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Inside Out:
A Study of Haunting, the Otherworld, Trauma, and Psychiatry

Vivienne Kent
ABSTRACT

The central theme of this thesis is haunting. Every culture has an Otherworld, an exclusion zone where some individuals, things, or ideas are banished, made taboo and repressed. This felt space exists at the margins of society, arising from the social conditions of its history and the circumstances of contemporary life. The past haunts the present, ghostly connections that bind us to what went before. We are all tied to these invisible historical and social effects, haunted by echoes and murmurations that hint at the uncanny rumbles of existence that hide behind dominant ways of knowing.

Psychiatric recognition of the effects of violence on victims, whether suffered in warfare or in the home, has long been marked by an oscillation between fascination with and denial of trauma as a cause of mental disorder, especially in the case of child sexual abuse (CSA). This thesis is an interdisciplinary work that makes a contribution to the sociology of mental health. It begins with an autoethnography, a work of sociological introspection and evocative storytelling that enters through the other door to describe my embodied journey with my son through the lifeworld of the psychiatric diagnostic process. This painful narrative of survival and recovery after sexual assault shows that CSA is linked to a wide range of emotional and behavioural problems, including the autistic-like symptoms that drove my son into the Otherworld. The thesis then turns to a history of the present, exploring historical alternatives that still haunt psychiatry as subjugated knowledges and subversive forces. I trace the contingent ways that psychiatric knowledge has become dominated by theories that privilege the inner world, whether of intrapsychic conflict or brain disease, and speak to an alternative approach grounded in the outer world: that terrible things actually do happen and trauma really can drive people mad.
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You are lambs among wolves. Be ye therefore wise as serpents, yet harmless as doves.
For Django

SCARECROW

Hung by the old field
The night in his eyes and the road by his side.
    He's trying to show me
It was a lightning bolt that set his body on fire.

Scarecrow
Caught in my mind
Scarecrow - not made for these times.

Clear as a diamond
The light reads plain in the back of his eyes
    We'd never know
He still dreams of a bird of a terrifying size.

Scarecrow
Caught in my mind
Scarecrow - not made for these times.

Cruel moon trying to weigh him down
Too soon
I'm glad to have him with me now

Death coat pecked bare
Red collar bled-white
No black heart there
No bark and no bite

Just this scarecrow
Caught in my mind
Scarecrow - not made for these times.¹

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CHAPTER 1. *Prelude.*

The more enlightened our houses are, the more their walls ooze ghosts.\(^2\)

Smith’s Bush

Smith’s Bush is where I come to enter the Otherworld. The North Shore City Parks Department, however, describe it more prosaically. Smith’s Bush is ‘a rare and precious remnant of old growth forest’, one of the few left in Auckland. This vestigial woodland is surrounded by the depredations of urban life, wedged between the Northern Motorway and the tennis courts, cricket and football fields of Ōnewa Domain. At its southern border is a reclaimed harbour bed. On one side there is a black-silt pond and traces of an ancient swamp. On the other is Akoranga Drive, where fast-food stores, an outlet warehouse and a garage jostle for business. Auckland’s traffic howl fades as you click the gate and tread softly along the boardwalk that takes you into the interior of the bush. The trees, mostly smooth-trunked pūriri and feathery, grey-green kahikatea, create a high canopy so dense that only a dim greenish light filters through, eerily underwater-like and stealthily quiet. I have seen kererū, the wood pigeon, and tui in the branches, and pīwakawaka, fantails, flit around with their distinctive diving swoops. Sometimes I catch sight of a vagrant band of Australian rainbow lorikeets, noisily foraging amongst the kahakaha, the massive epiphytes that festoon the oldest trees.

I have been coming to Smith’s Bush for many years now. The loop track of its raised boardwalk takes only thirty minutes to complete, but the entire bush is twenty-two acres in area, covered with thickets of old and young trees, shrubs, ground ferns and leaf litter. At its southern end a dirt track makes its meandering way through spreading moss, following a stream that plunges over a small waterfall and into the swamp, and then, gaining strength, rushes into the Waitemata Harbour. Ōnewa means basalt, referring to the substrate of volcanic stone that underlies the ground, laid down after the eruption of Rangitoto Island six hundred years ago. But despite the swamp, this was not originally a wetland forest. The oldest trees are the giant pūriri that grow together in a central grove; these trees were an important component of the original forest and pūriri is not a wetland tree. In the early years of the twentieth century the area was milled for straight pūriri to make into fence posts for the grazing land cleared by European settlers; the most prominent tree now in the forest is kahikatea, or white pine, a species which seems more able to re-establish itself than native podocarps such as tōtara, miro, mataī, and rimu. All this history makes the walk into Smith’s Bush a journey into the past, a palimpsest where history has been overwritten. But for me, it is also an expedition into an Otherworld of nature and time.

In Māori tradition the past lies before one, with the individual believed to live facing the experience and wisdom of the ancestors – i ngā wā ō mua, or the time in front – with the unknown future hidden behind his or her back. The modern western notion of time as a linear progression from Before to After is connected to the incarnation of Christ, which turned the faces of believers toward the future, hoping for Christ’s return in glory. Time as an unending stream of life and death, a flow of inner and outer events, feels more real to me when I am feeling oneness with nature. Time seems to stop, as it does in those stories when the protagonist enters a faery world and emerges years later feeling only a few hours have elapsed, as in the Celtic tale of Oisín and the hero Finn MacCumal.

On my bush walk I am often accompanied by my six-year-old son, Django, who has been diagnosed with several developmental disorders, the most prominent of which is Asperger’s disorder, a kind of high-functioning autism. He is a synæsthete, seeing sounds as colours, and images as tactile intrusions; he has a sense of smell as acute as that of a dog; he hears voices, of people in the air, he says. The incessant noise and electric glare of the modern, consumer-driven city overwhelms him and sends him spinning into a
black hole of panic. The natural world calms him, and allows him to extend his delicate antennae into the space around him. I think he can feel the energy fields of living creatures and connect with the thrumming of the xylem and phloem, the pumping internal life-rhythm of the giant trees. Immediately we walk into Smith’s Bush Django’s body changes shape, he stops hunching his back, he lifts up his face to the gentle filtered light, and he stops shouting, which he does to be heard over the echoing noises inside his own head. In the underwater-like muted sounds and half-light of the forest he can unwind and look around, no longer defensively keeping things out.

Django often feels socially excluded, an alien in the company of children his own age who are leading ‘normal’ lives and enjoying the ‘normal’ satisfactions of life in twenty-first century western civilization. Django can comfortably understand the moods of Tulip, our bull terrier, and is irresistibly drawn toward the company of animals in preference to people. Unless, that is, people respond to him in an open, uncomplicated way, quietly, and with expressions of genuine emotion and unfeigned interest. The natural world of forests, running water, filtered light, and the sound of birdsong is a place where he feels at ease, where he can shrug off his defences against bright lights, explosive noises, and incomprehensible social conventions. Until such time as we can move out of the city, places like Smith’s Bush are havens where Django and I can replenish our stores of resistance against the dark arts of materialism and the tyranny of social convention which prescribes the correct ways of being in the world.

Having a child that is so different from the normally accepted ways of living in our particular culture presents a challenge. The conventional approach is to try to train the child, like a recalcitrant wild animal, into becoming a simulacrum of a ‘normal’ child, teaching him or her to mimic the ways of children who are born able to negotiate the emotional minefield of social interactions. Some of this is of course desirable, as Django could easily grow up socially ostracised and already he sometimes feels lonely and notices his exclusion from his most of his peers. To this end he attends social skills classes, and takes a low dose of medication that suppresses the wildest excesses of his sensory sensitivities, but I worry that by these means his creativity is also attenuated. Oliver Sacks recalls that Robert Lowell (in Sacks 1995: 261) once told him about taking lithium for his bipolar disorder, saying: ‘I feel much “better”, in a way, calmer, stabler – but my poetry has lost much of its force.’ Perhaps there will always be a trade-off for Django, where it is sometimes worth paying the price for calm, and if he misses the frenzy of emotion he will have to learn to finely-tune his chemical balance. Certainly his whole physical, emotional and mental being is very delicate and easily thrown out of whack by exhaustion, conflict, stress and certain sensory stimuli. I hope that by teaching him that a walk in the woods is an important aid to rebalancing through reconnection with the earth and communion with the trees I am giving him a valuable method of natural calming, more constant than medication.

According to Colin Ross (2004b: 3-5), a maverick psychiatrist who runs a psychological trauma treatment centre in Dallas, Texas, trees communicate with each other and animals by means of energy fields that communicate presence and knowledge. Ross studies what he terms the disease of modern civilization, the way that modern men and women are dissociated from the knowledge of what he terms ‘spirit power’, the roots of which lie deep in the body and the natural world. To Ross, studying and communicating with trees is a key to reversing this disconnection; trees touch with their energy fields, enabling a fluidity of consciousness in humans and other animals that can allow them to connect with sources of energy in the landscape and the
cosmos. Ross believes that regular walking in the wilderness provides more than exercise for the body, as it re-establishes physical, sensual and intuitive ways of knowledge, unseating the dominance of the ‘normal’ industrial state of consciousness that is usually fixed in place and validated by most science.

I have spent most of my life living in big cities in many different countries, but wherever I am I have always felt drawn to the wilderness. To me, trees radiate a spiritual connection to nature. Along with years studying the humanities and the human sciences I have had a parallel fascination with different ways of knowing; something deeper and more ancient, more intuitive and sensual, and something more rooted in the natural world of immediate sensuous experience. For years this search for meaning drew me to shamanism, mythology, rituals and spiritual cosmologies, but the essential connection is much more earth-bound: the smell of leaf-mould and moss, the sound of water, the feel of tree-bark and the sight looking upward from the ground toward a high canopy of ancient trees. As Dylan Thomas (1972: 8) says, ‘the force that through the green fuse drives the flower’ keeps me alive in a way that is not only physical but is an umbilicus to the various ways of being alive on earth, and my particular connection to harmony.

A Walk in the Woods

Let me take you for a walk in the woods with Django. Once again I open the gate, the latch clinks, and the Otherworld lies before us as we face the ancient forest. The sunshine is snuffed out and the shrieking traffic is muffled as we cross the threshold into the crepuscular greenness. We step between two tall, slender kahikatea trees, and walk over a small wooden bridge that crosses a trickle of stream, and the Otherworld sucks us into its submarine stillness, the muted light under the canopy lulling us into slow motion, as if swimming underwater.

I immediately undergo a shift in perception, feeling that I have shrunk in size as I stand under tall kanuka trees and clumps of slender kahikatea. I notice a difference here between Django and myself. He unfurls and somehow seems to expand, his senses fanning out around him, no longer needing to shield himself from the rude, shrill, gaudy shackles of outside. He lifts his arms and races toward the fork in the track where the enormous five-trunked pūriri tree stands at the portico of the Cathedral Grove, where he waits for me in the golden-green gloom, motes of dust sparkling in the shards of light. I have meanwhile gone into a kind of meditation space, where I feel myself physically slowing down but with my mind still flitting around, often having odd rhymes pop up, or disappearing down philosophical worm holes. I am hearing the words of the Corpus Christi Carol, a medieval poem: ‘Lully, lulley, lulley / The falcon hath borne my make away’ (Anonymous 16th Century: 36-37). Django, though, seems to experience a fusing of his inner and outer worlds whereby he is really in the present moment. Perhaps this is because he is an intensely visual thinker and does not suffer from a chattering internal monologue; the voices he hears come from outside his own head, he says, and they do not talk to him incessantly, only when they have something important to say.

We pause, looking up at the heavy clumps of kahakaha swathing the pūriri branches. These ‘tank lily’ epiphytes, so-called because they hold a lot of water, catch more light on their leaves by growing high up in a tree. The massive trunks of the pūriri are covered with holes and scars made by the larvae of the large, furry, pale-green pepetuna moth, which spend their five-year life cycle eating fungi and burrowing through their hosts. The openings of the tunnels carved by the larvae are concealed with webs made from silk and tiny pieces of chewed bark. When we come to the fork in the track we turn right and go around the
boardwalk widdershins; this is always Django’s choice and he always chooses the same direction. Django notices that one of the karaka trees has epicormic shoots sprouting from the bark, which is what happens when adequate light reaches the ground; he delights in pointing it out.

As the track bends further to the right, Django looks up at the light-gap in the canopy, created by a massive storm that bought down many large branches. Several tree species are competing to re-claim the light-gap. ‘He bare him up, he bare him down / He bare him into an orchard brown’ goes the Corpus Christi Carol. We drift dreamily past a large porokaiwhiri tree and a pale-barked māhoe, which Django loves to be reminded is the world’s largest violet; bulky akakaikū, or passionfruit, vines drape over the kahikatea trees, amid swathes of akakiore, or jasmine, and puwānanga, clematis. Thread ferns and a fine bamboo-like grass surround the track, and the earth is covered with leaves, the tough glaucous undersides of those from the taraire trees conspicuous amongst the skeletal remains of other species. A small subsidiary track branches off here, and we follow it around to the small waterfall. The boardwalk disappears, becoming a muddy trail that curls through large trees down towards the old harbour bed. Django walks over the shallow top of the waterfall, loving the sound of the water, the sight of the thick, green moss, and the smell of the leaf mould.

We return to the main loop track, which now turns sharp left near a large tōtara tree. There are two different fern tree species here, one a silver ponga with silver undersides to the fronds and silver stipes, and the other a large black tree fern or mamaku. The mamaku has very black, furry stipes, like a tarantula’s legs, says Django, and very large, green fronds. Django becomes energised around this part of the forest, which is full of tree ferns, small ferns, and rope-like vines; he likes it because it seems prehistoric, like another more ancient world. We often hear tui and bellbirds around here but rarely see the birds, their songs drifting invisibly down from the canopy. As we walk around, Django tells me the names of the trees and shrubs, asking me the names of anything he does not know, but he knows most of them. He likes the boardwalk because it feels safe, elevated above the leafy detritus of the forest floor and as we walk around it the trees appear in their expected places, ready to be familiarly greeted like old friends. As we pass another māhoe tree we are surrounded by a thicket of slender kahikatea and Django looks out for one of his favourite markers by the track: two kahikatea which have grown close together and fused branches so that they spell the ancient runic symbol for Hagalaz, meaning hail, or icy rain.

Why this wintry sign should be written in our subtropical woodland is a mystery, but as creatures that take pleasure in reading meaning into random events we enjoy some imaginative speculation. Django squirrels away facts and is always surprising me with his esoteric knowledge.

There are wooden benches placed at intervals around the boardwalk and we sit and look around the forest, soaking up the otherworldly greenness. Looking across the forest from this eastern side is like peering into a massive aquarium. Pūriri stand like giant corals with their heavy burdens of sword-leafed tank lily epiphytes, their huge trunks receding greenish-grey into the canopy and their roots covered with pukupuku fern,
kōwaowao or hound’s tongue fern, mokimoki or fragrant fern, and kamu or hook grass. Light-gaps admit tongues of sunlight from above, and from this vantage point we sometimes see rainbow lorikeets flitting like jewels through the glimmering sunbeams, their fiery colours exotic in the muted palette of the forest. The Corpus Christi Carol returns to my mind:

In that orchard there was an halle,
That was hanged with purpill and pall.

And in that hall there was a bede;
It was hanged with gold so rede.

The poem is a dream allegory, every part of which has a deeper symbolic meaning. A giant falcon carries a human in its claws as if it were a mouse, flying over a landscape into an orchard, the traditional symbol for heaven. Maybe because I feel so safe here, lulled by the greenwood, I often hear this poem reciting in my mind while I walk around Smith’s Bush. Maybe it is also to do with the way I feel so little next to the giant trees, like the person carried by the falcon, not a smallness of insignificance but a smallness of scale; how tiny humans actually are compared to the size of the earth. In the poem the colours change from the brown of death through sacred purple, to the gold of eternity and the red of blood. ‘Lully lulley, lully lulley.’

Django, though, has no such inner monologue to contend with; he is just here, being in the moment, looking and hearing and smelling around him with no distracting poetry running through his mind. He comes up to me, his green eyes glowing in his pale round face, not saying anything but looking fully alive. I am suddenly reminded of the pūriri dwellers, the pepetuna moth larvae; outside in the ‘real’ world, Django covers the entrance to his consciousness with a veil every bit as finely-woven as that of the pepetuna tunnels, but here, in the Otherworld, he can let everything in because all around him is gentle, dim and muffled. Django opens and shuts his mouth to me, like a little fish, a wordless communication that means he is satiated; the energy fields of the ancient trees have filled him up with their calming presence and it is time to go.

We complete the circle of the track, halting at the five-trunked pūriri that guards the fork. The giant trees stretch out behind in the dimness of the Otherworld, but we turn and make our way back over the bridge, crossing the running water. My mind hurriedly finishes the poem before we reach the gate:

And in that bede there lithe a knight,
His woundes bleding day and night.

By that bede side kneleth a may,
And she wepeth both night and day.

And by that bede side there stondeth a stone,
Corpus Christi wreten there on.

The poem is an evocative song about the passing of time, the inevitability of death and the promise of the resurrection of the soul. It connects me to my ancestors and the image of a giant falcon carrying me across treetops to an orchard often appears in my dreams. I open the gate and we turn our backs on the
Otherworld; the sun’s glare hits us like an oven door opening. Django snaps down his pepetuna moth silk veil; antennae in, head lowered, he slouches into the brightness and clatter of everyday existence.

* * *

It is not what they built. It is what they knocked down.
It is not the houses. It is the space between the houses.
It is not the streets that exist. It is the streets that no longer exist.
It is not your memories which haunt you.
It is not what you have written down.
It is what you have forgotten, what you must forget.
What you must go on forgetting all your life.
And with any luck oblivion should discover a ritual.
You will find that you are not alone in the enterprise.³

Haunting
To place storytelling at the opening of this thesis, as I did by writing an account of walking with my son in Smith’s Bush, is a way of establishing a ‘structure of feeling.’ As Raymond Williams (1977: 132) puts it, what ‘structures of feeling’ articulate is ‘not feeling against thought, but thought as felt and feeling as thought: practical consciousness of a present kind, in a living and inter-relating continuity.’ This speaks to a concern ‘with meanings and values as they are actively lived and felt,’ (R. Williams 1977: 128-135) incorporating almost unconscious affects with cognitive processes, and enabling a narrative that is personal as well as academic, with a range of experiences that weave past and present. Ethnography, says Clifford Geertz (1993), is ‘thick description’ – writing that explores not only human behaviour, but also the context within which it occurs, so that the behaviour becomes intelligible to an outsider. My opening story is designed to draw the reader into my world, a world which here has many layers of meaning. In Smith’s Bush – and it would be hard to devise a more generically English name – traces of pre-European history remain, the vestiges of the once-mighty forest a palimpsest written over by colonisation. I have given many of the flora and fauna their Māori as well as English classifications; to foreshadow the way the narrative of my thesis provides perspectives other to the dominant view of psychiatric discourse.

Every culture has an exclusion zone. Some topics eliminated from rationality and the historical record, and further marginalised through the violence of modernity, may be pushed into the shadows. But these terrors are never simply absent: the cruelty of child sexual abuse, childhood maltreatment, rape, and domestic abuse are, to use Avery Gordon’s words (2007: 6-7), ‘ghostly matters.’ Ghosts return to haunt, never entirely excluded, and to truly study the intricacies of social life these aspects of society need to be investigated. In describing her own work of searching for presence amongst absence, Gordon (2007: 7) says:

Ghostly Matters is about haunting, a paradigmatic way in which life is more complicated than those of us who study it have usually granted. Haunting is a constituent element of modern social life. It is neither pre-modern superstition nor individual psychosis; it is a generalizable social phenomenon of great import. To study social life one must confront the ghostly aspects of it. This confrontation requires (or produces) a fundamental change in the way we know and make knowledge, in our mode of production.

Haunting is at the centre of Gordon’s work: people who live in the most ruinous situations possess an ambiguous subjectivity, she says, and their humanity is never totally apprehended by regarding them as either victims or heroes. This turns people into ciphers at the very moment when they need a fuller understanding of the twists and turns of ill fortune that overwhelm them: ‘life is complicated,’ she argues, and as a consequence all people exist in a state of ‘complex personhood’ amidst the vast network of society (Gordon 2007: 4).

Lives are plagued by contradictions as well as beset by forgetting and remembering, and at times people both understand and misunderstand themselves and other individuals. People endure their sufferings with egotism or acceptance, often becoming trapped in the symptoms of their misfortunes, and yet can also transform themselves:

Complex personhood means that even those called ‘Other’ are never never that. Complex personhood means that the stories people tell about themselves, about their troubles, about their social worlds, and about their society’s problems are entangled and weave between what is immediately available as a story and what their imaginations are reaching toward…. Complex personhood means that even those who haunt our dominant institutions and their systems of value are haunted too by things they sometimes have names for and sometimes do not (Gordon 2007: 4-5).

These Others are social figures that have been pushed outside ‘normal’ society, scarcely visible, banished to the periphery, to the Otherworld. Traces of these Others can be seen through the descriptions of those in power, but to decipher these spectral footprints is a fragile and risky project that tries to track the shape of these ghosts through history, ‘a particular kind of social alchemy that eludes us as often as it makes us look for it’ (Gordon 2007: 6). People labelled with mental disorder, especially children, are marginal figures: they are diagnosed, treated and examined by powerful medical authorities, but what of the Otherworld they, and on occasion I, inhabit, the structure of feeling they and I exist within, their and my way of seeing? Mad people haunt the social world of the ‘sane’, and their ghosts interweave the social fabric, with normality and abnormality written and overwritten on society’s walls.

Marginalisation is a sociopolitical process that is centred in power relations, and many diverse groups have historically found themselves peripheralised: the struggles and experiences of subaltern ethnic groups, women, the poor, the mentally ill, and sexual minorities have all informed the way exclusion is understood. Marginalisation is both a process and an experience: it is both inclusive of and a consequence of oppression (Hall 1999: 90). Marginalisation, as Joanne Hall (1999) notes, produces both vulnerability and resistance, and as such it is a space of radical possibility as well as a site of deprivation. Indeed bell hooks (1990: 341) argues that living on the edge – in what I am calling the Otherworld – encourages people excluded from mainstream culture to develop a different way of understanding reality, a slantwise gaze that sees ‘both from the outside in and from the inside out.’ This Otherworld, both outside looking in and inside looking out, is the ghostly space where I am constructing my narrative.

The Otherworld
The supernatural world of the Celts contained several Otherworlds, such as Tír fo Thuinn, the ‘Land Under the Waves,’ and Tír na nog, the ‘Land of Youth.’ Time ceased to have any earthly meaning in these happy places, which were ruled over by dispossessed gods and inhabited by magical beings, and some people could visit if divinely invited, or they could fall into the lands by force. As well as these lands of bliss,
however, there was also an Otherworld filled with fear, horrors, and ghosts, sometimes called Ysbaddaden (Corcoran 1994: 234-235). In writing this thesis, I found the notion of the Otherworld ‘good to think’ with, as Claude Lévi-Strauss (1963: 89) once said about animal totems, not only for my previous meditation on the natural world, but also for the sphere that my son and other survivors of trauma inhabit, a realm of altered consciousness termed delusional by modern psychiatry. The Otherworld is reminiscent of Michel Foucault’s (1986: 22-27) ‘Spaces of Otherness,’ lacunæ that are simultaneously physical and mental, neither here nor there, like when you see your reflection in a mirror. I have also lived in this zone, banished from ‘normal’ society, and the Otherworld can be at times both pleasurable and terrifying. As Charlotte Delbo (1995: 261) so eloquently explains, there is no straightforward escape from danger after trauma: rather, a person lives alongside this darkness in a ‘doubling’ of existence, switching between these sites.

Psychiatric interest and awareness of the role of psychological trauma in the genesis of various psychiatric problems has oscillated throughout its history. Psychiatry, which organises emotional, behavioural and psychological problems using a diagnostic system solely based on surface signs and symptoms, has had a very problematic relationship with the notion that reality can have an overwhelmingly effect on a person’s body and psyche (van der Kolk, Weisæth and van der Hart 1996:47). Survivors, however, often find themselves trapped in their traumatic pasts, haunted by intrusive memories or suffering profound amnesia, compulsively repeating their experiences in further victimisation or on occasion re-enacting the violence by perpetrating it on others (McFarlane and van der Kolk 1996: 24-46). Lifting the veil on the secrets of societal violence such as rape, spousal abuse, and childhood sexual abuse and maltreatment leads to widespread denials over the scale of the problem. Although many individuals remain silent about their pain, these memories of cruelty and brutality remain, overwritten by the bright stories of progress and social advancement that society likes to tell. The dominant discourse of the psychiatric field has found this difficult to acknowledge and the reckoning on trauma falls mostly to literature and the arts, which have traditionally held a dark glass up to humanity, reflecting our tragic inclination toward violence and destruction (McFarlane and van der Kolk 1996: 44-45; Weil 1983).

**Palimpsest**

In theoretical discourse, palimpsests appear in psychology, history, culture, and architecture. Primal events only show through in glimmers; stories gain and lose characters, beauty and cruelty interchange, cultural motifs transform depending on what era we exist within. Our whole existence can be regarded as a palimpsest, where old ways are scraped away and overwritten, only to remain as ghosts. Historians use the term not only to describe revisionist histories and how they never work, but also to describe the way people experience time, as a layering of present events over faded pasts. We all wake up every morning with the memory of yesterday already smoothed for us to write the new day on, except that traces remain under the surface. In architecture, a palimpsest is an image of what once was there. Whenever a structure is rebuilt or remodeled, shadows remain – traces on the sides of a building, long after a neighboring house has been demolished, and painted areas where staircases have been removed. Jean Baudrillard (1986: 56) discusses the way modern American culture is simply a layered miasma of images of images of images – a totally mediated experience, so we no longer know where or what the originating scene was. Our whole experience of the world could be said to be like a palimpsest, the present-day haunted by traces of the past.

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4 According to Lévi-Strauss, animals are chosen as totems not because they are ‘good to eat,’ but because they are ‘good to think,’ that is, they symbolise attributes that the human mind needs to classify and theorise what is observed.
Indeed, it is common for people to feel the sensation that a new environment seems overwhelmingly familiar, or that while performing some new activity that they have actually engaged in the same process in the past (Brown 2004: 187). This strange experience, termed déjà vu, is a cognitive dissonance that feels uncanny, and both parapsychologists and scientists have grappled with the strange feeling of precognition evoked. Palimpsest or déjà vu, this sense of overlapping worlds symbolises the interstices explored in my work.

