenment, of whiteness, and of consumer capitalism have stripped many of us very bare of belonging, rites of passage, purpose, connection to spiritual practice and to the land. I think in the absence of some of those frameworks, diagnoses can much more quickly inform ideas of the self and identity. Diagnoses can lead to people more readily identifying as pathologised; as faulty, lacking or disordered, instead of identity being based on, for example, the worth of one's vulnerability which offers insight and outsight, or on the acknowledgment of personal capacity, gifts or potential.

It was a global Northern psychologist Erik Erikson who, in 1954, coined the term 'identity crisis' to speak of an individuated identity confusion. The sets of beliefs we have about ourselves, the way we conceptualise the self, the way we evaluate and categorise ourselves, and how we present to the world and inhabit social identity have

come to have huge prominence under neo-liberalism. We are encouraged to stand out, be 'someone', and there can be a strong emphasis on a kind of individual *exceptionalism* as an aspirational goal.

I think sometimes diagnoses and identity might fuse in an attempt to fulfil a profound need to be seen, understood and recognised. I think diagnosis can sometimes also attempt to fulfil a more culturally generated impulse to be seen and recognised as distinct and/or special. I think diagnoses can also attempt to fulfil a feeling of belonging to a group, a shared identity. While that can be affirming and supportive, I think there is a risk that the scripts diagnoses offer can be taken on as identity and people can be limited by – sometimes adhere to – that identity. Fostering and reinventing secure cultural and interpersonal attachment; challenging and minimising pressures around exceptionalism; affirming and honouring *everyone's* precious and unique worth and complexity, are integral parts of related remedy. And interwoven with generating more space for reconceptualising experience on non-biomedical and non-psych/iatric terms.

Scripts for experience/rescripting experience

In Part Two, I quoted Janis Hunter Jenkins speaking about scripts we are given for experience. I want to cite her words again here as a preface for this section, this time adding the *final* line of the paragraph, which is about the significance of *names*. Jenkins writes:

> a culture provides its members with an available repertoire of affective and behavioural responses to the human condition, including illness [...]. Individuals in a given place and time will react to illness similarly, in other words, because they share the same limited repertoire of cultural scripts for how to play their part. The different ways that cultures communicate expectations for behaviour are often quite subtle. Seemingly small differences, such as the disease's name, can make a difference.54

We are sometimes quite *literally* given scripts, and names. In 2010 Saatchi & Saatchi designed the advertising campaign for the so-called 'anti-psychotic' drug Seroquel XR. They explained:

54. Ethan Watters, 2011. *Crazy Like Us: The Globalization of the Western Mind*, Robinson Publishing, p.175

Bipolar depression is a new term for the consumer audience, so the campaign had to be as much about education as it was about medication. The ad team did a stunning job setting a tone and mood that made viewers turn to the TV and say 'That's me, that's what I feel like, and now it has a name'.55

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The liberatory potential of Jenkin's analysis speaks to me about how we inhabit our experiences often *on the terms that are set* by a culture around us. Those terms are culture bound and can be questioned and deconstructed. The addition of her final sentence about the differences a 'name' can make, makes me think again of the idea of hermeneutical injustice. In many instances we are 'told' by knowledge systems like biomedicine how to *name* and consequently *feel* and *understand* experiences of what might get called 'illness' or dis-ease. In many instances we just might not have any other framework or language to the ones we are offered, with which to understand and therefore feel and live our experiences differently.

I recently watched two videos about the menopause. In the first one I was being given a list of 'menopausal symptoms' by someone who was professing to offer a more genderqueer perspective. The list was a familiar biomedical and pathological one; hot sweats, memory loss, vaginal atrophy, etc., etc. If that was all I had access to, it would be what I predominantly *expected* to happen, and maybe what I would then *only look for* in my own experience, or be prepared for and so anticipate in myself.

In the second video, someone was speaking about her experience of the menopause, and I was offered a different, in Jenkins' terms, 'script'. The person in this video described:

I woke up in the middle of the night maybe about five years ago, completely drenched in sweat, kind of raised up, and I thought to myself, cos I'm a minister's daughter, I thought to myself, God is *finally* trying to *contact* me! [...] but what was happening was that I was having my first hot flash [...] but it was oddly exquisite, you know you hear people talk about hot flashes, but it was sort of, it was terrible but it was also like, sort of spooky and sort of otherworldly and kind of *exquisite* as well. The symptoms kept coming, there was, like, insomnia, there was, like, a sense of disorientation, like, definitely also some, like, feelings of gender transformation, it was all happening. I found myself, like, wandering around my house in the middle of the night like I was *moulting*, kind of, like a really strange feeling, like I felt, like, a new, very cool, but more androgynous creature was coming out of my more feminine self, my former feminine self. So it was, like, just a big transformation to me. Very disorienting, more disorienting than I ever thought it was going to be.56

It was exciting and energising to hear that you might experience and understand such potential intensities in this life passage in this kind of way. Through this voice, there was more opening to explore what my felt sense of things might be ahead, not necessarily in accordance with the dominant script of distress, embarrassment, depression, decrease, loss, limitation etc. It was also exciting to move away from the biomedical language of 'menopause' into language that speaks of experience as being exquisite, androgynous, transformation...

As well as 'scripts' for experience that we come to understand ourselves through and with, psych/iatric and dominant global Northern culture tend to also carve up consciousness. Some experiences are equated with one label (or identity) and other sets of experience with another, when our experiences may actually be much more fluid or overlapping, and defy that kind of classification. This classification and compartmentalisation emerges from a fracturing culture that splits

56. Darcy Steinke in conversation with Maud Casey about her book
Flash Count Diary, 2019. [Video]. Available from: www.youtube.com/

and separates things; distinct body systems; disciplines of study (history, politics, art) as if they weren't entirely interwoven. Many allegedly distinct experiences are more often mixed and merged within us. I think honouring that complexity is more useful in terms of engendering more multifaceted questions about our experiences, our humanity, and radically addressing personal and collective needs.

It puts me in mind of Hamja Ashan's book *Shy Radicals*. The book speaks to the experience of *Shyness* as a radical act in the context of what it calls 'extrovert supremacy culture'. It explores experience *and* context that experience is had within, in creative, smart, critical ways. Part Five of the book is written in the shape of an interview:

Interview with shy radicals political prisoner Amy Littlewood. [...]

Q: Why does the shy radical party still boycott the festival of neuro-diversity?

Divide and rule is their game. First the authorities attempted to divide us into varied pathologies: Asberger's syndrome, social anxiety disorder, depression. But we are all one. We suffer as one. We fight as one. And then it was 'extremist' introverts and 'moderate' introverts. They want to depoliticise shyness as a purely 'cultural phenomenon' or a medical pathology. Worse than that, they want to present us as the United Colours of Benetton of personality types. They want Little Miss Quiet here, and Cute Little Fragile boy there, Mr Clumsy here and Little Johnny Goofy there. They want us to accept the taxonomies of their diagnostic manuals like an aviary of exotic birds. But shyness is a political position.57

57. Hamja Ahsan, 2017. *Shy Radicals. The Antisystemic Politics of the Militant Introvert*, Book Works, p.63

I think this fact that we are given cultural 'scripts' for experience, and that these scripts can be compartmentalising, can be really useful to hold in mind, to decide whether labels for or definitions of experience resonate for us. It can help us in asking questions about our experiences that might offer up more profound and revolutionary insight and remedies.

We *can ask where has a definition for experience come from; who made the definition; what language is being used; in what ways is it culture bound? If we don't use that definition what other interpretations and definitions might we use, or feel resonant for a set of experiences?*

Could a set of experiences 'fit' into several dominant definitions or classifications that are offered, if so what does that mean?

Is a definition that is being offered reductive (reducing experiences down to the neurochemical, neural or neurological)?

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What definitions of our experiences support a strength rather than deficit based understanding of them? What in our experiences might offer valua- ble personal and collective insight, outsight, capacity, depth of feeling and connection? What are ways we might understand and respect experiences

– and take collective guidance from them – rather than pathologise them?

Many experiences (for example, ones which could get defined within conventional psych/iatric diagnoses as neurodivergence, highly sensitive, empathic, introverted) overlap and intersect with what might be called contemplative, religious, mystical, hermetic, poetic, creative consciousness.

Experiences in cultures where trance states, or states of prayer, concentration and deep states of attention for prolonged periods of time are considered typical and valuable, will necessarily be classified differently (and not pathologically) than in a culture that is rapid, aspirational, competitive and demands multitasking. Here the autistic diagnostic symptom called 'autistic inertia' for example – described as a resistance to changing states or difficulty changing tasks or stopping once you've started – might not be discussed either as a *difficulty* or even as an issue. A *different range of allowed* and *celebrated* human experience in a culture would simply *allow* and *celebrate* a *different range* of human experience. Our embodied experiences are culturally and socially contextualised. The language and ideas we are given, and the way we then perceive ourselves, can affirm dominant cultural values that the 'self ' is located within.

I found an article, *A time and space for Takiwātanga* (excerpt below), really interesting. It explains the journey taken by Keri Opai to come up with a Māori word for autism. Opai doesn't define as autistic himself, so arguably what he has done is problematic – he is languaging experience about others/for others that isn't immediately his own. (In the article he expresses hopes that his interpretation pays adequate respect to autistic folk). I think his endeavours though illustrate how consciousness and the particularity of how that *feels* could be languaged in ways that aren't reductive or individuated.

Opai's observation of experience doesn't just focus on experiences as felt by/in the *individual*. He considers what the felt sense of the experience of consciousness and the expression of that consciousness of someone identifying as autistic could be, located within a *cultural* and *communal* frame. Opai speaks about how the experience reminds him of the way kaumātua (Māori elders) speak, their communication style. He affirms this consciousness as profound.

Opai asks:

What is the Māori word for 'autism'? – Is there one?

As of yet, no. But I'd like to hope that I've come up with an appropriate interpretation for a glossary I'm producing for Māori language use in the Mental Health, Addiction and Disability sectors [...]. The word I have coined in te reo Māori for autism is 'Takiwātanga'. It is a derivation of my phrase for autism: 'tōku/tōna anō takiwā' – 'my/his/her own time and space'.

Opai speaks about meeting with an autistic person. How they spent time together, and how that person articulated their experience of being autistic.

Sitting there and talking for hours it reminded me very much of when I would spend time with kaumātua (Māori elders) and their style of teaching/informing/sharing. The conversation would meander and sometimes become tangential but if you leaned in, really listened, got into the same timing and rhythm, there were pearls of profound wisdom aplenty.

Opai said that is what he based his Maori interpretation on, that autistic people 'tend to have their own timing, spacing, pacing and life-rhythm'.

Opai58 concludes about (his Maori) naming, and about the way that language affects how experiences are perceived of by saying: ‘As my kaumātua says: “He mana tō te kupu” – “Words have great power”.’59

58. Keri Opai is Paeārahi – Māori strategic lead at Te Pou o te Whakaaro Nui, where he guides responsiveness to and engagement with Māori people, organisations and iwi. His experience is predominately in education and he has taught te reo Māori and tikanga Māori since he was a teenager. He is a licensed interpreter and has a master’s degree in Mātauranga Māori (Māori Knowledge).

59. Keri Opai , 2017. ‘A time and space for Takiwātanga’. *Altogether Autism Journal*. Available from: altogetherautism.org.nz/a-time-and-space-fortakiwatanga (Accessed 10.01.2021)

We can rescript (our) experiences. We can engage complex and *multiple* conceptualisations and perspectives that offer more complex insight/outsight and therefore also more complex approaches to collective care and healing.

Some reflections on *experience (instead of diagnosis)*

I want to return to the idea of hermeneutical dissent discussed in Part Two, (the processes of *interpretation* of experience that reinvents or resists dominant interpretations). Dissent is the opposite of consent, and comes from the Latin *dissentire* meaning 'differ in sentiments, disagree, be at odds, contradict, quarrel' from *dis* meaning 'differently' + *sentire* meaning 'to feel, think'. From the 1580s dissent as a noun meant 'difference of opinion with regard to religious doctrine or worship', and from the 1650s 'the act of dissenting, refusal to be bound by what is contrary to one's own judgment'. By 1772, it was used in the specific sense of 'refusal to conform to an established church'.60

In a way this section exercises hermeneutical dissent. I want to think about experience in a way that doesn't 'conform to an established church'. I want to think about language again, and the *sets of ideas* that come with the language we are offered.

I think about the term (and diagnosis) 'depression', and how it's a blanket term for speaking about so many *different* feelings. It doesn't really speak of the nuance of the felt sense per se. That *felt sense of the experience* might be languaged as feelings of isolation sickness, lack of connection; loneliness for either people or for connection to the divine. It might be felt as numbness, tiredness, deadened sensation, as lack of support, lack of deep spiritual connection with the earth and the animals, the elements, the ancestors. It might be felt as lack of

60. Online Etymology Dictionary, etymology of dissent, no date. Available from: etymologyonline.com/dissent (Accessed 9.02.2021)

motivation; of worthlessness or pointlessness; as an inability to sleep, or sleeping a lot. It might be felt as anxious existential questions about meaning, as a need for guidance and purpose. It might be sorrow or despair about the very real oppressive and harmful systems that we live within. It might be buried anger. It might be grief; personal and/ or collective for loss of life, loss of opportunity, loss of ecosystems. The list of experiences that get called 'depression' could go on.

'Depression', especially framed within the narratives of 'personal illness', can suggest a state of being that is *internal* ('*my depression', 'I am depressed', 'I suffer from depression*'). It can compromise naming what is actually being felt and experienced, and what might actually be needed as redress and rebalance. We might need space to mourn together; we might need more community; we might need to move the body

because we are stuck in habits which can be shifted through inhabiting our physicality. We might need physical touch, sexual pleasure and abandon; or to practice appreciation; or to feel more agitation and channel that energy into something. If we recognise ourselves as constitutionally tending towards melancholy we might need to let that be a source of wonder through creativity. We might need support to express and understand deep rage. We might need to be engaged with activity that is part of fostering social justice. To name just a few things.

I think about this quote, which speaks about the meaning of experience:

[...] feelings and symptoms that an American Doctor might categorize as depression are often viewed in other cultures as something of a 'moral compass', prompting both the individual and the group to search for the source of social, spiritual or moral discord. By applying a one size fits all notion of depression around the world, [...] we run the risk of obscuring the social meaning and response the experience might be indicating.61

And I think about this comment from the late Dr. Joe Couture, Cree Elder and psych/ologist which identifies in more detail some of the felt sense of an experience, and points to approaches to what is being felt:

I no longer use the word 'depression' while working with people. Depression implies that it is up here [holds his hand up in the air indicating that there is a disconnect between the person's experience and their depression] and it is something we use drugs to medicate. I use the word 'disappointment' because that gives us something to talk about [...] a process 'of beginning to search out and find what has brought sadness to them'.62

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In her book *Depression as a public feeling*, Ann Cvetkovich speaks about the ways we are emotionally impacted by things: 'Depression, or alternative accounts of what gets called depression is thus a way to describe neoliberalism and globalization, or the current state of political economy, in affective terms.'63

I love how Cvetkovich talks about the fact that there shouldn't necessarily be an immediate drive to transform feelings into useful action. Cvetkovich speaks about being 'patient with the moods and temporalities of depression, not moving too quickly to recuperate them or put them to good use. It might instead be important to let depression linger, to explore the feeling of remaining or resting in sadness without insisting that it be transformed or reconceived'. Also, that while revolutionary change might be the ultimate healing we are mobilising for, that we need gradual, sometimes challenging processes of building capacity and joy. She speaks about swimming, stretching, about crafting, about spiritual practice, about building altars. She speaks of transformation as being open-ended and marked by struggle, not by magic bullet solutions or happy endings, even the happy ending of social justice that many political critiques of ther-

apeutic culture recommend. It suggests that when asking big questions about what gives meaning to our lives, or how art or politics can promote social justice or save the planet, ordinary routines can be a resource. The revolution and utopia are made there, not in giant transformations.

While I would argue I think it can be *both* – giant unexpected transformations *can* happen, and steady unlearning and relearning and remedying processes can occur simultaneously, I definitely love the way she speaks about practice. That while we desire and work for societal change we also need to find ways of feeling alive, grounded, connected, resourced. 'But it's not an instantaneous conversion, resurrection, or cure. It's the result of slow and painstaking accumulation of new ways of living.'64

Energy. Tiredness

A kind of constant negotiation.... Should I run. Should I rest Drink water. Drink more water Wail. Weep. Yell.

Is this tiredness or are there reservoirs of energy? In 'me', aligning

What kind of energy? When?

No morning stimulants What do you feel?

How do you feel?

And when do you feel it?

Flux Feeling

The daily chat chat holding you apart from any depths Soc

ial press ure

How capitalism can have you conflate emotional fatigue with physical fatigue

Actually

Actually

What kind of tired you ask yourself?

900,000 people in minus temperatures in Idlib A million children starving in Yemen

The daily chat chat holding you apart

How do we speak of the fact of both

Overwhelm and Underwhelm

I think also about the term (and diagnosis) **Social Anxiety Disorder**. It's so significant the way the NHS page speaks about what gets called Social Anxiety Disorder – locating everything in the *you* and the *yours*.

It's a *common problem* and there are treatments that can help. Asking for help can be difficult, but your GP will be aware that *many people struggle* with social anxiety and will try to put you at ease. Your GP will ask you about your feelings, behaviours and symptoms to find out about *your* anxiety in social situations. If they think *you* could have social anxiety, you'll be referred to a mental health specialist to have a full assessment and talk about treatments [emphasis added].65

This hyperindividuation has people saying '*my social anxiety*' or '*I suffer from social anxiety*'. This can close off conversation about what the social realm under whiteness and consumer capitalism can often involve. i.e artificially making up conversation, not

emerging organically out of real connection, a pressure to speak, to have lots to say, to be cheerful, to present the self, to endlessly define the self

(*how are you? what have you been doing?*). That this can feel totally asphyxiating, and limiting. That it can feel like a cultural social anxiety disorder. Instead of critiquing dominant social modes, people are encouraged to internalise a self-perception of having some kind of personal incapacity or disorder.

This conceptualisation of what are also spoken of as various

distinct 'personal disorders' is artificial.

I was told by my doctor that I was suffering from both depression and acute anxiety. I had believed that those were separate problems, and that is how they were discussed for the thirteen years I received medical care for them. But I noticed something odd as I did my research. Everything that causes an increase in depression also causes an increase in anxiety, and the other way around.66

Those days too many violences

And life that moves so fast, too full. Break it down

Pare it back. Reduce Lean into support Breathe

Everything we never got taught sitting at the school desk What need for silence. For magic

For your hands curving to the skin of me Safety

and Ecstasy

And wishing, seeking for elders, guide you to the river, on those days asking how you manage

make it all add up,

66. Johann Hari, 2018. *Lost Connections: Uncovering the Real Causes of Depression – and the Unexpected Solutions*, Bloomsbury Publishing, p.12

fractured bits and pieces, fragmented origin stories social nervousness chatting, this chatting, those days

Not sure how to turn, or what towards

run the hill, run the mountain, run the streets

Good people, at the end of the phone, hear you out, blessing, connection

knowing the same struggle, saying yes and no to you, discerning hold you til you can hold yourself better

How we hold each other (re)orienting to power, joy,

(re)orienting to choice, to worth, to value

I think about the way that oppression can disorientate or make us absent from our senses, feelings and bodies. Whether that oppression takes the form of having to sit still at school, or stand in a work place all day denying our impulses to move. Or whether it involves navigating intense threats but having to act as if that wasn't the case.

Productivity v. Presence and Pleasure

Stuck in task mode. Taut.

Drag yourself out of bed to the same thing train bus car tram.

Clock watch, wish your life away.
All about the money makes it all about the money.
See the trace in the old Siemens machines
long gone, but etched in the psyche;
punch cards; clocking on, clocking off Arbeit Macht Frei –

For two years I worked at Sunnyside Cemetery in Long Beach [...]. When I first got the job I didn't fuck off much, but then we got this new supervisor. He had been a navy captain for forty years and wanted everything in order just like in the military. Sometimes he would just follow me around, checking up on everything that I did. He made us work when there was no work to be done. We had to cut the grass even if it didn't need it, just to keep busy [...]

I got tired of breathing the gas fumes from the lawn mower, and found that I could go out to the yard and just pretend that I was mowing the lawn. The yard was a thirteen acre circle so once I got a couple of acres away the supervisor couldn't hear if the mower's engine was running. Usually there were other machines going which helped increase my cover. I never turned the motor on. I just faked it; pulled the line and just walked around. I'd be out there for hours just pushing a switched-off mower around....67

I think of the way we can come to experience a really embodied confusion: we can come to think we feel tired when we actually need to run or dance, we can think we're hungry when actually we're lonely, we can think we feel sad when actually we're just still.

The feelings themselves can be disorientated as well because of how we have been shaped and schooled. We are often taught that loneliness, for example, is remedied with human company, but maybe loneliness we feel is really longing for connection with the animal or spirit realm.

67. Martin Sprouse, ed., 1992. *Sabotage in the American Workplace*, Pressure Drop Press, p.69

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In a session around trauma and collective care I facilitated, a woman shared that she sometimes uses the acronym HALT to check in with herself, asking: am I *Hungry, Angry, Lonely or Tired*, as a way to understand and acknowledge what might be going on, and then best respond. Of course that list, and acronym, could be extended to check in and enquire about lots of other experiences and needs...

68. Lisa Fannen, 2018. *Faultline.* Active Publishing.

Wheel of feelings

I think about how blown away I was years ago as a young woman finding Audre Lorde's 1978 speech/essay *Uses of the Erotic. The Erotic as Power.* It was and still is such an incredible inspiration giving permission to *feel*, and really have that feeling guide our choices and values.

This is one reason why the erotic is so feared, and so often relegated to the bedroom alone, when it is recognised at all. For once we begin to feel deeply all the aspects of our lives, we begin to demand from ourselves and from our life-pursuits that they feel in accordance with that joy which we know ourselves to be capable of. Our erotic knowledge empowers us, becomes a lens through which we scrutinise all aspects of our existence, forcing us to evaluate those aspects honestly in terms of their relative meaning within our lives. And that is a grave responsibility, projected from within each of us, not to settle for the convenient, the shoddy, conventionally expected, nor the merely safe.69

It's been great years later to read *Pleasure Activism* by adrienne maree brown, where she builds on Lorde's work, and uses it as an anchor for all sorts of amazing avenues and conversations around pleasure and social justice. In an interview between herself and Cara Page (then Executive Director of the Audre Lorde Project), Cara says:

How do we move toward liberation with our longing and desire? And what do we long for? And these questions were a beautiful realization that 'what do we long for?' to me holds what do we remember? What can we imagine? What do we desire? [...] our heart must be in this. Our spirit must be in this. Our memory is in this. Our collective bodies and desires must be in this. And all of that is integral to your transformation.70

I also think about how we can get held hostage by habits; by responses that are old and familiar but not always still relevant, and don't have to colour life in the same way now. I love this quote from Idelisse Malave that speaks to authentically counting blessings, but not in the way we are often encouraged to by consumer capitalism or new age positivity putting a denial smile on things. She speaks of gratitude, but not some uncritical gratitude blanket.

Bottom line, I've practiced noticing what works rather than what's not working, feeling gratitude, letting myself be awed and know it – by beauty, by mystery, by human creativity. If, as was true for

69. Audre Lorde, 1996. *The Audre Lorde Compendium. Essays, Speeches and Journals.* Pandora, p.109

70. adrienne maree brown, 2019. *Pleasure Activism. The Politics of Feeling Good*, AK Press, p.52 me and many, many folks I know, it was a struggle to survive and there was lots of trauma and pain, we get really good at checking for danger or either clamming down on and avoiding, or being overwhelmed by, moods that accompany suffering. They are familiar and so well-practiced that they might as well be hardwired. It can take intentional practice to rediscover the pleasure of just being, of life itself, right now, right here.71

I loop back around to the experience of what can get called depression and it makes me think about culturally 'allowed' emotional ranges of feelings. I know I feel most well, where well means wholeness, integrity, congruence, when I honour *all* my emotions, and

maybe especially ones that are more complex, that can involve a mixture of for example joy *and* sorrow.

It puts me in mind of Arundhati Roy speaking about joy in an interview with Imani Perry at the beginning of the Covid-19 pandemic. I love what she points to, in the context of a culture that can insist on a very narrow framing of 'happiness', and where not feeling 'happy' can also get pathologised.

IP: ...how do you cultivate joy in the midst of all of this, right, and sustain it?

AR: Well, see, I don't think joy should be cultivated or sustained...

IP: OK...

[they both laugh...]

AR: ...it's something which one has to know is ephemeral, you know, it isn't something that you can... I mean, except...

71. A conversation with Idelisse Malave and Alta Starr in adrienne maree brown, 2019. *Pleasure Activism*, AK Press, p.389

IP: ... a kind of property...

AR: Yeh...except when they tell us that we can own it and make it permanent in advertisements, you know, but otherwise it's something which I think, it's a really important skill to have on the radar and to recognise what it is that truly gives you joy and to know that it's ephemeral, you can't hold on to it, but that's why it's so beautiful when it comes, and it goes and it comes, but like I said, you know, as a writer, especially as a fiction writer I value every feeling....

IP: Yes.

AR: [...] I think the modern world has been sold this idea that somehow we are entitled to happiness, we're not, you know, that's an ephemeral thing, and yet to be unafraid of feeling, somehow is a powerful thing, you know.

IP: Yes.

AR: Sometimes grief can just tear you apart, you know, but, I don't know, sometimes I think that perhaps because feelings, and this is the alchemy of the work that I do, you know, that I write, so maybe that's what makes me say this, because there's a way in which I can do something you know, which helps me, which doesn't break me, even when the grief is...

IP: Yes.

AR: ... very acute, whereas perhaps if I didn't have that exit, that ability to write it, I may not be saying these things, but I don't know...

IP: [...] I think that there is something very bourgeois and western and particularly American about the idea that you can evade discomfort or create a life without suffering, which is often times sort of a life of things and distraction, that some degree of discomfort is unavoidable and it, that what you describe about writing is also about living a life that has meaning, right, which is different from happiness, but you know, is sustaining in its own way even in the most painful moments.72

I think about the term (and diagnosis) Obsessive Compulsive Disorder (OCD) which only speaks about symptoms. It mostly speaks of what get called compulsive, obsessive or repetitive behaviours, and *those* behaviours are defined as being the *disorder*. While they can be consuming, distressing and debilitating, it is essential to look *beneath* those expressions. I think about how deeply we are taught to suppress our somatic needs, and lock our bodies into tension patterns from a very early age, and then consistently in most working activity. There's such a deep systemic repression of movement and energy already mentioned above. There's also often embodied trauma, or deep existential crisis motivating a need for the displacement of fear or tension through activity or actions. Trauma can also be motivating attempts to maintain a high level of control over things in one's environment to avoid feelings, or to avoid stillness.

Obsessions, compulsions they say. Disordered they say What of repetition and consciousness held

depths of tension in the body?

Breathe, breathe to move through.

Let it shake out. Letting the tears come. Come back into presence.

72. Arundhati Roy hosted by Imani Perry, 2020. [Video]. *The Pandemic is a Portal.* An online teach-in. Available from: youtube.com/ watch?v=QmQLTnK4QTA&t=943s (Accessed 10.2.2021)

How can we steady the breath, spirit, body. Feel our feet on the ground.

Reconnect. Dance deep stillness. Again and again.

Let the fear travel out.

Right here now. In the grips of it being displaced. Checking kettles. Washing hands. Closing doors. Markers of distress.

Home ourselves.

Us within the greater whole.

I think again about what it means to build capacity to be able to stay with feelings (sensations, not necessarily interpretations or evaluations of them) so that those feelings lose some of their power because they aren't being suppressed or avoided.73 Also to build capacity to release feelings that need expression.

The book *Focusing* by Eugene Gendlin describes a practice of connecting and knowing through the embodied *felt sense.* Gendlin offers the beginner six steps for practice: clear emotional space; then feel into whether there is one thing/issue that might want some attention and get a *felt sense* of it; what is the feeling and where is it felt in the body? Find a word that resonates with the feeling, gently inquire about the feeling from which more insight might be gained. There may be a feeling of shift in the body as a result, or a feeling of understanding/knowing release. The practice can be explored on your own, though Gendlin celebrates it as an *exchanged* practice which can be done as partners witnessing and supporting each other; 'people helping people'.

While doing the practice Gendlin suggests:

73. A useful zine is Meg John Barker's *Staying With our Feelings*, 2016. Available from: rewriting-the-rules.com/wp-content/uploads/2016/11/

If words keep coming into your head, explanations and ideas and accusations and so on, keep repeating an open-ended question of your own. For example, keep repeating, 'What does this *whole* thing feel like?' That way you control the wordmaking part of your mind yourself, so it can't run off with you [...]. But the point isn't to fight words. It is quite all right for words to flow. The point is to feel behind and beyond them. To do this, it helps to keep repeating an open-ended question [...]. It is important not to stay stuck with the same old thoughts and feelings, but to widen the scope so that a different process can begin from the body's wider sense of the trouble.74

Mostly repetitive behaviour can feel like energy that is contracted and stuck or displaced. Energy that needs softening and releasing. I think it is also essential to look *laterally* at experience and what it might also have a relationship to in terms of our inhabitation of consciousness. Might for example the impulse to repeat something, driven by fear and tension, also be meeting with an impulse for repetition that is part of consciousness that *isn't* pathological? For example the repetition of mantra and prayer. Those states of immersion, locked into a repetitive loop that can be a doorway for the dissolution of the self. A holding frame for shifts of consciousness.

How might distress caught as repetition intersect with anchoring the self in chant, devotional repetitions?

How to access this? If this access is asked for.

How to know stillness,

sometimes through phrasing and rosary how to know divine ecstasy

sometimes through iteration and reiteration

74. Eugene Gendlin, 2003. *Focusing: How To Gain Direct Access To Your Body's Knowledge: How to Open Up Your Deeper Feelings and Intuition*, Rider, p. 89

praising with hands held high and held high find it, and find it again.

Again and again. Reconnect.

Grounded. Ground

This immersion.

This immersive space.

Immersive consciousness

that wants repetitive beats that wants silence

that wants to turn inward unravel undo

That wants freedom

Consciousness that wants to widen drum death that will

come mortality time time passing

This wild life

I think of the many old Scottish (Gaelic) charms, some of which were used as part of medicine and healing, which inhabit repetition and rhythm as power of engagement. The version of this chant was documented below in the late 19th century.

EXORCISM OF THE EYE

I TRAMPLE upon the eye,

As tramples the duck upon the lake, As tramples the swan upon the water, As tramples the horse upon the plain, As tramples the cow upon the 'iuc', As tramples the host of the elements,

As tramples the host of the elements.

Power of wind I have over it, Power of wrath I have over it, Power of fire I have over it, Power of thunder I have over it, Power of lightning I have over it, Power of storms I have over it, Power of moon I have over it, Power of sun I have over it, Power of stars I have over it,

Power of firmament I have over it, Power of the heavens

And of the worlds I have over it, Power of the heavens

And of the worlds I have over it.

A portion of it upon the grey stones, A portion of it upon the steep hills, A portion of it upon the fast falls,

A portion of it upon the fair meads, And a portion upon the great salt sea,

She herself is the best instrument to carry it, The great salt sea,

The best instrument to carry it.

In name of the Three of Life, In name of the Sacred Three, In name of all the Secret Ones, And of the Powers together.

(Translated from the Gaelic)

EOLAS A BHEUM SHULA

SALTRAIM air an t-suil, Mar a shaltrais lach air luin, Mar a shaltrais eal air burn, Mar a shaltrais each air uir, Mar a shaltrais earc air iuc,

Mar a shaltrais feachd nan dul, Mar a shaltrais feachd nan dul.

Ta neart gaoith agam air, Ta neart fraoich agam air, Ta neart teine agam air,

Ta neart torruinn agam air, Ta neart dealain agam air, Ta neart gaillinn agam air, Ta neart gile agam air,

Ta neart greine agam air, Ta neart nan reul agam air,

Ta neart nan speur agam air, Ta neart nan neamh

Is nan ce agam air, Neart nan neamh Is nan ce agam air.

Trian air na clacha glasa dheth, Trian air na beanna casa dheth, Trian air na h-easa brasa dheth, Trian air na liana maiseach dheth, 'S trian air a mhuir mhoir shalach, 'S i fein asair is fearr gu ghiulan,

A mhuir mhor shalach, Asair is fearr gu ghiulan.

An ainm Tri nan Dul, An ainm nan Tri Numh, An ainm nan uile Run,

Agus nan Cursa comhla.75 76

I think about the same power which flows through the long history of wordsmithing; of chant, litany, poetry.

Every housewife a political prisoner

Every teacher lying thru sad teeth a political prisoner Every Indian on reservation a political prisoner Every black man a political prisoner

Every faggot hiding in bar a political prisoner

Every junkie shooting up in John a political prisoner Every woman a political prisoner

Every woman a political prisoner

You are political prisoner locked in tense body You are political prisoner locked in stiff mind You are political prisoner locked to your parents You are political prisoner locked to your past Free yourself

Free yourself

I am political prisoner locked in anger habit I am political prisoner locked in greed habit I am political prisoner locked in fear habit

75. Alexander Carmichael, 1992. *Carmina Gadelica, Hymns and Incantations: Collected in the Highlands and Islands of Scotland in the Last Century*, Floris Books, p.138

76. 'The importance of words, numbers and movements at the very centre of the Gaelic healing tradition indicates a culture where science and the arts were one – where numbers were magical and words were chosen with precision.

To us... this 'centre' is imbued with glamour and mystery, as indeed it was probably always intended to be. However when these rituals and chants were still very much a real part of the old medicine, they were also a convention, a part of a protocol.' Mary Beith, 1995. *Healing Threads: Traditional Medicines of the Highlands and Islands*, Birlinn Ltd, p.189

I am political prisoner locked in dull senses I am political prisoner locked in numb flesh Free me

Free me

Help to free me Free yourself Help to free me Free yourself Help to free me77

Repetition that facilitates immersion and energetic shifts in consciousness makes me think about a Tibetan medicine practice which involves lengthy chanting over the preparation of herbs powdered into medicine.

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In 1981–82, Lama Thubten Yeshe prepared his first batch of chulen (taking the essence) pills according to traditional procedures, using extremely valuable natural ingredients. The pills were then blessed by more than seventy monks and nuns of the International Mahayana Institute through the recitation of one million Vajrasattva (one-hundred-syllable) mantras.78

I also think about the overlap between expressions of distress and aspects of consciousness that can be profound and necessary; a cusp territory. I think if there are no channels for the inhabitation of various consciousnesses, that they can be sought access to through complex routes which can involve/intersect with what feels like unwellness. This idea of cusp territory makes me think about the struggles of anorexia. Sometimes

devastating starvation (for all the reasons that it occurs: because of trauma, culturally manufactured body dysphoria, etc.) also involves high levels of self-discipline,

77. Diane di Prima, 1968. *Revolutionary letters*, City Lights Publishers, #49

78. Lama ThubtenYeshe, 1993. 'Taking the Essence'. *Lama Yeshe Wisdom Archive*. Available from: lamayeshe.com/article/taking-essence (Accessed 9.02.2021)

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and altered states induced by protracted fasting, which can be very elevated. Distress overlaps with inhabitations of being that can often be denied or disallowed in the spiritual wasteland of contemporary global Northern capitalism. Sometimes in the deepest struggle something else is also being accessed. I think that could be key also to the complex ways we might understand healing, if we share a broad dialogue about overt and sometimes more obscure meaning there might be in experiences.

Trance consciousness spoken about in the following ways speaks to that cusp territory. Trance can be accessed through repetitive singing, clapping, drumming, circular dancing and head movements, as well as rapid changes from light to dark and powerful olfactory stimulation such as burning incense [...]. Trance can also be achieved through becoming focused on just one or two stimuli, disrupting the normal, broken flow of consciousness [...] in addition extreme psychological distress can induce trance.79

Consciousness is so culturally prescribed, and either sanctioned or disallowed, and *control* of consciousness can be such a violent and also colonial force.

... in Western psychiatry, mystical or trance states are associated with 'loss of ego control' and seen as pathological because 'selfcontrol' is considered important in Western culture, leading to an over-diagnosis of people of African descent, Hispanics and Native Americans in the United States.80

It is this global Northern colonial pathologising of 'loss of ego control' which comes into play around the prohibition of practices, and

79. John Waller, 2008. *A Time to Dance, a Time to Die: The Extraordinary Story of the Dancing Plague of 1518*, Icon Books, p.189/90

80. Isabel Clarke, ed., 2010. *Psychosis and Spirituality: Consolidating the New*

plant medicine, that facilitate dissolution of 'the self ' and greater union. In Johann Hari's book *Lost Connections*, he records speaking with people working with psilocybin (magic mushrooms):

'having moments when your ego is' – as he puts it – 'dissolved and merged into the greater whole [...]. You gain a radically different sense of perspective on yourself' [...]. Everyone I interviewed who worked with administering psychedelics clinically emphasized that these substances most often leave people with a profound sense of connection – to other people, to nature, and to a deeper sense of meaning [...]. 'A pretty common theme when people get off the couch' after a psilocybin experience [...] 'is love. They've recognized the connection between themselves and others [...] they feel more motivated to connect to others'.81

It makes me think about the lack of stillness and deep concentration in contemporary global Northern capitalism. The culture functions in great part on the basis of a rapid

mania. Biomedicine will often still conceive of OCD as a fundamentally biochemical imbalance and treat the symptoms that way. It makes me think of how reductive biomedicine is about many experiences, which can foreclose other perspectives and healing approaches. I want to digress for a bit to look at that.

Tourette's is described as a *neurological* (i.e. of the nervous system; the brain, nerves, etc.) condition. There's no definitive test for Tourette's that correlates a particular kind of brain or nervous system with the condition. But it is classified as neurological because biomedicine asserts that consciousness is located and controlled by the brain and nervous system. Personal testimonies however speak about people engaging in embodied, somatic activity through music, singing, the breath, through imagination and connection, which profoundly alters

81. Johann Hari, 2018. *Lost Connections: Uncovering the Real Causes of Depression and the Unexpected Solutions*, Bloomsbury Publishing, p.236 them: some people who have the experience of ticcing speak about how that stops when they inhabit states of being that engage concentration and creativity.

In a documentary that follows someone called Greg, he explains that ticcing (often stress related) stops if he holds an inner drumbeat. '... his technique for keeping his Tourette's at bay is simple – in any stressful situation, he imagines himself playing complicated drum beats. An accomplished percussionist, Greg hosts a workshop to illustrate the point...'82

In other instances the same connection between accessing centre and stillness through concentration and/or creativity and ticcing abating is spoken about: 'No treatment has ever worked to stop his Tourette's, apart from a brief respite when he plays his guitar and piano.'83

When I start singing it feels really good [...] I don't have to repress or anything, I just don't tic when I sing, and I think that's the good thing about it and it's why I enjoy music and singing so much, it's a release [...]. When I am on stage and singing it's the best feeling ever, I just become really confident and just yeh, a completely different person.84

There seems to be a similar dimension to some experiences of stammering. Many people report that stuttering disappears when they sing. And general advice to support more ease sometimes suggests imagining that you are about to sing before speaking. I remember

82. Andrew Keddie, 2017. *'Tourette's documentary 'the best so far' says inspirational John*'. Available from: bordertelegraph.com/news/15026605. tourettes-documentary-the-best-so-far-says-inspirational-john (Accessed 10.2.2021)

83. *'I Have the Most Extreme Case of Tourette's'. Living Differently*, BBC documentary. (2019). [Video]. Available from: www.youtube.com/ watch?v=wL2viVwGeMs (Accessed 10.2.2021)

84. *'My Singing Stops Tourette's'. Living Differently*, BBC documentary. (2019). [Video]. Available from: www.youtube.com/watch?v=4-E34SYGVzg (Accessed 10.2.2021) a conversation with a woman from Nigeria who had an occasional stammer.