Why I Chose this Topic

I am a survivor of sexual violence and, when he was very young, my son Django was subjected to long-term sexual abuse by a family friend, a man who was sometimes his caregiver. As Django’s unusual experiences of hearing voices, synesthesia, memory loss, weird sensory disorders, and outbursts of rage drove him deeper into the Otherworld, I began to discover the bad things that had happened to him. Django’s crazy behaviour meant that he came under the scrutiny of many professions, medical, psychiatric, alternative healing, and educational, all of which tried to in some way diagnose his condition while attempting to ameliorate his symptoms. At times, experiences with these agencies mirrored contact that I had with psychiatric professionals when I was younger and suffering from problems caused by my own traumatic past. Django’s trauma, and the labyrinthine journey through the psychiatric diagnostic process, rekindled many of my psychic and emotional scars, and caused severe physical illness as my body carried the corrosive burden of its traumatic memory.

Psychiatry, with its psychopharmacological arsenal, insisted on a biogenetic origin for all of Django’s emotional and behavioural problems. I was constantly told that I was wrong in attributing Django’s troubles to the trauma he had suffered, and treated with massive condescension for trying to discuss the issue. I was astonished that psychiatric practice was still so dismissive of the effects of child sexual trauma; when I visited a psychiatrist in the 1970s I was told that my reports of violence and rape were fantasy, and although twenty five years later the focus had shifted to brain disease and genetics, it was still the inner world, rather than the outer, that was held to be the cause of mental distress. Grappling with this problem developed into one of my main research questions: What historical forces shaped psychiatry into a profession that still so vehemently denies the ill effects of adverse life events on an individual’s mental health, emotional wellbeing, and memory? What is revealed when we look beyond current psychiatric discourse, into the Otherworld?

I was repeatedly struck by the power and authority residing in the hands of the health professionals I came in contact with and it made me wonder what was really going on in the diagnostic process. Because I was so close to the way Django was treated during these procedures I was able to closely observe the practice of fitting unwieldy symptoms into neatly labelled boxes. I became curious about the history of psychiatric diagnosis as well as the way other cultures handle similar problems, thinking that alternative approaches may reveal a different, more effective, way of healing: these questions also informed my research. I wanted to know how things could be done differently for my son, how he could be helped back from the margins of sanity, a search that led me to take Django to alternative medical practitioners as well as mainstream psychiatric professionals.

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Alan Brown states that research findings indicate around two-thirds of the population experience déjà vu, most likely many times.
Research Questions
My major focus in this thesis is to explore the psychic effects of traumatic events and the ways in which the psychiatric professions have constructed diagnostic categories that occlude the reality of trauma. Childhood abuse or maltreatment is a major risk factor for many psychiatric disorders, but autistic symptoms are not usually understood as resulting from experiences of child sexual abuse. However, my story as recounted in this thesis persuasively shows that the constellation of symptoms that eventually led to my son’s diagnosis of autistic spectrum disorder as well as other comorbid psychiatric disorders was coloured by his experiences of sexual abuse when he was very young. Links between childhood trauma and autistic symptoms have been described or theorised by others, but the notion is not given credence by mainstream psychiatry. An autoethnography exploring this topic is a novel proposal, and my positioning as both a mother and a social science researcher provides a unique perspective. Other questions I address in this thesis are to do with the power relations between psychiatry and the service-user: how are individuals deemed mad, or mentally disordered, dealt with by the psychiatric professions? Why are personal histories of violent trauma nearly always disregarded by psychiatry? How does a diagnosis of mental disorder fit a person into a labelled category of disorder? How were these experiences of Otherness treated in the past, and in other cultures? How could things be done differently here and now? What tactics can the powerless use to subvert powerful psychiatric discourse, what loopholes can be exploited?

Weaving my story into several other academic strands – an exploration of psychiatric power, an historical examination of the profession of psychiatry, a consideration of the history of psychic trauma, and the social construction of the categories of mental disorder – requires an exercise of the sociological imagination (Mills 2000), which is a way of thinking that seeks to make connections between my individual life and a wider historical and social context. Private troubles are also public issues, and to understand my own and my son’s life experiences requires an understanding of the society in which we live. More than this, the way that our social reality is constructed by psychiatry, after years of disciplinary force, is mostly unseen: what is revealed when we look at the world in a different way? And, how do we do this? How do we recover what Avery Gordon (2007: 195), following James Baldwin (1995: xv), calls ‘the evidence of things not seen’ that are buried in that neglected archive where ‘my memory stammers: but my soul is a witness’?

A Counternarrative
With these questions in mind this thesis is in part a ‘history of the present’, a term used by Michel Foucault (1991: 30-31) to denote a way of looking at ‘intolerable’ contemporary social circumstances by mining the ‘intellectual subconscious’ of the past. Present day practices are not the inevitable result of scientific progress, but, rather, due to historical contingencies (Gutting 2005b: 1-28). This echoes the way Walter Benjamin characterises history, inspired by Paul Klee’s painting Angelus Novus. The ‘angel of history’ stands openmouthed, wings spread, facing the past:

Where we perceive a chain of events, he sees one single catastrophe which keeps piling wreckage upon wreckage and hurls it in from of his feet ... [t]his storm irresistibly propels him into the future to which his back is turned, while the pile of debris before him grows skyward. This storm is what we call progress (Benjamin 1999: 249).

In this thesis I step aside from the notion of time as a linear progression from past to future, an account that asserts a triumphalist history of psychiatric knowledge. We need to look towards the past, as in the Māori
view of i ngā wā ē mua, or the time in front, with the unknown future hidden behind our back, as we try to decipher structures of power and knowledge in the present.

My thesis is a counternarrative, designed to question the powerful apparatus of modern psychiatry by examining what Foucault (2003b: 7) calls ‘subjugated knowledges’, historical knowledges that are marginalised and disqualified from scientific status by the power relations of professional practice. These genealogical and archaeological approaches, defined by Foucault (2003b: 8) as a ‘coupling together of scholarly erudition and local memories’, here take the form of a historical and cross-cultural investigation. In outlining some of the hidden streams of unreason haunting modernity, currents that are now in part trapped within psychiatric discourse, I am revealing procedures of discrimination and exclusion exercised by modern psychiatry and attempting to use them as a tactic of struggle against these same practices. One of the ways that I show the experience of marginalisation by these power relations is by listening to the voices of people deemed ‘mad’ – now often part of the psychiatric survivor / service-user movement, but for many years suppressed by the dominant culture. These voices are often silenced, although several famous autobiographical accounts exist throughout history. Roy Porter (1999b: 4-5), who has published several social histories of madness, argues that ‘consciousness is a linguistic continuum’, and the stories of ‘mad’ people are interwoven with the ideologies of society and the values of psychiatry to show that concepts of ‘mental disorder’ do not exist in isolation but are, rather, products of culture.

**Interdisciplinary Research**

Avery Gordon (2007: 7) contends that the objective, disembodied, and factual accounts of much social science erase the complexity of social life, which rather demands an epistemology that can comprehend the fact that life is complicated, as well as an interdisciplinary approach that can reckon with the ambiguous dynamics of subjectivity. Mixing genres, blurring boundaries, and drawing from many branches of knowledge seems to me to be the best tactic for the questions I want to address in my thesis. Exploring the Otherworld, that liminal zone of hauntings and madness, where I, following Gordon (2007: 6-7), describe people denied personhood haunting the peripheries of society, requires a complex research methodology. Gordon (2007: 65-67) alludes to this kind of analysis as a sociology that enters ‘through the other door’ – looking awry, telling the story slantwise, using oblique strategies to find those elusive moments when the sociological imagination is flexed so that it conjures hidden and unconscious connections from the empirical. Illustrating this approach, Gordon (2007: 204) refers to Walter Benjamin’s (1986: 177-192) essay on the Surrealist art movement, where Benjamin muses on the way Parisian surrealists were attempting to break down the barriers between dream and reality, loosening the grip of individuality and the self. Benjamin (1986: 183) describes his concept of ‘profane illumination’, a way of seeing (sometimes but not necessarily driven by the ecstasies of drugs) past the banal obviousness of social life. Tumbling through a revolving door into a different region, the seeker can fall into a ‘crossroads where ghostly signals flash from the traffic, and inconceivable analogies and connections between events are the order of the day.’

What are these ‘ghostly signals’? They are signs that reveal things that are usually neglected or invisible, lost in the disregarded interstices of society. How do we see the unseen, and uncover the activity of unseen forces? The past, as well, may be apparently forgotten and hidden, but it lives on and is rekindled and revised by the incessant reshuffling of memory, writing, and conversation: through narration. Indeed, interpretive social constructionism holds that *the meaning of things is not inherent* and all things in time and
story, whether they are ‘cows, chairs, actions, selves, social problems, decades, or anything else that can be referred to – derive their meaning from the purposes and perspectives that people bring to them’ (Harris 2008: 232; emphases in original). In other words, meanings are formed, learned, tried out, and modified in social interaction. Connecting my personal experiences to wider cultural, political, and social meanings and understandings, at the heart of this thesis is storytelling: my autoethnography invites the reader to get caught up in the story, as it is a narrative that is written, as Arthur Frank (2010: 3) suggests, to ‘work on people, affecting what people are able to see as real, as possible, and as worth doing or best avoided.’

**Storytelling**

Performing a story of personal experience brings with it some fundamental problems. Frank (2010b: 11-17) calls this ‘dilemmas of narrative authenticity,’ whereby the storyteller needs to balance the essential relationship between an expression of authenticity and crafting the work as a tale of witnessing, advocacy, and healing. I cannot simply recount the dry facts: I do not wish to merely narrate a series of events, but want to denounce wrongdoing; I want to bear witness to my personal experience and to my son’s suffering, to *talk back* to the perpetrators of violence and to *take back* these stories and make them my own. Frank (2010b: 12-17) describes a process of socio-narratology, by which he claims stories as a form of social action: ‘rather than understanding the story as a portal into the mind of a storyteller’ we should attend to what the story actually does. Autobiographical stories are an active way of giving meaning to experiences within the flow, mutability, and complexity of life; indeed narrative theorists argue that the self is created, reworked, and revised through social stories, in response to interactions with other people (Sparkes and B. Smith 2005: 82). Although my autoethnography may seem unique, it is a social creation: it has grown out of the cultural milieu in which I am embedded; it is built on narrative templates learned in my culture; as it was constructed it connected me to other ‘human relationships, collectivities, mutual dependencies, and exclusions’ (Frank 2010b: 15); and the work of creating this story is a dialogical interpretation interweaving multiple voices, especially mine and Django’s, but also those of all the other people who I had contact with during the time this story was researched and written.

The way that human memory – especially traumatic memory – works is a contested issue, and these disputes will be investigated in a later chapter. For now, I, following Sidonie Smith and Julia Watson (2010) argue that memory is embodied; and in writing, I have constructed my identity by locating myself within a particular repertoire of emplotment: a narrative site that ‘inextricably links memory, subjectivity, and the materiality of the body’ (S. Smith and Watson 2010: 49). I believe that remembering is an active process, and a narrated memory is an interpretation of a past that can never be fully recovered. Memories are thus embodied recollections of experiences, not photographic replicas of events. Recalling and recreating a history of violence and sexual abuse is problematic: memory can fragment, and ordinary language often fails to capture the horrors of the past and its consequences. In trying to script and exorcise trauma I found Arthur Frank’s (1997: 75-115) three types of illness narratives useful templates to build my story upon. Frank considers how pain and illness alter an individual’s subjectivity. He submits that the recollection and recounting of personal experiences of suffering is a moral work that helps survivors to achieve some kind of self-understanding. The first way of structuring a life story is the ‘restitution narrative’, a story with a plot that traces a journey from sickness back into health. The second, the ‘chaos narrative’, tells of impotence, vulnerability, and futility. Chaos stories are threatening, they are full of horror, and there is no way to end the suffering. They are often told in the present tense as they spill from traumatic memory onto the page.
Thirdly, there is the ‘quest narrative’ that accepts illness and tries to make use of it: the sick person believes that there is something to be gained from the experience of pain and illness. Quest narratives meet suffering head on: they talk about a journey, hope, and difficulties overcome, and the remaking of the self through illness, disability, and pain. There are risks in this kind of adventure, but also dialogue and communication with others, and an empowerment through action. My storytelling is plotted mostly as a quest narrative, but with some eruptions of chaos narrative cutting into the text.

My lived experience is the primary kind of evidence asserted in my autoethnography. As Max van Manen (1990: 53) states, this ‘lifeworld … is both the source and the object of phenomenological research.’ A phenomenological approach tries to delineate and understand everyday lived experience directly as it appears in consciousness, before reflection or interrogation (Shaw 2010: 130). While studying ‘the things themselves’ (Merleau-Ponty 2000: 3) may be an impossible task, as we are all affected by our habits of thought, our embodiment, and our ways of seeing, we can, nevertheless, practice what Thomas Csordas (2002: 241-259) terms ‘somatic modes of attention.’ This strategy, as Rhonda Shaw (2010: 131) describes it, entails recognition of visceral bodily and sensory feelings, listening to these signals, and using them as a trigger ‘for analytical self-consciousness about specific issues’. Of course, all sensual experience is embodied, as indeed are subjectivity and consciousness. However, this kind of knowledge is not completely solipsistic: an individual lived body is intimately linked to the lived bodies of others, to relationality, to space, and to time (Shaw 2010: 132). Van Manen (1990:101-106) calls these interconnecting structures of meaning ‘lifeworld existentials’, and all of these categories influence the research process, in reflection and in writing. I interact with other people; I maintain relationships with them in shared interpersonal space; these spaces, where I travel and live, affect my moods and feelings as ‘felt space’; and past experiences, even if forgotten, inscribe indelible traces on my being, on my body, on my hopes and expectations for life.

My lived experience is my claim to authority: gaining knowledge from my subjective position is the way I invite my reader to believe my story and its claims to truth. I am aware that my assertion of cultural authority is unstable, and that it is negotiated by my various positionings: as a woman; as a survivor of rape and domestic violence from the age of fourteen to twenty-one years old; as a person who has experienced tactile, sensory, auditory and visual hallucinations; as a person once diagnosed with depressive disorder; as a former drug addict; as an individual who has lived, studied, and worked in many different countries; as an outsider; as a mother (married and now divorced); and, most recently, as a sociology graduate. These positions are of course intersectional, not additive: identity, as Smith and Watson (2010: 39) show, is dialogically constructed in language, and they follow Mikhail Bakhtin and Stuart Hall to assert that consciousness and cultural identities ‘are marked by time and place.’ What model of identity is currently available for me? The most reliable identity I can represent here to my reader is constructed from a complex matrix of experiences: I am a Pākehā woman; a damaged survivor of sexual violence; the mother of a son who is also a survivor of sexual abuse, and who has several developmental disabilities and psychiatric disorders; and I am a sociologist seeking to understand the human condition; and I am simultaneously struggling to transform the pain and suffering of myself and my son into some kind of enlightenment.

Although it is painful to speak out, I no longer wish to remain silent. I want to talk about childhood sexual abuse and the damage it causes: it is a widespread horror that is still all too often hidden, and the complex experiences of Django and I will, I hope, bring the statistics of child sexual abuse to life. I use, therefore:
The power of speech to transform, to fuse secret shame, pain and anger into a useful tool ... for cutting away lies and deception ... leaving the clean hard pit, that kernel of truth: these insults were inflicted, now, every day (Ellen Bass, in Ronai 1995: 422).

While I am telling this story for myself and for Django, I am also speaking to a listener who I do not know, the reader of this thesis. Reflecting the intersectionality of my own subjectivity, this story is told as a ‘layered account’ (Ronai 1995), a kind of impressionistic dramatisation of events, utilising what Laurel Richardson (2000c) calls crystallisation, a kind of methodological triangulation that uses multiple methods of analysis and differing genres of representation. In Frank’s (1997: 75-115) terms, my autoethnography is mostly a quest narrative, with elements of the chaos story erupting into the text, and I use various self-reflexive techniques to illustrate the problems of remembering and forgetting, the occurrences that trigger particular moods and memories, and of my own emotional and cognitive disturbances. I dramatise these themes by interrupting the narrative flow with poetry, introspective musings, and scripted conversations, and also by occasionally stepping into the text to make sociological observations, distancing myself from my immersion in the tale.

Autoethnography is a qualitative research method developed from social interactionism, an interpretivist methodological paradigm, which comes under the rubric of the theoretical perspective of social constructivism. Dichotomous thinking is still powerfully evidenced in social research, where the quantitative-qualitative polarity is still strongly demarcated and Laura Ellingston and Carolyn Ellis (2008: 445) note that qualitative research itself is divided, with ‘artistic interpretivists’ at one end, and ‘scientific positivists’ at the other. Social science researchers have traditionally wanted to present their accounts in a sanitised fashion, eliding mistakes, miss-steps, messiness, and embarrassments, as well as hiding their own role in a study, while presenting their findings in a passive voice as data collection (Ellingston and Ellis 2008: 453). Confessional tales were once considered too personal, and not authoritative enough (Tedlock 1991; van Maanen 1988), while the case for autoethnography as a legitimate and meaningful research method is surely established, it is still sometimes criticised for being insufficiently scientific or rigorous (Murray, Pushor and Renihan 2011: 46).

A struggle over what Arthur Bochner (2010: 663) calls ‘methodological sovereignty’ has led to disputes over the practice of autoethnography, with analytic practitioners focussing on theoretical explanations of social phenomena on one side (Anderson 2006: 373-395), and evocative autoethnographers, who instead emphasise narrative, dialogue, and emotion, on the other (C. Ellis and Bochner 2006: 429-449). I think that these attempts to discipline and tame qualitative enquiry show little understanding of feminist and postmodernist deconstructions and debunkings of expert objectivity and positivism. By trying to raise the status of the analyst by diminishing the standpoint of the storyteller there is a danger that all narrative research could be delegitimised, especially the emancipatory, therapeutic, and autoethnographic work carried out in the illness narratives of vulnerable subjects (Bochner 2010: 662-665). My autoethnography does have a realist backbone, and my thesis does involve theorising – the kind of social theory that, as Herbert Marcuse (2002: xlii) asserts, is interested in historical alternatives, the kind of different ways of being that ‘haunt the established society as subversive tendencies and forces.’ I argue that we narrate ourselves into being through this noisy parliament of the self by our heart-connection to our work. Writing from the heart (Pelias 2004) and sharing my embodied vulnerability, I am most certainly what Arthur Frank (1997) describes as a ‘wounded storyteller’ and I strongly believe that even when I am analysing and theorising, my writing can simultaneously, even thrillingly, be evocative, confessional, and messy. This conflict between
story-analysts and storytellers will be examined later in my thesis, but one area of current critique will be touched on here: the problem of ethics in autoethnography.

**Ethics**

Writing autoethnography, argues Martin Tolich (2010: 1599), raises particular ethical issues, especially concerning the rights of people mentioned in the text and who have not given informed consent. Tolich is correct when he notes that current ethical guidelines for doctoral candidates writing an autoethnography are contradictory and informal. When I began writing I was not required to submit an application to The University of Auckland Human Participants Ethics Committee (UAHPEC) for approval, and my doctoral supervisors were responsible for clearing ethical issues concerning my research material. Self-reflexive research, autoethnographies, and autobiographical narratives were then considered by UAHPEC to be observational studies and thus exempt from formal ethical guidelines, although since these methods are now growing in popularity they are more often defined as 'low risk research projects' and subject to Committee approval. Low risk research is identified as 'no risk of physical harm, psychological harm, exploitation or other potential adverse effect' and the researcher is required to obtain full informed consent and the right to anonymity for all participants (UAHPEC 2010: 7). This process is currently under review and may change, introducing stricter guidelines.

I am fully aware of Tolich's (2010: 1605-1606) concerns over guidelines for autoethnographic research, and that my story, when published and circulated, will permanently tattoo a stigmatised status – rape survivor, former drug addict, psychiatric service-user – on my *curriculum vitae*. My family and friends already know my history, and I have delivered public seminars at academic conferences disclosing these things: I believe that my speaking out is a political act to break the silence still shrouding the topic of child sexual abuse, and to thus bring attention to the damaging effects of trauma. Rhonda Shaw (2011: 62-63) determines that respect and care for participants, especially if they are in any way vulnerable, is a key principle in social research. This is an ethical value that I have worked hard to maintain. I spoke earlier about Arthur Frank's (1997) description of illness narratives as moral works that can assist in healing. This is certainly my intention in writing this thesis; and I am very conscious that I am telling a sensitive story about my own life, but also, undeniably, about my son Django's life, as he is a vital protagonist in the narrative. I could merely introduce him as a medical case-study, and I have already listed these dry facts: he has several developmental disabilities, he is a psychiatric service-user, he is prescribed psychopharmaceuticals, and he is a survivor of childhood sexual abuse. These issues significantly amplify his vulnerability. I agree that telling a story about real people needs to find a balance between authenticity and moral responsibility, and I have been careful to inscribe Django's life with sensitivity and discretion. More than this: in recounting a story of sexual abuse, suffering, and psychiatric labelling I am performing an act of empowerment and activism that tells a tale from the *inside*, revealing tactics of resistance and assertions of agency over models set by the dominant culture.

Frank (2004: 175-182) pronounces life writing about illness and disability as 'moral non-fiction' and describes parents writing about their disabled children as a sub-genre of this field, with the writer as 'a witness, whose testimony speaks not only for himself or herself but also for a larger community of those who suffer. Being a witness is a moral work.' Including Django in my narrative is a way to rescue him from being reduced to his disabilities: he is not just 'one of those kinds of kids' who should have been institutionalised or known merely.
by his diagnostic labels (Frank 2004: 184). Indeed, when I began my research, I talked to a friend who worked at a rape crisis centre and told her I wanted to tell Django’s story of sexual abuse and journey through the psychiatric diagnostic process, and she said that it would be a valuable tale to tell, but who wants to hear about mad kids? They are a profoundly marginalised population, with no voice save that of their caregivers. The kind of ethical non-fiction writing I am talking about is:

Inherently reflexive, questioning what sort of story it is, and even its own claim to be a story. This reflexivity is a moral work, since what’s at stake is personhood and its entitlements. If [the child’s] life is not narratable, then [the child] becomes “one of those kinds of kids”, and his entitlements – … to care and services, to respect as a person – are in jeopardy (Frank 2004: 184).

Storytelling in this way, insists Frank (2011), is an ethical act. When I began my research Django was still a child; now he is nearly seventeen years old, and he and my other adult children know what I have written, we have all talked about the story since its inception and discussed its construction, and Django has given his consent for me to present and publish this work.

I am aware that power differentials in parent and child relationships are a matter of concern. Django’s ability to understand my research and give his consent is not affected by his disabilities: he is a very aware and intelligent young man, and absolutely capable of critically thinking and weighing up the value of this research project. I believe that he would say no if he meant no; he has strong opinions and makes them very clear; I am also, naturally, aware that he trusts me and wants to please me. I have endeavoured to not betray this trust. His sexual abuse has been fully disclosed, and our family is still involved in a long process of recovery and support. During the research process, says Rhonda Shaw (2011: 62-63), minimisation of harm includes protection from ‘pain, stress, fatigue, emotional distress, undue embarrassment, cultural dissonance and exploitation.’ I am Django’s mother: I do not want any harm to come to him or to my other children or family members. But this is my story, my perspectives on a series of experiences and events, and I believe that although it is a painful story, it is important that it is told. I have ensured that emotional and psychological support has been available for Django whenever he has needed it, and for the last ten years he has been in regular contact with a very supportive psychotherapist. I have perhaps not been careful enough with my own reactions to the rekindling of traumatic memories, especially in the early stages of my work when I was unconscious of their power, and I have endured several illnesses, physical and emotional, during the process of writing this thesis; as Bessel van der Kolk (1996a) so astutely observes, ‘the body keeps the score’ and bears the burden of trauma. However I am presently in excellent physical and mental health.

All of the names of the characters in my autoethnography have been changed, except for my own. My youngest son has dubbed himself ‘Django’; Django is a Romany name meaning ‘I awake’ and it is an apt descriptor for the person he is still becoming. My other children have also been given *noms de plume* whenever they are directly mentioned: Paura (my eldest son, who is a jeweller and artist), Fionn (my middle son, a musician), and Lula (my daughter, a photographer and sculptor). I have also changed the designations of the various schools, mental health services, alternative healing centres, and hospitals mentioned in my work, as well as giving sometimes rather Dickensian pseudonyms to the individuals working within these institutions. The names Wolf and Reynard, marking the abusers with predatory monikers, are of course also aliases. I have done this in order to minimise risk, to make it difficult for any individuals in my narrative to be identified, and, most importantly, to protect Django. While absolute anonymity may be impossible, confidentiality can be established.
Chapter Outlines

Chapter 1. ‘Prelude’ establishes a structure of feeling for the work to follow, describing a walk through Smith’s Bush with Django. I explain my interest in my research topic and briefly describe some key influences on my work. I then clarify my theoretical and methodological stance in my thesis, especially an acknowledgement of interdisciplinarity, storytelling, and ethical considerations.

Chapter 2. ‘Inside Out,’ is my autoethnography, the heart of my thesis: an evocative story of myself my trauma history, and my journey through the psychiatric diagnostic process with my son Django, a survivor of child sexual abuse. Embracing reflexivity, I have written a layered subjective account of real events, interwoven with poetry, introspections, and memories. Flexing the sociological imagination, I tell a nuanced, haunting, and complex story, as well as involving theoretical perspectives on psychiatry, critical engagement, social problems, and social action. A dark tale of trauma and sexual abuse, I also articulate processes of healing, recovery, and hope.

Chapter 3. ‘Theoretical and Methodological Underpinnings’ describes the major sociological perspectives on mental disorder, and delineates psychiatric power, biopower and biopolitics. I then turn to a discussion of tactical writing and the need for resistance to the dominance of the discourses of the therapeutic authority of psychiatry. A description of autoethnography, its current conflicts between analytic and evocative approaches, and disputes over the ethics of confidentiality follows. Finally I explain my justification for combining autoethnography with a history of the present, a Foucauldian-influenced exploration of the psychiatric profession and subjugated knowledges, especially those of the service-user movement and of psychological trauma.

Chapter 4. ‘A History of the Present, Part I: The Storm of Progress,’ begins my history of the present, a counternarrative of the way mental distress has been constructed in Western culture, from mesmerism and degeneracy theory through hypnosis and the development of the notion of the unconscious. I compare the popular cultural mode of Gothic literature to the sensational scientific investigations of somnambulism and the enchantments of modernity in the eighteenth and nineteenth centuries, and link the Gothic to Sigmund Freud’s writings on the Uncanny. I argue that it is a congeries of historical circumstances rather than scientific progress that defines the current practices of psychiatry, and I begin an excavation of the ‘intellectual subconscious’ of the past in order to decipher the difficulties that psychiatric survivors and service-users face today.

Chapter 5. ‘A History of the Present, Part II: Classification and its Discontents,’ looks at the crystallisation of diagnostic categories in Western psychiatry, from the intrapsychic conflicts of the Freudian age to the brain disease model that dominates current psychiatric thought through the discourses promulgated by the ‘psychiatric bible’: the Diagnostic and Statistical Manual of Mental Disorders. I examine the contested diagnosis of schizophrenia, describe the dramatic rise and fall of psychosurgery, and trace the development of child and adolescent psychiatry, with particular emphasis on the diagnoses of attention-deficit / hyperactivity disorder (ADHD) and autistic spectrum disorder (ASD). I then explore resistance to dominant psychiatric discourse, through the anti-psychiatry movement, the deinstitutionalisation of psychiatric asylums, and various psychiatric service-user / survivor groups.
Chapter 6. ‘A History of the Present, Part III: Trauma,’ moves into a different space. I here ask a different question to those fixed on by the psychiatric professions: not what is wrong with the fantasies or the brains of the mentally disordered, but, rather, what bad things happened to these people, how have they survived the terrible things they have experienced, and at what cost? Those who experience violent traumatic events such as war, rape, child sexual abuse, childhood maltreatment and other brutalities suffer profoundly negative consequences. Although many individual responses to trauma are pathologised, the kinds of behaviours and emotional states that these survivors display are, I argue, human reactions to witnessing, perpetrating, or being subjected to extreme violence, and these people, like Django and myself, have tales to tell. In this chapter ‘ghostly matters’ finally move centre stage, and I tell the stories of the Others haunting psychiatric institutions and discourse, a haunting story where ‘their social worlds and society’s problems are entangled’ and interwoven (Gordon 2007: 4-7). Madness is not only faulty biochemistry, for ‘bad things happen and can drive you crazy’ (Read and Haslam 2004: 133-145).

Chapter 7. ‘Reflections’ returns to Django. Ten years after his journey through the psychiatric diagnostic process began we have a conversation about how he remembers these events, and what he thinks helped him most out of all of the therapies, interventions, and prescription medications he was given, as well as all the people who offered these things. I reflect on how the story came out, the effort and pain involved in getting the story right, the value in telling it. I think about sociology and transformation, and that to study social life we must attend to the ghosts, the lost people banished to the Otherworld.
In a world under glass
you can watch the world pass,
And nobody can touch you,
you think you are safe.
But the wind can blow cold,
in the depths of your soul,
where you think nothing can hurt you
til it is too late …
Run and hide,
to the corners of your mind, alone,
Like a nobody nowhere.

Through the Other Door

This autoethnography tells a story about my experiences as I navigated the mental health system, seeking a diagnosis and therapeutic assistance for the frightening array of behaviours that my son Django developed by the age of four. The story is one of negotiations; between the psychiatric profession and myself; between my love for my son and my own history and choices; between a child and the labellings that ‘make up’ a person in the modern world. As I stated in the previous chapter, my lived experience, my ‘lifeworld’, is the primary kind of evidence asserted in my autoethnography. This phenomenological approach is embodied. Max van Manen (1990: 101-106) asserts that the phenomenological research process, and the way the researcher reflects and writes, is influenced by four ‘lifeworld existentials’ that are interconnecting structures of meaning. My lived body interacts with other lived bodies in relational space; these spaces, as ‘felt space’, affect my moods and feelings; and past experiences, even if forgotten, leave permanent inscriptions on my being, on my body, on my hopes and expectations for life. In this autoethnography I practice ‘somatic modes of attention’ (Csordas in Shaw 2010: 131-132), paying attention to my senses, my visceral bodily states, and my emotions, and using these sensual messages as aide-mémoires that remind me to pause in my story, to analyse the specific issues that trigger these embodied reactions to the lifeworld outside my own consciousness and subjectivity. As Rhonda Shaw (2010: 133) notes, ‘the body acts as a threshold or hinge between mind and world. Consciousness and subjectivity are thus incarnate.’

To understand the invisible forces of disciplinary power, which operated on my own and my son’s journey through the labyrinth of the psychiatric professions, I was able to draw on an array of theoretical perspectives and methodological tactics that helped balance my fear that Django and I would become trapped in a diagnostic web as objects of clinical study. In telling this story, trying to capture the rich, ambiguous nature of the complexities of this experience, I use an interdisciplinary approach that combines analysis, delicacy, and imagination (Gordon 2007: 4-5). Life is complicated, as Avery Gordon (2007: 4-7) asserts, and subjective experiences, as well as the emotions that accompany these occurrences, cannot be apprehended by sociology’s habitual abstractions (Holmes 2010: 143). This is a sociology that, as Gordon (2007: 65-67 and 197; emphases in original) puts it, enters ‘through the other door’, using a kind of montage technique to attend to what I am thinking and experiencing as well as to the things out there around me.

Social science research typically relies on assumptions that phenomena studied can be observed separately from the environments in which they occur. Social scientists are still often ‘outsiders’ to the settings being researched; they are only temporarily visiting the area to frame research, collect data, write up results, and create a written report for particular readers. ‘Insiders’, on the other hand, have a different interest in gaining information about the situation. To them, the environment being studied needs to be understood as a means to taking effective action within it: action that impacts on their future life course, economic security, self esteem, social situations, and indeed happiness and fulfillment. To ‘insiders’ the results are therefore crucially more important than they are to ‘outsiders’, whose personally important settings reside elsewhere (Bartunek and Louis 1996: 2-3).8

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8 The insider / outsider formulation is commonly termed ‘emic’ versus ‘etic’ – derived from the distinction in linguistics between phonemics (sounds classified according to their internal function in language) and phonetics (sounds classified according to their external acoustic properties).
The mode of research where the perspectives of insiders are represented has a long history in the interpretive paradigms and fieldwork-based approaches of anthropology, feminist methodologies, and some strands of sociology such as social interactionism, phenomenology, and ethnomethodology. In other strands of the discipline, many researchers still make attempts at ‘seeing things from the native’s point of view’: whether this is identified as ‘experience near’, where subjects naturally use a concept to define their own and their fellow humans’ feelings, imaginings, and thoughts; or as ‘experience distant’, a more ‘objective’ perspective adopted by many allegedly scientific researchers and analysts (Geertz 1983: 56-58). Clifford Geertz (1983: 57), who has closely examined the academic wringing of hands over the claims to truth of various anthropological methodologies, argues that experience-near and experience-distant are not opposites. Total immersion in the former would result in drowning in a sea of vernacular intimacy; the latter would throw the researcher up onto the arid shore of jargon and abstraction. Following Geertz, an experience-near concept would be ‘my loved child is flailing about crazily’ whereas an experience-distant concept is a diagnosis for my child such as ‘Pervasive Developmental Disorder (Not Otherwise Specified)’.

Clearly, the way the concepts of experience-near and experience-distant are deployed in any particular study is a matter of degree. One cannot always have ‘an ethnography of witchcraft as written by a witch’, as Geertz (1983: 57) puts it, but neither should someone to whom witchcraft is incomprehensible undertake the research. If the issue is ‘you don’t have to be one to know one’, then both concepts ought to be deployed to produce an interpretation of peoples’ lives that is ‘neither imprisoned within their own mental horizons … nor systematically deaf to the distinctive tonalities of their existence.’ A researcher cannot directly hear or see what his or her informants are privy to, but must tune into the particular ways people actually represent themselves to themselves – and to one another – through symbolic forms such as behaviours, images, words and songs.

Exactly how one goes about poking one’s nose into another person’s consciousness is another question, but then the whole concept of personhood is also open to question. The unitary sense of self we identify with so strongly in Western cultures is, I would argue, a socially constructed illusion. I examine the concept of the self more deeply in later chapters but here I would like to let Geertz speak:

The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively both against other such wholes and against its social and natural background, is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world’s cultures (Geertz 1983: 59).

To achieve understanding, it is necessary to place the notion of the unitary self to one side, and to try to interpret others within the terms of their own beliefs.

I chose an autoethnographical method to explore my trauma history and my journey with Django through the mental health diagnostic system because, as William Tierney (1998: 66) says, ‘autoethnography confronts dominant forms of representation and power in an attempt to reclaim, through a self-reflexive response, representational spaces that have marginalized those of us on the borders.’ Autoethnography, as a genre, links the personal with the cultural, placing the person within a social matrix (Reed-Danahay 1997). It is, argues Tierney (1998: 66), a way of understanding the Other by allowing him or her to speak: people who usually find themselves portrayed in the texts of others, silenced, banished to an exclusion zone, can move
from 'the margins and consciously resituate the borders.' Jaime Romo (2006: 81-94), author of a wrenchingly honest autoethnography on child sexual abuse by religious authorities, asserts that the method is a useful way to work with information that is hidden and difficult to acquire: the seduction and rape of children by pædophile priests is a taboo subject that is not easy to research. Carol Rambo Ronai (1995: 395-426), in a painful story that mixes impressionistic sketches of her memories of sexual assault with a sociological analysis, describes her writing as a 'layered account', an early version of this genre. Autoethnography thus becomes a witness to trauma, loss, and marginalisation, and indeed there are many writings that concentrate on this kind of personal history.9

Trauma, especially when deliberately inflicted by another person, shatters assumptions about safely living in the world. The victim is diminished into a mere thing by the perpetrator, and is viewed as worthless, their subjectivity – their experience – rendered ineffective against the torment (Brison 1997: 14). As Judith Herman (1998: 53; emphases in original) remarks, '[t]he traumatic event thus destroys the belief that one can be oneself in relation to others' and furthermore, as Susan Brison (1997: 14; emphases in original) argues, losing this belief means that 'one can no longer be oneself even to oneself, since the self exists fundamentally in relation to others.' The self suffers abjection, a profound loss where 'nothing is familiar, not even the shadow of a memory,' says Julia Kristeva (1982: 4-5), a state caused by 'the shameless rapist …. a terror that dissembles, a hatred that smiles, a passion that uses the body for barter.'

It is a slow and painful process to piece together a self shattered by trauma; the ongoing narrative of the self is splintered, memories of earlier life are lost, and emotional and cognitive abilities are altered (Brison 1997: 20-21). It is hard to speak the unspeakable: for a child, especially, lacking the words to express this kind of personal demolition. To re-make the self in the aftermath of trauma requires an audience, an understanding listener, and a witness: the self is relational. I take this witness role in my relationship with Django; therefore this narrative is collaborative, dyadic storytelling. If we regard the self as not bounded or unique, but as porous and with multiple perspectives, the narrative, in the same way as the self, can build up between an elaborate conversation between inside and outside. The self, as a socialised, cooperative work of art, is a performance that goes on as ‘I’ affect others and others bump into me. The seething concatenation of the brain makes sense of hundreds of sub-systems: musical, analytical, and intuitive. The world reveals itself to ‘me’ by the performative way life unfolds: the way we work with others, with institutions, with cultures.

I argue that we narrate ourselves into being through this noisy parliament of the self by our heart-connection to our work. Writing from the heart (Pelias 2004) involves stepping forward as a ‘wounded storyteller’ (Frank 1997) and sharing my embodied vulnerability. Expressive writing that confronts trauma by articulating both the emotional and cognitive aspects of pain has helped me, enabling me to imaginatively process remembering and mourning from a position of safety (Baker 2009: 15-23). It has been, on occasion, difficult to access some of these recollections, with a constant wrestling between wanting to speak and simultaneously wanting to suppress the traumatic memories, a struggle Judith Herman (1998: 1) identifies as ‘the central dialectic of psychological trauma.’ Memories are always to some extent reconstructive, as they are retold and rebuilt through a narrative process, between one’s self, one’s relationships, and one’s environment (Hall and Kondora 2005: 1347). The actions we take, our work – and the way we tell ourselves

9 For example, Deborah Reed-Danahay’s 1997 collection Auto / Ethnography has chapters on political resistance, criminal identity and ethnic marginalisation, from writers based in Algeria, Corsica, Sweden, and Romania, to name only a few of her sources.
stories about this process – constructs our being: we build up our selves by narrative. As a writer and survivor this storytelling has helped me to heal while at the same time allowing me to share the circuitous ways of negotiating truth with my readers: speaking the unspeakable is a political act (Herman 1998:1; Giorgio 2009: 149-167).

In this autoethnography I adopt, as Arthur Frank (2000: 354-356) says, ‘the standpoint of storyteller,’ a stance which he describes as ‘a political and ethical act of self-reflection.’ To Frank (2000: 357), telling a story about illness is firstly an ethical act, and secondly an analytical act: ‘What makes an investigation principled is its advocacy. What counts … is not to describe the experiences of the ill but to provide resources for the ill to experience their situations differently.’ An academic clinical analysis is not empowering to the ill person: it tells the story of the other. This autoethnographic chapter describes the lived experience of illness for the other in a dialogical manner and provides, following Frank, an experience of therapeutic and emancipatory remoralisation. As Frank (2000: 358) says, ‘dialogue is an ethical stance of recognising that one’s life takes place not only among others, but also with responsibilities toward those others.’ Therefore, the storyteller, in this case myself, must be aware of this responsibility: if an outsider account of Django’s experience of selfhood risks being desiccated by a dependence on ‘experience-distant’ description, an insider account solely reliant on ‘experience-near’ narrative risks incoherence. Both would fail him ethically.

I am aware of the danger of exploitation inherent in speaking for someone who, like Django, is powerless, with no voice. This story explores the time up to when Django was just over six years old; he had been sexually abused from around one-and-a-half years old to when he was four-and-a-half years old; he was practically mute; he was examined, diagnosed, and prescribed medications and treatments by psychiatric experts and alternative healers; he enjoyed art therapy and sand-play with a psychotherapist; attempts were made to modify his behaviour and educate him. He had been traumatised by the abuse, ordered around by all these strange experts, and then became the subject of my thesis. The subordinated subject giving up their knowledge to academic use is a problematic issue recognised by many social science researchers. As bell hooks insists:

No need to hear your voice when I can talk about you better than you can speak about yourself. No need to hear your voice. Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become mine, my own. Re-writing you I write myself anew. I am still author, authority (hooks 1990: 341-343).

I cannot pretend to speak for Django. Gayatri Chakravorty Spivak (1998: 272-313) asks: ‘Can the subaltern speak?’ and answers, no, but suggests that speaking to the subaltern is possible; interrogating the ways the subject is absent. As Gordon (2007: 24) says, ‘[w]hat does the ghost say as it speaks … in the interstices of the visible and invisible?’ It is an uncanny imagining, but it is, argues Gordon (2007: 196-197), essential to witness the people and the things which are driven to the periphery of society – I am also part of this story, and must strive for a kind of reflexive authenticity.

As I said: speaking the unspeakable is a political act. Telling one’s story is a way of talking back to the perpetrators, and in this way taking back one’s own story. This is my story as well as Django’s: we are both survivors of sexual abuse, and not only does my own being resonate with his subjectivity by means of my
I nurtured Django; fought for him; faced down Reynard, his abuser; negotiated his appointments with health and education providers; researched his difficulties; and attempted to steer his diagnosis. Illness, especially disability, spoils identity, a damaging process Arthur Kleinman (1988) describes as demoralisation, whereby people are deemed unworthy of full moral respect, reducing them to categories such as sick, disabled, or mentally disordered. This is a counterstory and a remoralisation, an act of resistance:

Illness is an occasion to offer testimony about a suffering that society too often ignores, compartmentalizes, and diminishes. The writer of the illness narrative is primarily a witness, whose testimony speaks not only for himself or herself but also for a larger community of those who suffer. Being a witness is a moral work (Frank 2004: 177).

I am no longer the same woman who gave birth to Django in 1995: I have been transformed by my relationship with Django, just as I have been moulded by my interactions with my other children, my family, my lovers, my friends, my colleagues, my enemies, and by all other people and institutions I have been touched by. Django’s story, as narrated here, requires an appreciation of the interpersonal nature of the self.

Birth

Django’s birth was dramatic. Born several weeks early, a few days after my family and I had flown into Auckland from London, what began as a natural, midwife-assisted birth became a medical emergency as the umbilicus became compressed and Django’s heart rate slowed. An emergency caesarean ushered my new baby into the world, and I greeted him in a morphine haze. ‘What you have to do these days to get a whack,’ joked my brother when he visited me in hospital. My new baby was a boy: ultrasound scans had predicted a girl so this was a surprise, and he remained nameless for several weeks. But despite the traumatic nature of his arrival, all of Django’s vital signs were normal: there were no signs of any disability.

When Django was six months old, his father returned to London. We had only sporadic contact, and he sent no money to help support Django. Now a lone parent with three young children, I needed a survival plan. I know I am being defensive here in explaining why I made the choices I did, but I need to rationalise what happened, while knowing full well that this is just an attempt to gain control of the uncontrollable. I was renting an old villa with a leaky roof and hot water problems, and I had no paid employment. My mother helped with my children, but there just was not enough money: the Domestic Purposes Benefit that financially supported me provided the bare minimum required to put food on the table and pay the bills. I had always worked, but I did not believe my previous job skills would provide reliable sources of income. I made enquiries and discovered that I was eligible for a government grant which would pay most of my fees to attend university and re-train in a new career, so I firstly enrolled in a New Start programme at the University, and having successfully completed this, began a Bachelor of Arts degree majoring in history and anthropology. It was here I met a man I will call Reynard – the name of the cunning fox in many old tales – who was in the last stages of completing a degree at the same university. I had known Reynard twenty years before, when I lived in London working as a costume designer for performance artists, dancers, actors and musicians. Back then, Reynard worked with people I knew. I remembered Reynard rather dimly as a quiet and rather withdrawn person, but I also knew a lot about him from my friends, so when, after a while, he asked me if he could share the house, I felt comfortable with him moving into our spare room. The extra
money meant that we could afford to stay where we were, and my children all liked Reynard. My older son and daughter were thirteen and eight; Django was just over a year old.

I have thought back to these days many times. Reynard was friendly, relatively well off, as he had a small inheritance from his mother who had recently died; he was alone, having just ended a childless marriage; he was studying similar academic subjects to me and was very generous in his advice about academic writing; and, most importantly, he went out of his way to develop friendships with my children. They all liked him. He made friends with my mother, saying that she reminded him very much of his own mother. It was pretty clear that he had emotional problems: he drank quite heavily, he regretted never having major success as a musician, he was resentful of his ex-wife, and he still owned all of his mother’s personal effects (her clothes, jewellery, and household items), all professionally packed in boxes and stored. Still, he was a quiet and friendly drunk, he never acted out his anger, failed musicians are inevitably bitter, divorce most often ferments aggrieved feelings, and his grief over his mother’s death sounded more like Bambi than Psycho. This was in 1996: by 2001 I was staring back over Reynard’s behaviour with a colder eye – I had seen beneath his façade of normality.

This is a difficult narrative to construct. Telling a story, especially as a social science researcher, generally means using the fragments to validate a hypothesis, to categorise, to generalise, and to theorise. I will no doubt tell this story in a different way than you, my reader, because we have different perspectives, histories, and knowledge. Arthur Frank declares that it is necessary to think with stories, not think about them:

To think about a story is to reduce it to content and then analyze that content. Thinking with stories takes the story as already complete; there is no going beyond it. To think with a story is to experience it affecting one’s own life and to find in that effect a certain truth of one’s life (Frank 1997: 23).

This story is not data, but is, rather, what Frank (1997: 24) terms ‘a highly personal sedimentation of experience’ whereby I have lived with this story and had it shape my perceptions over many years.

Arthur Frank (1997) describes three types of illness narratives. The first is the ‘restitution narrative’ (Frank 1997: 75-96), an emplotment that traces a heroic journey from sickness back into health. The second, the ‘chaos narrative’ (Frank 1997: 97-114) is the opposite of a restitution story, with no plot and no narrative order. These are threatening tales, full of horror and suffering, telling of impotence, vulnerability, pain, and futility. Chaos stories are often told in the present tense – or perhaps the tense present – as events erupt unbidden from traumatic memory, a place that has no consciousness of historical past but lives on in flashbacks, dreams, and sudden intrusions, split between what Charlotte Delbo (1995: 261; 1990: 2-4) calls the ‘deep memory’ of trauma and the ‘ordinary memory’ of everyday life. Thirdly, there is the ‘quest narrative’ (Frank 1997: 115-136). This perspective accepts illness and tries to make use of it: the writer believes that there is something to be gained from the experience of pain and illness: perhaps transformation, or at least a remoralisation, a reclaiming of personhood. My autoethnography is mostly a quest narrative, but with some elements of the chaos story stirred through it: like the red food colouring in a marble cake, the chaos story does not blend, remaining a blood trace through the quest narrative.
Tell all the Truth but tell it Slant –
Success in Circuit lies.\textsuperscript{10}

\textbf{Descent}

What really caused Django’s disintegration from apparently normal childhood development toward the howling, screaming, panicking, aggressive creature he had become by four years old? Why had he stopped talking? Why was he hearing voices? This story could be told like a psychiatric case study, a description of the complex diagnosis of a young child with several developmental disorders. But I write from a different perspective – taking Emily Dickinson’s advice: the truth oftentimes needs to be approached circuitously, seen aslant, told obliquely, especially so when the truth is impossible to absolutely verify.

When Django was around four and a half years old, I asked Reynard to move out – he was drinking more, or perhaps just more openly, and I didn’t want him around any longer. The conversation rapidly developed into a confrontation where I saw for the first time the underside of his carefully constructed social self; I blindingly knew he was a different kind of person altogether. Time slowed, a red light flashing at an accident site. Unless you have had personal experience of the perpetrators of violent crimes that involve sadism and depravity, you may not notice the mask slip, or see the man who wants power and authority over others; but if you have then it is unmistakable, even in a glimpse. They, of course, can also tell that You Know. This is a key moment: much of what I now understand about Django is coloured by this realisation.

How did I recognise Reynard’s veiled persona? Through personal experience. Was this knowledge any use at all in getting official assistance in prohibiting Reynard in making any further contact with my family or I? No. Was it helpful in eventually getting assistance for Django? No. Would it have served any useful purpose for me to turn my suspicions into accusations of criminal abuse? Again, no. I could just stop here – do you, reader, really need to know any more? Perhaps you could just take my word for it that I usually have an eye for the signs of violence, but I think I have to disclose some of my history if you are to understand how I have tried to help Django. It is, after all, my qualification for working in the field of trauma: I am a survivor.

When I was fourteen I was raped, and I never told anyone. My behaviour changed from obedient to rebellious; I was expelled from two schools; I left home; at fifteen I began a relationship with a man – I will call him Wolf – who totally entrapped me until I was able to escape him when I was twenty-one. When I was sixteen I fell pregnant, and Wolf forced me, with considerable viciousness, to give up my son for adoption. The day I returned home from giving birth in hospital, having left my baby in the care of social services, he beat me and raped me, breaking the stitches I had from an episiotomy during a bruising and difficult delivery.

The notion of being a father horrified Wolf; I can see now that he was a very damaged person and I know that his father used to beat him and his mother mercilessly when he was a child, but at the time I was just terrified of Wolf. It didn’t help that I was living under a cloud of social opprobrium – it was still scandalous to be an unmarried, teenage mother in 1971, and even the doctors and nurses at the hospital treated me with total disdain while I was in labour and recovering after the birth.\textsuperscript{11} Wolf was addicted to amphetamine, and obsessed with heavy metal music and black magic, and he controlled nearly every aspect of my life.


\textsuperscript{11} I later searched for my son, and we re-connected when he was twenty-one years old. I am very fortunate that we were able to find each other. E kore e mimiti te aroha mōu, Paura.
enforcing discipline with rape, beatings, and verbal aggression. He practiced frightening rituals of bondage and blood, drawn from the writings of Aleister Crowley, which were, he said, intended to promote power and freedom (Sutin 2002). To Wolf, no doubt, not to me: my only freedoms were a useful ability to dissociate, and my job: I only left the house without Wolf when I went to work, which was my salvation as I was able to squirrel money away and save for my escape. When I was finally able to break out, I bought a plane ticket to London. I didn’t feel safe in Auckland, as Wolf had threatened to kill me if I left him; I didn’t live permanently in New Zealand again until after Wolf died in 1992. I didn’t tell anyone about any of this trauma. Going to a different country where no one knew me seemed like a blank slate, but my new life in England was inevitably underlaid by my old life; I was often depressed, and I spent several years addicted to heroin.

I had lost most of the memories of my relationship with Wolf, but five years after leaving him, following an abortion, I began to suffer from strange flashbacks and panic attacks as I remembered vivid but disconnected episodes from my past. I asked my doctor for help and was referred to a psychiatrist for evaluation. The psychiatrist was male, middle-aged, and extremely cold in his professional manner. Years later I obtained my case notes, and read that the psychiatrist had described me as an ‘Alice in Wonderland’ type, noting that he did not believe anything I told him about my history of abuse, dismissing my truth as fantasy. And I was apparently alexithymic, unable to identify and name my emotions. In the 1970s, before biological psychiatry upturned the arena of clinical practice, I could still be considered a fantasist – ten years later I would have been diagnosed with disordered brain chemistry or a neurochemical imbalance instead, and prescribed medication. As it happens, I did find the help I needed eventually; I spent two years with a female psychotherapist and we developed a supportive therapeutic relationship I found invaluable. In 1978, though, I am sitting in this grumpy shrink’s office apparently completely composed: I am not upset, as I am floating up near the ceiling watching myself tell him the story of Wolf; I am, in short, dissociating. You are a lamb among wolves, I think. Be ye therefore wise as serpents yet harmless as doves (Holy Bible, Matthew 10:16).

I now know that traumatic memory is different to the kind of memory underpinning ordinary consciousness. Traumatic memory is unconscious, and when it irrupts into the self it is profoundly alienating. As Russell Meares (2001: 1-3) points out, memories of traumatic experiences often seem distorted as they lack what he terms ‘the peculiar feeling-tone which attaches to those ideas, behaviours and so forth which make up the core of self and gives them value.’ These memories are presented to others as a ‘stunted narrative’ that reinforces feelings of inferiority and worthlessness in the individual, and for the person listening to this story it lacks intimacy, complexity, and, sadly, often seems unbelievable. My unsatisfactory encounter with this psychiatrist, with his domineering manner and condescending attitude, undoubtedly coloured my later judgements of the psychiatric professionals I met during Django’s diagnosis and treatment, although I have endeavoured to make a fair evaluation of their interventions.