She was participating in a workshop series about plant medicine that I was facilitating and we were chatting after a session one day where she told me she had enjoyed the pace of it and felt at ease because there was no rush or pressure. She said, ‘I never had a stammer until I came here, but here people talk so fast and they don’t listen and I started to stutter. Back home there was just a lot more time.’

There’s also testimony about the use of psychedelics and a supportive effect on stuttering.

I first discovered the potential psychedelics have for treating stuttering during an experience with psilocybin mushrooms. For the length of the trip, I was able to speak as fluently and effortlessly as I ever have – more than I ever have.85

Another account, about the mycologist Paul Stamets, tells us:

He tried psychedelic mushrooms for the first time when he was

18. He ended up climbing a tree and was stuck there during a heavy thunderstorm. At the time, Paul realized he could die at any moment but also found the experience overwhelmingly beautiful. Looking inside himself, he felt as if he was part of the forest and the universe. As he reflected on his life, he told himself over and over in his mind to stop stuttering. Later, when the storm ended and he headed home, he ran into an attractive woman who was a neighbor of his. Normally, talking to her was nearly impossible because of his shyness and stammer. But this time, they exchanged greetings without incident, to the surprise of them both. His stuttering never returned. This transformation led Paul to devote his life to studying psychedelic and other

85. H.T, 2018. ‘Psychedelics and the Full-Fluency Phenomenon’. *psymposia.com* Available from: psymposia.com/magazine/psychedelics-and-the-fullfluency-phenomenon (Accessed 10.2.2021) species of mushrooms.86

It makes me think about the significance of the relationship between certain experiences and stress, as well as the profound disconnection from stillness, concentration, prayer, creative, altered and expanded consciousness in much of global Northern culture. But still, a biomedical lens will insist that a ‘condition’ is personal and neurological. The location of experience in ‘the neurological’, or ‘neural’, shuts down all of the incredible and complex ways we might share understanding about consciousness; what consciousness even is; how inhabiting various forms of it affects us.

The biomedical understanding of experience being located in the ‘neurological’ when actually it can’t be reduced down to *just* that, makes me also think about the way experiences *themselves* can be understood in so many different ways. I remember reading about the Russian writer Dostoevsky’s experience of auras, the term given to the felt sense that can precede what biomedicine calls epilepsy or seizures.

The air was filled with a big noise and I tried to move. I felt that heaven was going down upon the earth and that it engulfed me. I have really touched God. He came into me myself, yes God exists I cried, and I don’t remember anything else. You all, healthy people, can’t imagine the happiness which we epileptics feel during the second before our fit [...]. I don’t know if this felicity lasts for seconds, hours or months, but believe me, I would not exchange it for all the joys that life may bring.87

And in the book, *The Spirit Catches You and You Fall Down, A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, Anne Fadiman chronicles the struggles centred round the

86. 'Paul Stamet, Stuttering Stops, Career Begins'. (No date). *Psychedelic Review.* Available from: psychedelicreview.com/person/paul-stamets (Accessed 10.2.2021)

87. Fyodor Dostoevsky, 1881. *A Writer's Diary, the diary*, Northwestern University Press experiences of a daughter of a Hmong refugee family and their interactions with the health care system in America. Where biomedicine described the daughter Lia Lee's experiences as epilepsy, the family recognised the experience as *quag dab pe*g, which means 'the spirit catches you and you fall down'.

The spirit referred to in this phrase is a soul-stealing, *dab*, *peg* means to catch or hit, and *quag* means to fall over with one's roots still in the ground, as grain might be beaten down by wind or rain. In Hmong-English dictionaries, *quag dab peg*, is generally translated as epilepsy.

Fadiman explains, 'the Hmong consider *quag dab peg* to be an illness of some distinction', and that

Hmong epileptics often become shamans. Their seizures are thought to be evidence that they have the power to perceive things other people cannot see, as well as facilitating their entry into trances, a prerequisite for their journeys into the realm of the unseen. The fact that they have been ill themselves gives them an intuitive sympathy for the suffering of others and lends them emotional credibility as healers. Becoming a *txiv neeb* is not a choice; it is a vocation. The calling is revealed when a person falls sick, either with *quag dab peg* or with some other illness whose symptoms similarly include shivering and pain [...] (*Txiv neeb* means 'person with a healing spirit.').88

There's absolutely no intention to oversimplify or romanticise experiences by citing the above. There's no wish to minimise the struggle, pain, frustration, limitation and debility that can be felt, or make any generalisations about experience. I've referenced it all

88. Anne Fadiman, 1997. *The Spirit Catches You and You Fall Down, A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, FSG Adult p.21/ 22 because of how it points to the range of ways experiences can be embodied, and perceived, some of which might seem unexpected because of the way an experience or 'condition' is usually framed by the dominant biomedical narratives.

I think about the term (and diagnosis) of Psychosis where the conversation about which consciousness is culturally allowed or deemed pathological feels particularly relevant; where the conversation about the cusp territory between variable/ freedom of consciousness and distress also feels particularly relevant.

Linklater speaks about the value judgments about what is considered an authentic reality, and the way psych/iatry typically asserts that there is 'ordinary' and 'non-ordinary' reality, or 'alternate' reality. She challenges that conceptualisation:

The term 'parallel realities' and 'multiple realities' are intended to replace 'psychoses' and 'psychotic episodes.' [...] terms such as ordinary and alternate imply that

there remains an authentic and perhaps more acceptable reality that is understood as legitimate. Parallel and multiple realities recognize the value and legitimacy of these experiences, which often reveal important content that is vital to one's healing process.89

Linklater cites Gilbert, an Indigenous practitioner reflecting on the fact that:

It is recognized that medication has its purpose; however, medication often gets in the way of healing. 'I know the symptoms when people are receiving something from the traditional side of things', Gibert points out. 'Sometimes they're not able to sleep because they're frightened and are full of fear'. If these individuals come into contact with the mainstream medical system, they are often prescribed medication to 'calm

89. Renee Linklater, 2014. *Decolonising Trauma Work: Indigenous Stories and Strategies*, Fernwood Publishing Co. Ltd, p.24 them down', says Gilbert. 'The medications do a lot of damage, because it interferes with the cultural teachings that they are receiving. Our way is powerful, but when there's something pushing that away things start to get worse'. Many people who are going through a spiritual awakening have an extended period of spiritual activity, which could involve communication with other Spirits, vivid dreams, and an intense connection with the natural environment. These experiences are not illness, and therefore will not be aided by psychotropic medication.90

I'm not in *any* way denigrating the use of medication. Drugs can be useful, and lifesaving, whether that is short or long term. I am also not suggesting all experiences of multiple or parallel, what I have been calling *variable* consciousness, are purely spiritual awakenings. They can be terrifying and painful for everyone concerned. There can be a sense of being very lost in fear, distortion or dissociation, or realities that we don't have the cultural or spiritual support or means to navigate. But I know there is meaning to find, to sometimes *decode*, in experiences, and I am interested in ways we can support each other to negotiate intense experience, and avoid overwhelm, or becoming caught in very disoriented space. I think about embodied practices we can use as support; the breath, gravity, touch, to help us hold steady, regroup and reground, like containers for intensity. I think about physical spaces (nature, retreats, houses) we can generate to do the same.

I think it's important to name that the meaning in experiences isn't always primarily 'personal' meaning or revelation; most often the meaning speaks to wider collective needs, it points not just to what might be useful, insightful or necessary transformation for some 'one', but for *all of us*.

I appreciate what radical psych/ologist David Smail articulates:

For the purposes of understanding how and why people

90. Ibid. p.129

experience and act in the world as they do, and what freedom they may have to act otherwise, the concept of 'responsibility' has become virtually useless. What we need

is a psychology that switches its attention from a metaphorical 'inner world' to try instead to elaborate the ways in which powerful influences in the external environment of social space-time serve to liberate or enslave us, as well as to shape our consciousness of ourselves.91

What can be so painful is that the wider transformation needed to profoundly tend to distress can often feel too slow and too inadequate. I think we can encourage and support each other to engage in transformation at a more personal level, *at the same time as*, and as *an inherent part* of mobilising for systemic transformation. I like the collective focus Smail speaks to in terms of how we need to build radical understanding of the effect of context in order to find and apply remedies.

For people to be able to understand and act upon the powers and influences within society that bring about their personal misery and confusion, we need to reopen the ethical space that allows us to share and evaluate our subjective experience in solidarity with others. The structures that will enable this are not *therapeutic*, but *political*.92

How do we ground ourselves in intensities, experiences? What are the holding frames for variable consciousness? How do we inhabit that, draw from that, learn from that?

Dance the sun up

We danced the sun up

Opal sky in our open pupils –

91. David Smail, 2005. *Power, Interest and Psychology; Elements of a social materialist understanding of distress*, PCCS Books, p.78 & 97

92. Ibid.

Clean dawn came, daybreak Dancing the sun up

We danced the sun up Dancing the sun up

Oh daylight, rise! atoms are dancing The souls, lost in ecstasy, are dancing

To your ear, I will tell you where the dance will take you. All the atoms in the air and in the desert,

Let it be known, are like madmen. Each atom, happy or miserable,

Is in love with the Sun of which we can say nothing.93

In the collection of essays, *Psychosis and Spirituality*, the concept of *liminality* is spoken about. That we can shift into liminal states of consciousness. And that we might feel anxious about that unfamiliar territory. It speaks about the way conventional medicine, which pathologises and tries to suppress or 'treat' people, can sometimes block a process of shifting into and back out of that consciousness again.

The concept of liminality is interesting with regard to understanding psychosis. Arnold Van Gennep identified three stages of transition: 'separation' (from an earlier condition), liminal (the condition of being in transition), and post-liminal (incorporation into a new situation). I wonder how many individuals have been diagnosed in the West as suffering from psychosis who have simply switched, unsolicited into liminal space, and are anxious about this. This concept is also covered by psychiatrist Barrett,

who suggests that patients with ‘so-called’ schizophrenia are in a state of ‘suspended liminality’. Barrett suggests that psychiatric institutions may

93. Omar Khayyam, 1872. *Rubáiyát of Omar Khayyám*, Wordsworth Classics

‘freeze liminality into a permanent state’.94

I’ve drawn insight and solidarity from cross-cultural inhabitations of consciousness that I’ve learned about, and historical ones also, that are often not understood, supported or culturally sanctioned in the contemporary global North. The American philosopher and psychologist William James – who is credited as being the ‘father of American psychology’ – published a book in 1902 called *The Varieties of Religious Experience*. It’s in part a meditation on direct divine and religious experience which he suggests is the precursor of organised religion. It’s also a powerful document of its time and place, about mysticism and direct commune with the realm of spirit, from visions to presences. He cites various experiences of visions and communications, including George Fox’s (founder of the Quakers) calling from God, and normalises these as a fundamental part of the human experience.

In a chapter, *The Reality of the Unseen*, he references the experience of impermeable space between what might be felt as the self, and other presences.

Whenever I practice automatic writing, what makes me feel that it is not due to a subconscious self is the feeling I always have of a foreign presence, external to my body. It is something so definitely characterised that I could point to its exact position. The impression of presence is impossible to describe. It varies in intensity and clearness according to the personality from whom the writing professes to come. If it is someone whom I love, I feel it immediately, before any writing has come. My heart seems to recognise it.95

There are so many experiences that are disallowed and pathologised

94. Isabel Clarke, ed., 2010. *Psychosis and Spirituality: Consolidating the New Paradigm*, Wiley, p.46

95. William James, 1902, *The Varieties of Religious Experience: A Study in Human Nature*, Penguin Classics, p.62 or dismissed in contemporary rationalist global Northern culture. I remember when I first travelled to the far north of Scotland to a beach on Cape Wrath called Sandwood Bay. I learnt it was the place where there was the last *recorded* sighting of a mermaid. No doubt there are records in many places of the last sightings also of fairies. No doubt there are folk who still see/encounter both.

Alexander Gunn, a local farmer, was on the beach, searching for one of his sheep, when his dog made a startling discovery [...] Gunn’s collie suddenly let out a howl and cringed in terror at his feet. On a ledge, above the tide, a figure was reclining on the rock face. At first he thought it was a seal, then he saw the hair was reddish-yellow, the eyes greenish-blue and the body yellowish and about 7ft long. To the day Alexander Gunn died in 1944, his story never changed and he maintained that he had seen a mermaid of ravishing beauty.96

Nowadays most people would say that mermaids are imaginary, or folkloric. They aren't 'real'. We don't look for them, so almost no-one sees them anymore. I think the same can be said for profound connections in the spirit realm that we have been disenfranchised from, for example from the ancestors. I think we learn about consciousness culturally, for example to only be conscious of (and so attentive to) the material world, and to close filters to the metaphysical, to the unseen, to experiences that are denied, or disputed. Sometimes we can have experiences or they can come to us regardless, and can feel challenging because we don't have frameworks to navigate them with.

What of the mystery of consciousness of connections...

96. John Muir Trust properties. (No date). Sandwood Estate: culture: Memories of Sandwood. Available from: web.archive.org/ web/20041014140837/http://jmt.org/ cons/sand/cult.html (Accessed

the deadening Enlightenment making reason and scepticism

and science that cuts us away from the sensual world a kind of criminal negligence

a kind of criminal fraud

Permission disallowed

How culture shapes how we feel, about how we feel how culture shapes what we see when we see

I want to avoid cultural appropriation by citing partial or anthropological accounts of cross cultural experience of consciousness. There are anyway plenty of contemporary global Northern experiences of consciousness to consider, share and have guide shaping social and spiritual infrastructure.

And then it happened. Something peeled off the visible world, taking with it all meaning, inference, association, labels, and words. I was looking at a tree, and if someone had asked that's what I would have said I was doing, but the word 'tree' was gone, along with all the notions of treeness that had accumulated in the last dozen or so years since I had acquired language. Was it a place that was suddenly revealed to me? Or was it a substance

– the indivisible, elemental material out of which the entire known agreed-upon world arises as a fantastical elaboration? I don't know, because this substance, this residue, was stolidly, imperturbably mute. The interesting thing, some might say alarming, was that when you take away all human attributions

– the words, the names of species, the wisps of remembered tree-related poetry, the fables of photosynthesis and capillary action – that when you take all this away, *there is still something left.*97

97. Barbara Ehrenreich, 2014. *Living With a Wild God: A Nonbeliever's Search for the Truth about Everything*, Hachette USA, p.48

In an essay, *Alternatives or a way of life?* Bhargavi Davar speaks about the trauma of witnessing her mother in mental institutions in India in the 1960s. And about the creativity and devotional life her mother wished, and eventually was able to inhabit living in a temple in South India. The article talks about the conflict of 'modern'

asylums and faith based healing centres in India. In the article where Davar is speaking about connecting to ways of life that predate and decentre biomedical psych/iatry, she comments on 'troubled Westerners seeking spiritual redemption' in India.

I am curious about this overwhelming interest in 'alternatives' in such East/West transactions: there must have been these *ways of life* in the West as well, but there seems to be no cultural memory of them anymore, so people are now moving towards Eastern knowledge and practice, which are sometimes at risk of being adapted to suit Western ways of life.

Can we predict this erasure of cultural memory in India too, and in other low and middle income traditional societies like India?

She continues: ' "Awareness raising" about mental illness is eroding ways of life and bringing about the closure of community healing spaces or allowing psychiatry to occupy these spaces.'98

I'm always searching for traditions and knowledge that have been damaged or eroded in my own lineages. The following are a couple of citations that gave me huge permission pointing to '*ways of life*' that engaged and celebrated consciousness that is schooled out now by the current dominant culture. Alastair McIntosh's book *Soil and Soul. People versus corporate power* looks at community empowerment and land reform, and draws on Scottish highland and island

98. Bhargavi Davar, 'Alternatives of a way of life?' 2016, in *Searching for a Rose Garden: Challenging Psychiatry, fostering Mad Studies* edited by Jasna Russo and Angela Sweeney, PCCS Books, p. 17

culture. McIntosh cites two accounts that speak of a wide, magical consciousness. The first tells that 'the accomplished female bard, Maighread Ni Lachainn, would 'see' her poems running along the green turfs that formed the intersection of wall and roof in her blackhouse'. The second is an account recorded on the Isle of Skye in 1695 that describes the way that bards (whose training is said to have been seven years) 'would compose their works by lying on their backs for a day in a darkened room, with their woven woollen plaids or mantles wrapped around their heads, eyes covered, and a stone on their bellies'. McIntosh talks about them inhabiting consciousness that was akin to the use of psychoactive mushrooms, and explains that the bards would have been held in higher esteem than doctors of medicine at that time.99

The thoughts above are subjective reflections, considering *expe- rience* instead of diagnoses. They are based on personal experience, shared experience and conversation with family, friends and workshop participants, and with people I've allied with through one-toone bodywork. They speak directly and indirectly, and refer back to the limitations of diagnosis already listed; a nosology (naming) that looks at symptoms and calls those pathologies, instead of understanding what meaning or opportunity might be available. Of course mine is just one voice here exploring experience, and seeking wider conversation we might have together.

Relanguaging experience together

'For the master's tools will never dismantle the master's house.'

I cite this incredible quote from Audre Lorde, Black, lesbian activist, scholar and poet, in reference to generally challenging structural oppression, and I use it here in relation to the institution of biomedicine and psych/iatry. I respectfully reference

99. Alastair McIntosh, 2001. *Soil and Soul: People versus Corporate Power*, Aurum Press Ltd, p.72

blackfeminisms.com to honour the context these words were specifically spoken in, and to, so as not to eclipse the specific focus of that work.

Now that I'm more aware of the erasure of Black women's labor in academia I realize now that I and other Black feminists need to give due diligence to rectifying this erasure. Here's the full quote in which Lorde makes the now famous statement:

'Those of us who stand outside the circle of this society's definition of acceptable women; those of us who have been forged in

the crucibles of difference – those of us who are poor, who are lesbians, who are Black, who are older – know that survival is not an academic skill. It is learning how to take our differences and make them strengths. For the master's tools will never dismantle the master's house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change. And this fact is only threatening to those women who still define the master's house as their only source of support.'

Frequently I hear people invoke the phrase in reference to oppression in general. It is important to note that these words were spoken by a Black lesbian feminist in 1979 on a panel titled 'the personal and the political' at the Second Sex Conference, an event sponsored by the New York Institute for the Humanities. Lorde's words served as a critique of White feminism, which she charged failed to dismantle White supremacy.100

100. Black Feminisms, 2017. 'The Master's Tools, White Feminism according to Audre Lorde'. Available from: blackfeminisms.com/white-feminism (Accessed 10.02.2021)

Naming on our own terms

If we don't use diagnosis, then what do we use?

There is vast and radical healing potential in regaining control over the meaning of psycho-emotional experiences, and how we understand consciousness. I think we can access that by coming together in solidarity and *languaging/relanguaging* (giving language to) what we experience, both to ourselves and to each other on our own, various, and contextualised terms. In this instance 'our own terms' means ones that aren't laid down for us by reductive biomedicine or psych/iatry. In this way I think naming or renaming experiences of consciousness and of distress can function as a liberatory power. We can gain insight *and* 'outsight': I want to reference the radical psychologist David Smail again here, who writes that if conventional therapy about the self and self-improvement encourages 'insight', that the aim of a more politicised radical approach is 'to help the person achieve 'outsight' such that the cause of distress can be demystified and the extent of their own responsibility for their condition put into its proper perspective'.101

With support we can name what the felt sense of our experiences are and forge broader understanding that points us to approaches, remedies, tools, re-sources and changes we need to make. We can consider experiences and name things from our own inner and shared collective understanding, and we can explore with others we trust who might offer perspectives that shed light on useful paths of action or inaction, navigating life, coping, and thriving. We can harness courage to name what is unbearable and intolerable. We can speak together to honour our *unique* experiences and histories, as well as *common* ones – and draw insights from them to shape the choices we make together for the ways we want to live.