I needed to gain some control over my psychic disintegration, to establish more awareness of my body to help me identify my emotional states. I explored psychotherapy, spiritualism, dance, art, music, creative writing, hallucinogenic drugs, meditation, yoga, rebirthing, deep tissue massage, past life regression, naturopathy, homeopathy, astrology, personal growth workshops, monastic solitudes, and wilderness retreats. I travelled around the world, became apprenticed to a Native American shaman and participated in ceremonial work. My ability to dissociate was valued in shamanism, as I was able to enter trance states at
will, and the fact that I saw spirits was treated as a gift, not as a sign of madness. I had always been interested in different ways of knowing, and these experiences were therapeutic, empowering, and emancipatory. I was able to stop using heroin. I made several important and deep friendships and relationships; I had a son and a daughter and loved them. I did not suffer from psychotic episodes; my life did not fall apart; and although I sometimes suffered from depression I became stronger. When I later undertook academic study at The University of Auckland I trained in another way of knowing: analysis, research, and theory, I regarded these more reasoned and critical methods as complementing rather than replacing what I already knew.

When I left the knife-wielding maniac, as I fondly remember him, I was twenty-one. Since then – and in 2000 this was over twenty years later – I had not been in any kind of abusive relationship, although I had recognised the portents of cruelty in various men I had worked with or met. I thought that I had a nose for this kind of man and that I could avoid all close contact with them (and thus all harm), but until the red light glimmered around Reynard I had never noticed this underlying violence in him. My first concern, obviously, was to remove Reynard from any contact with my family or myself, which I immediately did. At this stage I did not know that Reynard had sexually abused Django, who was around four-and-a-half years old. However, Django’s conduct was worrying, to me and to his other caregivers. He was aggressive with other children at his early childhood centre and was not developing sociable play behaviour, so he had been referred to a child psychiatrist who had diagnosed attention-deficit / hyperactivity disorder (ADHD); he was wetting the bed every night; he was smearing faeces on the walls; he had constant abdominal pains; he was noticeably regressing in his learning and behaviour; and he was spitting and growling instead of talking. I could not understand why Django’s behaviour was so destructive, or why he had become so animalistic.

Reynard was in constant communication after he moved out. He sent me intimidating letters and emails, and as his own research took him frequently to the university library, I had to steel myself every time I needed a book. When he saw me he watched me and followed me round. After I complained to a mediation service at the university, Reynard stopped stalking me on campus, and instead began harassing me and my mother by legal means, employing a lawyer to make financial claims on my mother, alleging she owed him money. I applied for a legal protection order on the grounds that I feared for my own and my family’s safety, but the presiding judge declined my petition. Reynard’s lawyer argued that his client was no danger to others, and my anxieties were merely paranoia resulting from my previous history of abuse, and these fears were misdirected. I was, in short, an unreliable witness due to my traumatic experiences twenty years ago.

Pain is impossible to describe
Pain is the impossibility of describing
Describing what is impossible to describe
Which must be a thing beyond description
Beyond description not to be known
Beyond knowing but not mystery
Not mystery but pain not plain but pain
But pain beyond but here beyond

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Beyond

As I recount these events I can feel my heart rate rising, my breathing becoming shallow, and I am resisting the desire to get up from my desk and walk out the room. The reactivation of traumatic states can be triggered by external events or internally by a recurrence of brain states associated with traumatic experiences (Meares 2001: 96-97). High anxiety is the characteristic state of mind associated with trauma, and I am aware that this feeling triggers cascades of negative and disorganising effects. I know this, but I cannot stop feeling it – I just notice the anxiety and wait it out. Traumatic memory operates in a different way to ordinary memory. Russell Meares (2001: 98) states that ‘the contents of the traumatic system are not organised in narrative form’ which in practice means that when the traumata are triggered, disconnected series of abuse come into the mind. The episode can trap the person in the triggered traumata, as it ‘does not have the sequencing, progressing, and evolving characteristics of a true personal narrative that depends on episodic and autobiographical memory.’ Tell all the Truth but tell it Slant is maybe one way, as when I try to examine traumatic events my analytical abilities fragment: images are more likely to come out than a reasoned observation. I get kind of vivid intrusions of images, often of places, or rooms, or furniture, or scents, or the quality of the light; imaginative rushes of emotional memory. Toni Morrison says that for writers:

The act of imagination is bound up with memory. You know, they straightened out the Mississippi River in places, to make room for houses and livable acreage. Occasionally the river floods these places. “Floods” is the word they use, but in fact it is not flooding; it is remembering. Remembering where it used to be. All water has a perfect memory and is forever trying to get back to where it was (T. Morrison 1990: 299-305).

This kind of emotional memory recollects the place that we were before things altered, remembered in the skin, in the nerves, in the body (T. Morrison 1990: 305). Memory lives in the body; it resides in ‘felt space’ – places where I live, where I travel, where I have been before; it dwells in past experiences, things forgotten but indelibly marked on my being (van Manen 1990: 101-106).

In traumatic memory, the fluidity between one’s body and the felt space around it is shattered. Instead of one’s whole body being integrated into present-day experiences, parts of the body remain connected to past traumata, which feels this fragmentation and constriction, along with shock, pain, numbness, and intense dread. ‘[S]evere, unresolved physical and psychic trauma retains a threatening, ghastly aura’ and one way to channel this horror, and to keep it from consciousness, is to contain it in a specific part of the body, to somatisise it (Hall and Kondora (2005: 1350), a process once termed hysteria. I used to experience a lot of chronic pelvic pain, and I still get migraines and headaches, body memories that were powerfully activated when I underwent deep tissue massage – Rolfing and Hellerwork – to deal with my traumatic memories of Wolf. I used to self-harm, or take drugs: these behaviours could both release and interrupt emotional responses to my past trauma, but always helped me to dissociate. Now, I still dissociate, and sometimes have panic attacks.

During this period I was split. I was monitoring Django’s wellbeing, and once he turned five years old I was trying to help him fit into the primary school system; I was looking after my two older children; I was studying, by now doing my Bachelor of Arts honours year; I was fighting to keep Reynard away from us; and I was constantly trying to manage my own trauma scripts. Looking after Django was complicated. While trying to keep him in the mainstream school and medical care system, I was simultaneously investigating alternative
healing and trying to figure out what was really happening to him. The diagnostic criteria of psychiatry seemed absurd, and most professionals working with it were arrogant, distant, and unhelpful. They briefly observed Django and expressed no doubts about their conclusions, which were based, I thought, on the flimsiest of evidence. As part of my academic work I studied the history and sociology of mental illness and the various psychiatric disciplines, and was dismayed. How could anything so contradictory and problematic have so much power over the life of my child? My brush with psychiatry in the 1970s was at a time when psychotherapy and the ‘talking cure’ were fashionable, and I had found some of its tenets extremely valuable, despite the pomposity of the psychiatrist I initially saw. Now, though, this approach had fallen out of favour, and biological psychiatry was triumphant, with its emphasis on brain disorder, neurotransmitter imbalances, and psychopharmacology.

Although I have frequently used alternative healthcare in preference to modern Western medicine, I do, also, ascribe to the scientific rigour of biomedicine. But psychiatry, although a branch of medicine, is different: it is a peculiar profession. Mental health work differs from other health care interventions, in that it can entail coercive treatment and involuntary detention rather than responding to the needs of sick people. It is well known that a function of psychiatry is the latent and sometimes explicit social control of a disruptive underclass in the interests of parties other than the individuals being treated (Rogers and Pilgrim 2005: 53).

Furthermore, as I will argue in a later chapter, Western societies have increasingly become ‘psychopharmacological societies’ wherein citizens routinely have their conduct, moods and thoughts modified by pharmacological means: we have become what Nikolas Rose (2003a: 46) terms ‘neurochemical selves.’ The belief that neurochemistry and its imbalances (in, say, neurotransmitters) determines an individual’s personality and mood is pervasive nowadays, as is the notion that some kind of rebalancing can be attained by regular ingestion of the right kind of drug, that is, one that is medically prescribed. However, psychiatry is not a unified discipline: it is a loosely assembled set of practices. Running alongside so called ‘hard’ psychiatry, with its leanings toward biological and genomic research, is a ‘softer’ side, the psychotherapies, that are concerned more with listening to what people in mental distress have to say. But these psychologically oriented alternatives are not unproblematic: they also have specific histories of emergence, and their methods tend to complement rather than challenge biological techniques (Blackman 2001: 2).

The Diagnosis du Jour

From an experience-distant perspective, according to all of the professionals I consulted, Django was suffering from a behavioural and possibly a developmental disorder; it may be difficult to exactly specify a diagnosis, I was told, but all agreed that ADHD was the most likely. There are no explicit physical features associated with the condition, and neither are there any diagnostic tests based on neurological or laboratory evaluations: clinical assessments rely, therefore, entirely on professional observation and judgement (APA 2000: 88-89). ADHD was criticised as ‘the Diagnosis du Jour’ in the late 1990s, when up to 20% of children in the USA were so labelled. It has become, argue Celia Hinton and Miranda Wolpert (1998: 315-317), a shorthand term to describe the conduct of children who are compliant, inattentive, and fidgety, without addressing why these behaviours occur. The diagnosis implies underlying neurological impairments, especially as medication is effective in helping many children to better focus, but it is only an assumption that these underlying causes are actually organic. Hinton and Wolpert assert that:
For the health professional, the diagnosis of a specific disorder may seem to provide a tidy encapsulation of an array of difficult behaviours that are hard to work with. By diagnosing ADHD, the professional may feel gratified at being able to present him or herself as an ‘expert’ in possession of the correct technical knowledge. Reaching the diagnosis of ADHD operates for the professional as the gateway for prescription of drugs which may help children enormously – a fact which itself may be assumed by all concerned to confirm the ‘accuracy’ of the diagnosis (Hinton and Wolpert 1998: 316).

According to usual clinical practice, Django was prescribed methylphenidate, or Ritalin. I was invariably told a simplistic version of the entire diagnostic process, and instructed to ensure Django regularly took his medication. To the clinicians, it seemed, end of story, but I found this process of diagnosis and prescription as mystifying as I found the lack of explanation both worrying and infuriating. Django’s condition was diagnosed based purely on observation and expert opinion, not medical testing, and with a condition, furthermore, that required him to regularly ingest amphetamine-related medications.

When I complained to the child psychiatrist that Ritalin did not help Django and actually made him more restless, sleepless, and irritable, I was accused of being ‘one of those mothers’ (obviously, it was inferred, bad mothers) who were anti-drugs; ‘just say no’ only applies to street drugs, which is certainly paradoxical when the drug in question, amphetamine, can be both both medical or illicit, depending on the provider. Clearly, a good mother does what the psychiatrist tells her to do. It did not help that I knew quite a bit about drugs myself; this tended to make the professionals suspicious of me, and I tried to engage them on a more intellectual level, telling them that I was studying history and sociology at university, and that I was researching mental disorder (this was true: I wrote a substantial research essay on depression during my honours year in my Bachelor of Arts degree). Indeed, my interest was taking over my studies, hijacking any other topics I was meant to be investigating, and the more I read, the more sceptical I became about psychiatry’s claims to truth.

At Django’s school, the principal and teachers insisted that Django took his Ritalin or they would not permit him to attend classes. I started playing around with the dosages, sometimes sending him to school unmedicated, while saying that he was regularly on the drugs. The teacher could not tell the difference – I would ask her, sweetly, how was Django now he was taking Ritalin and was told what a huge difference the drug made to his behaviour. Neither the psychiatric professionals nor the teachers were really interacting with Django: he was to them a child with ADHD, not a child who suffered, screamed, and bafflingly flailed around. They were concerned with fitting him into the normal templates of childhood development, but how far could a child be bent into shape without splintering?

During the long summer break from school Django did not take Ritalin at all. We played in the garden, in the woods, at the beach, in the house. He was happier away from the restrictions of school, much happier now he didn’t have to fit into what Michel Foucault (1991: 135-169) called the docility projects of ‘disciplinary society.’ Django still didn’t talk much, usually just pointing and growling when he wanted something – words he had once known had dropped out of his vocabulary, although I could tell that he understood everything that was said to him. He was like a little animal, growling, spitting, and kicking when frustrated, and of course he could not – or would not: who knows? – talk about what he was feeling, but perhaps now that he didn’t have to spend so much energy fighting conformity at school and was consequently more relaxed, Django began to reveal some of the strange experiences he was having. His senses were mixed up: he ‘heard’ colours, peoples’ voices had diverse shapes, colours, and flavours, and different types of music had
different shapes and colours too: sometimes colours even had certain scents. All of these occurrences had an emotional component – Django sometimes felt overwhelmed with joy, and, sometimes, with anguish. Synaesthesia has long been explored in artistic circles, but in the medical world it is still regarded as mysterious, although possibly connected with seizures in the limbic system of the brain (Baron-Cohen and Harrison 1997).

As the weeks passed Django spent a lot of time drawing and painting. He’d show me his pictures and tell me, very cryptically, what the illustrations meant: what he told me was fragmentary as the images were more powerful to him than any words. His art was full of scenes of frightening monsters and tiny creatures hiding away from them. I tried to ask him about his pictures, and using the images Django was able to communicate. Images, shapes and colours speak to us in ways that language cannot articulate. Traumatised children who have been abused and exposed to violence can safely express overwhelming emotions through their drawings; it is also a way of gaining symbolic control over terror and a way of revealing secrets (Malchiodi 2007: 135-144). But I did not know, yet, what had happened to Django, or what Reynard had done – I was just getting more and more uneasy; something dark was emerging, and while I could feel the shadow I could not yet see the shape.

Robert Krizek (1998: 93-94) suggests that social science researchers employ creative devices as a way to engage readers in their ethnographic work. Telling a story, he argues, should at least be partially in the voice of the person being studied, rather than in an objectifying authoritative overview. The literary devices of fiction, such as dialogue, give a ‘multilayered immediacy’ to the text, and provide a way to condense the experience portrayed. The conversations I recount in this chapter, therefore, are composites assembled from various events and interactions. They straddle fiction and non-fiction, as these incidents did happen, even if they actually unfolded in a way not explicitly told.

**Drawing from Within**

**ME:** Tell me about the picture you’ve drawn.
**DJANGO:** Grrrr … crocodile, rock, and baby lamb.
**ME:** What’s the lamb doing?
**DJANGO:** Lamb’s hiding behind rock.
**ME:** Oh, I see, I wonder why the lamb’s hiding behind the rock?
**DJANGO:** It’s good.
**ME:** It’s good to be behind the rock? I wonder why that is?
**DJANGO:** Safe there … hiding.
**ME:** The crocodile can’t see him?
**DJANGO:** No.
**ME:** What would happen if the crocodile could see the lamb?
**DJANGO:** Shhhhh … lamb frightened.
**ME:** Oh, I see. The lamb would be afraid. I wonder why the lamb would be afraid. Will the crocodile eat him?
**DJANGO:** No …
**ME:** What does the crocodile want to do?
**DJANGO:** Grrrr … huurt.
ME: Mmmmmm. Is the lamb safe behind the rock?
DJANGO: No.
ME: So is the lamb always frightened?
DJANGO: Yes.
ME: Can the lamb do anything else?
DJANGO: Don’t know … grrrr … lamb eat up … too sharp …

The drawing is ‘too sharp,’ the crocodile teeth are too dangerous, and Django rips up the paper. Django is spacing out a lot, and I know he’s dissociating – I can recognise dissociation and trance states, surely – and he keeps erupting into sudden rages. When he gets angry he sounds like a different person, not only because of his banshee screams, but the tone of his voice changes as well. He’s communicating with me now, with the drawings providing a bridge out of his silence. He tells me that people keep telling him to do bad things like break things, kick, hit, spit, scream, hurt other people, and hurt himself. What people? Whispering, Django tells me he can’t see them, he can only hear their voices – deep, scary voices sounding like monsters, and they keep telling him he is stupid and bad. He’s heard these growling voices for ages, but they’re getting louder. There’s also some other sounds, ‘voices from the sky’, that try to help him. He draws a picture of himself with an angelic figure on one side and a demon on the other. The red demon is bigger.

What do I do with this information? I don’t want Django’s case file to contain evidence of hallucinations – what effect will this have on him when he gets older? I am really worried about the way he keeps growling, and it sounds so weirdly bestial it makes me feel frightened, although I try to remain calm. He’s also terrified of heights, and, strangely, windows. But when I carefully bring up the issue of the voices with one of the psychiatrists he says Django, at just over five years old, is too young to be having auditory hallucinations. Perhaps Django is suffering from a communication disorder, and anyway, disorganised behaviour is symptomatic of ADHD. Django is very imaginative, I am told, and maybe the voices are a technique for avoiding taking responsibility for his actions. My concerns are unheard.

**Hearing Voices and Listening to What They Say**

Nobody wants to know about a mad kid who hears voices. Nobody thinks Reynard may have hurt Django. Only me. I am getting more and more shadowed by dread. I keep trying to show Django that I can help him. I guess that I must demonstrate that I can fix things, that I can save things. If Django breaks something, I immediately glue it together and show him that things can be mended. I also make up stories, where Django is the protagonist, threatened by monsters but surviving by clever tricks and help from good people and friendly animals. He loves these stories. Gradually Django starts talking to me, but he always looks as though he is scared that he may be overheard. He only talks while he is drawing.

ME: Tell me about the voices. What do they sound like?
DJANGO: Grrrr … scary.
ME: Are they deep voices, or high voices?
DJANGO: Grrrr … deep.
ME: How many different voices?
DJANGO: I don’t know … lots. But one big one … GRRRRR … RED one …
ME: Is there one voice that is more scary than all the others?
DJANGO: Grrrr ... yes.
ME: Can you keep safe from the voices? Can someone tell them you won’t do what they tell you to do?
DJANGO: (whispering) Voices from the sky can help me.
ME: (whispering) Are you able to tell me something the scary voice told you to do that you didn’t do because the voices from the sky saved you?
DJANGO: (whispering) It told me to jump out the window through the glass but I could see the angel on the other side and she said no don’t jump out you will break.
ME: (whispering) What did the scary voice do then?
DJANGO: (whispering) It shut up but it was mad ... grrrr.
ME: (whispering) Do you think I can stop the scary voices from hurting you?
DJANGO: Grrrr ... I don’t know ... maybe ...
ME: (whispering) Can you try to tell me when the scary voices tell you to do bad things?
DJANGO: (whispering) I don’t know ... they sharp ... grrrr.
ME: (whispering) Did the scary voice tell you not to tell anyone?
DJANGO: (whispering) Yes ...
ME: (whispering) Does the scary voice have a name?
DJANGO: (extra soft whispering) Reynard.

I can hear what Django is saying ... but what he is telling me is not all there in the words. Django trusts me enough to tell me the name of the scariest voice. It is Reynard.

I cannot respond. This is one of those ‘crossroads where ghostly signals flash’ (Benjamin in Gordon 2007: 204), and everything is suddenly lit up, choking me with realisation: REYNARD. I had sensed what he was capable of, and with a growing foreboding had known that there was something profoundly wrong – a secret that was beginning to come to light. The shadow had taken shape. What can I do? How can I help? (HOW DID I NOT KNOW?) A lamb among wolves. Be ye wise as serpents yet harmless as doves.

Django’s fear now makes more sense ... he is hearing the voice of the person who hurt him, a voice that is still controlling him. Whatever Reynard had done to Django, it is still going on: the abuse lives on in Django’s emotions, in his memory, in his mind. I’m feeling light-headed and nauseous, I have a phantom metallic taste at the back of my throat, my perceptions change and everything looks so far far away, Django is tiny, sitting on the floor staring up at me with huge green eyes while I hover on the ceiling. My face is frozen. Quickly, scan my body, notice sensations in my hands and feet, remember to breathe, come back, come back. Slow the heartbeat the pulsing blood the yammering in my ears.

The Body Keeps the Score
It is around this time that I got sick, but my memory of myself at this time is fragmented and everything runs together. I had begun work on my doctorate, which began as an examination of the social construction of mental disorder, and spent the first year researching psychological trauma as a way of trying to understand what was going on with Django as much as for academic interest. I have suffered from migraines since I
was fourteen (yes, I know, they began after I was first raped), but I now developed constant heart palpitations and dizzy spells, I lost weight until I weighed under 50kg, I had tremors in my hands, I suffered from debilitating fatigue, my hair started falling out, and swelling behind my eyes caused them to bulge outward. After a year of worsening health I was finally diagnosed with hyperthyroidism: Graves' Disease, an autoimmune disorder, and with an associated thyroid eye disease. There was no obvious cause: probably stress-related, said the doctors, but I am sure that the pressure of coping with Django's suffering, combined with the rekindling of my own traumatic memories, caused my illness (van der Kolk 1996a: 214-241; Rothschild 2000). When under threat, real or imagined, the autonomic nervous system sets the body into a state of heightened arousal ready for fight or flight. Epinephrine and norepinephrine are released, and heart rate and respiration quicken, but if fight or flight are impossible the parasympathetic nervous system is simultaneously aroused by the limbic system and the body freezes instead. Large amounts of the stress hormone cortisol are secreted, produced by the adrenal glands, and longstanding exposure to cortisol primes the autoimmune system into a state of hypervigilance where it can begin to attack its own body (Rothschild 2000: 46-50).

You see what I just did? I switched from 'experience near' to 'experience distant'. It's a defense: displacement, or as Sigmund Freud (1999: 232-236) called it, Verschiebung – a 'sliding out of place' – I diverted attention away from something emotionally intense by talking about something removed from the central experience. In much the same way I'm sure that I somaticised my awakened trauma scripts into a physical illness, which was easier to gain control over. I wasn’t conscious of this at the time, of course, but I soon realised that regular visits to the eye hospital, with its reassuring routines of medical checkups, steroid infusions, and radiotherapy, was a kind of solution to the chaos of traumatic memories intruding into my life. Here was an injury I could conquer and defeat: I embraced the full gamut of the medical arsenal, as well as several alternative treatments, and was praised by the doctors for being a perfect patient. Eventually, I even won the battle: the hyperthyroidism and eye problems subsided and I am now ‘cured.’

Arthur Frank (1997: 107) writes of this experience of illness, suggesting that the terror of chaos stories can be blunted by hospitalisation and the possibility of transforming stories of dissolution into a restitution narrative. Talcott Parsons (1951) famously labelled people who are unwell as seeking a 'secondary gain' when they linger in the 'sick role' when they no longer need to do so, gaining benefits such as avoidance of responsibilities, care, and attention. Frank (1997: 107) argues that this explanation is dubious, saying: 'Much illness behavior can only be understood when the would-be interpreter is able to enter imaginatively into a world without purpose.' My gain from the 'sick role' was to define an area where I could defeat the forces of darkness, and while I was battling illness I was able to face Django’s traumata from an oblique angle, to look at things aslant: I must be wise as serpents yet harmless as doves.

Childhood Trauma

Around five percent of the population hears voices regularly. In Britain, this figure represents around three million individuals, around half of whom will never have contact with psychiatric services (A. Morrison: 2004: 299). Although a high proportion of people find these voices benign, some are extremely frightening (Leudar and P. Thomas 2000: 116-118). Auditory hallucinations are a so-called first-rank symptom of schizophrenia, but as I will write in more detail later in this thesis, there is evidence to suggest that hearing voices, especially the voice of the perpetrator, is also linked to experiences such as childhood trauma, especially
sexual abuse (Read 1997: 448-456; Romme and Escher 1989: 209-216). My research led me to study the ways that traumatic events can cause symptoms of mental disorder, and I was inevitably drawn to research on childhood trauma. I read widely on child abuse and trauma, wrote and presented academic papers on the topic, and met several prominent academic researchers and therapists in this field. As I have said, the mental health professionals concerned with Django’s diagnosis and treatment were unanimous in their belief that he had ADHD, and Django’s ‘voices’ were deemed to be part of this syndrome. But the diagnosis did not fit: Django’s behaviour was increasingly unmanageable, the drugs didn’t work, it was increasingly difficult to keep him in school, and no alternative therapeutic regime was offered. I had to work this out myself: if no help was offered, how could I find it? If childhood trauma can trigger behaviours that look like ADHD, conduct disorder, dissociative disorder, panic attacks, phobias, and obsessive-compulsive disorder, to name but a few clinical manifestations, then how could I disentangle cause and effect? Django may actually have neurological problems as well, but these internal disturbances could have been precipitated by external traumatic events (Terr 1995: 301-320).

Colin Ross works as a trauma therapist in the United States and although he works with adults, not children, he does comment on childhood disorders. According to Ross (2000b: 215-218), some childhood disorders are definitely neurological in origin, such as learning, tic, and stereotypic movement disorders; some derive from traumatic events, such as conduct disorder, oppositional defiant disorder, selective mutism, and attachment disorders; and he assigns some feeding and eating disorders and ADHD to a mixed bag between the two other categories. Ross says he finds ADHD conceptually interesting, as it presents as a puzzle of various symptoms that could have several aetiologies from birth injury, infections, and vaccinations to psychological trauma. Disentangling these causes is, he says, complex, but failures in the efficacy of medication may indicate trauma pathways to the disorder. I was hooked. I met Ross and attended two of his workshops on professional practice in trauma therapy offered at a trauma conference in Melbourne.

In trauma therapy, the person is treated as a whole, not as a diagnosis. In this model, the diagnosis is instead regarded as a coping strategy, and not in and of itself the problem. Ross argues that the disease model of psychiatry as outlined in the many diagnoses and sub-diagnoses of the current Diagnostic and Statistical Manual of Mental Disorders (DSM) – the psychiatric ‘Bible’ published by the American Psychiatric Association (APA 2000) that classifies all legitimate mental disorder diagnoses – does not tend to fit severely disturbed and traumatised people as they have extensive comorbidity that does not benefit from a simple treatment plan. The best approach, says Ross (2000b: 225-234), is to use a mix of cognitive-behavioural therapy, expressive techniques informed by psychodynamic approaches, and, if necessary, medication to stabilise the mood of the person in therapy. As Django is a child, it is not suitable to undertake the same kind of trauma therapy as would be offered to adults. Ross (2000b: 235) divides his trauma therapy into three stages: ‘stabilisation, safety and education; the active work phase; and resolution or completion.’ Due to Django’s age, it is only appropriate to utilise the first stage of therapy, and then try to give him some skills to help him navigate through his childhood, using cognitive-behavioural therapy (CBT) and social skills training.

In Auckland, I look for a therapist experienced in working with traumatised children. I have been trying to find a male psychotherapist, as I want Django to be able to form a trusting relationship with a man: two major male figures in his life, Reynard and his father, have hurt, betrayed, or abandoned him. All of the
mainstream psychiatric professionals I consult dismiss any notion that Django may have suffered some kind of abuse from Reynard so to get help I need to pay for it myself, which at a hundred dollars a visit is very difficult: I’m a lone parent, not in paid employment, and still studying at university. The therapist, Wade, charges me a reduced rate due to my financial circumstances, and Django goes to see him at least once a week, sometimes twice. Django is just over five years old when he begins seeing Wade, and his gentle psychotherapeutic practice cushions the other, harder, psychiatric scrutiny. I also regularly take Django to see Robyn, who works with CBT and social stories, and Maya, a homeopath; as well as listening to Django and I, and offering helpful advice, Maya gives him remedies of tiny pills and miniature vials of clear liquid that we call fairy drinks and tablets. This is the point where I begin to live a double life: I need the mainstream professionals to provide some kind of psychiatric label for Django, as he needs a label to access funding, schooling, and some treatments that may be subsidised or free. But I also need to find and use alternative therapists who can actually work with Django and help him to construct a manageable social self. Wade, Robyn, and Maya all have years of experience in working with abused children; all of them think that Django has been sexually and emotionally abused.

Children who are abused often dissociate, and 98% of kids diagnosed with dissociative disorder hear voices, often that of the perpetrator; these kids are frequently aggressive, impulsive, have nightmares, and often self-harm (Stover, Berkowitz, Marans and Kaufman 2007: 705-706). Dissociation enables a person who has been terrorised to slip away from their body, the source of their pain (Frank 1997: 102-104). The body feels dangerous. I know this: I still dissociate when I am frightened. When a child is sexually molested in the home it is rarely a one-time occurrence, as the perpetrator continues to abuse the child until the secret is revealed, or until contact is ended. Victims are often forced to remain silent by threats, which reinforce a natural inclination to try to forget the abuse, and profound amnesia is a particularly common result when the perpetrator is a trusted person who the child is emotionally attached to. Jennifer Freyd (1997) shows that the most devastating psychological trauma resulting from childhood sexual abuse occurs when a trusted caregiver abuses the victims: this is experienced as a profound betrayal.

Betrayal Trauma
Roland Summit (1983: 183-184) maintains that a child, who, like Django, lives in the same house as the perpetrator, is essentially trapped and has to learn to live with and accommodate to the sexual demands of their abuser. Jennifer Freyd (1997: 74-78), building on this idea, argues that if the abuser is, like Reynard, a caregiver who has an affectionate relationship with their victim, then it is very difficult for the child to recognise this behaviour as a betrayal of trust. Because the child cannot withdraw from this relationship, and indeed depends on it for approval and affection, the betrayal must be blocked from consciousness. Memories are suppressed or dissociated until the child is much older and no longer dependent on the caregiver: this traumatic amnesia is thus an adaptive response (Freyd 1994: 307). Summit (1983: 184-188) believes that the child not only has to accommodate these unwanted sexual demands but also has to continually re-invent the perpetrator as a ‘good’ person, and this performance splits the child’s consciousness. To Summit, this knowledge is not always forgotten, but Freyd (2002: 140-141) goes further, contending that in betrayal trauma the memory is often completely blocked (see also V. Edwards et al. 2001: 247-263; Hopper and van der Kolk 2001: 33-37; van der Kolk, Hopper and Osterman 2001: 9-31).
Reading Freyd’s work, I am captivated by her insights, which seem to speak directly to me. Then, I read the afterword to her book (Freyd 1997: 197-199), and am electrified: not only is she a survivor of incestuous sexual abuse perpetrated by her father, her parents (both academics) later formed the False Memory Syndrome Foundation (FMSF), a powerful political organisation that works to discredit claims of childhood sexual abuse, especially the phenomenon of recovered memory. No wonder she understands these issues. She writes that memories of her childhood, long blocked, began to resurface as she researched the complexities of memory – the stuff she was reading and studying triggered memories of long-forgotten trauma, and this is exactly what is happening to me. As I am trying to help Django, immersing myself in the literature, I am constantly facing the rekindling of memories of my own past trauma with Wolf. Freyd (1997: 3-4) also affirms that this buried knowledge can erupt unconsciously as somatic symptoms and disruptive behaviour, like the way Django acts out – all that screaming and ripping things up, all those stomach upsets and sensory disruptions. And I experience this effect too, with my migraines and my autoimmune diseases. Furthermore, very young children, like Django, commonly forget terrible events that were ‘forbidden to consciousness’ and the resurfacing of these long-lost memories in adult life has been widely reported, as well as corroborated. It’s not unusual, then, that he hasn’t yet talked about Reynard.

I’m finding out a lot about how memory works. Children can’t form narrative memories until they are able to construct meaningful phrases, says Lenore Terr (1994: 224-233), so the cut-off point for recall is around two and a half to three and a half years old; Reynard lived with us from when Django was one-and-a-half until he was four-and-a-half years old. Early trauma, especially if it takes the form of repeated assaults, is nearly always repressed, ‘forgotten’, with only fragments consciously retained, usually in visual memories that can be described in word pictures, but not in any kind of structured story. These splinters can be re-enacted in play, and things that unconsciously remind the child of the trauma can provoke fear. Memories of childhood, ordinary as well as traumatic, can be accessed by mapping out places, on paper as well as in our minds. So if we walk into a long-ago-familiar room, or even if we remember the placement of furniture, something can suddenly emerge into consciousness, but not verbally, just in images (Terr 1994: 224-233).

As I found out, even when we are older – I was fourteen when my abuse began – memory can be ‘lost’, and not telling anyone assists in suppressing thoughts of traumatic events, leading, eventually, to forgetting (1994: 46). This made me think about Django’s fears, of heights, windows, and dark rooms. Also, what about the time Django got a piece of glass in his foot? He fought so furiously when I tried to get the glass out that he ended up having to go to hospital and have a general anaesthetic: absolute terror at losing control, at being held down. I thought it was just fear of the glass, but was it because Reynard was trying to hold him still for me to use the tweezers on the glass shard? Django had two general anaesthetics (the other a later one for a dental procedure) and both times in the disoriented post-anaesthetic state as he emerged from unconsciousness he went wild: growling, screaming, biting, shouting ‘Go ’way!’ at me, and not letting me comfort him. Had this enforced immobility triggered memories of his traumatic experiences with Reynard? Lenore Terr (2003: 1404) describes this as a possible scenario in abused children, following Anna Freud’s (1937) work on displacement activities in children.

In a world where biological psychiatry is king, Django needs to be diagnosed with something neurological, something serious: ADHD is not a robust enough diagnosis, I realise, to ensure a steady flow of benefits and funding. I am starting to see the possibility for subversion in the diagnostic game: if diagnosis rests on the
clinical observation of a trained psychiatrist, then surely I need to take Django to another, maybe several other, psychiatrists, and suggest the possibility of another disorder? Michel de Certeau (1988: 29-39) describes two kinds of behaviour: the strategic and the tactical. A ‘strategy’ is an entity that is recognised as an authority, such as a business, a scientific institution, or even a city; it may create products, impose order, and is defined as a producer, as opposed to a user. A ‘tactic’, on the other hand, infiltrates, poaches, and relies on loopholes; ‘a tactic is an art of the weak,’ argues de Certeau (1988: 29-39), as it camouflages itself with a façade of conformity, seeking to fulfill its needs through a form of subversion that plays out in ‘the space of the other.’ I need to become a tactician, and I must be careful to mask my intentions when dealing with powerful gatekeepers in the psychiatric field: Jennifer Freyd (1997: 198) warns that anyone researching child abuse, especially women who recover memories of childhood trauma, risk being judged as unstable or deluded. I am a lamb among wolves. Be wise as serpents yet harmless as doves.

I’m sure Reynard did sexually abuse Django, but to what extent and in what way I will never know. If I had verifiable evidence, I would make criminal charges: I do not, so I need to work with what is available. Also, because of my own past, I am always unsure whether I am reacting to my own trauma scripts rather than Django’s needs, so I have to be careful. Colin Ross (2000b) offers a concept of ‘therapeutic neutrality’, by which he means the historical reality of trauma is mostly inconclusive and cannot always be confirmed by ‘clinical judgement’. When working with traumatised people, who are inevitably dissociative, there is usually no way to tell the difference between truth or confabulation, between innocence and denial, unless there is external evidence: memory is never 100% accurate, and is moreover fragmented and vague. The important thing is the therapeutic plan, and this is not determined by what may or may not have really happened: ‘Trauma therapy is not just focused on memory content,’ says Ross (2000b: 243-253). Django is the person who is important to me, not Reynard. Reynard may have to be confronted some day, but not yet.

Sand Play

Django’s psychotherapist, Wade, uses art and sand play. Wade stays inside the play so he can talk to Django about the characters he invents, rather than trying to transfer play incidents into real life situations. This technique is recommended by Melanie Klein (1959), who argues that play is children’s primary mode of emotional communication. Wade wants to work with Django’s voices: the conventional psychiatric approach is to prescribe an antipsychotic medication that suppresses the voices – or is supposed to – but in trauma therapy the voices are part of the whole person. An experienced therapist can build up a relationship, negotiate with the voices, which, says Ross (2000b: 233), ‘hold thoughts, feelings, conflicts and elements of the personal narrative which the executive self has denied or disavowed.’ However, some people who are severely abused as children, especially if the abuse is sexual, hear voices they identify as the voice of the perpetrator, in the form of command hallucinations telling them to harm themselves (Read, Goodman, Morrison, Ross and Aderhold 2004: 229-236). I already know that Django sometimes hears Reynard’s voice, as he told me Reynard threatened to make him jump through the glass of a first-floor window. What else does Django hear? Who are his Voices in the Air? I never find out who these are – they are some revenant, some haunting of inherent goodness in Django’s psyche.

Spontaneous expression of art is believed to be a way of releasing unconscious conflicts in a visual form. When performed with a trained therapist, the meanings of the resulting drawings, scribbles, and paintings can be explored using the technique of free association (Malchiodi 2007). For a child such as Django, who

INSIDE OUT
is unwilling and perhaps unable to speak about what happened to him, it is a way of communicating frightening and painful feelings and thoughts. Wade uses large sheets of paper, and provides a wide variety of different materials, pencils, crayons, charcoal, pastels, and paint. Django prefers to use pencils, pastels and charcoal – he says they are ‘rounder’ whereas pens are ‘too sharp’ – but also uses the red and black ink a lot. I sit and read a book in the corner of the room (in later months, after Django feels safe with Wade, I sit outside in the waiting room) while Wade provides Django with the art materials – he doesn’t direct Django in what to draw.

The drawings are always similar: tiny animals are threatened by monsters or animals with huge mouths and teeth and phallic sticks; red or black ink spills over the paper; the protagonists are scribbled over with black charcoal sticks, or drowned in ink; the paper is crumpled or ripped up. The monsters win all the time, and Django gleefully identifies with the perpetrator as it crushes its victims. The tiny animal victims try to hide behind rocks, behind trees, behind houses, behind furniture, and Django charts their destruction with no emotion, unable at first to empathise with their fate. After months of sessions, Django begins to be able to admit feelings for the victims, and angels and exotic birds are sometimes drawn in swooping down to protect the hiding things, foiling the monsters’ evil plans. Traumatic play – the repetitive acting out of fearful memories – is often an essential process for children who have been sexually victimised, and the child may re-enact aspects of the abuse. Once children begin to incorporate rescues into the game – intervention strategies – ‘play may represent an attempt at mastery’ (Putman 2009: 82).

Wade also has a collection of toys, a sand box, and water. Django makes worlds in the sand and always uses a tiny furry lamb, which he hides in a variety of places. Who is the lamb? Me, he says. I catch my breath … I am a lamb among wolves … Sometimes winged birds or angels fly in and carry the lamb away from the monster – the king of the sand box monsters is a plastic two-headed red dragon. Sometimes serried ranks of plastic animals are placed protectively between the lamb and the dragon. After several months, Django tries deluging the dragon with water so it cannot reach the lamb. He is delighted with this new strategy. One day Django draws an underwater picture. A furry baby seal is hiding behind a rock, threatened by an enormous red shark-like monster. Django pours black ink all over the picture, and then rips it up. It’s too cold, says Django. Is the water cold? Yes, … the baby seal is cold. Why is the seal so cold? He’s not allowed to wear any clothes. Why not? The shark says so. Who is the shark? IT’S A SECRET, he whispers. After this session Django won’t talk at all for days. Red: yes, the colour of blood and danger … and Reynard has red hair.

Facing the Red Dragon
I decide to contact Reynard: if he agrees to meet me I will find a way to try to find out something, anything, about his relationship with Django. Wade and I discuss this. He thinks it’s too risky, but I just have to do it. This is a dangerous confrontation for me: face-to-face with the two-headed red dragon. I am anxious, nervous, sleepless. I email Reynard – does he still have the same email address? Yes, he replies, and will meet. Where? A public place – a café, I decide. I put on armour, I wear protective runes, I put a folding knife in my pocket. I breathe carefully as I walk to the café. I am early: I want to be there first, and I am very carefully holding my emotional energy undercover; I am wearing black clothes because the colour feels protective. I will let no energy out: I am a black fortress of defences. I am already sipping black coffee when
Reynard arrives. He is flustered, his coat flapping, his energy unconstrained and disturbing. I was unsure how to begin the conversation, but he speaks, immediately belligerent:

REYNARD: I suppose you want to ask me about Django? – I suppose you are going to tell me I abused Django?

(The air is suddenly full of the snapping snapping of iron teeth. Dragons, wolves, foxes, sharks).

ME: Why are you saying that? What do you mean?

REYNARD: I think about him all the time … I can't stop. I'm in therapy. I need to, I don't know, talk.

(Silence).

ME: What do you want to tell me?

(What is hiding now in the depths?)

REYNARD: I don't know … I see my therapist twice a week and there are two people I'm stuck on, my father and Django. There are things I can't tell her. I'm taking all this medication and I can't keep bottling everything in. I just want to tell someone.

(What kind of strange creature is sitting in the chair opposite? His words declared with a sly smile).

ME: What's the connection between Django and your father?

REYNARD: My father died when I was five, and Django was nearly five years old … and then I never saw him again, either.

(A long silence).

ME: You hardly ever spoke about your father to me, you always sounded frightened of him. You said he was always very tough on you and your mother.

(This gets a reaction – Reynard rattles the coffee cup, hands shaking, eyes staring).

REYNARD: Yes … but they are both lost … lost to me …

ME: Do you want to tell me anything about Django?

(Another stuttering silence. He's not going to answer).

REYNARD: I know you know …. I was waiting for you to speak to me, to find out about our special games … no-one ever understands.

(Reynard looks angry now, fists clenched by his sides).

ME: What do you mean? What do I know?

(Reynard abruptly stands up, eyes staring, veins standing out on his temples – everyone in the café is looking over at us).

REYNARD: I ... I ... I ... can't say ...

(A hum of voices, buzzing, rustling).

ME: What do you mean?

(I'm feeling breathless, frightened, close to tears, and don't know how to get Reynard to tell me what it is he's almost saying. Reynard notices he has an audience. He sits down, his hands still shaking, but I can see something has shifted; he has visibly gained control of himself).

REYNARD: I need to work this out with you … I like all children, but Django is special.

(Long silence, again. Reynard watches me, eyes cold. I must say something).

ME: Why do you say I think you abused Django? What do you mean by abused? What do you mean by special games?

(A blade in the brain, zero hour).
REYNARD: You don’t understand …
ME: … Please … can you explain?
REYNARD: Django understands me … does he ever talk about me?
ME: Well, he has drawn some pictures (should I have said that?). What do you mean, he understands you? He hasn’t been very well, and he doesn’t talk much, really.

(Something slyly flickers across Reynard’s face – a kind of cunning glint).

REYNARD: Django will be all right if you let me see him again.

(Reynard leans forward; his mood has shifted to something more menacing).

ME: I don’t understand … you’re right, I don’t understand … and I told you we don’t want to see you.

(Reynard’s eyes are distant; I have lost my chance to find out more. Swallow the emptiness).

I have to leave. Reynard didn’t tell me anything coherent, and he was too frightening to be around – his energy chaotic, his speech alternating between self-pity, rage and threat. What could I understand from this meeting? Reynard said he was waiting for me to find out about his ‘special games’ with Django, but he did not explain any further. Reynard came straight out and asked me if I wanted to see him because I thought he abused Django – it was the very first thing that he said – and yes, of course that is why I wanted to see him. But then once he knew Django wasn’t talking he felt in control again. I didn’t handle this meeting very well – I was too nervous and let Reynard gain control. But now I’m even more convinced that something very bad happened to Django, and Reynard’s secret life almost flooded out.

On the bus home I finger the sharp knife in my pocket; over the motorway hawks swing in the dark air. I’m crying.

The Weirdness

I begin taking Django to a naturopath who was recommended by a friend. Drogo runs the Anubis Centre and he is highly regarded in alternative medicine, in iridology and sclerology, alternative medical practices that the eye for evidence of inflammation, tissue weaknesses, or toxicity in organs or tissues. Drogo claims to have cured cancer and other severe conditions and his house is bedecked with Egyptian gods and goddesses and pyramids, with golds and purples everywhere. There is something very creepy about him, and maybe it is the occult trappings that bother me, but I find myself thinking there is something dark and hidden in his psyche. His eyes are weirdly sapphire, with small pupils, like Wolf’s. Maybe I am being unfair, influenced by memories, but the black magic feel to the place is unsettling. Drogo is not good with Django, who doesn’t like him, and instead of talking to Django he addresses all his remarks to me. Django has to take high doses of expensive multivitamin and mineral supplements and his eyes are examined to discern any underlying biochemical imbalances.

After testing, Drogo provides Django with a pair of eyeglasses with violet-tinted lenses, which he is to constantly wear. I don’t notice any improvement in Django’s behaviour or learning abilities, but he loves wearing the eyeglasses. Drogo lectures me on the evils of vaccination, especially the measles, mumps and rubella triple vaccine (MMR) that Django had been given when he was younger. (This has been a controversial vaccine with many debates over its dangers and efficacy, a point I will return to in a later chapter).
Drogo has a weird machine he calls a ‘Hemaview’ that is basically a microscope with a video screen that shows enlarged pictures of blood cells. According to Drogo, samples of Django’s blood show misshapen cells and too many white cells, and this proves immune system and biochemical imbalances, and probable nutritional deficiencies, biochemical and immune system imbalances, and organ toxicity from a build up of heavy metals such as lead and mercury. Django is given a supplement pill containing algae, garlic, and coriander, which will cleanse his system of these impurities. Progress will be charted by weekly tests on the Hemaview, and Drogo prints out pictures of the results so I can see how well the treatment is progressing.

I check up on all this mumbo jumbo. The Hemaview is clearly a scientific prop, designed to give verisimilitude to an otherwise unconvincing treatment, and online I read that practitioners have been caught placing the microscope over the edges of the blood sample, where the cells are beginning to coagulate and thus look unhealthy when magnified. As treatment continues, they use fresher parts of the blood sample, to make it look as though the procedures are working. After a few sessions, I refuse to let Drogo use the Hemaview any more, citing the pinpricks as a reason: unsurprisingly, Django doesn’t like these. Multivitamin treatment is controversial as well, but at least, I think, it can do no harm – Django isn’t taking toxic amounts.

Drogo’s a quack. He makes me feel uneasy, Django doesn’t like him, and his procedures are ridiculous – but I keep hoping that maybe something will help. My friends, after all, are totally convinced by his abilities: he cured kidney stones! It is so easy to feel guilty when your child is ill, especially with a kind of sickness that is so difficult to diagnose. If Reynard did abuse Django it is my fault for not seeing it earlier ... If it is the MMR vaccine it’s my fault for having inoculated … Drogo is weird, but is it unreasonable of me to mistrust him because he reminds me of Wolf? Is it my own trauma scripts that are giving me the jitters?

Because I rejected the Hemaview, Drogo recommends kinesiology, a muscle-testing therapy, and something called Emotional Freedom Technique. I take Django to one kinesiology session, but it is not a very credible treatment. Applied Kinesiology holds that every organ dysfunction is accompanied by a specific muscle weakness, so diseases can be diagnosed through muscle-testing procedures. If the subject is an uncooperative child, such as Django, surrogate testing is used, so my arm strength is tested while I hold Django, so the therapist can determine what problems he has. We don’t try Emotional Freedom Technique, which claims that negative emotions are caused by disturbances in the body’s energy field. I’m increasingly worried that Drogo’s healing centre is asset stripping my financial resources, such as they are. But Drogo disregards my protestations: how can I even think about the cost when it comes to the wellbeing of my child? Maybe we can come to some arrangement, he says, maybe I can do a few favours for him in exchange for treatment? This might just mean helping on the reception desk, but I avoid asking him to be more precise. Nothing would persuade me to be in closer contact with Drogo, but in his office I feel under some kind of spell. I reach for my credit card instead.

Disappointed that I rejected kinesiology, Drogo next recommends Radionics, a treatment with a special machine that can allegedly diagnose and treat disease-causing agents by tuning in on the radio-like frequencies allegedly released by diseased bodily organs. I look it up: Radionics is based on the notion that different parts of the body emit electrical impulses with different frequencies that vary with health and disease. After an initial diagnosis session, the female practitioner informs me that Django’s difficult behaviours are caused by ‘problems in his brain’, and feeding in proper vibrations with a different machine
will help treat the problem. This treatment involves wearing a metal hat with various wires attached to a machine that gives off a faint buzzing sound. The practitioner leaves the room for the treatment session, and as Django is very fidgety all the wires fall off the hat so it is no longer joined to the machine. When the practitioner returns at the end of the session, I tell her this, but she is unconcerned, saying that the healing energy is in the room anyway and the wires are only there because of patients’ expectations. We do not repeat the session – it cost $80 – and despite my hopes I could find some help for Django on medicine’s fringes I give up on the Anubis Healing Centre. I avoid seeing Drogo again, instead leaving a message on his voicemail terminating all future appointments.

I am angry with myself for returning so often to the Anubis Centre – I have given them a lot of money I can ill afford, and none of the therapies have made any difference to Django’s problems. Why did I find it so hard to get away from Drogo? I kept telling myself I need to keep trying: some treatment I haven’t tried yet will be the very one that makes all the difference to Django. I felt like I was constantly on my guard – did keep going back because I needed to prove to myself that I could get away whenever I wanted to? That I wasn’t under his power? Was Drogo really dangerous, or are my psychic defenses so jumpy he just seems so? I must be more careful of whom I get involved with: my judgement is shaky. I am a lamb among wolves. Be wise as serpents yet harmless as doves.

Django is still going to see Wade, as this is a therapeutic relationship that is definitely beneficial, and the art therapy, especially, is really helping. Working with children who have been abused at a young age necessitates a different kind of treatment than the methods aimed at the uncovering of repressed or lost memories in order to lead to a resolution of inner conflict. Anne Alvarez (1992: 153) suggests ‘almost a theory of forgetting,’ as the child cannot, as it is sometimes termed, ‘face the truth’ if this truth is unthinkable because of fragmented visual memories repressed during very early stages of development. This is what Wade believes: he says the process of ‘remembering’ cannot be forced, as there are millions of tiny integrations that need to take place and these need to be explored maybe one aspect at a time. It is best to follow the child’s pace, with the first step being to help the child reassemble the pieces of their shattered selves before they can even begin to comprehend that someone did something to them that they should not have done (Alvarez 1992: 153-154). A couple of years later, after Django seems to reach a state where he will not engage any further with his voices or his fragmentary memories, we decide to respect his boundaries and stop the psychotherapy. (It is resumed when Django is older). I decide to avoid any other alternative therapies and concentrate instead on trying to persuade mainstream psychiatry to provide a more robust diagnosis. At this point in the narrative, Django is six years old, in his second primary school: the first school couldn’t cope with him, and I voluntarily moved him.

School
Django starts this new school, let’s call it Calliope, with an Individual Education Plan in place, the result of several meetings between me, the principal, the class teachers, a resource teacher for learning and behaviour (RTLB), and a representative of the Special Education Services (SES). The SES agrees to provide funding for two full-time teacher aides to ease Django’s entry into the school – this is a very high level of intervention, which I petitioned relentlessly to obtain. I am very optimistic about Calliope: the school presents itself as inclusive and kind of artistic, attracting a cohort of children from families who all seem to be from that segment of the middle classes who like to believe they are anti-establishment even though the
fathers are suit-wearing professionals like lawyers and the mothers are housewives who play tennis and jog. I'm hoping that their laid back appearance will equal an acceptance of Django's differences, but find, alas, a rigid intolerance underneath the apparent open-mindedness.

I originally enrolled Django at Calliope because the RTLB teacher who was so sympathetic while he was at his first primary school was based here, but she leaves almost as soon as Django begins. Then the principal leaves, and with the arrival of her replacement the welcoming climate abruptly changes. So much assistance comes from personal goodwill, I am 46abelin46, and the educational system itself is not to be relied on. Django's behaviour at school is very challenging: he can be aggressive to other children and adults who upset him. However, the school knew this when it accepted his enrollment, and they have the assistance of the SES and two full-time teacher aides who are meant to devote themselves entirely to Django. The school knows Django is under the care of the local child psychiatry unit and that he has a constellation of behavioural problems. The school also knows that I am available to come to the school and assist when required, and if I am unavailable then my mother will help. However, this school placement is an unqualified disaster.

Django is continually sent home, suspended, and I am regularly called in to meet the principal and be told that my son's behaviour is unacceptable. The two teacher aides who work with Django are not trained to manage children with challenging behaviour, and, furthermore, no-one supervises the breaks in the playground, and it is here that most of the problems occur. Other, older, boys tease Django incessantly, knowing he will lose his temper, scream, and kick. The principal knows this is the case, but always blames Django for not being able to control his responses. It is Django who is suspended, not the other boys. I call into the school one day, and when I go to see Django in his classroom he is sitting way on the other side of the room – away from the other kids – on a yellow plastic square stuck onto the floor. I am told he always sits here – the first I know of this innovation. How is this inclusive? Why can't the teacher aides do better than this? While Django is sitting on the yellow square, they are both working with other children, running reading groups. The school, I 46abelin, is using Django's funding to provide assistance for other pupils instead of for Django, although when I confront the principal, he denies this is the case.

Django began attending Calliope Primary in May, and by August he is regularly stood-down and not permitted to attend school. When I am called in to meetings at the school I am criticised for my lack of parenting skills, and am even told that I am insufficiently committed to my son's wellbeing as I am studying part-time at university. One letter from the principal states:

I am writing to inform you that today at lunchtime Django bit a pupil on the arm. The duty teacher withdrew Django to the office … while being supervised … Django spat at her and ran away. I am alerting you to the fact that this is another example of the on-going difficulties we are facing with Django with his violence towards adults and pupils. This behaviour is becoming continual and as such can lead to a suspension under the Education Act. I am disappointed in Django's behaviour. Please discuss this with Django.