101. David Smail, 2005. *Power, Interest and Psychology; elements of a social materialist understanding of distress*, PCCS Books, p.32

Diagnosis: Ways of knowing

The word *diagnosis* comes from root words meaning to *distinguish*, *discern, recognise*, and *know.*

Diagnosis from *diagignōskein* (Greek) meaning to 'distinguish, discern'

dia 'apart' + *gignōskein* 'recognise, know'

We could use those root meanings as a guiding principle, and ask how might we come to distinguish, to discern, to recognise, to know *on our own terms.*

I'd like to reference a handful of things that can be useful and important frameworks for shaping what 'discerning', 'recognising' and 'knowing' could look like. The first is something called Formulation, which comes from global Northern psychology. The second are concepts shared by an Indigenous practitioner of Mohawk heritage, Ed Connors about reconnecting to Indigenous relational healing modalities; related is reference to the Finnish practice of Open Dialogue as a relational practice. Lastly I reference the framework shared by *Black Women's Mental Health* through the acronym BREATHE.

Formulation

Formulation used in psych/ology is a process of co-constructing (between a person and a practitioner) an understanding of experiences. It is based on a combination of a person's *own* knowledge and a psych/ologist's perspectives and experience. In an article, *Psychological Formulation as an Alternative to Psychiatric Diagnosis*, Lucy Johnstone explains:

Formulation can be defined as the process of co-constructing a hypothesis or 'best guess' about the origins of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them [...] the clinician brings knowledge derived from theory, research, and clinical experience, while the service user brings expertise about their own life and the meaning and impact of their relationships and circumstances.

Johnstone explains that formulation isn't an expert judgement and it is also not based on deficits. Instead it draws attention to a person's resources and strengths. She emphasises:

Most important, and in contrast to psychiatric diagnosis, psychological formulation approaches all expressions of distress with the assumption that 'at some level it all makes sense [...] that however unusual, confusing, risky, destructive, overwhelming, or

frightening someone's thoughts, feelings, and behaviours are, there is a way of making sense of them'.102

While this formulation practice is situated in a professional context, some of the principles feel really useful, and can be drawn from to use in non-hierarchical and non-professional encounters, both one-to-one and in groups, to make sense out of experiences. We can 'formulate' understandings *together*, then name what might be needed on all levels to remedy experiences of pain, confusion or distress. This as a shared process can be a vital aspect of 'discerning' and 'knowing'; moving away from just *individuated* inquiry of dominant global Northern models, in order to understand things relationally and *collectively*.

102. Lucy Johnstone, 2017. 'Psychological Formulation as an Alternative to Psychiatric Diagnosis'. *Journal of Humanistic Psychology.* Available from: https://doi.org/10.1177/0022167817722230 (Accessed 10.02.2021)

An Indigenous perspective on relational healing

Ed Connors, psychologist and Elder advisor on the Board of Directors for the Native Mental Health Association of Canada, speaks about the way: a lot of clinical psychology doesn't encourage people to go beyond the self. It tends to be self-focused [...] focused on the 'I'. And that's why the clinical psychology that has been more relevant and informed my work more has been family therapy because it moves us beyond the 'I'. And group therapy, these kinds of ways of healing which are more connected to our Indigenous practices of healing.103

We need to explore the experiences we have contextually, not as the illusion of 'isolated' units. We can come to much wider understandings of what is going on for us with an analysis of the contexts we are living in, and often through the shared wisdom of a *group*. Ed Connors goes further to say of the healing/therapeutic relationship:

We're looking to discover what the imbalances are in their lives and where they lie: Are they in the physical, the mental, the emotional or the spiritual areas? Are they in all those areas? Do they exist in terms of their relationship with others in the world around them? Do they exist in terms of their relationship with all of Creation? Does it exist in terms of their relationship with the spirit realm? And then we talk and start to explore where they are, what they then need to do to correct those imbalances, to set those things right and put them back into balance.104

103. Renee Linklater, 2014. *Decolonising Trauma Work: Indigenous Stories and Strategies*, Fernwood Publishing Co Ltd, p.70

This wisdom to explore what might be happening for us psycho-emotionally 'moving us beyond the 'I', takes me to other relational therapeutic processes, like *Open Dialogue.*

Open Dialogue

Open Dialogue is a therapeutic model that's been developed in Western Lapland in Finland over the last 35 years. It's not an alternative to the psych/iatric system there, it *is* the psych/iatric system, and has some of the best documented outcomes in the global North. It's been brought to the UK and is being adapted and piloted within a couple of NHS trusts. It speaks of the 'patient' as being 'the person at the centre of concern', and tries to understand what is going on for and needed by that person, through 'Network meetings'. These can include family and social networks, always with the consent and presence of the person at the centre of concern themselves. It is a *dialogical* approach, which means that a process of dialogue hopes to open up meaning, and shed light on useful processes and action to mitigate the experiences of distress. The person at the centre of concern, family, social network and therapists, all meet together to speak – with a regularity and frequency of meetings that feels appropriate to the situation – and try to understand what is going on. Generally this happens at home, not in a medical or hospital setting. All reflections, questions and realisations had by everyone in the meetings are shared transparently, and discussed together so meaning and understanding can be found.

The Open Dialogue UK website explains:

Open Dialogue teams work to help those involved in a crisis situation to be together and to engage in dialogue. It has been their experience that if the family/team can bear the extreme emotion in a crisis situation, and tolerate the uncertainty, in time shared meaning usually emerges and healing/recovery is possible.105

In an article, *The Promise of Open Dialogue* by Mary Olson, she explains:

Open Dialogue provides an immediate response within 24 hours of the first contact to the crisis service. In advance of any decisions about hospitalization or therapy, the radically revised treatment meeting brings together the person in acute distress with all other important persons, including other professionals, family members, and anyone else closely involved. Everyone's voice is heard and respected. Any decisions about medication and hospitalization are made with everyone's input. The team that comes together at the start remains the permanent team, whether a crisis lasts three weeks or three years. Transparency in Open Dialogue is also a main value. The professionals try to be as open and forthcoming as possible [...] influential social thinker Lynn Hoffman describes this approach as a 'witness' versus an 'aboutness' practice. In other words, Open Dialogue emphasizes 'being with' rather than 'doing to'.106

Again, like formulations, we can use some of the principles of Open Dialogue with which to meet together and gain understanding. We can 'be with', rather than 'do to'.

A group process might not feel right for everyone, or at a given point in someone's life. Groups of any size, be that a group of three or a much larger group, and collective processes can however be important places of knowing. As can be frameworks for discerning, recognising and knowing that offer distinct and specific recognition

105. Open Dialogue UK, no date. Available from: opendialogueapproach. co.uk (Accessed 10.02.2021)

106. Mary Olson, 2014. *The Promise of Open Dialogue.* Available from: www. madinamerica.com/2014/01/promise-open-dialogue-response-marvin-ross (Accessed 10.02.2021) of experience, and therefore distinct approaches. Below is one such framework.

BREATHE

The book *Black Women's Mental Health; Balancing Strength and Vulnerability* offers a specific framework for naming and knowing and responding which it calls BREATHE. The acronym recognises and speaks to the experiences of Black Women. In its introduction it makes clear:

As with the thirteen guiding principles defined by the Black Lives Matter founding manifesto, we unapologetically recognize Black women's issues broadly to include diversity, queer and transgender affirmation, families and communities, intergenerational and global perspectives, and an unwavering commitment to restorative justice.

They outline:

BlackWomen's Mental Health; Balancing Strength and Vulnerability offers a toolkit of resources for conceiving Black women's selfconsciousness, self-concept, and self-definition in ways that defy fragmented caricatures of fear, anxiety, inadequacy on one hand or, at the other extreme, the StrongBlackWoman myth (as coined by Chanequa Walker-Barnes). Unhealthy images are presented, represented, and internalized and inadequate models are developed and reflected in history and education, media and culture, policy and politics [...].

Our 'BREATHE' model values characteristics of both strength and vulnerability. Explicitly building on the groundbreaking book *In and Out of Our Right Minds: The Mental Health of African American Women.* This book foregrounds balancing the two narratives, and acknowledges grains of truth in each pole. Yet, we also provide research and recommendations that address the excessive social inequalities that damage Black women's mental wellness and overall health. This model also honours activist traditions by 'talking back' to oppressive forces that would stifle our ability to breathe while Black.

The introduction details the BREATHE model which is defined as:

[...] a set of principles by which one can engage the process of restoration and lifestyle change as well as increase one's understanding of Black women's mental health [...]

B – Balance

R – Reflection

E – Energy

A – Association

T – Transparency

H – Healing

E – Empowerment107

The acronym speaks to balancing commitments, setting aside time for contemplation and audits, reinvigorating goals so they can be realised, creating and maintaining social networks that encourage and affirm well being, actively avoiding remaining silent about painful experiences, looking for ways to nurture wellness in self and others, and enlisting one's own agency.

BREATHE as a framework for inquiry and action relates to and regards a particular history and context of lived experience. It exemplifies the need for frameworks that honour specific cultural and community experiences. Frameworks that have a distinct, vital shape to their discerning, recognising, knowing and healing.

107. Stepahnie T. Evans, Kanika Bell, Nsenga K. Burton, eds., 2017. *Black Women's Mental Health; Balancing Strength and Vulnerability*, SUNY Press, p. 2, 3, & 4

Diagnosis: Myriad ways of knowing

There are so many different ways of discerning, recognising, knowing which can happen in different *consciousness*, like embodied, magical or mystical consciousness, in dream space, or consciousness that is engaging more directly with the spirit(ual) realm. In this next section I've pulled some different threads together to honour these ways of knowing. Below are references to ways of knowing through family and ancestral constellation, planetary constellation, through dream states, sleep patterns, night wakefulness, and through divination practice.

Constellations #1

Practices with ancient traditional Southern African roots, have been developed to connect to and understand relational, familial and ancestral patterns and dynamics. In this work someone's family is represented using other people, or dolls, or objects, in order to access knowledge about family and ancestral relations, and about how the past might be impacting on the present.

Several modalities have been developed for this kind of intergenerational healing: Family Constellation (also known as systemic constellation) was developed by Bert Hellinger; contemporary modalities include African Constellations by Tanya Meyburgh, and Ancestral Constellation developed by Sonia Welch-Moring. All the practices explore the relational, mapping families in ways that consider *everyone* in a family history; those present and those absent; those living and those passed.

Hellinger, a German psychotherapist called the 'founder' of Family Constellation, lived in South Africa as a Roman Catholic priest for 16 years in the 1950s and 60s. During these years he became fluent in the Zulu language, participated in Zulu rituals, and gained what he felt was an understanding of Zulu culture. Some of his work is modelled directly on aspects of that culture. Hellinger

>18

noticed a difference between traditional Zulu attitudes toward parents and ancestors (who are regarded as positive, constructive, and creative presences) and those typically held by Europeans.

Practitioners of Family Constellations speak in some of the ways that trauma therapy does; acknowledging present-day problems and difficulties related to unresolved trauma suffered in previous generations of the family, even if those affected now are un-

aware of the original event. Hellinger referred to the relation between present and past problems that are not caused by direct personal experience as systemic *entanglements*.

Hellinger appropriated from Southern African culture in his work, enacting a very familiar pattern of white cultural appropriation of Indigenous traditions. This work is known and used internationally usually without referencing its history. It is also being reshaped, remodeled and reclaimed through different practitioners like Sonia Welch-Moring, who is reasserting it as an African heritage practice, and reclaiming it as a tool for the African diaspora. On her website she describes the way:

Ancestral Constellations explore family relationships, community networks and diaspora journeys through the creation of a transgenerational family map. The approach incorporates African traditional teachings. 'Other ways of knowing', that have sometimes been lost or forgotten, but remain deeply embedded in African heritage culture.108

Constellations #2

I like to think of astrology as the *felt sense* of astronomy; observing the movement of the planets in relationship to the earth and to

108. Sonya Welch-Moring, no date. *Ancestral Constellations.* Available from: ancestralconstellations.com (Accessed 10.02.2021)

each other, to understand and know about larger forces at work through us, and their influence on us. Astrology as it is expressed in popular culture can sometimes feel dumbed down and simplistic. It can also feel abstract. I've found it useful to understand some tangible basics. On that basis it's possible to foster a relationship to what the movement of the Cosmos might mean.

If we can look up at the night sky away from city lights we see constellations; groupings of stars that have been given names, like Taurus, and Gemini. There are 12 main constellations called the Zodiac that form a ring around the earth as we look up at them. As the earth turns on its axis the constellations move across the sky. The planets move through space on their elliptical orbit (Mercury, Mars, Venus, Jupiter, Saturn can be seen with the naked eye), and the moon orbits around the earth. Night by night, they move 'through' the constellations; if we look up at the sky we can see the planets and the moon 'sitting' within the constellations. The moon might appear to be in front of Taurus (Moon in Taurus), Mars might be seen appearing 'in' Sagittarius (Mars in Sagittarius).

When we're born our emergence is synchronous with a pattern of the planets all in various positions in the sky and in various constellations. We therefore emerge within a set of energetic patterns, and then live within them as they constantly change day by day and season by season. The time that we are born can be depicted showing all the planets in the constellations that they would have been in at that moment, as seen from that place on earth where we were born. This is called our natal chart. Popular

astrology focuses on where the sun was in the sky at the time of birth (i.e. Sun in Taurus), which has come to be called our singular 'starsign', but *all* of the planets represent energies and aspects shaping who we are, and how we might be inclined to move in the world. I've found exploring natal charts can give really useful insight into possible qualities, tendencies and energies we might embody and that might motivate us.

Astrology has centuries and centuries of history, across many cultures. It used to be absolutely interwoven with life. In England for example, there were court astrologers who would suggest fortuitous or counter against times for events or journeys to be planned or made. Astrologers across cultures have also used astrology as a way to understand and support potential personal health issues/tendencies we might be inclined to (medical astrology).

This way of knowing, locating us within, and entirely interconnected with an ever shifting and unfolding universe can be another profound way to make sense of time, timings, experiences, and one's 'self '.

'It is not necessary to pray, one looks at the stars and has the feeling of wanting to sink down to the ground in wordless adoration.'109

Turn to the night fire, spiralling galaxies what you notice, if you notice

You look up into the dark skies planets 'the wandering ones' travelling through the constellations Moon in Libra, Mercury in Virgo

Cycles and returns, (re) configurations tendencies, synchronicities

patterns, aspects, vibrations oppositions, conjunctions orbits, ellipses

109. Edith Södergran, 1984. *Complete Poems.* Translated by David McDuff. Bloodaxe Books. p.154

Alignments swinging, push and pull in the body, in your body

You wonder about this You wonder

And how do you mark and make meaning of time? (Re)framing time, ritualising time

passages to mark passages holding spaces, and containers

sitting by the same tree

sitting at the same bit of water every day

every day for a week or a month, or a year observing

nothing more

Novena by the water novena on the hill

with thanks

You marked three days fasting. or thirty.

Three days, nine, a lunar month commit to a practice full to full moon mark (fire) festivals, the seasons

long ceremonies

all of our calendars

Asclepius and the dream temples

Asclepius was the god of medicine and healing in ancient Greek religion and mythology. The rod of Asclepius, a snake-entwined staff, remains a symbol of medicine today.

Asclepieia were healing temples in Ancient Greece, of which over 300 have been discovered. These temples were often in secluded locations surrounded by beautiful and tranquil scenery, and

Logo of the British Medical Association

Asclepian medicine, holistic in its approach to care, emphasised therapy through the natural environment as well as care for the person's psychological and emotional and spiritual states.

Asclepieia included carefully controlled spaces conducive to healing, and excavated remains show that sanctuaries included stadiums, gymnasiums, libraries, and theatres to promote rest, relaxation, and exercise. Treatment at these temples largely centred around promoting health in a broad sense, with a particular emphasis on a person's spiritual needs.

'There were two steps in order for a patient to be considered to be treated in the Asclepeion. The first of which is the *Katharsis* or purification stage.' People seeking to redress imbalance, and healing, would take a series of baths and other methods of purging, like a cleansing diet, over a series of several days, or purge their emotions through art.

Afterwards came something called incubation110 or dream therapy. People would sleep in the 'Abaton' or 'Enkoimeterion', which was a dormitory located in the *Asclepeion.*

Here, they would be lulled into a hypnotic state, likely induced by hallucinogens, and begin their dream journey. As they slept, they were visited by Asclepius or his daughters Hygeia and Panacea. These dream visitations were prognostic in nature, revealing the projected course of the disease and ultimate patient outcomes. During this time, patients would also discover what it was they needed to do once they woke

110. Incubation is the religious practice of sleeping in a sacred area with the intention of experiencing a divinely inspired dream or cure. It was also adopted by certain Christian sects and is still used in a few Greek monasteries. in order to treat their disease. Upon awakening, the patient would recount their dream to a temple priest, who would then prescribe a treatment based on their interpretation.111

The *Ascleapieia* illustrate a widespread culture that was inhabiting transcendent consciousness to know and heal from and within.

Of dreams and sleep

The power and knowing that can be accessed through dreams makes me think of specific accounts of dream knowledge. Like map dreams among the Dane-zaa, whose

traditional territory is around the Peace River in what is now called Alberta and British Columbia.

Some old-timers, men who became famous for their powers and skills, had been great dreamers. Hunters and dreamers. They did not hunt as most people do now. They did not seek uncertainly for the trails of animals whose movements we can only guess at. No, they located their prey in dreams, found their trails, and made dream-kills. Then, the next day, or a few days later, whenever it seemed auspicious to do so, they could go out, find the trail, re-encounter the animal, and collect the kill.

Maybe, said Atsin, you think this is all nonsense, just so much bullshit. Maybe you don't think this power is possible. Few people understand. The old-timers who were strong dreamers knew many things that are not easy to understand. People

– white people, young people – yes, they laugh at such skills. But they do not know. The Indians around this country know a lot about power. In fact, everyone has had some experience of it. The fact that dream-hunting works has been proved many times

111.Savel, RH; Munro, CL, 2014. 'From Asclepius to Hippocrates: The Art and Science of Healing'. *American Journal of Critical Care.* 23 (6): 437–439

[...]. Today it is hard to find men who can dream in this way. There are too many problems. Too much drinking. Too little respect. People are not good enough now. Maybe there will again be strong dreamers when these problems are overcome. Then more maps will be made. New maps [...] good men, the really good men could dream of more than animals. Sometimes they saw heaven and its trails [...]. You may laugh at these maps of the trails to heaven, but they were done by good men who had the heaven dream, who wanted to tell the truth.112

In Koyukon culture, whose traditional territories ran along the Koyukuk and Yukon rivers in what is now called Alaska, there is also profound transmission of knowledge through dreams, in this instance of song from the Caribou.

Koyukon culture tells that other animals and the plants once shared a common language with human beings. This was in the Distant Time (*Kk'adonts'idnee*), a time during which all living beings shared one society and went through dreamlike transmutations from animals to plants to humans, and sometimes back again [...] the various discourses of humans and animals still overlap and interpenetrate in the everyday experience of Koyukon persons. Caribou, for instance, are said to 'sing through' human beings when in their vicinity, granting the tribespeople songs that certain persons remember upon waking from their sleep.113

I'm aware that it's problematic referencing experiences from a culture without understanding any wider cultural context that they might be situated in. Also that it's problematic citing accounts of Indigenous culture mediated by global Northern voices. I include these two

112. Hugh Brody, 1981. *maps and dreams*, Faber, p.44–46

113. David Abram, 1996. *The Spell of the Sensuous: Perception and Language in a More-Than-Human World*, Vintage Books, p.146 examples to point towards the multitude of perceptions and understandings of consciousness, many of which have been

interrupted or disallowed by colonial whiteness. In the global North, dreams came to be minimised or denigrated. By the early 20th century for example, Freud, called the founder of psycho-analysis, considered dreams significant, but claimed they were simply activity in an individuated mind (displaying what he called wish-fulfillments) to be interpreted. Freud claimed that: 'The interpretation of dreams is the royal road to a knowledge of the unconscious activities of the mind.'114 An example of more profound denigration of dreams is seen in the way Kraepelin, the key instigator of psych/iatric classification and naming (see Part Two): 'believed dreams to be meaningless phenomena caused by transient neuropathological conditions'.115

Dreaming the ancestors Dream contact Dreaming...