I am not at all happy about Django biting or spitting, but calling it 'violence' is a bit over the top. When I went to pick Django up from school after this incident he was very distressed – he had been locked in an office with no supervision.
After another suspension, in early September, I am informed that Django is to be excluded (or expelled, as it used to be called). I go to a Board of Trustees meeting and beg them to let me take Django out of the school instead of having an exclusion order: if he is excluded no other primary school will legally have to accept him. One woman on the board, beautifully groomed and made up, lectures me on my lack of parenting skills, deemed especially grievous due to my apparently pariah status as a lone parent. Because ‘his continual disobedience is a harmful and dangerous example to other students at school,’ says the principal, Django’s suspension is extended until such time the Specialist Education Services and myself can find a suitable placement for him. They tell me there is a special unit designed to cope with children with challenging behaviour at another primary school, about a half-hour drive from where we live. When I contact them they say Django can be accepted into the Centre of Extra Support, ‘but unfortunately the CES is not in operation at present as we do not have a site for it.’ I’m getting used to this kind of response: yes, Django’s needs are such that he needs serious help, but there isn’t any of the right kind of help available.

Fortunately, I am able to enroll Django at yet another mainstream local school, Philomel, where the principal is very sympathetic, but Django will only be permitted to attend school on three mornings a week, from 9am until 10.30am, working in the library with a new teacher aide. I don’t have a car, and Philomel School is too far away to walk to from home, so have to I borrow my mother’s car to get him to school.

Two parents of children attending Calliope Primary come to visit me. I don’t know them very well, but they were friendly to me whenever I saw them at the school. They tell me that they are very upset at the way Django was treated at Calliope, and that they have written letters to the principal, the Board of Trustees, and to the Ministry of Education, complaining of events. Here are some excerpts from their letters:

I feel it is necessary to voice an opinion myself. This child [Django] I’ve been around and seen a fair amount of. That he would in any way endanger others is a totally pathetic and to say the least questionable decision. Based on what professional and thorough investigation of the situation? You don’t toss a kid with a problem in the trash so easily and only after two terms. Perhaps a few parents now feel content that their children are safe. What ever happened to a sense of community and caring? Are we to teach our children that others are so easily disposable? Pathetic. We have two kids of our own in the school and what I would describe as a ‘witchhunt’ certainly doesn’t send a lesson I feel is appropriate.

The other parent tells me that there was a petition going round the school, 47abeling47 by parents, to put pressure on the principal and the board to exclude Django.

The dismissal of Django was another example within our community of that square peg not quite fitting. I was shocked at the ‘witch hunt’ atmosphere that surrounded his dismissal. Parents phoning other parents at home encouraging them to sign a letter so that Django was no longer a part of our school community ... I have witnessed problems with Django, especially between one particular boy and Django and can honestly say that one is as bad as the other is. Why do we not work together to solve a problem such as this? It was not as bad as it was made out to be. What is going to happen to this little six-year-old boy now? This child was not a threat to others and I’m sure that if proper help in that of a trained aid was put in place and the support of our school and parents, we all could have helped a child that needed help, understanding, love and support.

Well, as I had thought, Calliope School was a seething mass of intolerance, the management had not used the resources provided by the Special Education Service to properly work with Django, and neither had the staff tried very hard to help him become part of the school community. This was overwhelming. I never received any response from the school or the Ministry of Education in reply to the two letters.
Stigma

This experience of discrimination is unfortunately common for children and adolescents with mental disorders. Stigmatisation is likely when symptoms result in eccentric behaviour that lies outside conventional norms, such as inappropriate remarks and emotional displays, and, especially, if the child’s conduct can be construed as dangerous to self or others (J. Martin, Pescosolido, Olafsdottir and McLeod 2007: 50-67). Erving Goffman (1986: 1-5) asserts that once an individual possesses a ‘mark’, such as a mental health diagnosis, many so-called 48abeli respond to the person in a negative way; in short, their social identity becomes undesirable, tainted, and ‘spoiled.’ Sociological argument has long claimed that 48abeling 48ing and its consequent moral sanctions is shaped by the relative social, political, and economic power of those judged and their judgers: a person is more likely to be rejected if they are a member of an already disadvantaged group (J. Martin, Pescolido, Olfsdottir and McLeod 2007: 52). In my opinion, the fact that I was poor and a single mother, compared to the economic and social capital of most other parents at Calliope School, was a significant factor in Django’s 48abeling; parents, teachers, the principal, and the Board of Trustees repeatedly invoked my lone parent status as an indicator of my allegedly poor parenting skills, and thus the cause of Django’s ‘violent’ actions.

Thomas Scheff (1984), in his work on 48abeling theory, claimed that merely being diagnosed as ‘mentally ill’ has a powerfully negative effect on social relationships, and, indeed, this was the case at Calliope School, where the problem was further exacerbated by perceptions of dangerousness that resulted in not only social distance, but in expulsion from the school. A recent study undertaken in the United States found that if a child’s behaviour (especially if the child is a boy) is interpreted as the result of a mental illness such as ADHD, rather than as part of the ‘normal ups and downs of childhood’, the child is much more likely to be treated as an outsider and perceived as dangerous by the parents of ‘normal’ children (J. Martin, Pescolido, Olfsdottir and McLeod 2007). Acquiring a diagnosis of a mental illness may enable access to state resources, but it is freighted with highly complex social problems. And Django was slowly being pushed outside social life, further into the Otherworld. Django was becoming one of the Others that Avery Gordon (2007: 4-7) speaks of, haunting the hinterlands of society, pushed into an exclusion zone. Says Gordon, the story of ‘complex personhood,’ the complicated entangling between subjectivity and society, is woven between narratives that are immediately available and the stories that their imaginations are reaching toward. Can I help to weave Django a new type of identity that can be incorporated into society? How do I achieve this inclusion?

New Solutions?

Philemon School is a tolerant oasis, but attending school for only three short sessions a week is not a long-term solution. The principal – a very sympathetic man, with a lifetime’s experience of working with ‘difficult’ children – tells me he has seen kids with autism who have similar behavioural problems to Django, and that if Django could be diagnosed with autism he would be funded to attend a Special School and able to access other benefits: maybe then I could pay for treatment I could not presently afford. I know that Special Schools are rare in Aotearoa / New Zealand, as government policy favours the mainstream education of children with disabilities, but I now 48abelin that mainstreaming does not equal inclusion. I research autistic disorder and find there is a whole cluster of developmental disorders that Django’s psychiatrists have never mentioned: one is Asperger’s disorder, a milder form of autism that is often not diagnosed until a child begins school and social difficulties become more evident (APA 2000: 80-84).
The more I discover about Asperger’s disorder the more I am convinced Django exhibits its symptoms. Whatever abuse actually caused Django’s behavioural problems is irrelevant to his needs: I know now that I need to find a medical or psychiatric diagnosis that fits his symptoms and gives them a state-approved label. On the other hand, it is possible that Django may actually have an underlying problem that was exacerbated by whatever Reynard did. Maybe Asperger’s disorder fits both of these possibilities, although I am (understandably) uneasy about any more diagnostic labels that may adhere to Django. I discover some writings from the Tavistock Clinic in London, proposing that a precipitating factor in the development of autism in some children may be an experience of trauma in early childhood, and suggesting a diagnostic sub-group of ‘Autistic Post-Traumatic Developmental Disorder’ (Reid 1999: 93-109). This won’t help me to get a diagnosis, as no-one I talk to here, apart from those working in the trauma field, will consider this possibility: it’s unthinkable in the paradigm of biological psychiatry.

I make Django an appointment with a paediatrician who works in both the private and public health systems, and after an examination she says Django definitely displays behaviour consistent with an autistic spectrum disorder, although she places any discussion of causes wholly in the context of brain abnormality. I have been recommended to this paediatrician by a woman I met at an autism support group – it is apparently very difficult to gain a diagnosis of Asperger’s disorder, as New Zealand psychiatrists don’t like the term: it is relatively new in the mental illness classifications of the DSM and is regarded as too American, too new-fangled. To be diagnosed with autism in New Zealand in 2001 nearly always means classic autistic disorder, and although some professionals concede children may suffer from milder versions they prefer the terminology of autistic spectrum disorder, which as this stage is only used to diagnose seriously autistic children. The paediatrician knows all about this hair-splitting, and is happy to help me to thread my way through the diagnostic maze. She tells me that to get the best help available for Django I need to get the very worst diagnosis possible, and she recommends a referral to a 49abeling49in unit based at a large children’s hospital for a full assessment. Thus begins a paper trail as I go from paediatrician to child psychiatric centre to hospital, begging for Django’s entry to this special unit.

I have since come across an article that examines the possibility that Asperger’s disorder is a pattern of abnormal behaviours that has been socially constructed as a developmental disorder within the medical paradigm. Amusingly – for me, anyway – Harvey Molloy and Latika Vasil (2002: 659-669) suggest that Asperger’s disorder has become readily adopted as a diagnostic category simply because it is particularly useful in enabling schools to apply for funding for special education resources. Molloy and Vasil (2002: 668) are concerned over the social implications for children who are pathologised due to their psychiatric 49abeling, as what they rightly term ‘the powerful academic discourse on emotional disturbance’ intervenes in their lives. I wholeheartedly agree, and I abhor the notion of fitting Django with Goffman’s (1986) ‘spoiled identity’, but needs must: I am a recalcitrant cog in the wheel of psychiatric discourse but a cog nevertheless.

Remember: this story is not a ‘restitution narrative’, a tale with a plot that traces a journey from sickness back into health (Frank 1997: 75). Admission to the special unit at the Hospital is a goal, if you like, but not a holy grail that leads to a cure. The paediatrician is an important ally, though, and she has met many parents who, in a desperate quest to do the best for their child, hunt for the most useful psychiatric diagnosis for accessing

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13 The task force working on DSM-5, the latest version of the APA’s classification manual due for publication in 2013, intends subsuming Asperger’s disorder into autistic spectrum disorder – more of this in a later chapter.
funding, treatment, and education. In fact I have met several parents who have taken their children to other countries – at great expense – to obtain the ‘right’ diagnosis refused by New Zealand psychiatrists. It’s a game: if a legitimate psychiatrist confirms a diagnosis of, say, autistic spectrum disorder, then other psychiatrists, even if they don’t entirely agree, will have to give some credence to this label, which then helps to open the door to benefits for the child back in New Zealand. I can’t afford to do this.

The psychiatrist (I’ll call him Selby) at the child psychiatric unit where Django is a client is initially reluctant to refer him to the Hospital, but the letter from the paediatrician helps sway his opinion. I have found out that the special unit contains a small school, where children can have their educational abilities assessed as well as their other problems examined, but the unit will only accept children if there is evidence to suspect an underlying severe mental health concern: ADHD is considered a behavioural problem not severe enough to warrant admission. I demand Django is given an electro-encephalogram (EEG): his dissociative spells could perhaps be due to complex partial seizures? The EEG is inconclusive, but since it shows abnormal spike patterns it provides evidence for possible brain dysfunction. Could Django’s fidgety movements be repetitive enough to be interpreted as tics? This would be evidence of neurological problems. So, a letter proposing an autistic spectrum disorder, an abnormal EEG that may suggest complex partial seizures, speculation on neurological tics, and months of incessant hassling with letters and phone calls from me harping on about Django’s terrible problems at school eventually results in an appointment at the Hospital, which then agrees to accept Django for a one-term placement in their special school and assessment unit.

The Beyond

You drive 500 miles – 500 miles 500 miles
And it is a Far Off Place
this place they call Cure
where the streets are named Treatment and Therapy
and a wild wind rushes through

They call the wind The Unknown
– kin to The Unlikely
the side-effect of thinking you don’t know where you stand

It is a big hospital, of bricks and black windows closed
You recognise Another Universe when you see it
You have driven 8 hours for visiting
You get lost before you arrive

At the desk a man in a uniform marked Security points to a corridor marked No Admittance. He unlocks the distant door with a secret key that he turns under his desk, where you cannot see

You go Down –
Down the No Admittance Corridor
Through the Distant Door.14

Ludi Incipient

Let the games begin. Every morning Django is picked up from home by an ambulance and transported, in morning traffic, across the Harbour Bridge to the Hospital. It is a long journey. Every afternoon I leave my university studies and pick him up from the rear of the Hospital and take him home. The front entrance with the imposing portico is only for children with physical illnesses: mad kids are discreetly hidden around the back, through a different door. The special unit is painted in friendly colours but is a large building with safety glass and steel bars; I navigate security guards, correct procedures, locked doors, and long corridors. My shoes squeak on the shiny floors. Every week there are several formal meetings with the clinical team, and every afternoon there are informal meetings in the unit’s kitchen, where various caregivers wait for their children. Due to the Privacy Act, we aren’t told anything by the staff about other people’s children, but we all talk to each other while we drink our afternoon tea, swapping stories and information, so actually we all know more than we are officially supposed to know. There are four other children, and all are older than Django; three of them are boys. I only get to know two of them: Amina, a refugee from Eritrea, who became mute after seeing her family shot, and Hunter, who witnessed his father knife his mother. Django becomes friends with Amina, and when she eventually begins to speak it is often to him, but he is terrified of Hunter, who frightens him by talking about lakes of blood. Django stays at the Hospital School for two school terms.

I know that Django’s acceptance at the Hospital means that I am effectively handing over his care to the clinical team, and I have to sign an official agreement confirming this arrangement. To get him into the unit has meant exaggerating the severity of Django’s problems. But it is scary seeing your child portrayed like this: ‘he has a severe neurodevelopmental disorder and there is unlikely to be any substantial improvement through the course of his childhood,’ which is how the letter from the child psychiatrist described him to the Hospital. I am not able to be closely involved in what goes on at the special unit, as I have given up that right, and there is a strong assumption that I will agree to whatever diagnosis and treatment regimen is decided. One of the first rules is that I must sign a consent form to permit physical restraint to be used on Django; there are several large male orderlies who are trained to safely hold aggressive children, and a padded room is used for ‘time out.’ I also am told that it is necessary, especially in the first few weeks, for me to keep my distance from the unit, so the team can build up relationships with Django away from any interference from me. They need to see how he behaves away from maternal attachment – also, I’m guessing, they want to isolate him in case I’m the cause of Django’s problems. I will be called in to attend regular meetings where I will be informed of progress. I can see that I won’t be given much scope to influence what goes on at the Hospital, but think that once I get my foot in the door, so to speak, I’ll be able to get more involved in the process. This does become the case, but at first it is the White Coats who are totally in charge.

At our first meeting to discuss Django’s case, the clinical team outlined their approach. I was anxious, and I asked about the diagnoses that Django had already accumulated – what did attention deficit / hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD) mean, in their expert opinions? What kind of future could I plan for Django, how would they predict what kind of person he would be when he was adolescent, or adult? The lead psychiatrist, Dr Crapaud, said that in his experience (considerable and unchallengeable experience, I was meant to understand), children like Django (so, he was a type of child) generally followed a developmental trajectory towards more serious disorder. In adolescence, conduct disorder was the most likely diagnosis for aggressively antisocial boys, in fact there is a childhood-onset subtype of the disorder
and the clinical team were considering if Django already fit the criteria, and he would be observed to see if
this was the case. I should, said Crapaud, 52abelin that many boys with this diagnosis end up in prison.

I suppose this conversation-stopper was meant to show me the seriousness of this entire enterprise. My
incredulity was dismissed; a mother obviously would disagree with this assessment, it was to be expected.
The team gave me some photocopies describing conduct disorder to take away and read. It is ‘a repetitive
and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms
or rules are violated’ (APA 2000: 93). This, to a sociologist, reads like a social construction of deviance. The
list of characteristics is, though, horrifying: aggression, irritability, temper outbursts, threatening, intimidation,
use of weapons, cruelty to people or animals, little empathy to others, robbery, destruction of property, lying,
truancy, and sexual assault. The clinical team is predicting that Django will become a sociopath.

Un-understandable communications from a parallel universe –
carbamazepine valproate-semisodium myoclonic clonic tonic-clonic atonic seizures methylphenidate
dexamphetamine selective-serotonin-reuptake-inhibitors fluoxetine citalopram paroxetine atypical
antipsychotic risperidone quetiapine electroencephalography magnetic resonance imaging partial agonists
extrapyramidal reactions dopamine pathways dysphoria akathisia dystonia hyperprolactinaemia tardive dyskinesia neuroleptic malignant syndrome.

As a way of conveying the flavour of my experience of the diagnostic process at the Hospital, I will script a
couple of the more significant episodes. My voice, as researcher, needs to be captured as part of the
performance. Following Michelle Miller (1998: 71-72), I use a character called ‘Narrator’ to represent my
persona as the social scientist who just happens to be the mother of a child being assessed for a psychiatric
diagnosis. The Narrator guides the reader through the sequence of events, and explains some aspects of
the interactions. The Narrator also provides information already known, what she is attempting to know, and
what she discovers. Thus, she provides a way of inserting data into the dialogue, as well as keeping the
reader informed of her reflections, decisions, doubts, feelings, and thoughts.

‘The Label: Or, How a Psychiatric Diagnosis Can Change Your Life.’

LOCATION: The Otherworld.

CAST: WHITE COATS / CFU CLINICAL TEAM:

Dr Crapaud, child psychiatrist, head of clinical team.

Large, Pākehā New Zealander, male, aged around fifty, neatly dressed in suit and tie. Reminds me
irresistibly of a Dalek (from the Dr Who TV series), as he strives for total emotionless control.

Dr Kaeguri, child psychiatrist, specialist in child psychopharmacology.

Small, Korean, male, aged around fifty, neatly dressed (under white coat), friendly.

Dr Mouche, child psychiatrist, specialist in gender dysfunction.

Slender, Pākehā New Zealander, female, aged around forty, fashionable casual clothes (under white
coat), always wears flashy earrings, distant.

Dr Lapin, clinical psychologist.
Medium build, Pākehā New Zealander, male, aged around forty, casual clothes (somewhat untidy), friendly and approachable.

Merle, teacher at the Hospital School.

Medium build, Pākehā New Zealander, female, aged around forty, bleach-blonde cropped hair, colourful clothes, friendly, approachable, and very helpful.

MINOR PLAYERS: (Several nurses and nurse aides)

Due to shift work, these change regularly. All wear nursing uniforms. The nurse aides are all very large men, employed to safely restrain the children (I nearly said inmates).

ME.

NARRATOR (also me).

SCENE ONE:

NARRATOR: As I mentioned, I have had to sign a consent form permitting restraints to be used on Django, and I am not allowed to enter the Hospital special unit whenever I feel like it. Django is now, effectively, in the care of an institution during the day. As a sociologist I am, of course, haunted by Erving Goffman’s (1961) work, *Asylums*, on the labeling effects of total institutions. As Goffman (1961: 7-9) points out, ‘[s]ocial mobility between [supervisory staff and inmates] is grossly restricted; social distance is typically great and often formally prescribed.’ This extends even to the tone of voice used by staff to ‘talk across the boundaries’; in the Hospital the ‘special voice’ is mostly condescending and authoritarian, and knowledge is restricted, especially, as Goffman affirms, if it is ‘information about the staff’s plans for inmates.’ I need to appear compliant; camouflaging any subversion behind the façade of conformity, using tactics – de Certeau’s (1984: 29-39) ‘art of the weak’, infiltrating and poaching territory, relying on loopholes in the spaces controlled by the powerful. I have to perform the role of the caring mother who defers to the psychiatric professionals, for as Goffman (1961: 335-336) observes, to make life bearable within the total institution of a mental hospital, one has to pretend acceptance of the place one is given, ‘and the place accorded … is to support the occupational role of those who appear to force this bargain.’

CRAPAUD: We will begin by reintroducing Django to a course of stimulant medication, as his primary diagnosis is ADHD.

ME: When he took Ritalin before, it really didn’t work … actually, his behaviour became worse.

CRAPAUD: That is irrelevant. One of the reasons Django has been admitted to this unit is so he can be properly examined for a psychiatric assessment. Part of the process is checking his response to various medications. The unit provides a safe space in which to experiment with various treatments, and we have a specialist in child psychopharmacology on the team. He will be present whenever drug treatment is considered. I have applied for special authority permission for Django to be
prescribed methylphenidate and the trial will begin immediately. If, as you say, methylphenidate is not tolerated, we will next trial him on dexamphetamine sulphate.

NARRATOR: Crapaud did not like his decisions being discussed. He expected to give me the minimum of information required by law (informed consent), and then get on with the CFU’s plans. (He was, however, much less authoritarian than Drogo). I called in to pick Django up one afternoon to find the unit in a state of uproar: Django screaming, and Crapaud, sweating, trying hard to retain his composure. Django had been forcibly restrained by one of the nurse aides and put in a padded room until the meds wore off. Later, our usual child psychiatrist, Selby, rather smugly described this experiment to me as ‘a short ill-fated re-trial of stimulants.’ He had of course tried the same drugs before, and was pleased to not lose face.

SCENE TWO: (a few weeks later)

NARRATOR: Django developed a good relationship with Merle, the teacher, who was happy to talk to me like a real person. Merle’s help was crucial to the success of Django’s stay in the Hospital, and he made significant improvements in social skills, behavioural management, and his reading and writing aptitude spectacularly advanced. Dr Lapin, the clinical psychologist, was also very helpful, but he didn’t like Crapaud to notice him crossing any professional boundaries so we always met when we could have a private conversation. Lapin was quite open about the possibility of Django’s behaviour being interpreted as signs of an autistic spectrum disorder, and even came, at my request, to meet Autism New Zealand, an advocacy group. However, in the professional pecking order, Merle and Lapin were well below the White Coat double-act of Crapaud and Mouche, the yin and yang of the Hospital. One day they called me to what they described as a serious and important meeting.

CRAPAUD: After some time observing Django’s behaviour, we have come to some conclusions about certain issues of concern. We have some information we would like you to read, and Dr Mouche would like to explain a few things to you.

ME: Ummmm … OK.

MOUCHE: I have been observing Django’s play behaviour as a way of understanding the problems he has when interacting with his peers. As you have seen, there is a playroom in the unit with a wide range of toys. Under observation, Django always shows a marked preference toward playing with what we would define as girl’s toys.

ME: Ummmm … yes … girl’s toys? You mean dolls? I think I told you before that he is obsessed with Barbie dolls. He has a huge collection at home, and spends ages dressing them them and …

MOUCHE: Yes, he tends to direct his attention to dolls, and often to role-playing toys like cooking, cleaning, and the doll’s house. He likes rearranging the furniture.

ME: Yes, he has a lot of Polly Pocket toys at home, and they have houses, cars, and whatever (I’m obviously annoying Crapaud and Mouche as I try to explain what is to me normal play activity, and they keep rustling their papers and fidgeting) … he likes
building places the dolls can play … it often seems like he uses the dolls as a way of
learning how people interact … like practicing social skills or something …

MOUCHE: Well, we have plenty of toys more appropriate for boys in the playroom and he
shows no interest in them.

ME: Boy's toys?

MOUCHE: Yes, more gender-specific toys such as cars and guns.

ME: Actually, he plays a lot with cars and trains at home, as well as with the dolls …

MOUCHE: I have also observed that when Django has a choice of dressing-up clothes to
choose from he always chooses to wear girl's clothes.

ME: Yes, he does like to wear dresses … he really likes the silky material … I am quite
happy for him to wear whatever he likes at home, and he has one of my daughter's
old dresses which is cream silk … he likes wearing high heels as well … but it's
dressing up.

MOUCHE: Yes, well, I have been observing Django's behaviour, and given his other issues it is
likely that there is an underlying deviation from the norm that may be further
exacerbating his problems.

CRAPAUD: We have some reading material for you here, but after extensive consultation we
need you to be prepared for some perhaps disturbing information. … We are
convinced that Django has muddled issues over his gender identity.

ME: He's only six years old – plenty of kids like to dress up, and why should playing with
dolls be weird? And anyway, why is it a problem?

CRAPAUD: Well, we would like you to read these articles. This is a very emotive topic, and we
don't expect you to be able to take all this on board right away.

NARRATOR: The articles are photocopies of an excerpt from John Money's writings on gender roles and a
newer article on gender identity disorder (GID), which is included in the DSM-IV-TR. When Crapaud and
Mouche talked to me about GID I had already heard about it, as I had recently taken an anthropology paper
in human sexuality at university. GID was introduced into the DSM-III in 1980 at the same time that
homosexuality was removed as a disorder following agitation by gay activists. The introduction of GID was a
political move to counter this victory: an attempt to prevent homosexuality in adults by focusing on childhood,
and boys are diagnosed with GID much more frequently than girls.15

15 Crapaud and Mouche gave me uncredited photocopied excerpts from some of John Money's writings. They did not mention that
Money's most notorious case, in the 1960s, the gender 'reassignment' (surgical removal of penis and testes, and hormonal treatments)
of a young boy into a girl, failed tragically. The boy switched back to a male identity once he reached adolescence, re-naming himself
David Reimer. David and his twin brother (who had not been reassigned as female) both accused Money of sexual abuse during
childhood photoshoots, and both of the brothers committed suicide when they were adults. See Colapinto 2006. Crapaud and Mouche
were not, of course, suggesting gender reassignment surgery – they gave me an article to study (Bradley and Zucker 1996: 872-880); I
still have the article. Django is now 16 years old and shows no sign of confusion over his gender identity.
SCENE THREE: (the next week)

ME: I’ve read these articles ... actually ... at university ... I really don’t understand why you think Django has issues over his gender identity ... he has never said that he would prefer to be a girl ... he just likes to play with what are usually called girl’s toys, and he likes dressing up.

MOUCHE: This is why we are trying to introduce you to these concepts gradually, as we 56abelin the idea is very disturbing at first (meaningful look).

ME: … I’m not disturbed: I just think you’re wrong. Not because I’m upset that he may be gay when he grows up – why would that disturb me? It’s fine by me if he’s gay. But it’s just that this is a ridiculous diagnosis.

CRAPAUD: Vivienne, you have to put your feelings to one side here (leans forward for effect) ... Dr Mouche is an expert in her field. Unfortunately it is difficult sometimes for parents to 56abelin that they may have inadvertently exacerbated some of their child’s pathologies.

ME: What pathologies?

CRAPAUD: Yes, boys of Django’s age with gender identity issues are, on average, considerably more disturbed than much younger boys with similar problems, and maternal support for this behaviour may indicate that the mother has significant issues as well, perhaps with depression or even (significant pause) borderline personality disorder. 16

ME: Well as you know, as I filled in your forms and told you, I have suffered from depression in the past ... (meaningful glances between Crapaud and Mouche) but ... borderline?

MOUCHE: (smoothly) Of course, we are not suggesting that you have borderline personality disorder, just pointing out what is commonly observed. But in Django’s best interests we want you to discourage him from playing with girl’s toys and dressing in girl’s clothes. Instead, encourage him to play with more gender-appropriate objects. This will assist him to become more integrated socially with his peers.

ME: You mean, because he prefers girls to boys? Isn’t that just because he mostly finds girls quieter and friendlier than boys his own age? You know, he does like some boys, when they’re gentle and quiet.

MOUCHE: Well, it will help Django if he can engage with his male peers in a more normal manner.

NARRATOR: This discussion wasn’t going very well. I think Crapaud and Mouche just put me down as unco-operative in the end, but the diagnosis was never mentioned to me again. However, they got the last word, as gender identity disorder is listed on Django’s discharge papers as part of his diagnostic comorbidity. Despite Crapaud and Mouche’s bullying manner I must however point out that they were never as overbearing – or as frightening – as Drogo, who was undoubtedly a total charlatan. The clinical team at the

16 Judith Herman (1998: 123) says borderline personality disorder (along with hysteria and multiple personality disorder) is notorious as a diagnosis for troublesome women, and is ‘frequently used within the mental health professions as little more than a sophisticated insult.’
Hospital, although sometimes smug and pompous, was always reassuringly professional and willing to at least pretend to listen to my opinion, even when they disagreed with my views. I always felt that I was in the hands of people who were making a genuine effort to help Django, apart from their comments about Django’s future career as a sociopath and their suggestion that I may have borderline personality disorder.

**Degradation Ceremony**

Django had been at the Hospital for two school terms. By the end of this period the clinical team had hammered out a list of diagnoses that they could all agree on. Although I could not influence events enough to ensure a diagnosis of either Asperger’s disorder, my ally Dr Lapin persuaded Dr Crapaud to include pervasive developmental disorder (not otherwise specified) on the list, which was at least on the autism spectrum. As a sociologist, I see this document, dated 5 May 2002, as an official award of a ‘spoiled identity’ (Goffman 1986: 2-19). It was given to me, on behalf of Django, in a formal ceremony on the last day at the Hospital. Harold Garfinkel (1956: 420-424) calls this reduction in social status a ‘degradation ceremony’, formally led by a public figure – a ‘denouncer’ – in this case Dr Crapaud, the head of the White Coats clinical team. Ronald Laing (1984: 101) explicitly links this kind of institutional ritual to the psychiatric diagnostic process. The discharge paper states:

**DSM IV Diagnosis:**

- Oppositional Defiant Disorder
- Pervasive Developmental Disorder, NOS
- Attention-Deficit / Hyperactivity Disorder (Combined Type)
- Tic Disorder, NOS
- Features of Gender Identity Disorder

Django was later diagnosed with Asperger’s disorder and autistic spectrum disorder, so his ‘moral career’ and ‘mortification’ as a person with a mental disorder, as Erving Goffman (1961: 14) describes it, was not over when he left the Hospital. Despite misgivings over Django’s labeling, I was nevertheless pleased that the journey through the Hospital was worthwhile: this piece of paper should open doors to resources and education, revealing avenues that were closed before the diagnoses were awarded. Merle, who had built up a remarkably close and trusting relationship with Django, recommended a special school, rather than trying again to navigate mainstream education, and this opened up the next arena for strategic play.

**Special Education**

According to the Ministry of Education, Group Special Education (GSE), only three percent of children in Aotearoa / New Zealand are defined as having educational needs best met by behavioural support and special education (Ministry of Education 2008). Django’s earlier contact with GSE had resulted in allocated funding for teaching and behavioural support within a mainstream educational setting, but securing him a place in a special school required a different strategy. My main reason for getting Django admitted to the Hospital was to obtain a diagnosis severe enough to acquire funding for his education and therapeutic interventions. I hoped I had achieved this. With Merle, I begin visiting the special schools in Auckland. Two Special Schools agreed to accept Django, but only on condition he was awarded funding from the Ongoing and Reviewable Resourcing Schemes (ORRS) provided through the GSE for children with disabilities.

The ORRS application is an unwieldy beast, entailing laborious form-filling and documentation from myself and all the health and education professionals involved in Django’s care. An educational psychologist told
me in confidence that Django would not qualify for ORRS funding unless there was one more governmental agency involved in his care: she recommended that I contact Child, Youth, and Family (CYF) and bring them on board by pretending that Django’s home life was collapsing under the stress of caring for him, putting him at risk. If CYF wrote a letter as part of the ORRS application it was much more likely to be successful, she says. But I just couldn’t do this: CYF is a child protection agency that undertakes social work with abused and neglected children, as well as managing young offenders. Django didn’t fit into this category of need, and I felt horrified at the idea of pretending that Django was currently at risk of abuse, when I had just managed to remove him from this very situation. My application for ORRS funding was declined, despite the weighty imprimatur of the Hospital; Django was not considered to have a sufficiently disabling condition to qualify. ORRS funding is notoriously difficult to obtain, with unsuccessful applications running at around fifty per cent. In 2002, when I first applied for Django to get ORRS, there were 1596 applications, of which only 52.7% were successful (Education Counts: ‘Ongoing and Reviewable Resourcing Scheme (ORRS)’).

One of the Special Schools, due to the compassion of the principal, agreed to accept Django’s enrollment despite the fact that he didn’t have ORRS funding. The principal, Merle, and I managed to secure a different type of funding for Django. Several different agencies that provide educational, social, and health support for children with ‘high and complex needs’ were involved, with repeated negotiations between the different agency boundaries. I now had to continually choreograph meetings with all the professionals involved, just to raise enough money for Django to be able to attend a school where he could learn and feel safe. Although the funding raised was a much lesser amount of money than ORRS, it did at least provide some remuneration to the school. The major disadvantage was that the funding was negotiated anew at the beginning of every school term, as Django’s problems were, it was ordained, likely to improve over time. Well, Django has ‘improved’ by now, ten years later, but it’s been a long process, and he will always need support, both emotionally and with practical things. I don’t think he’ll ever be able to live independently.

The funding limped along for several years, but was very fragile: in 2005 it was all suddenly withdrawn, when a bureaucratic intervention from GSE deemed Django and several other pupils at the Special School able to return to mainstream education. After a stress-filled few months, during which time I appealed to Youth Law and every other government agency involved in Django’s and the other children’s care (I took charge on behalf of the other parents), GSE backed down. A couple of years later, when the ORRS criteria were altered to include the social impairments of autistic spectrum disorders, I reapplied for ORRS funding, but was again rejected. On the second application it was noted that Django’s learning abilities were too high for him to qualify for funding: the intensive interventions assisting him in his huge improvements in reading and writing had worked too well.

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This autoethnography is not, remember, a ‘restitution narrative’ (Frank 1997: 75): its plot line does not trace Django’s journey from sickness to health, or from marginalisation to inclusion. Finding Django a place in society, pulling him back from the Otherworld, is an ongoing process. Django’s diagnoses were established during a lengthy process of compromise between various mental health professionals, with me doing all I could to influence matters. I have learned that not only are mental disorders products of culture, they are also a way of ‘making up people,’ a term devised by Ian Hacking (2006: 23-26) to explain how understandings of human nature shape human beings. New classifications create new ways for people to exist, and the people who are altered by being labelled then change in ways that impact on the systems of thought that constructed their original classification: Hacking calls this the ‘looping effect.’

Django’s journey through the diagnostic system reveals the myriad negotiations that were involved in ‘making him up’ as a person with Asperger’s disorder and autistic spectrum disorder, diagnoses that are themselves shifting into different classifications in the next edition of the psychiatric bible, DSM-5, which will be published in 2013. Subjectivity and the professional discourse of psychiatry are interwoven and entangled. The chapters that follow, after a brief theoretical interlude, describe a social history of mental disorder – two centuries of ‘making up people’ – and the arguments, compromises, and negotiations involved in the construction and classification of these diagnoses. While reading through my history of the present it is important to remember that the psy professions, with their focus on intrapsychic conflict, neurochemical imbalances, and genetic abnormalities, have always had great difficulty in recognising that bad things really do happen in the outside world and actually can drive you crazy (Read and Haslam 2004: 133), a problem that will be addressed in my concluding chapter, on the topic of psychic trauma.
Social theory is concerned with the historical alternatives which haunt the established society as subversive tendencies and forces.  

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17 Colin Ross. 2004b. *Spirit Power Drawings: The Foundation of a New Science*. Richardson, TX: Manitou: pp. 54-55. Ross says that he has learned a great deal about psychology from working with clients who have dissociative disorders.

Outside In

Psychological and biological approaches to the aetiology and treatment of mental disorder examine the inner world: an individual’s qualities, behaviours, and brain characteristics. The distinctive emphasis of sociological approaches, however, is the outer world, and how social structures and conditions, social roles, and cultural systems of meaning impact on states of mind concurrently with the life events of a particular individual. How people feel or behave does not only depend on their neurochemistry or their psychological conflicts, but on their environment and the social conditions they live within. Research methodologies based on positivist theoretical perspectives are unsuitable for my work, which explores psychiatric power, subjugated knowledges, and experiences of marginalisation in both personal and societal ways. My approach, which I have already touched on, is interdisciplinary, blending autoethnography with a history of the present. This chapter looks both ways: a hinge between biography and history, and the axis around which the rest of my thesis rotates. Here, therefore, I will clarify the conceptual, theoretical, and methodological underpinnings of this thesis as a sociological document. There are several sociological perspectives on mental illness, all with differing theoretical points of view. Each has been influential and popular during particular historical eras, but disciplinary trends are not, say Anne Rogers and David Pilgrim (2005: 11), neatly periodised, but ‘[r]ather, there are sedimented layers of knowledge which overlap unevenly in time and across disciplinary boundaries and professional preoccupations.’

Sociological Perspectives on Mental Disorder – An Overview

The five major sociological perspectives are critical theory, social causation, social constructivism, social realism, and labelling theory. All have been applied to the analysis of mental disorder by sociologists, and this thesis draws on the full spectrum to varying degrees.

Critical theory is associated with both the Frankfurt School, whose founder members (Theodor Adorno, Max Horkheimer, Herbert Marcuse and Erich Fromm) used psychoanalytical insights to examine the pathological interrelationships between society and individual psyches; and the French intellectual current that fed into the work of Louis Althusser and Jacques Lacan, who re-examined Freudian orthodoxy in the light of Marxist social theory, creating a hybrid of these ideas (Rogers and Pilgrim 2005: 12-14). My readings from within these schools informed much of my early thinking about the research process, but other perspectives proved more relevant to this study and its execution.

Social causation perspectives, such as social strain theory, trace the links between mental illness and social disadvantage, and tend to regard psychiatric diagnoses as legitimate facts, as does stress theory (Rogers and Pilgrim 2005: 12; Thoits 2010: 107-119). Serious stressors like war, rape, childhood physical and sexual abuse, and being caught up in natural disasters, are all known to be powerful predictors of not only post-traumatic stress disorder (PTSD), but also of other types of psychopathology such as major depression, antisocial personality disorder, and alcohol and substance abuse disorders (Dohrenwend 2000: 1-19). Repeated trauma in childhood, argues Judith Herman (1998: 96-97), can ‘foster the development of abnormal states of consciousness in which the ordinary relations of body and mind, reality and imagination, knowledge and memory, no longer hold.’ These symptoms, often diagnosed as dissociative disorder, borderline personality disorder, anorexia, amnesia, sexual dysfunction, and depression, would in earlier times (if the sufferer was female) have been classified as hysteria.

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Although I draw significantly on theories of social causation when addressing the issue of childhood trauma, an unquestioning acceptance of the validity and reliability of psychiatric diagnoses was not the aim of this thesis – far from it. I want to emphasise the fact that terrible, painful things really do happen to people – my most pressing interest is, as I have made clear, the damaging effects of child sexual abuse (CSA) trauma. However, as I show in later chapters, psychoanalysis, through Sigmund Freud’s imaginative speculations, buried this reality under notions of fantasy and the Œdipus complex. Psychiatry, although acknowledging the external world through a clinical acceptance of post-traumatic stress disorder, still routinely obscures the damage of CSA by persisting in addressing mental disorder in biological and genetic terms, despite paying lip service to biopsychosocial theories (Read, Bentall and Fosse 2009: 299). My major theoretical perspective in this thesis is social constructivism, which assumes that the way social reality is interpreted and understood is a product of human activity, rather than a stable, objective truth. Through this lens, the classificatory status of mental illness is problematised, and the links in modern society between the productions of selfhood by mental health expertise and the dominance and control of social deviance by psychiatry can be established (P. Miller and N. Rose 1994: 29-64; Rogers and Pilgrim 2005: 15-16; N. Rose 1999; N. Rose 1998; Szasz 1961: 59-65). Although my work is critical of many of the truth claims of psychiatric knowledge, I do however acknowledge that some problems classified as mental illness originate in very real disorders of the brain, such as temporal lobe epilepsy, dementia, and many learning disabilities. These complaints are not, however, the focus of this study.

In my autoethnography I am informed by symbolic interactionist and social realist viewpoints, which place less emphasis on ideas and more on action and negotiation. According to George Herbert Mead (1934) and Herbert Blumer (1969), human beings are best understood in relation to their environment. Individual identity is constructed through interaction with other people, by interpreting each other’s action through a shared cultural vocabulary of symbols and signification. From the social realist point of view, Roy Bhaskar (1989; 1978), following Marx, argues that human action does not simply construct social reality, nor the reverse: material reality exists and constrains action but is not merely determinate, with individuals becoming agents who can transform or reproduce the society they live in (Rogers and Pilgrim 2005: 16-17). Several other perspectives also illuminated my research process and will be outlined below.

**Labelling Theory and Deviance**

Labelling theory is drawn from symbolic interactionism and is concerned with the roles that society enforces for deviant behaviour (Lemert 1951: 75-76). Howard Becker (1991) argues that deviance is not a universally understood infraction of social rules; it is, rather, created by the particular society in which we live:

> Social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an ‘offender.’ The deviant is one to whom that label has been applied; deviant behavior is behavior that people so label (Becker 1991: 9; emphases in original).

Deviant roles powerfully affect how society perceives those who are assigned those roles, how the person labelled deviant perceives him or herself, and his or her relationship to society. The deviant role and label affixed by rule enforcers such as the police or psychiatric professionals – termed by Becker (1991: 147-163) ‘moral entrepreneurs’ – isolates the labelled person as different, an outsider, and subject to social control.
Viewing chronic mental illness as in part a social role follows Talcott Parsons’ (1951: 431) work on the ‘sick role’, where he argues that illness is a type of response to social pressures, being ‘partly biologically and partly socially defined,’ and perhaps a way of ‘evading social responsibilities.’ However, interpreting any advantages gained from assuming the ‘sick role’ requires an imaginative leap into a purposeless world with little actual benefit (Frank 1997: 107). Much illness is never formally diagnosed, and when an individual turns to professional medical or psychiatric care it can be assumed that a person is suffering significant tension and strain, which makes him or her vulnerable to suggestion from a physician or a psychiatrist who works in a medical profession suffused with social prestige and expertise (Scheff 1984: 84). In agreeing to enter the ‘sick role’ of the proffered diagnosis, the person’s status changes detrimentally, particularly so in the field of mental illness as this carries profoundly negative connotations. As Thomas Scheff (1984: 84-85) points out, the ‘patient’ sometimes enters the ‘sick role’ unnecessarily, when wrongly diagnosed: most people, when told that they are ill by an authoritative figure ‘will obligingly come up with appropriate symptoms.’ Labelled with a mental disorder (whether rightly or wrongly diagnosed) the ‘patient’ assumes a deviant role, often withdrawing to the margins of a society that is inclined to reject the mentally ill (Link et al. 1989: 400-423; Link and Phelan 2010: 571-587).

**Stigma**

Any mental illness diagnosis means, therefore, that a person is reduced from a useful member of society to someone tainted, or spoiled. Erving Goffman (1986: 2-19) argues that individuals who do not conform to ‘normal’ societal standards become disqualified from full social acceptance: a person with a stigma is not quite human and has to constantly adjust to a precarious social identity. In not conforming to social norms, the stigmatised person becomes subject to various forms of discrimination, exclusion, rejection, and disapproval, with the entire ‘stigma process … entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the labeling of persons as different and the execution of disapproval and discrimination’ (Link in Rogers and Pilgrim 2005: 27). It has long been recognised that the stigmatisation of people diagnosed with psychiatric disorders is harmful to the individuals affected and their families, and people deemed ‘mentally ill’ are often judged by the general public as more dangerous, violent, unpredictable, irresponsible, incompetent, and irrational than ‘normal’ people (Read and Law 1999: 216-229). There have been many anti-stigma campaigns promoting the notion that ‘mental illness is an illness like any other.’ Scandinavian research shows that these are of limited success in changing negative opinions, especially towards people diagnosed with serious mental disorders such as schizophrenia (Read, Haslam, Sayce and Davies 2006: 303-308). However, the ‘Like Minds, Like Mine’ movement operating in Aotearoa / New Zealand claims that their anti-stigma and anti-discrimination campaign has resulted in improved attitudes towards people with mental illness (Bishop and Hennessy 2010: 8-9). Significantly, though, it is not only diagnostic labelling that is related to the public perception of dangerousness and a desire to avoid the mentally ill – it is also the belief that the cause of the disorder is biogenetic. If psychosocial explanations are used, if for example, the public is informed that a traumatic event caused a person to develop psychotic symptoms, then the person with psychosis is much less likely to be stigmatised by their malady (Read, Haslam, Sayce and Davies 2006: 303-308). If causes are biogenetic, the danger is inherent within the damaged individual, but if they are psychosocial, the person is, rather, a victim of tragic circumstance that everyone can understand.
Degradation Ceremonies and Mortification

A person labelled as mentally disordered, therefore, suffers from stigmatisation, acquires a spoiled identity, and is disqualified from full social inclusion. This reduction in social status, from the previous self to the spoiled self, is initiated, according to Harold Garfinkel (1956: 420-424), by a formal procedure that he terms a ‘status degradation ceremony.’ Garfinkel (1956: 421-423) maintains that the ritual must be led by a denouncer acknowledged as ‘a public figure, drawing upon communally entertained and verified experience … invested with the right to speak in the name of these ultimate values.’ The denounced person’s original identity is destroyed, replaced by another of lesser value: ‘He must be placed “outside,” he must be made “strange.”’ Ronald Laing (1984: 101) explicitly links the degradation ceremony to the psychiatric examination, after which, says Laing, the person, now labelled with a serious mental disorder (for example, as schizophrenic) by a psychiatrist, will have their civil liberties revoked, be imprisoned in a mental hospital and subjected to psychiatric treatments against their will, ‘until the label is rescinded or qualified.’ Goffman (1961: 14) describes this process as a fundamental change in the individual’s ‘moral career’: the person’s self is ‘mortified’; he or she is systematically stripped of personal identity, social supports, and often of possessions, and submitted to the embrace of the total institution of the asylum or hospital ward.

It is, important, though, to note that not all people experience detrimental effects from a psychiatric label, as it is a necessity to access many psychological and pharmacological treatments, as well as state-funded disability allowances and other benefits (Rogers and Pilgrim 2005: 33). Notwithstanding these gains there are, however, profound inequalities in access to effective treatment, and poor, ethnic minority, and unemployed service-users are much more likely than wealthy, white service-users to receive coercive in-patient treatment (Rogers and Pilgrim 2005: 157-158). Despite strenuous campaigns to reduce discrimination, being mentally ill is undoubtedly a stigmatised social status, frequently associated in public consciousness with other forms of deviance such as drug abuse, prostitution, alcoholism, and serving time in prison (Rogers and Pilgrim 2005: 33). A psychiatric diagnosis is not only a label, but represents a new, abnormal persona embedded in the exercise of power relations (Bracken and Thomas 2005: 93).

Psychiatric Power

It is nowadays a commonplace to state that one of psychiatry’s functions is the social control, whether stealthy or overt, of a troublesome underclass in the interests of parties other than the individuals being treated (Rogers and Pilgrim 2005: 53). For much of the twentieth century, scholars examining psychiatry and its affiliates – the various forms of authority, knowledge, and techniques that Nikolas Rose (1999: vii) terms ‘psy’ – were concerned with concepts of power. These questions of dominance, control, and violence are central to the work of Michel Foucault, as he progressively refined a new conception of relations of power over the course of his lifetime. Foucault came to understand power explicitly as:

[A] multiplicity of relations of force, of incessant tactical struggles and confrontations that affect the distribution and arrangement of these relations of force, and of the strategies in which these relations of force take effect, with their more general lines of integration, their patterns and crystallizations (Davidson 2006: xv).

Power, stated Foucault (in Davidson 2006: xvi), is ‘the name that one gives to a complex strategic situation in a given society’ and his work makes clear the interrelations between individual expertise and knowledge and the management of a population (P. Miller and N. Rose 2008: 4).
Foucault (2006a; 2006b; 2003a; 2003b; 1992; 1991; 1990; 1983b; 1980) shows how modern ways of thinking, behaving, and relating to the ‘self’ emerged, linked historically to the development of innovative medical techniques, that were in turn connected to new forms of industrial production, new ways of urban living, and new ways of administering epidemic disease and human populations. Clinical medicine, as a way of observing disease and practicing treatment, created new forms of subjectivity both for physicians and for their patients, both embedded in a new and rationalised discourse (Foucault 1989). Foucault further examines the administration of the self, showing how technologies of power work to normalise behaviour, and in disciplining and controlling individuals (P. Miller and N. Rose 2008: 4-5). Peter Miller and Nikolas Rose (2008: 6) point out that all expert administrators – ‘these little engineers of the human soul’ – such as psychiatrists, physicians, prison governors, social workers, and even factory managers, town planners, and accountants, share a concern with deviations from the norm, and with ways in which the norm can be restored by modifying the actions of populations in such a way that its individuals become self-regulating. These technologies of power can be understood through the concepts of biopower and biopolitics.

**Biopower and Biopolitics**

Biopower, an increasingly prescient term coined by Foucault, originally referred to a sovereign's juridical power of death over his or her subjects (Cooter and Stein 2006: 196). Paul Rabinow and Nikolas Rose (2006: 196) assert that in the modern world, biopower ‘is now situated and exercised at the level of life,’ rather than of death. Foucault’s (1990: 135-159) model of the way organised power over life is deployed proposes that one pole, *biopower*, focuses on disciplining the individual human body, seeking to maximise its forces and integrate it into efficient systems; while the second pole is one of regulatory controls, a *biopolitics* of the population, that focuses on the species body: birth, morbidity, mortality, and longevity. Foucault (1990: 138) claims that this bipolar technology began in the seventeenth century, and by the nineteenth century, he argues, its two poles were conjoined within a series of ‘great technologies of power’ of which sexuality was only one.

By the end of the eighteenth century in Europe, declares Foucault (2003b: 242-244), power over the living person was entrenched within techniques of surveillance, punishment and discipline, as the ‘biopolitics’ of humanity-as-species emerged. Statisticians began measuring phenomena such as birth rates, fertility, mortality rates and longevity, and a state-sponsored biopolitics targeted a range of related economic and political problems (such as public hygiene, medical care, and disease) that were perceived to weaken the population, cause a drop in productivity and waste energy. As the process of industrialisation expanded, biopolitics also intervened in the lives of individuals who were incapacitated by accidents, medical conditions, disabilities and other abnormalities that removed them from the workforce and cost money to treat. Insurance schemes, diagnostic standardization in medicine, savings plans, and safety measures were all introduced. New kinds of struggle could now emerge, in which life itself became politicised, turning back against the controls exercised over it in the name of claims to a ‘right’ to life, to one’s body, to health, to the satisfaction of one’s needs. Foucault’s exposition of biopower and biopolitics was situated within his scrutiny of the transformations attending the rise of the European nation state and industrial capitalism, but as an heuristic tool the expression can be used by extension to make sense of a variety of current global issues. While I rarely refer directly to the concepts of biopower or biopolitics in this thesis, the terms are a useful way of understanding the power relations between psy professionals and their clients, and they have provided a theoretical underpinning for the way I have thought about my research.
Paul Rabinow and Nikolas Rose, discussing the efficacy of the concepts of biopower and biopolitics in analysing contemporary matters, assert that:

Biopower … entails one or more truth discourses about the ‘vital’ character of living human beings; an array of authorities considered competent to speak that truth; strategies for intervention upon collective existence in the name of life and health; and modes of subjectification, in which individuals work on themselves in the name of individual or collective life or health (Rabinow and Rose 2006: 195).

When Foucault wrote about disciplinary power within carceral institutions such as the prison, the psy professions are a clear example of what he had in mind when he discussed a more generalised technology of social power. Indeed, Foucault’s (2006a) History of Madness, which remains a pivotal text in the history of mental disorder, reveals that the origins and functions of psychiatry are far from the high-minded quest dedicated to the service of humanity that most authoritative accounts would have us believe.

**Therapeutic Authority**

The exercise of power over the behaviour of other human beings has become invested in what Peter Miller and Nikolas Rose (1994: 29) term ‘therapeutic authority.’ Therapeutic authority, the expertise and praxis of the psy disciplines, is a category of what Foucault (1983b: 334) describes as ‘new form[s] of pastoral power’ ensuring the ‘salvation’ of people in worldly, rather than religious, terms. Since the end of the Second World War a number of academic departments and clinics in the United States and the United Kingdom sought to meld the psy disciplines, sociology, and anthropology into ‘a general science of social relations’ that could attempt to resolve issues such as criminal conduct, child welfare problems, marital discord, and social conflict in line with the demands of personal fulfillment, the requirements of liberal governments, and workforce productivity. Miller and Rose (1994: 31-33) argue that therapeutics, a set of related forms of expertise and practice informed by psychoanalysis and dynamic psychology, now function as forms of intervention ‘that transform relations of power between authorities and those whose lives they claim to understand and seek to improve.’

There are three areas of experience in which therapeutic authority operates, argue Miller and Rose (1994: 29-30): firstly, phenomena such as personal distress and difficulties have been construed as problems requiring expert intervention, ‘addressed in terms of an inner world of psychological processes and an interpersonal world of human relations.’ Secondly, the psy disciplines use new ways of diagnosing these problems to make life intelligible in line with the discourse of social psychology and psychoanalysis; and thirdly, the first two areas combine, giving therapeutic authority the right to intervene in these psychological realms in order to improve them, through forms of consultancy, for example in marriage guidance, child-rearing, or employment management skills.

How, though, does a comparatively small number of psy professionals transform the way the multitude of the general population both understands its inner processes and interacts with others people? To Foucault (1983b: 340), power does not directly act on others, rather ‘it acts upon their action: an action upon an action, on possible or actual future or present actions.’ Miller and Rose (1994: 35; emphases in original), following Foucault, argue that this ‘action on the action of others’ operates most efficiently not through overt domination but through constructing the ways in which people can become self-regulating through new techniques and abilities. Professional therapists are trained within an institutional group practice designed to
transform their personalities. Those enrolled in this therapeutic network became part of a new form of expert authority, one that merges professional and personal development: the mastering of the self and the government of others (P. Miller and N. Rose 1994: 50-51).