It's incredible to think of people learning from and making sense of their dreams over the centuries. I imagine pre-Enlightenment there would have been significant engagement with dream space also in the global North, and even in its recent cultural history with its emphasis on reason, there were strong threads of inquiry into dreaming. The Dutch psychiatrist Frederick van Eeden is said to have coined the term *lucid dreaming* – a state of dreaming where you can have agency in your dream space – after observing it in his 1898–1912 *A Study of Dreams*. He defined the experience as one where 'you are completely aware of your surroundings and are able to direct your actions freely, yet the sleep is stimulating and uninterrupted'.116

114. Sigmund Freud, translated by James Strachey, 2010. *The Interpretation of Dreams*. Basic Books, p.604

115. Richard P. Bentall, 2003. *Madness explained. Psychosis and Human Nature*. Penguin books, p.12

116. Frederik van Eeden, 1913. *A Study of Dreams*. Available from: www. lucidity.com/vanEeden.html (Accessed 10.02.2021)

Some global Northern affirmation of the importance of dreaming, in a culture where it has been denigrated and demoted, can be seen in the work of American scientist Eugene Aserinsky who explored research in the 1950s to correlate rapid eye movement (REM) to dreaming. In his observation he noticed what he perceived to be a *need* to dream; after sleep deprivation, something called REM 'rebound' happens where people move more quickly into REM and have longer and more frequent periods in that space.

Today it's well established that normal sleep in human adults includes between four and six REM periods a night. The first starts about 90 minutes after sleep begins; it usually lasts several minutes. Each subsequent REM period is longer [...]. Adults spend about two hours a night in REM, or 25 percent of their total sleep. Newborns spend 50 percent of their sleep in REM, upwards of eight hours a day, and they are much more active than adults during REM sleep, sighing and smiling and grimacing.117

I've been interested and inspired by Tony Wright, someone who has done personal exploration into the experience of sleep *deprivation*. In a youtube interview he speaks about the altered consciousness he has accessed through deliberate lack of sleep. He

said that on one occasion, after about three or four days with no sleep: 'things got really interesting', and for about a whole day he could only speak in rhyme.118

It makes me want to speak more generally about sleep. When I learned about the history of something called Second Sleep it was

117. Chip Brown, 2003. 'The Stubborn Scientist Who Unraveled A Mystery of the Night', *Smithsonian Magazine*, www.smithsonianmag.com/ science-nature/ the-stubborn-scientist-who-unraveled-a-mystery-of-thenight-91514538 (Accessed 10.02.2021)

118. Sleep Deprivation Experiments With Tony Wright, 2015. [Video]. Available from: www.youtube.com/watch?v=Nxn26-vUOI4 (Accessed 10.02.2021) profound and correlated with, and in some ways corroborated my own experiences of sleep patterns. Biomedical advice suggests that we should have a certain amount of uninterrupted hours of sleep per night, but research shows that historically, and pre-industrialisation we had different sleep patterns that involved two periods of sleep per night. Sometimes called bi-modal sleep, this sleep involves a passage of wakefulness called *the Watch*, between the two periods of sleep. Parenting manuals of pre-industrial Europe firmly encouraged that children should get their 'second sleep' after the watch.

A. Roger Ekirch [...] documented that in early-modern Europe and North America the standard pattern for night time sleep was 'segmented'. There were two periods, sometimes termed 'dead sleep' and 'morning sleep,' with intervals of an hour or more when the person was awake, sometimes called 'the watching', during which people might pray or read or have sex. In some indigenous societies in Nigeria, Central America, and Brazil, segmented sleep persisted into the twentieth century. Ekirch hypothesized that segmented sleep was our natural, evolutionary heritage, and that it had been disrupted in the West by the demands of industrialization, and by electricity, which made artificial lighting ubiquitous [...]. Ekirch, who asserted that the fact that many people experience insomnia in the middle of the night, after a few hours of sleep, indicates that our ancestral rhythms have been disrupted by modernization.119

It is liberating to have a thread back through history to that pattern. One I had already come to experience, make sense of, and embrace. It gave more permission to take space in the night; honouring how the night time can be a place of particular quiet and connection, where there can also be deep *knowing*.

119. Jerome Groopman, M.D., 2017. 'The Secrets of Sleep'. *New Yorker*. Available from: www.newyorker.com/magazine/2017/10/23/the-secrets-of- sleep (Accessed 10.02.2021)

Navajo Diagnosticians

In the book *The World we Used to Live in*, Native American author, theologian, historian, lawyer and activist Vine Deloria collated a mass of documentation about spiritual power across various Indigenous cultures in North America. He cites source

materials (Wyman; Newcomb) which document the work of diagnosticians in Navajo culture:

Today in several tribes, medicine men work closely with Western-trained doctors. The most publicised cooperative effort between Western doctors and medicine men seems to be happening on the Navajo Reservation in Arizona. Perhaps it is fitting that this joint effort should occur there, because Navajo healing powers are immensely complicated. They use a two-step process of diagnosis that is as sophisticated as Western practices, but often more thorough. According to Leland Wyman: 'The function of the diagnostician is to discover not only the cause of the illness but also to recommend the treatment to be used (sometimes he recommends actual therapeutic measures, although usually he simply tells what kind of chant should be sung over the patient), and to recommend a particular practitioner who can apply that treatment. This sometimes results in a change in Medicine men during an illness.'

There are three kinds of diagnosticians used by the Navajo: 1.) the Hand Trembler; 2.) the Star gazer; and 3.) the Listener. Franc Newcomb explained the differences in this way: 'When it is a case of diagnosing some stubborn ailment, or when it is a desire to learn if a past event has cast a malicious influence over a certain person or family, the Shaking Hand ceremony is generally employed [...]. During prayer and thereafter the diagnostician sits with eyes closed and face averted, and as soon as the singing begins his extended hand usually begins to shake. Although it was said that the motion of the hand usually begins any time, even during prayer (in which case the prayer is discontinued and a song is sung), it more often than not begins at the start of the song [...]. While the hand is moving the diagnostician thinks of various diseases or causes of diseases. When something happens which tells him that he is thinking of the correct one, he then thinks of various chants which might cure the disease; then, of what medicine man might be the best one to give the chant; then perhaps of plant medicines or other therapeutic measure which might be used. After all the desired information has been divined the shaking stops and the diagnostician opens his eyes and tells those assembled what he had discovered.'120

Expanding perspectives on the senses

The way we *know* things involves all the many senses. In the global North we are currently schooled to account for just five senses.

In Plato's *Theaetetus* written around 369 BCE, he cites Socrates (his teacher) stating that there are *innumerable senses without names*, and that the senses with names include hearing, sight, smell, senses of heat and cold, pleasure, pain, desire, and fear.

Aristotle (student of Plato) then proposed there were *four* senses. In a short treatise called *De Sensu et Sensibilibus* he defined them as: sight (associated with water because the eye contains water), sound (corresponding to air), smell (corresponding to fire), and touch (corresponding to earth). Aristotle viewed taste as merely a specialised form of touch, which he in turn viewed as the primary sense (because all life-forms possess it). He rejected an earlier view by

120. Vine Deloria, 2006. *The World We Used to Live In: Remembering the Powers of the Medicine Men*, Fulcrum Publishing, p.45

Democritus (a pre Socrates philosopher) that there was only one sense, touch.

By the early 17th century, there was an understanding of the five outward senses: sight, hearing, smell, touch, taste, and also of the five inward 'wits'. The five inward wits were 'common wit', 'imagination', 'fantasy', 'estimation', and 'memory'. 'Common wit' corresponds to Aristotle's concept of the *sensus communis* (common sense), and 'estimation' roughly corresponds to the modern notion of *instinct*.

The contemporary conceptualisation of five senses is limited. Even if we do only consider these, there are anyway more complex experiences of these senses, like synaesthesia, where the senses blend or are united or interrelating in some way, and are less distinct than we are usually told they are. In auditory-tactile synaesthesia, certain *sounds* can induce *sensations* in parts of the body. Mirror-touch synesthesia is a form of synaesthesia where individuals *feel* the same sensation that another person feels. When such a synesthete (someone who experiences synaesthesia) observes someone being tapped on their shoulder for instance, they involuntarily feel a tap on their own shoulder as well. With this type of synaesthesia people have been shown to have higher empathy levels compared to the general population.

Chromesthesia is when *sounds* are experienced in *images*. Pamela Coleman Smith, illustrator of the Rider Waite Tarot cards, painted a lot using what gets called chromesthesia. In the June 1908 edition of *The Strand* magazine featuring her work, *Pictures in Music*, paintings she made of well known pieces of music, she said:

You ask me how these pictures are evolved [...]. They are not pictures of the patterns of the music there – pictures of the flying notes – not conscious illustrations of the name given to a piece of music, but just what I see when I hear music-thoughts loosened and set free by the spell of sound.121

There are also senses beyond the 'five' that locate us, and give us more nuanced internal and relational information: *extero- ception* is the perception of stimuli arising from outside the body; *interoception* is the perception of the internal – pain, pressure, temperature, fatigue, hunger; *proprioception* is the perception of the relative position and movement of parts of the body in space...

There are many other senses, like 'sixth sense'; seers, clairvoyants (French for 'clear sight'), and the Scottish 'second sight' for example. Second sight, *an da shealladh* in Gaelic, still acknowledged as an experience in Scotland, 'translates literally as two sights – the first referring to normal vision, the second being premonitions of the future'.122

121. Stuart Kaplan, 2009. *The Artwork and Times of Pamela Coleman Smith*,

U.S. Games; Deluxe edition

122. 'William Daniell wrote in his V*oyage round Great Britain* (1815–25): "In no very remote times this notion (of Second Sight) retained a strong hold on the minds of the vulgar (in the Highlands); and, if current testimony may be credited, the race of seers is not wholly extinct. A sibyl of the age of forty could take a view into futurity

through the lens of a well-scraped blade bone of mutton, which on some occasions, figured to her the graves of her friends and relatives."

This method of divining the future, with a mutton shoulder blade, was recorded on the Isle of Lewis well into the 19th century. John Abercromby noted in his book *Traditions, Customs and Superstitions of the Lewis* (1895): "The shoulder blade of a black sheep was procured by the inquirer into future events, and with this he went to some reputed seer, who held the bone lengthwise before him and in the direction of the greatest length of the island.

"In this position the seer began to read the bone from some marks that he saw in it, and then oracularly declared what events to individuals or families were to happen." ' *The Newsroom*, 2016. 'Scots belief in the Second Sight

– the gift of premonition'. *Scotsman Newspaper*. Available from: scotsman. com/ news/scots-belief-second-sight-gift-premonition-1482608 (Accessed 10.02.2021)

Not only can there be premonition of someone's death, but the senses can mediate perception of the wider metaphysical realm beyond death. There can be feelings of a sense of contact with the dead.

Suppose, for example, that your deceased partner loved lilacs, and on the anniversary of her death you're on the front porch having a drink and feeling sad. At that moment your new neighbour walks over to share with you, out of the blue, that she's thinking of planting a lilac bush and asks if you like lilacs. You feel a wave of energy pass through your body and sense that something magical is happening, a temporary drawing close of the worlds. You reply that yes, you like lilacs. Even though you have not experienced your partner as a spirit, after the conversation you're left with a sense, against all logic, that she has reached out to comfort you.

In this example, the ancestors are speaking through an unlikely event that involves a striking convergence of meaning. Songs on the radio, written signs and messages, spontaneous animal encounters, and signs in nature are only a few of the ways in which the world around us can respond to some aspect of our inner life and generate a meaningful event. For me, noticing a synchronicity feels like déjà vu in that it's never anything I can predict, and the initial feeling doesn't tend to last too long. Nevertheless I am more inclined to ascribe meaning to synchronicities than to déjà vu experiences.

Synchronicities for me are also more likely to be accompanied by a sense of contact with or communication from another being or force, such as the ancestors.123

The senses can also mediate the divine, as seen in accounts of some of the medieval mystics:

123. Daniel Foor, 2017. *Ancestral Medicine: Rituals for Personal and Family Healing*, Bear & Company, p.27/28 & 48/49

The senses played a key role in the person's experience of God: Margery experienced a number of mystical sensations, such as smelling odours and hearing pretty music or awful music from the celestial realm. She could discern the divine origin of this music by its sweetness and the way it surpassed the beauty of earthly music. The melodies

have a strong effect on her: every time afterwards that she hears any laughter (a sign of joy) or music, she sighs or cries.124

I want to include a Buddhist conceptualisation which extends beyond the notion of the five senses, and considers the 'mind' as being like the other sense organs. For example a tree might come into our sense of sight and we can then consider it as an appearance, or an occurrence. Similarly a thought might come into the mind as a sense organ, and we can consider it as an appearance, or an occurrence. Thinking activity, in this conceptualisation, is understood as being the same as external phenomena that one can experience. The interpretation text of Bhikkhu Anālayo explains:

It is particularly intriguing that early Buddhism treats the mind just like the other sense organs. Thought, reasoning, memory, and reflection are dealt with in the same manner as the sense data of any other sense door. Thus the thinking activity of the mind shares the impersonal status of external phenomena perceived through the five senses.

[...] Just as it is impossible only to see, hear, smell, taste, and touch what is wished for, so, too, with an untrained mind, it is not possible to have thoughts only when and how one would like to have them.125

124. Andrea Janelle Dickens, 2009. *The Female Mystic: Great Women Thinkers of the Middle Ages*, I B Tauris & Co Ltd, p.168

125. Anālayo, 2003. *Satipatthana: the Direct Path to Realisation*, Windhorse Publications, pp.217–218

This *breadth* of what the senses can include and encounter opens up more possibilities for how we might understand experiences. Understanding where there is more space and freedom of interpretation and knowing than is offered by rationalism and reason, which insists on notions of reality that are located in the five material senses.

I've gathered the frameworks and reference points in all the sections above to weave into conversation about what it might be to *discern, recognise, know* about and *name* experience together, and what that might point to in terms of addressing imbalance, and making both personal and collective/systemic change. With that in view...

Collective Care, Collective Healing; practices, remedies, strategies (continued...)

In Part Three there was an invitation to gather practices, remedies and strategies that might be useful with which to personally and collectively negotiate, tend to and heal trauma. I recognise that it's totally artificial to separate trauma out from looking generally at experiences of distress and consciousness. The decision to do that, both in the workshop sessions that were the basis of this book, and as a structural choice for the book itself, was in order to be able to go deeper into exploring what the distinct and inter-relating issues and factors are that inform experience. The conversation below *necessarily* invites integrating the conversation about trauma into any broader conversation here that we might have about distress and consciousness. It will *necessarily* echo, overlap and revisit what was being explored in the conversation about collective care and healing in Part Three.

In this second conversation below – which might be useful to work with in groups – there's an invitation to examine and relanguage experiences of distress/consciousness together, and through that consider again what collective care and collective healing could and can look like. It might be that it revisits some of the conversation in Part Three about practices, remedies and strategies to *release; rest, restore & renew; reconnect, to reassociate;* and *respond and reimagine.*

There is also an invitation to consider how both experiences themselves, and remedies we share, might function also as embodiments of *refusal, resistance, rebellion and (r)evolutionary transformation.*

Creating and holding the space

Like the Collective Care, Collective Healing Conversation

#1 in Part Three, this is just *one* approach, or invitation for dialogue and solidarity.

Same as in Part Three, it can be useful to set an intention for the level of respect and *care* that is desired whilst sharing conversation. And to set an intention for the focus and spirit of the conversation, i.e. that there is a desire for it to be non-reductive and liberatory.

It can be useful to create some ground rules together that support safety in the group space and conversation. It can be helpful to write them up on a sheet so that they can be referred to if needed. They might be agreements like:

– Respecting confidentiality and anonymity – that what is shared in the space remains in the space, that if something shared is referenced outside the space it doesn't disclose anyone personally; i.e. *we spoke about the need for...,* not *X person said they needed...*

– Listening well, and deep listening – where you just *receive* what has been said, and don't offer any reflection, and that that kind of listening can be requested by people when they speak.

– Honouring difference of opinion

– Turning off mobile phones

– Agreeing on the length of the conversation and on timings for comfort breaks

– Making sure everyone feels free to take a break from the space if they need.

It can be useful to honour that the smallest personal remedies and approaches, and the largest structural ones are *all* welcome! That there is space to focus in on what may seem small and/or intimate needs and remedies, and on dreaming big.

It can be useful to agree on a way to close the space together when the time has come to an end. For example a closing circle where everyone says what they particularly valued in the exchange, or anything they would like to revisit in a second conversation, or what could be improved for future conversations.

Collective Care, Collective Healing Conversation # 2

Choose a common diagnosis or label, i.e. depression, anxiety, OCD, psychosis – whatever is of interest to look at in the group. Then gently lay it aside, even if it is a diagnosis that has meaning for you personally. Be gentle laying the term aside if it *doesn't* have meaning for you as well, to ensure respect for everyone who is present.

Hold Parts One, Two and Three in view, to think beyond just the individual and 'brain chemistry'; to hold in view how everything is shaped culturally and culture bound, and can also be shaped by trauma. Also hold in view some of the reference points in Part Four; frameworks for knowing, and relanguaging experience together.

In a group, with adequate space and time that is agreed on, work through the following three steps, making notes of what is shared on large sheets of paper...

1. Ask what are *all* the experiences and feelings that can be had under this diagnosis which you have laid aside? Write them *all* down, those that appear to be common ground, and those that are very different from each other. Ones you may have personally experienced, or witnessed. Allow conversation to meander, and importantly listen deeply, don't attempt to deny anyone their interpretation or 'fix' anyone else's situation if they share their experiences.

2. Ask together – how or why might these experiences have come to be, or be felt? What are all the factors, reasons, causes that might have contributed or contribute to these experiences and expressions? Ask what personal or collective meaning there might be found or understood in the experience. Write everything down, again, allow conversation to meander.

3. Pool practices, remedies and strategies in relation to what was shared in the two conversation steps above. Consider which are ones you can take away and engage/ implement personally and collectively.

Listening Sensing Intuiting Trusting Knowing Speaking

We are finding our bearings...

How we touch each other how we know the world how we wonder at it how we make it better

'Our task is to make trouble, to stir up potent response to devastating events, as well as to settle troubled waters and rebuild quiet places.'126

... that we have some alternative lens to look at the world, none of us have a monopoly on truth, we're all in this jazz orchestra together, we're raising our voices trying to empower others, all with a partial view, none of us having the full truth,

but together we come closer to reality with more love, commitment to justice, more courage, and then go down swinging before the worms get our bodies...127

Not alone with grief, distress, with pain, with sorrow, with anger, fear

not alone in trance, vision, variable consciousness not alone with sensitivity, empathy, vulnerability this being a human being

this time and place

The inner and the outer working apace simultaneous transformations breakdown to breakthrough competition to cooperation

crisis to collective care

This conversation to share Urgent. These urgent things

I want to tell you I am listening That I hear you. Hold you. Hold me We'll hold each other

This far too much. This not enough The wounding and the weight

Power, grounding ours

Justice, vitality, connection, freedom ours Joy, pleasure, peace ours

Part 4 References

126. Donna J. Haraway, 2016. *Staying with the Trouble: Making Kin in the Chthulucene*, Duke University Press. p.1

127. Dr. Cornell West, 2020. *On Being a Revolutionary Christian, on the Michael Brooks Show*. [Video]. Available from: www.youtube.com/ watch?v=Mw3bzHTllLM (Accessed 19.3.21)

Appendix

Embodied practices for release, rest and reconnection

Below are a few simple embodied practices for release, rest and reconnection. Some of them involve stretching, and gentle or more dynamic movement, some involve self-touch, some connecting with the breath, and stillness. Connecting with the breath and stillness, or practices that involve sitting or lying still might not feel right for everyone, or right on a particular day, or the right way to begin. It might feel better to choose practices that involve movement, and sometimes sharing that movement including touch and physical contact with others. Follow your intuition and desire, for yourself generally, and/or on any given day as needs and desires change.

The practices can be done individually, just as you feel drawn to them, or you could combine a few as you feel relevant/useful. An intention to orient to connection, pleasure, ease or curiosity can be a useful way to step into them. They can be turned to as and when, or form the foundation of a regular daily or weekly practice. Part Three includes some thoughts about the transformative power of practice. Establishing a regular practice can be as small or large a commitment as you want or feel able to make. Just five minutes of inhabiting, stretching, moving, or grounding your body can be a place to return to again and again, and deepen into for sustenance, especially in times of stress or struggle.

For each practice below I have tried to acknowledge the source, tradition or lineage they have come from, as I have learned of them, to the best of my knowledge.

1. Standing and grounding

Stand with your feet hip width apart, the outer edges of the feet can be parallel.

Take your weight over your left foot and let it pour through that foot into the ground to anchor you, raise the right heel off the ground leaving the toes on the ground, and then lean some weight into the toes to stretch them and the sole of the right foot open. Take a few breaths while yawning that foot open. Come back to centre and repeat on the other side.

Then come back to centre, leave the left heel on the ground, stretch the toes of the left foot up and away from the heel and then place them back on the floor. Repeat that on the right side, to make good contact through the soles of the feet with the ground.

Stack the bones: feel the hips and pelvis stacked over the knees, the knees over the ankles, and ankles over the feet so you stand easily without lots of exertion in the muscles. Let the architecture of your bones hold you. Soften the upper body, especially

the belly, shoulders and jaw. Let your upper body find length above this solid and easy foundation. Allow the breath to come and go.

Drawn from: Yoga; Tadasana: Mountain pose

2. Sitting and grounding

Sit as comfortably as you can, really feel the seat under your body, allow your weight to fall deeply into the pelvis, through the seat and into the ground. Soften the upper body, especially the belly, shoulders and jaw. Allow it to find length above this solid and easy foundation. Allow the breath to come and go.

Drawn from: Yoga; Tadasana: Mountain pose

3. Small movements of the head for release Standing or sitting as above, close the eyes if comfortable and take a breath or two. Then make a *really* small YES nod, make it the smallest, almost imperceptible movement you can. Let that go and pause for a breath or two.

Then make a really small NO nod, make it the smallest, almost imperceptible movement you can. Let that go and pause for a breath or two. Repeat a couple of times to release the tiny muscles at the base of the skull.

Drawn from: Feldenkreis

4. Gravity

Rest on your back on the ground. Let your legs rest stretched out on the ground too, or if more comfortable place the soles of the feet on the ground near your glutes. Experiment with the distance between your feet and glutes and also the width between your feet, so that your legs can be upright in that position without gripping or muscular effort. If you were making a print in warm sand, what would it look like? Notice the difference between the left and right side. Feel the weight of your body sinking back into the support from beneath.

Roll the skull: let the skull fall just a little to the left side, then back through the centre and then a little to the right side: really feel the *weight* of the skull.

Let the knees fall just a little from side to side, and really feel the *weight* of the pelvis, and allow the pelvis and glutes to get a little massage on the ground.

Drawn from: Yoga; Shavasana: Corpse pose, and Feldenkreis

Surrender to Gravity – gravity is your best friend always present, always available always ready to respond gravity is holding you absorbing the tiredness sucking the tiredness out of your body1

5. Rocking your own body on the ground

Lie comfortably and begin rocking the toes on the heels away from and back towards the body, to rock the body length wise. Play with the speed of that rocking to explore what your body enjoys. Then interlink your hands, raise them above your torso and gently sway the arms side to side to rock the body width wise. You can begin

1. Sandra Sabatini, 2006. *Breath: The Essence of Yoga – A Guide to Inner Stillness*, Pinter & Martin Ltd with your hands above your lower belly and travel them up and over the diaphragm, then up and over the collar bones, to rock different parts of the back and ribs. The impulse for the movement comes from your really soft wrists which

your arms and then the weight of your body follow. This practice works best on a slightly harder surface, like the floor or a mat, to give a bit of resistance to the body so it can rock and release.

6. Bodyscan – guidance text to follow/read out/adapt

Before the practice:

Ideally find a warm, uninterrupted space for the practice.

You can loosely memorise or record the body scan to listen to, or it can be slowly read out by someone in a group. Below is a template to use/adapt:

The // suggests a place to pause in the reading/bodyscanning.

The word 'soften' can mean whatever is useful for you... it can be an invitation to imagine an area of the body softening, melting, widening or easing, it can just be a way to invite more awareness to a particular place in the body, to acknowledge, notice or feel for it... you can also invite a feeling of warmth or coolness if that's useful.

Find a comfortable way to lie on your back on a mat or blanket on the ground, or sit in a chair allowing the most ease and length in the spine that's possible. If you feel comfortable to, close your eyes. Let yourself arrive in the body for a moment //

Feel where you are making contact with the ground or seat, and let your weight fall through those places and feel yourself supported by gravity //

Soften the body and let go //

If you were making a print in warm sand what would it look like? Is there a difference between the left and right side? //

Soften the scalp, the face, soften in at the jaw, soften the back of the eyes, soften the base of the skull, soften the neck, soften the throat //

Soften the top of the shoulders, the upper arms, soften in at the elbow joint, soften the lower arms, soften deep in at the wrist joint. Soften the skin on the palms of the hands //

Soften the whole of the front surface of the body; the chest, the breast tissue, soften the front of the ribs, soften the diaphragm, soften the belly //

Soften the whole of the back surface of the body; soften round the shoulder blades, soften the back of the ribs, the lower back//

Soften the groin, where the legs meet the body, soften the genitals //

Soften the glutes (the strong muscles of your ass) and soften deep into the hips //

Soften the upper legs; the quads (front) and hamstrings (back), soften in the knee joints, soften the lower legs; shins (front) and calves (back), soften deep into the ankle joints. Soften the tops of the feet and the soles of the feet. Soften the big toes, the second toes, the third toes, the fourth toes, and the small toes //

Scan through the body and notice if there is any pain or tension anywhere and bring your awareness to that place, and invite it to soften a little more, or invite warmth or coolness //

Without *changing* the breath you can observe it coming and going for a while; how it travels towards you and in, and travels out of you and away again //

Have a sense of the body resting on the earth. And the mind resting in the body //

Have a sense of leaning into the trees near you, leaning into the nearest green space or landscape around you, leaning into the nearest hills or rise of the land...//

Drawn from: Yoga Nidra

7. Tensing and releasing

Pandiculation is the term given to flexing and stretching muscle groups to help them release and reset. This practice is a slightly more active bodyscan that involves tensing muscle groups and *slowly* releasing them to counter transient or habitual tension. Continue to *breathe slowly while* tensing and releasing. Begin by tensing the hands into fists, squeeze as *tightly* as you can, hold for five seconds, then *slowly* release, pause for a moment and allow a couple of breaths to come and go. Next tense the hands and the whole of the arms together, squeeze as *tightly* as you can, hold for five seconds, then *slowly* release, pause for a moment and allow a couple of breaths to come and go. Next tense the shoulders up towards the ears, squeeze as *tightly* as you can for five seconds, then *slowly* release. Next tense the face, really tense up the facial muscles, squeeze as *tightly* as you can, hold for five seconds,

then *slowly* release, pause for a moment and allow a couple of breaths to come and go. Next tense the torso, pull in the abdomen and tense all the core muscles, squeeze as *tightly* as you can, hold for five seconds, then *slowly* release, pause for a moment and allow a couple of breaths to come and go. Next tense the legs and feet, feel the glutes contract and raise the body up a little bit, squeeze as *tightly* as you can, hold for five seconds, then *slowly* release, pause for a moment and allow a couple of breaths to come and go. Take a moment to feel the effects of the contracting and releasing, and let the breath come and go.

8. Hand and arm stretches

Extend your arms out in front of you and flex the hands and fingers up and back towards the body, stretching through the lower forearms, hold for 1 minute. Then extend the hands down, making a loose fist, stretching through the upper forearms, and hold for 1 minute. Breathe softly, soften the shoulders and the back of the knees, and keep good contact with the ground through the feet.

Drawn from: Kung Fu

9. Pulsing and shaking the body

From standing position (#1), begin letting the body bounce *very* gently, start with a *really* small bouncing to notice and observe the small movements as they happen. Where do you feel the bounce, in your belly, genitals, just beneath the collar bones, the jaw? Increase the size of the bounce so that you really let the body find release, as if you are settling rice to the bottom of a sack. Allow more vigorous bouncing and shaking. Really shake the arms, body and also the legs. Notice where you feel the pulsing or shaking in your body as it goes from small to large. Practice between 1–5 minutes. Then allow your body to come to stillness again and observe how the body feels.

The practice can be done seated. Begin shrugging the shoulders up and down to release, alternating left and right, then shake the shoulders backwards and forwards,

and pulse and shake out all movable limbs to release those muscle groups in turn, generating energy and blood flow. Practice between 1–5 minutes. Then allow your body to come to stillness again and observe how the body feels.

Drawn from: Chi Kung and Bioenergetic massage

10. Percussion

Standing or seated, tap the fingers very gently over the face, head and muscles of the back of the neck either side of the spine. Then with soft palms or very loose fists pat up and down the back and front of the arms, gently over the chest and up and down the back and front of the legs if possible. You can support the patting arm (see image) to percuss the top of the shoulders on either side. If standing, you can loosely draw the arms behind the body and keeping the shoulders soft let your fists swing in, alternating left and right, to percuss into the strong muscles of the glutes. Make good contact with the breath, and through the feet or pelvis with the ground throughout.

Drawn from: Shiatzu practice called Do-in

11. Roll slowly up and down through the spine

Standing or seated, let the chin, then the whole head gently tip forward and slowly roll down through the spine. Explore and notice where there are feelings of ease, and/or of restriction. Slowly roll up and down a few times. As you roll back up each time, drop your weight through your heels if standing, or pelvis if sitting, to soften the uncurling movement.

12. Sounding

Sitting comfortably, take a few breaths, then practice gentle humming, or sounding vowel sounds. Notice how they all feel in the body; where do you feel them? Explore very quiet and then stronger volumes, and how that feels in your body.

Drawn from: yoga; and various voice practices

13. Embodied Movement Practice

Set a timer for 10 minutes.

Begin in any position, standing, sitting or lying. Make a good connection with the ground under you. Take three easy breaths then sense/feel into your body and follow an impulse into movement, and follow that movement for a while; see if movement can support you accompanying the sensations in your body. Alternatively initiate a movement with *one* part of your body (your chin, an elbow...) and follow it. Let the rest of your body and attention follow the movement until you aren't interested anymore. Then follow another impulse or choose to begin another movement initiated by *another* body part, follow it with your body, see where it takes you.

Foster curiosity throughout the practice.

Let the breath come and go easily as you move.

Allow any sound you might want to make, or that just comes, throughout the practice.

Movement, to be experienced, has to be 'found' in the body, not put on like a dress or a coat. There is that in us which has moved from the very beginning. It is that which can liberate us.2

14. Self listening to the breath

Find a comfortable place to lie on your back, legs extended or feet on the floor (#4). Rest soft hands on the lower belly for a moment and just observe the breath come and go for a while. Then slide your hands up to rest on the ribs and just observe the breath come and go for a while. Then slide your hands to just rest the fingertips beneath the collar bone, and just observe the breath come and go for a while. Slide the hands back down to the belly, just observe the breath come and go again here and invite softening everywhere in the body.

15. Self listening; skin, fluids, muscle, bone

Find a quiet space to sit or lie, and get really comfortable.

Close your eyes if you want to, and take your fingertips to your face to explore how the skin feels there. Keep your shoulders relaxed. Notice all the curves and contours, and where your fingertips meet hair and lips. Slow your exploration down to *half* the speed.

Rest your arms by your side for a moment, then take your fingertips to your face, have a sense of the fluid that is in your

2. Mary Starks Whitehouse (Authentic Movement)

fingertips (lymph, blood) connect with the fluid that is in your face, just make contact with your face at this depth, with this intention. Notice how this feels.

Rest your arms by your side for a moment, then take your fingertips to your face and let your fingers explore *all* the muscles of your face and scalp; forehead, cheeks, chin, jaw, etc.

Rest your arms by your side for a moment, then take your fingertips to your face and let your fingers explore the bone, all the architecture of the skull, where the bones all meet, all their shapes and structure, the depths of the face. You can explore *as if you have never touched your face before*, remaining curious about each texture and depth. The practice is transferable to other body parts, and can be explored as a consensual exchanged practice with others.

16. Palming – to rest the eyes and whole system

Lie comfortably on your back and begin by rubbing your hands together and warming them a little. Then rest the palms over the eye sockets, without putting any pressure on the eyes themselves, the fingers will cross a bit resting on the forehead. Soften the shoulders and arms so they can rest in this position without lots of muscular effort. Focus on the darkness, soften the back of the eyes and let them rest, feel the weight of the body drop back and soften, and be supported by the ground. At first there might be light and colours as the eyes search for stimulus. Allow the eyes to settle and rest in the darkness for a while, and let the whole body soften and settle.

This practice can also be done seated, with the elbows resting on a table, and letting the head tip forward slightly into the hands as they cup over the eye sockets.

As well as deep rest, it can help ease eye strain, especially from computer use, and it can also be used as part of practice to improve eyesight.

Drawn from: yogic practices for rest, connection, focus and improv- ing eyesight. It is also practiced in something called the Bates Method, developed for resting and improving eyesight.

17. 5-4-3-2-1 Senses Meditation

Find a way to sit comfortably, make good contact with the ground beneath you, feel the support.

Notice 5 things you can see (really noticing the colours, shapes). Then notice 4 things you can hear (following each sound until it ends, before choosing the next). Then notice 3 things you can feel (the wind, sun, the ground under you, your clothing). Then notice two things you can smell. Finally notice one thing you can taste.

Come again into contact with the ground beneath you, feel the support.

18. Inner/outer nature connection practice

Choose a relatively safe place somewhere outside by a tree, or a body of water, or wherever you feel drawn to on the earth. Find a comfortable way to sit or stand. Soften the body and take a few deep breaths. Spend 10–15 minutes just observing what is there, and what is happening. Notice plants, trees, the colour of the soil, any animals or birds or weather passing through. Afterwards it can be useful to journal what happened – outer and inner experiences you had. It can be nourishing to make a commitment to return to the same place every day for a week or a month, or season by season to connect, observe and get to know a place.3

3. All illustrations Selma Augestad | Instagram: @solskinnskroken

Online Resources1

There is an online repository to accompany this book with information about plant medicine and food and nutrition related to psycho-emotional health, as well as other re-sources related to psycho-emotional health and social justice.

The appendix is also hosted there with audio and video links to support the embodied practices.

The repository welcomes being collectively shaped so if you have suggestions or additions, please get in touch!

threadsbook.org

1. I hyphenate re-sources as a way to point to the mass of amazing work and source material that's been made available by so many different people and projects.

References

Books

Abram, David. (1996). *The Spell of the Sensuous: Perception and Language in a More-Than-Human World*. Vintage Books.

Ahsan, Hamja. (2017). *Shy Radicals. The Antisystemic Politics of the Militant Introvert*. Book Works.

Allen, M.D. Frances. (2013). *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*. HarperCollins.

Aposhyan, Susan. (2004). *Body-Mind Psychotherapy: Principles, Techniques, and Practical Applications*. W. W. Norton & Company.

Association, American Psychiatric. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM–5)*. American Psychiatric Association.

Anālayo. (2003). *Satipatthana: the Direct Path to Realisation*. Windhorse Publications.

Badenoch, Bonnie. (2018). *The Heart of Trauma. Healing the Embodied Brain in the Context of Relationships*. W. W. Norton & Company.

Barratt, Barnaby B. (2013). *The Emergence of Somatic Psychology and Bodymind Therapy*. Palgrave MacMillan.

Beith, Mary. (1995). *Healing Threads: Traditional Medicines of the Highlands and Islands*. Birlinn Ltd.

Bentall, Richard P. (2003). *Madness explained. Psychosis and Human Nature*. Penguin Books.

Berceli, David. (2005). *Trauma Releasing Exercises (TRE): A revolutionary new method for stress/trauma*. BookSurge.

Breggin, Peter. (1993). *Toxic Psychiatry. Drugs and Electroconvulsive Therapy: The Truth and the Better Alternatives*. HarperCollins.

Brody, H. (1981). *maps and dreams*. Faber. brown, adrienne maree. (2017). *Emergent Strategies. Shaping Change, Changing Worlds*. AK Press. brown, adrienne maree. (2019). *Pleasure Activism. The Politics of Feeling Good*. AK Press.

Bulhan, Hussein Abdilahi. (2004). *Frantz Fanon and the Psychology of Oppression*. Springer.

Caldwell, Christine. & Leighton, Lucia Bennet. eds. (2018). *Oppression and the Body: Roots, Resistance, and Resolutions*. North Atlantic Books.

Callanan, M. (2012). *Final Gifts: Understanding the Special Awareness, Needs, and Communications of the Dying*. Simon & Schuster.

Carmichael, A. (1992). *Carmina Gadelica, Hymns and Incantations: Collected in the Highlands and Islands of Scotland in the Last Century*. Floris Books.

Chai, R. Makana Risser. (2005). *Nā Mo'olelo Lomilomi: The Traditions of Hawaiian Massage and Healing*. Bishop Museum Press.

Chesler, Phyllis. (1972). *Women and Madness*. Palgrave Macmillan. Clare, E. (2017). *Brilliant Imperfection. Grappling with Cure*. Duke
University Press.

Clarke, I. ed, (2010). *Psychosis and Spirituality: Consolidating the New Paradigm*. Wiley.

Cooper, David. (1978). *The Language of Madness*. Pelican. Curtis, Ted. & Dellar, Robert. & Leslie, Esther. & Warson,
Ben. eds. (2003) *Mad Pride. A Celebration of Mad Culture*. Chipmunkapublishing.

Cvetkovitch, Ann. (2012). *Depression, a public feeling*. Duke University Press.

Damasio, Antonio. (2000). *The Feeling Of What Happens: Body, Emotion and the Making of Consciousness*. Vintage.

Darrell, Nikki. (2020). *Conversations with Plants*. Aeon Books. Davies, James. (2013). *Cracked: Why Psychiatry is Doing More Harm
Than Good*. Icon Books Ltd.

Degruy, Dr. Joy. (2005). *Post Traumatic Slave Syndrome. America's Legacy of Enduring Injury and Healing*. Joy Degruy Publications Inc.

Deloria, Vine. (2006). *The World We Used to Live In: Remembering the Powers of the Medicine Men*. Fulcrum Publishing. di Prima, D. (1968). *Revolutionary letters*. City Lights Publishers. Dickens, Andrea Janelle. (2009). *The Female Mystic: Great Women
Thinkers of the Middle Ages*. I B Tauris & Co Ltd. Dostoevsky, Fyodor. (1881). *A Writer's Diary*. Northwestern
University Press.

Ehrenreich, Barbara. (2008). *Dancing in the Streets, A History of Collective Joy*. Granta Books.

Ehrenreich, Barbara. (2014). *Living With a Wild God: A Nonbeliever's Search for the Truth about Everything*. Hachette USA.

Ehrenreich, Barbara. (2009). *Smile or Die. How Positive Thinking Fooled America and the World*. Granta Books.

Evans, Stephanie. Y. & Bell, Kanika. & Burton, Nsenga, K. eds. (2017). *Black Women's Mental Health: Balancing Strength and Vulnerability*. SUNY Press.

Fadiman, A. (1997). *The Spirit Catches You and You Fall Down, A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. FSG Adult.

Fannen, Lisa. (2018). *Faultline*. Active Publishing.

Fisher, Mark. (2009). *Capitalist Realism. Is there no alternative?* John Hunt Publishing.

Foor, Daniel. (2017). *Ancestral Medicine: Rituals for Personal and Family Healing*. Bear & Company.

Forbes, David. (2021). *Mindfulness and Its Discontents: Education, Self, and Social Transformation*. Fernwood Publishing Co Ltd.

Foucault, Michel. (1961). *Madness and Civilisation: A History of Insanity in the Age of Reason*. Vintage Books.

Freud, Sigmund. translated by James Strachey (2010). *The Interpretation of Dreams*. Basic Books.

Fricker, Miranda. (2007). *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford University Press.

Ganz, Marshall. (2009). *Why David Sometimes Wins: Leadership, Organization, and Strategy in the California Farm Worker Movement*. Oxford University Press.

Gendlin, E. (2003). *Focusing: How To Gain Direct Access To Your Body's Knowledge: How to Open Up Your Deeper Feelings and Intuition*. Rider.

Glendinning, Chellis. (1994). *My Name is Chellis & I'm in Recovery from Western Civilisation*. Shambhala.

Goldacre, Ben. (2013). *Bad Pharma. How medicine is broken and how we can fix it*. Fourth Estate.

Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Anchor Books/Doubleday.

Greenberg, Gary. (2010). *Manufacturing Depression, The Secret History of a Modern Disease*. Bloomsbury Paperbacks.

Greenberg, Gary. (2013). *The Book of Woe, The DSM and the Unmaking of Psychiatry*. Scribe Publications Ltd.

Hacking, Ian. (1998). *Mad Travellers: Reflections on the Reality of Transient Mental Illnesses*. Harvard University Press.

Hanh, Thich Nhat. (1991). *Peace Is Every Step: The Path of Mindfulness in Everyday Life*. Rider.

Hains, Staci. (2019). *The Politics of Trauma: Somatics, Healing, and Social Justice*. North Atlantic Books.

Haines, Steve. (2015) *Trauma is Really Strange*. Singing Dragon. Hari, Johann. (2018). *Lost Connections: Uncovering the Real Causes of*
Depression and the Unexpected Solutions. Bloomsbury Publishing.

Haraway, Donna J. (2016). *Staying with the Trouble: Making Kin in the Chthulucene*. Duke University Press.

Hartman, Betsy. (1987) *Reproductive Rights and Wrongs: The Global Politics of Population Control*. Haymarket Books.

Heaton, Mathew, M. (2013). *Black Skin, White Coats: Nigerian Psychiatrists, Decolonization, and the Globalization of Psychiatry*. Ohio University Press.

Herman, Judith. (1994). *Trauma and Recovery. From Domestic Abuse to Political Terror*. Rivers Oram Press.

Howes, David. ed. (2004) *Places Sensed, Senses placed: Towards a Sensuous Epistemology of Environments in Empire of the Senses*. Routledge.

Hunter, D. (2018). *Chav Solidarity*. Classworksproject.

Hutson, Lucy. (2018). *Everything in my head at one time in my life*. Live Art Development Agency.

Huxley, Aldous. (1954). *The Doors of Perception*. Harper & Row.

Icarus Project, The. (2007). *Navigating the Space Between Brilliance and Madness: A Reader & Roadmap of Bipolar Worlds*. The Icarus Project.

Incite! Women of Color Against Violence. (2017). *The Revolution Will Not Be Funded: Beyond the Non-Profit Industrial Complex*. Duke University Press.

James, William. (1902) *The Varieties of Religious Experience: A Study in Human Nature*. Penguin Classics.

Jim, Kahuna Harry Uhane. & Arledge, Garnette. (2007). *Wise Secrets of Aloha: Learn and Live the Sacred Art of Lomilomi*. Red Wheel/Weiser.

Johnson, Don Hanlon. (2019). *Diverse Bodies, Diverse Practices. Towards an Inclusive Somatics*. North Atlantic Books.

Johnson, Rae. (2017). *Embodied Social Justice*. Routledge.

Kaplan, S. (2009). *The Artwork & Times of Pamela Coleman Smith*.

U.S. Games; Deluxe edition.

Kaptchuck, Ted J. (2000). *Chinese Medicine: The Web That Has No Weaver*. Rider.

Kilomba, Grada. (2008). *Plantation Memories: Episodes of Everyday Racism*. Unrast Verlag.

Kotowicz, Zbigniew. (1997) *R.D Laing and the Paths of Anti- Psychiatry*. Routledge.

Khayyam, O. (1872) *Rubáiyát of Omar Khayyám*. Wordsworth Classics.

Laing, R.D. (1967). *The Politics of Experience and The Bird of Paradise*. Penguin.

Lame Deer, John (Fire). & Erdoes, Richard. (1972). *Lame Deer Seeker of Visions*. Pocket Books.

Lacey, L. (1975). *Lunaception: a feminine odyssey into fertility and contraception*. Coward McCann & Geoghegan Inc.

Levine, Peter. with Frederick, Ann. (2011). *Waking the Tiger: Healing Trauma – The Innate Capacity to Transform Overwhelming Experiences*. North Atlantic Books. libcom.org *Class Struggle and Mental Health* pamphlet. Freedom Press. Linklater, Renee. (2014). *Decolonising Trauma Work: Indigenous*

Stories and Strategies. Fernwood Publishing Co Ltd.

Lisa, Collated by. (2009). *Threads*. Active Publishing, also at threadsbook.org.

Linton, S. & Walcott. R. ed. (2018). *The Colour of Madness: Exploring BAME mental health in the UK*. Skiddaw Books.

Lorde, Audre. (1996). *The Audre Lorde Compendium. Essays, Speeches and Journals*. Pandora.

Magdelena, Yarrow. (2020). *Rituals – simple & radical practices for enchantment in times of crisis*. Yarrow Magdelena.

Marohn, Stephanie. (2003). *The Natural Medicine Guide to Schizophrenia*. Hampton Roads Publishing.

Martin, Emily. (2007). *Bipolar Expeditions, Mania and Depression in American Culture*. Princeton University Press.

McIntosh, Alasdair. (2001). *Soil and Soul: People versus Corporate Power*. Aurum Press Ltd.

McKenzie-Mavinga, Isha. (2009). *Black Issues in the Therapeutic Process*. Palgrave.

Menakem, Resmaa. (2017). *My Grandmother's Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies.*

Central Recovery Press.

Mignolo, Walter D. (2011). *The Darker Side of Western Modernity*. Duke University Press.

Mills, China. (2013). *Decolonising Global Mental Health: The psychiatrization of the majority world*. Routledge.

Milstein, Cindy. (2017). *Rebellious Mourning. The Collective Work of Grief*. AK Press.

Moncrieff, Joanna. (2013). *The Bitterest Pills: The Troubling Story of Antipsychotic Drugs*. Palgrave Macmillan.

Moncrieff, Joanna. (2007). *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment*. Palgrave Macmillan.

Patterson, Jennifer. (2020). *The Power of Breathwork: Simple Practices to Promote Wellbeing*. Fair Winds Press.

Penfold, P. Susan. & Walker, Gillian A. (1984). *Women and the Psychiatric Paradox*. Open University Press.

Piepzna-Samarasinha, Leah Lakshmi. (2018). *Care Work. Dreaming Disability Justice*. Arsenal Pulp Press.

Porges, Stephen W. (2017). *The Pocket Guide to the Polyvagal Theory. The Transformative Power of Feeling Safe*. W. W. Norton & Company.

Purser, Ronald. (2019). *McMindfulness*. Repeater Books. Read, Jim. & Reynolds, Jill. eds. (1996). *Speaking our Minds.*

Palgrave.

Rose, Nicole. (2019). *Overcoming Burnout*. Active Distribution. Russo, Jasna & Sweeney, Angela. eds. (2016). *Searching for a Rose Garden. Challenging Psychiatry, Fostering Mad Studies*. PCCS Books.

Sabatini, Sandra. (2006). *Breath: The Essence of Yoga – A Guide to Inner Stillness*. Pinter & Martin Ltd.

Samuel, Julia. (2017). *Grief Works: Stories of Life, Death and Surviving*. Penguin Life.

Schulman, Sarah. (2016). *Conflict Is Not Abuse*. Arsenal Pulp Press. Schwarz, Richard C. & Sweezy, Martha. (2019) *Internal Family*

Systems Therapy. Guilford Press.

Scull, Andrew. (2015). *Madness in Civilization. A Cultural History of Insanity from the Bible to Freud, from the Madhouse to Modern Medicine*. Thames and Hudson Ltd.

Sedgwick, Peter. (1982). *Psycho Politics*. Unkant Publishers. Sharpe, Christina. (2016). *In the Wake. On Blackness and Being*.

Duke University Press.

Shepherd, Nan. (2011). *The Living Mountain*. Canongate Books Ltd. Showalter, Elaine. (1985). *The Female Malady*. Virago.

Singh, Julietta. (2018). *No Archive Will Restore You*. punctum books. Sjoo, Monica. (1992). *New Age and Armageddon. Goddess or the*

Gurus? – Towards a Feminist Vision of the Future. The Women's Press Ltd.

Smail, D. (2005). *Power, Interest and Psychology; elements of a social materialist understanding of distress*. PCCS Books.

Smith, Dorothy E. & David, Sara J. eds. (1975). *Women Look at Psychiatry*. Press Gang Publishers.

Smith, Linda Tuhiwai. (2012). *Decolonising Methodologies. Research and Indigenous Peoples*. Zed Books Ltd.

Södergran, Edith. (1984). *Complete Poems*. Translated by David McDuff. Bloodaxe Books.

Somé, Malidoma Patrice. (1993). *Ritual, Healing and Community*. Penguin Books.

SPK. (1993). *Turn Illness into a weapon*. KRRIM – PF-Verlag für Krankheit e.k.

Sprouse, M. ed. (1992). *Sabotage in the American Workplace*. Pressure Drop Press.

Szasz, Thomas, S. (1961). *The Myth of Mental Illness*. Harper.

Thornton, Cassie. (2020). *The Hologram. Feminist Peer-to-Peer Health for a Post-Pandemic Future*. Pluto Books.

Ussher, Jane. M. (1991). *Women's Madness: Misogyny or Mental Illness?* Pearson Education Limited.

Van Der Kolk, Bessel. (2014). *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma*. Penguin.

Van Dernoot Lipsky, Laura. with Burk, Connie. (2007). T*rauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*. Berrett-Koehler Publishers.

Waller, J. (2008). *A Time to Dance, a Time to Die: The Extraordinary Story of the Dancing Plague of 1518*. Icon Books.

Washington, Harriet A. (2006). *Medical Apartheid. The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. Harlem Moon.

Watson, Jo. ed. (2019). *Drop the Disorder: Challenging the culture of psychiatric diagnosis*. PCCS Books.

Watters, Ethan. (2011). *Crazy Like Us: The Globalization of the Western Mind*. Robinson Publishing.

Weller, F. (2015). *The Wild Edge of Sorrow: Rituals of Renewal and the Sacred Work of Grief*. North Atlantic Books.

Whitaker, Robert. (2010). *Anatomy Of An Epidemic. Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. Broadway Books.

Whitworth, Victoria. (2017). *Swimming with Seals*. Head of Zeus.

Articles & online references (in order of citation)

Part One

Hozumi, Tada. (No date). ‘Cultural somatics’. Available from: selfishactivist.com/cultural-somatics (Accessed 11.01.2021)

Costa, Lucy. (2014). ‘Mad Studies – what it is and why you should care’. *Mad Studies Network*. Available from: madstudies2014. wordpress.com/2014/10/15/mad-studies-what-it-is-and-why-youshould-care-2 (Accessed 10.01.2021)

Walker, Nick. (No date). ‘The Neurodiversity Paradigm’. Available from: autloveaccept.files.wordpress.com/2015/08/ finalneurodiversity.pdf (Accessed 10.01.2021)

Walker, Nick. (2013). ‘Throw away the master’s tools, liberating ourselves from the pathology paradigm’. August 16th.

Neurocosmopolitan. Available from: neurocosmopolitanism.com/ throw-away-the-masters-tools-liberating-ourselves-from-thepathology-paradigm (Accessed 10.01.2021)

Webb, Richard. (No date). ‘Quantum physics’. *New Scientist*. Available from: www.newscientist.com/term/quantum-physics (Accessed 11.01.2021)

Popkin, Gabriel. (2018). ‘Einstein’s ‘spooky action at a distance’ spotted in objects almost big enough to see’. April 25th. *Science Magazine*. Available from: www.sciencemag.org/news/2018/04/ einstein-s-spooky-action-distance-spotted-objects-almost-bigenough-see (Accessed 11.01.2021)

Mind my Peelings. (2020). Jan 1st. ‘Daily Dose of Happiness Chemicals?’ Available from: www.bananatreelog.com/blog/daily- dose-of-happiness-chemicals? (Accessed 11.01.2021)

Grant, Bonnie. L. (No date). *Soil helps depression.* Available from: www.permaculture.co.uk/articles/soil-helps-depression (Accessed 11.01.2021)

‘Arvo Pärt interviewed by Björk’: Modern Minimalists. (No date). *bjork.fr*. Available from: www.bjork.fr/ bjork-arvo-part-Modern-Minimalists-BBC-1997 (Accessed 11.01.2021)

Backström, T. & Winberg, Svante. (2017). ‘Serotonin Coordinates Responses to Social Stress, What We Can Learn from Fish’.

25th October. *Frontiers in Neuroscience*. Available from: www. frontiersin.org/articles/10.3389/fnins.2017.00595/full (Accessed 11.01.2021)

Haynes, Trevor. (2018). ‘Dopamine, Smartphones & You: A battle for your time’. *Harvard University*. Available from: sitn.hms. harvard.edu/flash/2018/dopamine-smartphones-battle-time (Accessed 11.01.2021)

Parkin, Simon. (2018). ‘Has dopamine got us hooked on tech?’ 4th March. *The Guardian*. Available from: www.theguardian.com/ technology/2018/mar/04/ has-dopamine-got-us-hooked-on-techfacebook-apps-addiction (Accessed 11.01.2021)

Brooks, David. (2017). ‘How evil is tech?’ Nov 20th. *New York Times*. Available from: www.nytimes.com/2017/11/20/opinion/ how-evil-is-tech.html (Accessed 11.01.2021)

Christie’s Auction Lot 389: Dali. (2002). Available from: www. christies.com/en/ lot/lot-3863326 (Accessed 11.01.2021)

Editorial of the fifth issue of New Scientist: The Collection. (2019). ‘Mysteries of the Human Brain’. *New Scientist*.

Sharfstein, Steven S. (2005). ‘Big Pharma and American Psychiatry: The Good, the Bad, and the Ugly’, *Psychiatric News*. Available from: psychnews.psychiatryonline.org/ doi/10.1176/ pn.40.16.00400003 (Accessed 11.01.2021)

Read, John. (2005). ‘The bio-bio-bio model of madness’. *The Psychologis*t. 18(10), p.596–597. Available from: thepsychologist. bps.org.uk/volume-18/edition-10/bio-bio-bio-model-madness (Accessed 11.01.2021)

NHS Scotland. (2013 & 2016). *Mental Health First Aid for Young People*. Packs and workbooks.

‘Open, Honest, Proud’. (No date). *Mental Health Foundation*. Available from: www.mentalhealth.org.uk/projects/honest-open- proud (Accessed 12.1.2021)

Heads Together. (2017). [Video]. Available from: www.youtube. com/watchh?v=45RqUmxDXiY&l ShtN0iEXF6mGwfL7D4Y&index=3&t=0s (Accessed 12.1.2021)

Silverstein, Ken. (1999). ‘Prozac.org An influential mental health nonprofit finds its ‘grassroots’ watered by pharmaceutical millions’. *Mother Jones*. Available from: www.motherjones.com/ politics/1999/11/prozacorg (Accessed 12.01.2021) generative somatics. (2014). E/PA preparation, training document. generativesomatics.org

Introduction to the PTMF. (No date). The British Psychological Society. Available from: www.bps.org.uk/power-threat-meaning- framework/introduction-ptmf (Accessed 12.01.2021)

The Power Threat Meaning Framework: Summary. (No date). Available from: www.bps.org.uk/sites/www.bps.org.uk/files/ Policy/Policy%20-%20Files/ PTM%20Summary.pdf (Accessed 12.01.2021)

Cooper, Nick. dir. (2006). [Video]. SOMA: An Anarchist Therapy documentary. Available from: youtube.com/ watch?v=hMTk4QazKOA (Accessed 12.01.2021)

Part Two

May, Vivian M. (2013). 'Speaking into the Void'? Intersectionality Critiques and Epistemic Backlash'. *Hypatia*. Available from: www. cambridge.org/core/journals/hypatia/article/speaking-into-thevoid-intersectionality-critiques-and-epistemic-backlash/66EBD2F A2567BBDA97FB90442161290C (Accessed 14.01.2021)

Spivak, Gayatri Chakravorty. (1988). 'Can the Subaltern Speak?'. *Marxism and the Interpretation of Culture*. Macmillan Education UK.

Bhargava, Rajeev. (2013). 'Overcoming the Epistemic Injustice of Colonialism'. *Global Policy* 4(4) DOI: 10.1111/17585899.12093 Available from: www.researchgate.net/publication/259546123_Overcoming_the_Epistemic_Injustice_ of_Colonialism (Accessed 14.01.2021)

Mignolo, Walter D. (2007). 'Delinking: The rhetoric of modernity, the logic of coloniality and the grammar of de-coloniality'.

Cultural Studies. 21(2–3): p.450

Quijano, Aníbal. (2007). 'Coloniality and Modernity/Rationality'.

Cultural Studies. 21(2–3): p.176

Quijano, Aníbal. (2000). 'Coloniality of Power, Eurocentrism, and Latin America'. *Nepantla: Views from South*. 1(3): p. 544

Correll, Christoph U. MD & Stetka, Bret S. MD. (2014). 2*0 More Rare and Unusual Psychiatric Syndromes*. Medscape. Available from: www.medscape.com/features/slideshow/culture-synd (Accessed 14.02.2021)

Hoffman, Kelly M. & Trawalter, Sophie. & Axt, Jordan R. & M. Oliver, Norman. (2016). 'Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites'. *Proceedings of the National Academic Sciences of USA*. 113(16): 4296–4301

Saint Martin, Manuel L. (1999). '*Running Amok: A Modern Perspective on a Culture-Bound Syndrome*'. Primary Care Companion.The Journal of Clinical Psychiatry. 1(3): p. 66–70

Rowett, Jenny L. (No date). '*Etuaptmumk*: A research approach and a way of being'. Available from: file:///Users/lis/Downloads/25740Article%20Text-1882519048-1-10-20180527.pdf (Accessed 14.01.2021)

McGill University. (No date). L*istening to One Another to Grow Strong (LTOA): Mental Health Promotion for Indigenous Youth*. Available from: www.mcgill.ca/mhp/about (Accessed 14.01.2021)

Shiva, Dr. Vandana. (2013). 'The Seeds Of Suicide: How Monsanto Destroys Farming'. *Global Research, Centre for Research on Globalization*. Available from: www.globalresearch.ca/the-seeds- of-suicide-how-monsanto-destroys-farming/5329947 (Accessed 14.01.2021)

Hess, Shirin. (2018). '*Zapatista women inspire the fight against patriarchy*'. Waging Nonviolence. wagingnonviolence.org/2018/04/zapatista-women-inspire-fightagainst-patriarchy (accessed 14.01.2021)

Zapatista Army of National Liberation. Mexico. (No date). *Sixth Declaration of the Selva Lacandona*. Available from: enlacezapatista. ezln.org.mx/sdsl-en (Accessed 14.01.2021)

Mingus, Mia. (No date). 'Interdependency' from her blog *Leaving Evidence*. Available from: leavingevidence.wordpress. com/2010/01/22/interdependency-exerpts-from-several-talks (Accessed 14.1.2021)

Leach, Anna. (2015). 'Exporting trauma: can the talking cure do more harm than good?' *The Guardian*. Available from: theguardian.com/global-development-professionals-network/2015/ feb/05/mental-health-aid-western-talking-cure-harm-goodhumanitarian-anthropologist (Accessed 14.01.2021)

Solomon, Andrew. (No date). *Notes on an Exorcism*. [Audio]. Available from: themoth.org/stories/notes-on-an-exorcism (Accessed 14.01.2021)

Goetze, T.S. (2017). 'Hermeneutical Dissent and the Species of Hermeneutical Injustice'. *White Rose Research Online*. Available from: eprints.whiterose.ac.uk/115077/ 3/Hermeneutical%20 Dissent%20%28formatted%20for%20press%2C%20April%20 2017%29.pdf (Accessed 14.01.2021)

Part Three

Barker, Meg-John. (2020). *Chronic Shame*. Available from: www. rewriting-the-rules.com/self/chronic-shame (Accessed 23.01.2021)

Columbia University Irving Medical Center. (2019). 'Bone, not adrenaline, drives fight or flight response'. *phys.org*. Available from: phys.org/news/2019-09-bone-adrenaline-flightresponse.html?fbclid=IwAR3uxuMPsJJaFwipo3SJh-Jovi6_

ZHplHas76BThJvDls1lUbPYxBqYGC4A# (Accessed 23.01.2021) Bichell, Rae Ellen. (2017). 'Scientists Start To Tease Out The

Subtler Ways Racism Hurts Health'. *npr*. Available from: www. npr.org/sections/ health-shots/2017/11/11/562623815/scientistsstart-to-tease-out-the-subtler-ways-racism-hurts-health (Accessed 23.01.2021)

Menakem, Resmaa. (2020). 'Notice the Rage; Notice the Silence'. *On Being*. Available from: onbeing.org/programs/ resmaa-menakem-notice-the-rage-notice-the-silence (Accessed 23.01.2021)

Jones, Lucy. (1999). 'Smiling lessons end service with a scowl in Greenland'. *The Guardian*. Available from: www.theguardian.com/ world/1999/oct/23/7 (Accessed 24.01.21)

Myerscough, Paul. (2013). 'The Pret Buzz'. *London Review of Books*. Available from: www.lrb.co.uk/the-paper/v35/n01/paul- myerscough/short-cuts (Accessed 24.01.21)

Porges, Stephen. (2019). Therapists Uncensored # 93: 'Polyvagal Theory in Action – The Practice of Body Regulation'. *Therapists Uncensored*. Available from: therapistuncensored.com/episodes/ tu93-polyvagal-theory-in-action-the-practice-of-body-regulationwith-dr-stephen-porges (Accessed 24.01.2021)

Schwarz, Silke. (2018). ‘Resilience in psychology: A critical analysis of the concept’. *Theory and Psychology*. Available from: journals. sagepub.com/doi/abs/10.1177/0959354318783584 (Accessed 24.01.2021)

Bazzano, Manu. (2016). ‘The conservative turn in person-centered therapy’. *Person-Centered and Experiential Psychotherapies*.

15(4):1–17

Becker-Blease, Kathryn A. (2017). ‘As the world becomes trauma– informed, work to do’. *Journal of Trauma & Dissociation*.

18(2):131–138

NHS website. (No date). *Mindfulness*. Available from: www.nhs. uk/conditions/stress-anxiety-depression/mindfulness (Accessed 24/01/2021)

The moment is now. (No date). *In-house mindfulness session attendees, Tesco Bank*. Available from: www.momentisnow.co.uk/become- mindful/mindfulness-workplace (Accessed 24.01.2021)

Munden, Kate. (2019). *More than just stretching...*. Available from: katemunden.com/advanced-tre-more-than-just-stretching (Accessed 24.01.2021)

Sensorimotorpsychotherapy website homepage. (No date). Available from: sensorimotorpsychotherapy.org/about (Accessed 24.01.2021)

Flanagan, Bob. (1985). *Why?* featured in the 1997 documentary film *Sick: The Life and Death of Bob Flanagan, Supermasochist*, 1997, directed by Kirby Dick

Dixon, Bruce A. (2008). ‘The Age of Oprah, Cultural Icon for the Neoliberal Era’. *The Black Agenda Report*. Available from: www.blackagendareport.com/content/age-oprah-cultural-icon- neoliberal-era (Accessed 24.01.2021)

Harvard Health. (2010). *Takotsubo cardiomyopathy (broken-heart syndrome)*. Available from: www.health.harvard.edu/heart-health/ takotsubo-cardiomyopathy-broken-heart-syndrome (Accessed 24.01.2021)

Spinney, Laura. (2020). ‘Consciousness isn’t just the brain: The body shapes your sense of self ’. Available from: www.newscientist.com/ article/mg24632881-300-consciousness-isnt-just-the-brain-thebody-shapes-your-sense-of-self (Accessed 24.01.2021)

Hozumi, Tada. (2019). ‘The key to healing whiteness is understanding cultural somatic context’. Available from: selfishactivist.com/the-key-to-healing-whiteness-is-understandingcultural-somatic-context (Accessed 24.01.2021)

Sahdra, Baljinder K. & Shaver, Phillip R. (2013). ‘Comparing Attachment Theory and Buddhist Psychology’. *International Journal for the Psychology of Religion*. Available from: www. tandfonline.com/doi/abs/10.1080/10508619.2013.795821 (Accessed 24.01.2021)

Simard, Estelle. (2011). ‘Developing a Culturally Restorative Approach to Aboriginal Child and Youth Development: Transitions to Adulthood’. Available from: culturalattachmenttheory.blogspot.com/2011/06/culturalattachment-theory.html (Accessed 24.01.2021)

Treanor, Professor Morag. (2019). 'ACEs – repackaging old problems in shiny new (Emperor's) clothes'. Available from: blogs.ed.ac.uk/ CRFRresilience/2019/08/ 01/repackaging-old-problems (Accessed 24.01.2021)

Ellis, W. & Dietz, W. (2017). A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. *Academic Pediatrics*,

17 (2017) pp. S86-S93. DOI information: 10.1016/j. acp.2016.12.011

Freyd, Jennifer J. PhD. (No date). 'What is a Betrayal Trauma? What is Betrayal Trauma Theory?' Available from: dynamic.uoregon.edu/ jjf/defineBT.html (Accessed 24.01.2021)

Freyd, Jennifer J. PhD. (No date). 'Institutional Betrayal and Institutional Courage'. Available from: dynamic.uoregon.edu/jjf/ institutionalbetrayal/index.html (Accessed 24.01.2021)

Goldhill, Olivia. (2019). 'Palestine's head of mental health services says PTSD is a western concept'. *Quartz*. Available from: qz.com/1521806/palestines-head-of-mental-health-services-saysptsd-is-a-western-concept (Accessed 24.01.2021)

Alleyne, Dr. Aileen. (2019). [Video]. Speaking at the conference: 'Post-Slavery Syndrome: Exploring The Clinical Impact Of The Trans-Atlantic Slave Trade'. *Confer*. Available from: confer.uk.com/ module/module-slavery.html (Accessed 25.01.21)

Ogorchukwu, Jacquelyn. (2020). 'The Four Bodies: A Holistic Toolkit for Coping With Racial Trauma'. Available from: medium. com/nappy-head-club/the-four-bodies-a-holistic-toolkit-forcoping-with-racial-trauma-8d15aa55ae06 (Accessed 25.01.21)

Brave Heart, Maria Yellow Horse. (No date). 'The Return to the Sacred Path: Reflections on the Development of Historical Trauma Healing presentation'. Available from: www.ihs.gov/sites/ telebehavioral/themes/responsive2017/display_objects/documents/ slides//historicaltrauma/htreturnsacredpath0513.pdf (Accessed 26.01.2021)

Walters, Karina. (2018). [Video]. Speaking about *Historical Trauma Research*, Smith College School for Social Work. Available from: youtube.com/watch?v=OxilPSnbU9I (Accessed 26.01.2021)

Zapata, Karina. (2020). 'Decolonizing mental health: The importance of an oppression-focused mental health system'. Available from: calgaryjournal.ca/more/calgaryvoices/4982decolonizing-mental-health-the-importance-of-an-oppressionfocused-mental-health-system.html (Accessed 26.01.2021)

Mckenzie-Mavinga, Dr. Isha. (2011). *The concept of Recognition Trauma and emerging from the hurt of racism*. Available from: www. baatn.org.uk/wp-content/ uploads/The-concept-of-RecognitionTrauma-and-emerging-from-the-hurt-of-racim-Paper-1-1.pdf (Accessed 26.01.2021)

McCarthy Woolf, Karen. & Bury, Dominic. (2018). 'Grievous Bodily Harm – Karen McCarthy Woolf and Dominic Bury talk climate change, grief and decolonising ecopoetics'. Frears, Ella.

& Scott, Richard eds. *Magma #73, Changeling*, Magma Poetry Journal. p.20

Walker, Melissa. & Fredericks, Bronwyn. & Mills, Kyly. & Anderson, Debra. (2013). 'Yarning' as a Method for CommunityBased Health Research With Indigenous Women: The Indigenous Women's Wellness Research Program'. *Healthcare for Women International.* Available from: www.tandfonline.com/doi/ abss/10.1080/07399332.

2013.815754?mobileUi=0&journalCode=uhcw20 (Accessed 26.01.2021)

Kenyon, Georgina. (2019). 'If the land is sick, you are sick': An Aboriginal approach to mental health in times of drought'. *Scroll. in.* Available from: scroll.in/ pulse/921558/if-the-land-is-sick-youare-sick-an-aboriginal-approach-to-mental-health-in-times-ofdrought? (Accessed 26.01.2021)

Mannell, Jenevieve. & Ahmad, Lida. & Ahmad, Ayesha. (2018). 'Narrative storytelling as mental health support for women experiencing gender-based violence in Afghanistan'. *Social Science*

& Medicine. Available from: www.sciencedirect.com/science/ article/abs/pii/ S0277953618304350?via%3Dihub (Accessed 26.01.2021)

Hozumi, Tada. (2017). 'The connection between heart-centredness, burnout and colonization'. Available from: selfishactivist.com/ the-connection-between-heart-centredness-empathy-burnout-andcolonization (Accessed 26.01.2021)

Maina, Ng'ethe & Hains, Staci. (2019). 'The Transformative Power Of Practice'. *generative somatics.* Available from: generativesomatics.org/wp-content/uploads/2019/ 10/ Transformative-Power-of-Practice.pdf (Accessed 26.01.2021)

Part Four

Stedman, Thomas Lathrop. (No date). *Practical Medical Dictionary.* Available from: archive.org/stream/ stedmansmedical00unkngoog#page/n282/mode/2up (Accessed 9.02.2021)

Schwarz, Silke. (2018). 'Resilience in psychology: A critical analysis of the concept'. *Theory and Psychology.* Available from: https://doi. org/10.1177/0959354318783584 (Accessed 9.01.2021)

Attewill, Fred, (2007). Police link full moon to aggression. *The Guardian.* Available from: www.theguardian.com/uk/2007/jun/05/ ukcrime (Accessed 9.01.2021)

Woodhouse, Jayne. (2006). 'Eugenics and the feeble-minded: the Parliamentary debates of 1912–14'. *Journal of the History of Education Society.* 11: 2, 133

Sostar, Tiffany and collective. (2020). 'BPD Superpowers. What the Borderline makes possible'. Available from: tiffanysostar.com/bpdsuperpowers (Accessed 10.02.2021)

Lester, Rebecca (2013). 'Lessons from the Borderline: Anthropology, psychiatry, and the risks of being human'. *Feminism and Psychology.* 23(1): 70–77

Watt Smith, Tiffany. (2017). [Video]. 'The History of Human Emotions'. *TED Talk.* Available from: https://www.ted. com/talks/tiffany_watt_smith_the_history_of_human_ emotions?language=en (Accessed 9.02.2021)

Barrett, Lisa Feldman. (2017). [Video]. 'You Aren't at the Mercy of your Emotions: Your Brain Creates Them'. *TED Talk*. Available from: www.ted.com/talks/ lisa_feldman_barrett_you_aren_t_ at_the_mercy_of_your_emotions_your_brain_creates_the transcript?language=en (Accessed 9.02.2021)

King, Jr., Dr. Martin Luther. (1966). 'Don't Sleep Through the Revolution'. Ware Lecture at the Unitarian Universalist Association General Assembly, Hollywood, Florida. May 18th. Available from: www.uua.org/ga/past/1966/ware (Accessed 10.2.2021)

Recovery in the Bin. A critical theorist and activist collective. (2016). *The Unrecovery Star*. Available from: recoveryinthebin.org/ unrecovery-star-2 (Accessed 10.2.2021)

Interview on a web page titled *Broken Promises*. (No date). Available from: heygatewashome.org/displacement.html (Accessed 10.2.2021)

Online Etymological Dictionary etymology of 'character'. (No date). Available from: etymonline.com/word/character (Accessed 10.2.2021)

Online Etymological Dictionary etymology of 'personality'. (No date). Available from: etymonline.com/word/personality (Accessed 10.2.2021)

Ayurdhi, Dhar. (2015). 'When Psychology Speaks for You, Without You: Sunil Bhatia on Decolonizing Psychology'. *Mad in America*. Available from: www.madinamerica.com/2020/05/sunil-bhatia-on- decolonizing-psychology (Accessed 10.2.2021)

Emre, Merve. (2018). 'The Capitalist Origins of the Myers-Briggs Personality Test: The pseudoscientific tool was a popular, and powerful, force in corporations across the United States'. *Forge*. Available from: forge.medium.com/the-capitalist-origins-ofthemyers-briggs-personality-test-309187757d4e (Accessed 10.2.2021)

Knibbs, Kate. (2018). 'What's Your Type? The Myers-Briggs Test and the Rise of the Personality Quiz'. *The Ringer*.

Available from: www.theringer.com/2018/8/31/17800414/ myers-briggs-personality-brokers-merve-emre-book (Accessed 10.2.2021)

Liberatore, Stacy. (2016). 'Is there a criminal gene? Up to 70% of jail inmates have disorder also seen in serial killer Jeffrey Dahmer – and it could be in their DNA'. *Daily Mail*. Available from: dailymail. co.uk/sciencetech/article-3787469/Does-DNA-predict-end-jailScientists-closer-finding-genetic-roots-crime-reveal-40-inmatesdisorder-seen-serial-killer-Jeffrey-Dahmer.html (Accessed 10.2.2021)

Desai, Geetha. & Chaturvedi, Santosh K. (2017). 'Idioms of Distress'. *Journal of Neurosciences in Rural Practice*. Available from: www.ncbi.nlm.nih.gov/pmc/articles/ PMC5602270/ (Accessed 10.2.2021)

Hedva, Johanna. (2020). *Sick Woman Theory*. Available from: johannahedva.com/ SickWomanTheory_Hedva_2020.pdf (Accessed 10.2.2021)

Proposal for a text for international use concerning SPK. (No date). Available from: www.spkpfh.de/ProposalSPKtext.htm (Accessed 10.2.2021)

Darcy Steinke in conversation with Maud Casey about her book *Flash Count Diary*. (2019). [Video]. Available from: www.youtube. com/watch?v=RELxnLmlImE (Accessed 10.02.2021)

Opai, Keri. (2017). 'A time and space for Takiwātanga'. *Altogether Autism Journal*. Available from: altogetherautism.org.nz/a-timeand-space-for-takiwatanga (Accessed 10.01.2021)

Online Etymology Dictionary, etymology of dissent. (No date). Available from: etymologyonline.com/dissent (Accessed 9.02.2021)

NHS website. (No date). *Social Anxiety (Social phobia)*. Available from: www.nhs.uk/mental-health/conditions/social-anxiety. (Accessed 10.2.2021)

Lorde, Audre. (1996). *The Audre Lorde Compendium. Essays, Speeches and Journals*. Pandora.

Arundhati Roy hosted by Imani Perry. (2020). [Video]. The Pandemic is a Portal. An online teach-in. Available from: youtube. com/watch?v=QmQLTnK4QTA&t=943s (Accessed 10.2.2021)

Barker, Meg John. (2016). *Staying With our Feelings*. Available from: rewriting-the-rules.com/wp-content/uploads/2016/11/ StayingWithFeelingsZine.pdf (Accessed 10.02.2021)

Yeshe, Lama Thubten. (1993). 'Taking the Essence'. *Lama Yeshe Wisdom Archive*. Available from: lamayeshe.com/article/takingessence (Accessed 9.02.2021)

Keddie, Andrew. (2017). 'Tourette's documentary 'the best so far' says inspirational John'. Available from: bordertelegraph.com/ news/15026605.tourettes-documentary-the-best-so-far-saysinspirational-john (Accessed 10.2.2021)

'I Have the Most Extreme Case of Tourette's'. L*iving Differently, BBC documentary*. (2019). [Video]. Available from: www.youtube.com/ watch?v=wL2viVwGeMs (Accessed 10.2.2021)

'My Singing Stops Tourette's'. *Living Differently, BBC documentary.* (2019). [Video]. Available from: www.youtube.com/watch?v=4- E34SYGVzg (Accessed 10.2.2021)

T.H. (2018). 'Psychedelics and the Full-Fluency Phenomenon'. *psymposia.com*. Available from: psymposia.com/magazine/ psychedelics-and-the-full-fluency-phenomenon (Accessed 10.2.2021)

'Paul Stamet, Stuttering Stops, Career Begins'. (No date). *Psychedelic Review*. Available from: psychedelicreview.com/person/paulstamets (Accessed 10.2.2021)

John Muir Trust properties. (No date). Sandwood Estate: culture: *Memories of Sandwood*. Available from: web.archive.org/ web/20041014140837/http://jmt.org/ cons/sand/cult.html (Accessed 10.2.2021)

Black Feminisms. (2017).'The Master's Tools, White Feminism according to Audre Lorde'. Available from: blackfeminisms.com/ white-feminism (Accessed 10.02.2021)

Johnstone, Lucy. (2017). 'Psychological Formulation as an Alternative to Psychiatric Diagnosis'. *Journal of Humanistic Psychology*. Available from: https://doi. org/ 10.1177/0022167817722230 (Accessed 10.02.2021)

Open Dialogue UK. (No date). Available from: opendialogueapproach.co.uk (Accessed 10.02.2021)

Olson, Mary. (2014). The Promise of Open Dialogue. Available from: www.madinamerica.com/2014/01/promise-open-dialogue- response-marvin-ross (Accessed 10.02.2021)

Welch-Moring, Sonya. (No date). Ancestral Constellations. Available from: ancestralconstellations.com (Accessed 10.02.2021)

Savel, RH. & Munro, CL. (2014). 'From Asclepius to Hippocrates: The Art and Science of Healing'. *American Journal of Critical Care*. 23 (6): 437–439. van Eeden, Frederik. (1913). *A Study of Dreams*. Available from: www.lucidity.com/vanEeden.html (Accessed 10.02.2021)

Brown, Chip. (2003). 'The Stubborn Scientist Who Unraveled A Mystery of the Night'. *Smithsonian Magazine*. Available from: www.smithsonianmag.com/science-nature/the-stubborn-scientist- who-unraveled-a-mystery-of-the-night-91514538 (Accessed 10.02.2021)

Sleep Deprivation Experiments With Tony Wright. (2015). [Video]. Available from: www.youtube.com/watch?v=Nxn26-vUOI4 (Accessed 10.02.2021)

Groopman, M.D., Jerome. (2017). 'The Secrets of Sleep'.

New Yorker. Available from: www.newyorker.com/ magazine/2017/10/23/the-secrets-of-sleep (Accessed 10.02.2021)

The Newsroom. (2016). 'Scots belief in the Second Sight – the gift of premonition'. *Scotsman Newspaper*. Available from: scotsman. com/news/scots-belief-second-sight-gift-premonition-1482608 (Accessed 10.02.2021)

West, Dr. Cornell, (2020). [Video]. On Being a Revolutionary Christian, on the Michael Brooks Show. Available from: www. youtube.com/watch?v=Mw3bzHTllLM (Accessed 19.3.21)

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