In our society, becoming a member of the medical profession offers an admired and highly desirable social status (Becker, Geer, Hughes and Strauss 1961: 4; Parsons 1951: 434). Professional training requires years of instruction and supervised practice, and the trend is for the length of training to increase. Students occupy a specific position within the social system of the medical school, interacting in ways defined by institutional rules organised in an extremely authoritarian manner. As such, the faculty exercises a powerful influence on student activities, and their thinking and professional perspectives (Becker et al. 1961: 46-48).

As Robert Merton (1982: 180) points out, like all professions, medicine ‘has its own normative subculture that is a body of shared and transmitted ideas, values, and standards towards which physicians are expected to orient their behaviour. These norms codify and specify the values of the profession.’ Within this subculture, physicians are socialised, selectively developing the culture – the attitudes, values, skills, knowledge, and interests – that is dominant in the group to which they desire membership. Trainee physicians learn social roles: they must become emotionally detached in the way they relate to their patients, keeping their emotions ‘on ice’ while not becoming callous (Merton 1982: 181-187), a process Parsons (1951: 435) terms ‘affective neutrality.’ Various medical specialties offer different levels of prestige and status, with surgeons high in the hierarchy and psychiatrists on a lower rung (Merton 1982: 178-180). Although lower in the medical hierarchy, the role offered by the practice of psychiatry commands tremendous authority over its patients, an issue I examined in my autoethnographic chapter.

**Tactical Writing**

I have claimed that this thesis is about haunting: an exploration of a cultural exclusion zone where people who have suffered experiences of trauma and madness are banished. As Avery Gordon (2007: 7) asserts: ‘To study social life one must confront the ghostly aspects of it.’ To explore this exclusion zone – this Otherworld – I need a methodology that traces shadowy connections and listens to the susurrations of resistance to psychiatric power: the kind of tactical approach that relies on loopholes, poaching, and infiltration (de Certeau 1984: 29-39). Sociology does not have to cleave to rigid disciplinary boundaries; it can be a creative mix of genres, drawing from diverse areas of research (Brewer 2007: 1-5; Game and Metcalfe 1996: 6-25; Jovanović 2011: 1-27). Apprehending the complexity of an ambiguous human subjectivity that is entangled within the immense networks of society and history calls for a sociological perspective that enters through ‘a different door’ (Gordon 2007: 4-7 and 65-66 and 197). This gaze seeks ‘the profane illumination’ (Gordon 2007: 204) finds at the ‘crossroads where ghostly signals flash from the traffic, and inconceivable analogies and connections [are made] between events’ (Walter Benjamin in Gordon 2007: 204), an explanation that captures what the dominant discourse has exiled.

Haunting, says Gordon (2004: 24), is a phenomenon that makes it clear that linear time is jammed: people, knowledge and events that we think of as past unsettle and disrupt the present, making our certainties flicker, subverting the order of things. Gordon (2004: 23) points to Herbert Marcuse’s (2002: xl-xliv) insistence that ‘[s]ocial theory is historical theory,’ and the aim of any critical theory of contemporary society should be to confront ‘its used and unused or abused capabilities for improving the human condition.’ The way that society is currently organised should be measured against historical alternatives, tracing contingent
ways in which human life has been judged as worthy or unworthy of living. ‘Social theory is concerned with the historical alternatives which haunt the established society as subversive tendencies and forces.’ My main tactics to achieve this entrance ‘through the other door’ (Gordon 2007: 65-67 and 197; emphases in original) are autoethnography, an insider narrative that was told in the previous chapter, and an exploration of subjugated knowledges, a history of the present that follows on from this theoretical interlude.

Autoethnography

In autoethnography the writer becomes the subject of the study. The unitary sense of self, the notion of a person as a bounded, unique being, is a product of Western culture, and I follow Erving Goffman (1959) in agreeing that this troublesome concept is really a concatenation of roles demarcated by thousands of socially mediated needs, desires, necessities and demands. Human nature, as Clifford Geertz (1983: 59) makes clear, is never independent of its cultural matrix. The concept of the self, with its apparently self-evident opposition between inwardness and external reality will be explored in the following chapter; for now, I wish to note that to a symbolic interactionist, self is not a structure, it is a process – indeed, a process that exists fundamentally in relation to other people. As Goffman (1972: 31) says, there is ‘a double definition of self: the self as an image pieced together from the expressive implications of the full flow of events in an undertaking; and the self as a kind of player in a ritual game.’ Interaction creates the self:

Face-to-face interaction may be roughly defined as the reciprocal influence of individuals upon one another’s actions when in one another’s immediate physical presence. An interaction may be defined as all the interaction which occurs throughout any one occasion when a given set of individuals are in one another’s continuous presence; the term ‘an encounter’ would do as well. A ‘performance’ may be defined as all the activity of a given participant on a given occasion which serves to influence in any way any other of the participants (Goffman 1990: 15).

Qualitative researchers in the social sciences, have, in recent years, become increasingly interested in narrative forms of enquiry, resting on the assertion that human beings create themselves through language: through talking, writing, and telling stories (M. Crossley 2000: 10). Researchers in this field are unanimous in their conviction that our selves and our identities are actively and interpretively composed through embodied narrative (B. Smith and Sparkes 2006: 170), and ‘shaped by the larger socio-cultural matrix of our being-in-the-world’ (B. Smith and Sparkes 2008a: 6).

The self – my self – lives in a body that acts, declares Rhonda Shaw (2010: 133), ‘as a threshold or hinge between mind and world. Consciousness and subjectivity are thus incarnate.’ This body – my body – is intimately bound to the lived bodies of others, to relationality, to space, and to time (Shaw 2010: 132) and this lived experience, this ‘lifeworld … is both the source and the object of phenomenological research’ (van Manen 1990: 53). Max van Manen (1990: 101-106) calls these interconnecting structures of meaning ‘lifeworld existentials’, and all of these things have influenced my research process, my reflection and my writing: I interact with other people; I sustain relationships with them in shared interpersonal space; these spaces, where I live, travel, and work, affect my moods and emotions as ‘felt space’; and past experiences, even when apparently forgotten, inscribe indelible traces on my being, on my body, on my hopes and expectations for the future.

My lived, embodied, life experience, then, is my claim to authority as I construct my autoethnography. My various positionings, as a woman, as a former mental health service-user, as a survivor of rape and domestic
violence, as a mother, as a mother of a child traumatised by sexual abuse, as a sociologist, and other intersectional identities marked by time and place, are all threads in my narrative, and the knowledge gained in these various subjectivities is the way I invite my reader to believe my story and its claims to truth. Django’s experiences and trauma have loudly reverberated in my own psyche, resonating with my own traumatic memories. I am at the same time a sociologically informed researcher, who is listening, watching, in dialogue with others, writing about my experiences. It has been suggested that autoethnography subverts the ethnographic issue of insider / outsider (or emic and etic distinctions) as the writer reports and reflects on their own life (Burnard 2007: 808-813). I am ‘inside’ the felt space of trauma, but I am simultaneously ‘outside’ it as an observer. I have constructed my narrative identity by locating myself within a particular repertoire of emplotment, a site that ‘inextricably links memory, subjectivity, and the materiality of the body’ (S. Smith and Watson 2010: 49).

Autoethnography developed within social constructivist research traditions as an interactionist and phenomenological approach. Carolyn Ellis (1999: 673) defines its practice in ‘Heartful Autoethnography’:

Autoethnography is an autobiographical genre of writing and research that displays multiple layers of consciousness. Back and forth autoethnographers gaze, first through an ethnographic wide angle lens, focusing outward on social and cultural aspects of their personal experience; then, they look inward, exposing a vulnerable self that is moved by and may move through, refract, and resist cultural interpretations. As they zoom backward and forward, inward and outward, distinctions between the personal and cultural become blurred, sometimes beyond distinct recognition. Usually written in first-person voice, autoethnographic texts appear in a variety of forms – short stories, poetry, fiction, novels, photographic essays, personal essays, journals, fragmented and layered writing, and social science prose. In these texts, concrete action, dialogue, emotion, embodiment, spirituality, and self-consciousness are featured, appearing as relational and institutional stories impacted by history and social structure, which themselves are dialectically revealed through actions, feelings, thoughts, and language.

Ellis (2004: xvii) terms this process, of jinking between inner and outer worlds, jolting back and forth in time, and switching betwixt genres, a ‘systematic sociological introspection’ – a sociology that enters ‘through the other door’, aligned with Avery Gordon’s (2007: 65-67 and 197; emphases in original) montage technique of subjective experiences, emotions, and observations of the complications of life. Emotional awareness, says Ellis (in Gilbert 2001: 10-11), should be integrated into the research process, and she argues that ‘[e]motional sociology – consciously and reflectively feeling for ourselves, our subjects, and our topics of study, and evoking those feelings in our readers – is necessary for apprehending important aspects of social life, in particular, the lived experience of emotions.’ This approach is also advocated by Mary Holmes (2010: 143), who insists that sociological research needs to pay ‘attention to the interactional nature of the self’ to emphasise the fact that emotions are social as well as introspective.

Illness narratives and narrative medicine are now an established genre in life writing. Through the use of narrative, stories of pain and suffering are used to give form and meaning to the experience of illness, with the listener and transcriber undertaking a service of ‘empathic witnessing’ (Kleinman 1988: 244-249). Authors of these kinds of narratives describe them as moral works that actively produce a process of healing as people tell their stories of illness and trauma, speaking their fears to themselves, their loved ones, and to health professionals (Charon 2008; Frank 1997; Kleinman 1988). These narratives are performed orally in psychotherapy, and also appear as written and published biographical and autobiographical accounts, which help to configure and articulate experiences and events that change one’s life and its fundamental conditions as a result of illness. Illness narratives capture the individual’s suffering in an everyday context, in contrast
to the clinical narratives that reflect the needs of the medical professions and institutions. Parents writing about their disabled children is a sub-genre of this field, and Arthur Frank (2004: 184) asserts that this kind of narrative 'is a moral work, since what’s at stake is personhood and its entitlements. If [the child’s] life is not narratable, then [the child] becomes “one of those kinds of kids”, and his entitlements – … to care and services, to respect as a person – are in jeopardy.’ Confessional tales of sexual abuse have been hailed as a powerful way of transforming pain, shame, and anger into tools for cutting away lies and trickery, ‘leaving the clean hard … kernel of truth’ (Bass, cited in Ronai 1995: 422).

The repertoire of emplotment that I make use of is that of the ‘wounded storyteller’ (Frank 1997), a standpoint that is ‘a political and ethical act of self-reflection (Frank 2000: 354-356). Frank describes three types of illness narratives, ways of recollecting and recounting personal experiences of suffering as a moral work that helps a survivor to achieve self-understanding and healing. One way to structure a life story is the ‘restitution narrative’, with a plot that traces a heroic journey from sickness back into health (Frank 1997: 75-96). Our cultural scripts powerfully reinforce this narrative: the mysteries of suffering are regarded as scandalous, and there are expectations that sick people can, through sheer will-power, self-control, and the correct medication, restore their bodies and minds to health, and cure their disease. These stories are compelling, and sometimes true. The ‘chaos narrative’ is the opposite of this: the plotline imagines a life that never heals (Frank 1997: 97-114). These stories are hard to listen to: they are wounding, threatening, full of horror, with no end to suffering, and they tell of vulnerability, helplessness, and futility. They often cannot be told, as memory stutters and trauma silences the voice, so the story becomes an ‘anti-narrative of time without sequence’ and without reflection (Frank 1997: 98). They become ‘the things themselves’ (Merleau-Ponty 2000:3), as traumatic experience erupts from the past into the present. The third type of plot is that of the ‘quest narrative’ (Frank 1997: 115-136). Here, the storyteller is the active player: suffering is met head on as the teller tries to make use of illness, travelling a journey that becomes a quest to remake the self anew through disability and pain. Quest stories are thus hopeful tales that engage in dialogue and communication with others, gaining empowerment through action. My storytelling is plotted through the structure of a quest narrative, but with elemental eruptions of chaos cutting into the text: a layering of accounts, bursts of poetry, scripted meetings, excerpts of letters, bodily and sensory feelings, authorial interruptions, and sociological musings.

Traditional objective social science writing conventions have been challenged by varieties of new ethnographic genres: categories that are both creative and analytical. Creative analytical processes – fiction, drama, theatre, poetry, storytelling, layered texts, letter-writing, visual texts, museum displays, and performance art are all types of qualitative research that have evolved and proliferated, influenced by post-structuralism, a theoretical perspective that links subjectivity, language, social organisation, and power (Richardson and St. Pierre 2005: 962-963). ‘Language,’ says Laurel Richardson (in Richardson and St. Pierre 2005: 960), ‘is a constitutive force, creating a particular view of reality and of the Self.’ Writing styles are neither neutral nor fixed, and they reflect the shifting dominance of currently fashionable schools, discourses, or paradigms. Social scientific writing is no exception, and, states Richardson (in Richardson and St. Pierre 2005: 962), these new ethnographies portend a paradigm shift, revealing ‘the writing process and the writing product as deeply intertwined; both are privileged.’ Social science valorises triangulation, the use of different methods – documents, interviews, data and similar artifacts – to validate research findings. However, the ‘central imaginary’ of post-structuralist texts is not the triangle but the crystal, with its multi-
faceted angles, shapes, and transmutations: ‘prisms that reflect externalities and refract within themselves .... what we see depends on our angle of repose – not triangulation but rather crystallization’ (Richardson and St. Pierre 2005: 962-963).

Trying to tell a story honestly surely means revealing the cunning orchestrations of the researcher as author, constructions that are normally glossed over when data and interviews are presented in realist terms. Some researchers use poetry as a means of analysing social worlds and communicating their findings to readers, believing that allowing a speaker's repetitions, pauses, alliterations, rhythms, and so on to be honoured might be a better way of representing what happened. Reading is not a passive process, and poems are more able than realist tales to evoke the emotional dimensions of experience, as well as a way of continually reminding the reader that the text has been artfully written (Richardson 1994: 3-13; Sparkes and Douglas 2007: 170-190). These new social scientific writing practices are '[e]vocative representations [that] do not take writing for granted but offer multiple ways of thinking about a topic, reaching diverse audiences, and nurturing the writer’ (Richardson 2000b: 5). Autoethnographic research is a relatively new approach in sociology, developed from anthropology and its ethnographic practices. The position of the ‘objective observer’ and realist conventions were both called into question in the disciplinary upheavals that attended anthropology’s deconstruction thirty years ago.\(^\text{19}\) As ethnographic techniques were taken up by a wider field of academic disciplines the approach became more autobiographical: as Clifford Geertz notes (2000: 22-23), '[m]ost social scientific research involves direct, intimate, and more or less disturbing encounters with the immediate details of contemporary life, encounters of a sort which can hardly help but affect the sensibilities of the persons who practice it.'

Autoethnographic research explores a single case: the life of the writer, and those individuals who feature as major characters in the story. The distance between the researcher and those with whom the research is done is dissolved: as I have said, the self exists in a process of interaction with other people; the autoethnographer is both author and subject, the teller and the tale, the still point at the intersection of biography and history (C. Ellis 2009: 13). Autoethnographic writing is both imaginative and creative, and it must be alert to the dangers of narcissism, otherwise it can turn into what Michael Crotty (1998: 48-50) calls ‘a rampant subjectivism’ more obsessed with conceit than curiosity, becoming a kind of solipsistic soap-opera (Coffey 1999) or attracting accusations of mere self-indulgence (Sparkes 2002: 209-232). The process of writing an autoethnography is a journey of self-discovery, and key issues of representation, voice, and ethical conduct must be addressed. Working in a social constructivist vein does not mean that I have abandoned reality: indeed my thesis, while exploring the notion of ‘making up people’ (Hacking 2006: 23-26) as categories of mental disorder, simultaneously insists that actually occurring traumatic experiences can profoundly damage the psyche of the survivor. However, I do not tell my story in a realist manner, instead hoping that the narrative will generate insights into my own lived experience, encouraging empathy, solidarity, and connection, informing readers of disturbing social processes that may be hidden from consciousness.

\(^\text{19}\) The changes that swept through anthropology since the 1980s are outside the remit of this thesis. Challenges to the authority of allegedly ‘objective’ ethnographic accounts made by elite anthropologists revealed that all ethnographies are academic performances, using rhetorical tropes and allegorical patterns. Ethnographic practice went through a political and epistemological crisis, and Western writers no longer portray non-Western peoples with unchallenged authority – cultural representation is inescapably contestable, contingent, and historical. See the landmark book that spearheaded this attack: Clifford and Marcus 1986. See also Marcus 1998; Marcus 1994: 563-574; Reed-Danahay 1997.
In my previous autoethnographic chapter I declared: 'Tell all the Truth but tell it Slant' (Dickinson 1975: 506-507; emphases added). Truth is, oftentimes, unverifiable, and my story was told obliquely, using a montage of concrete experience and intimate detail, of sociological introspection, emotions and bodily states, memories, vulnerabilities, dialogues, poetry, and layered writing; I show my concern with the moral, ethical, and political consequences of trauma; I explore the meaningfulness of human experiences; I seek to fuse literature and social science; I encourage compassion; and I speak from the heart (Pelias 2004), writing a 'heartful autoethnography' (C. Ellis 1999). I do want my work to be – as Laurel Richardson (2000a: 253-254) advises – both literary and expressive of a lived reality. I mean this in the sense that my descriptions, although recounted using evocative writing techniques and forms, are empirically based: I was there with Django, in a world where real things happened; I had conversations with therapists, psychiatrists and educators; I kept letters and journals; I knew Wolf and Reynard; I have my own memories of trauma to draw on; I saw and I listened. I have endeavoured to make this story read as a real, embodied, fleshed-out expression of lived experience, and the lenses I have used, I hope, have revealed the truth behind the artifice of narration.

One way of establishing credibility is to make a space for self-reflexivity. For Laurel Richardson (1993: 695-710), claiming her writing is both scientific and literary does not mean a blind adherence to positivist or post-positivist techniques that confer an emotionless authenticity through the use of a passive voice and an omniscient narrator. Indeed she worries more about respecting her participants, and claims a kind of 'transgressive validity' for her work, writing field notes as a drama, an interview as a poem, and articles with a mix of diverse genres, critical analyses, and personal experiences:

I challenge traditional kinds of validity and call for different kinds of science practices. The science practice I model is a feminist-postmodernist one. It blurs genres, probes lived experiences, enacts science, creates a female imaginary, breaks down dualisms, inscribes emotional labor and emotional response as valid, deconstructs the myth of an emotion-free social science, and makes a space for partiality, self-reflexivity, tension and difference (Richardson 1993: 695).

By transgression Richardson does not mean merely that sociologists should become poets and dramatists – as she says, most cannot write well enough to carry this off – her intention is, rather, more radical. Richardson (1993: 706) suggests that we 'step outside the normative constraints for social science writing .... find and deploy methods which allow us to uncover the hidden assumptions and life-denying repressions of sociology; resee / refeel sociology. Reseeing and retelling are inseparable.'

In evaluating the strength of an ethnography, Richardson (2000a: 254) advises five criteria should be addressed: substantive contribution to the understanding of social life; aesthetic merit; emotional and intellectual impact on the reader; the expression of a lived experience; and reflexivity. Interpretive and critical writing that stresses the construction, rather than discovery, of social reality during the research process defines reflexivity as:

Research that turns back upon and takes account of itself, to explore the situated nature of knowledge; the institutional, social and political processes whereby research is conducted and knowledge is produced; the dubious position of the researcher; and the constructive effects of language (Alvesson, Hardy and Harley 2008: 480).
Self-consciousness, a critical perspective, and introspection are, as Pierre Bourdieu (in Bourdieu and Wacquant 1992: 36-46) points out, vital to checking the preconceived notions that all social researchers are laden with: reflexivity is not only a solution to the problem of bias, but, argues Bourdieu, it also increases ‘the scope and solidity of social scientific knowledge.’ As a reflexive researcher, it is important to note the multiplicity of different theories and perspectives that claim to understand a phenomenon, and then to search for what is overlooked or unsaid, as well as what is shared or given voice. In writing my autoethnography, furthermore, I have had to challenge the authority of my own assumptions and motivations, and attempt to expose and explain my own limitations. In examining the field I was situated within – the psy professions – I also needed to explore the relationship between my own claims and that of the dominant discourse. Reflexivity is also a destabilising practice: it challenges the central epistemological and theoretical assumptions of the field of research (Alvesson, Hardy and Harley 2008: 482-486).

Autoethnographers, like traditional ethnographers, engage in participant observation, but the fieldwork is one’s own experience. Narrative ethnography moves from participant observation to what Barbara Tedlock (1991: 81) describes as ‘the observation of participation,’ where Self and Other, rather than allegedly being entirely separate categories, are acknowledged to be engaged in a dialogue; the cultural analysis emerges from this ‘engaged writing.’ My project at the same time becomes a ‘confessional tale’ that shows the impact of the research process on myself as fieldworker (van Maanen 1988). Autoethnography uses the conventions of a literary novel to connect the political and the historical, the social and the cultural, to autobiography, embodiment, emotion, and introspection (C. Ellis 2009: 13; 2004: xix). Research as reflective writing, trying to bring things into being through artistry, through evocation, is difficult. Max van Manen (2002: 243) describes this writerly space as a place where ‘the uncanny rumble of existence itself’ rules. This space is where ‘the things themselves’ (Merleau-Ponty 2000: 3) are, in all their frightful presence: the traumata that cannot be spoken directly. The phenomenological text, in trying to describe this uncanniness, does not only have a surface message, but speaks directly to its reader by the way the story is structured and told: in trying to evoke experience, some things will sing out as they stir up resonances in the reader, validating experiences, touching another person’s consciousness with what Maurice Merleau-Ponty calls ‘wild being’ and Jacques Lacan describes as ‘the “terrifying beauty” of the Real’ (van Manen 2002: 237-252). Indeed as Max van Manen (2002: 238) so perceptively notes, ‘to write is to stir the self as reader.’ I have written from inside my own life experience, ‘where meanings resonate and reverberate with reflective being.’ This ‘uncanny rumble of existence’ (van Manen 2002: 243) is reminiscent of Walter Benjamin’s (1986: 183) notion of ‘profane illumination’, a way of seeing through the everyday banality of life. Jolted into a different space, the reader falls into a ‘crossroads where ghostly signals flash from the traffic, and inconceivable analogies and connections between events are the order of the day.’ My research and writing touches another being, another reader, who then writes the text anew at every reading.

When writing a meaningful text one must try to write what cannot really be written, trying to evoke what cannot really be heard, seen, or touched. Personal experience, though, can be constructed as the framework of the storytelling. C. Wright Mills (2000) claims that the proper subject of the sociologist is the space where history and biography intersect. Mills argues that the best scholars do not separate their lives from their work, instead using each experience to enrich the other:
What this means is that you must learn to use your life experience in your intellectual work: continually to examine and interpret it. In this sense craftsmanship is the center of yourself and you are personally involved in every intellectual product upon which you may work. To say that you can ‘have experience,’ means, for one thing, that your past plays into and affects your present, and that it defines your capacity for future experience (Mills 2000: 196).

Mills suggests keeping a journal, which I have done for many years, with many notes that include the time around Django’s birth and early childhood. These journals and notebooks are the basis of my autoethnographic writings, along with a vast collection of medical and psychiatric records, letters, and other texts. Contingency, argues Howard Becker (1998: 32-33), is what connects one event to another, and my story could be constructed differently, just as the incidents I remember and describe occurred in unpredictable and indirect ways. My narrative shapes and makes meaning out of these disparate and sometimes random experiences. Following Norman Denzin (1997: xvii), I use both autoethnography, based on my own experience, and ‘messy’ texts – stories that others have told to me (Marcus 1994: 563-574). ‘Messy’ texts examine ‘those events, narratives, and stories people tell another as they attempt to make sense of the epiphanies or existential turning point moments of their lives’ (Denzin in B. Cohen 2008: 51). In autoethnography and ‘messy’ texts a realist ethnography that claims authenticity is commonly rejected in favour of a multi-voiced, open-ended narrative that privileges emotion – a story told to kindle social critique and social action. Academic and literary, the ‘messy’ text joins ‘the personal, the biographical, with the political, the social’ (B. Cohen 2008: 50-51).

There are different ways in which stories can be told, with different methods: ‘story analysts’ use narratives as data to be used for systematic and rigorous analysis, with the researcher abstractly theorising from a distance; for ‘storytellers’ the stories themselves do the work of analysis and theorising (B. Smith and Sparkes 2008a: 21). Carolyn Ellis and Arthur Bochner (in B. Smith and Sparkes 2008a: 21) insist that this dichotomy is misleading, as ‘when people tell their stories they employ analytic techniques to interpret their worlds. Stories themselves are analytical.’ Storytellers do not generally write realist tales, instead preferring to reach out to the reader to encourage intimate involvement, evocation, and embodied participation in their stories (B. Smith and Sparkes 2008a: 21). As Max van Manen (2002: 237-252) says, the important thing is to evoke a resonance in the reader, to stir the self of the other. Autoethnography is a creative practice, displaying multiple layers of consciousness along with sociological introspection and emotional recall, inviting the reader to step into the embodied, intimate world of the other in such a way that they are stimulated to reflect on their own life – a resonance of the heart, the emotions, and the moral connection between people as interconnected, relational beings (C. Ellis 2004). Autoethnography, notes Ellis, is an ‘autobiographical genre of writing and research’ and just as the individual self merges during interaction with others, autoethnographic writing blurs the boundary between social science and literature, a process Ellis (2004: xix; emphases in original) describes as akin to writing a ‘methodological novel.’

A struggle over what Arthur Bochner (2010: 663) terms ‘methodological sovereignty’ has resulted in disputes over ways to practice autoethnography. The dominance of the kind of writing that favours blurred genres, self-reflexivity, emotion, and a scepticism over the generalisability of knowledge claims in ‘evocative’ autoethnographic research has been challenged by Leon Anderson (2006: 373-395), who proposes instead an ‘analytic’ autoethnography that attends more to social realist concerns. Anderson (2006: 377) expresses uneasiness with what he describes as ‘postmodern sensitivities’ as well as the way that evocative autoethnographers privilege the creation of ‘an emotional resonance with the reader that is the key goal of
Anderson’s (2006: 373-374) main concern seems to be with capturing the field of autoethnographic enquiry away from the radical nontraditional methodology that is currently championed by practitioners such as Carolyn Ellis, Arthur Bochner, Laurel Richardson, and Norman Denzin and hauling it further back into a more cerebral framework, one that is more focused on ‘developing theoretical understandings of social phenomena.’ This is – as Anderson (2006: 377) admits – in part a tactic to bring autoethnography in from the margins, an attempt to shape it to conform to the norms of traditional social science values and thus increase its publication and dissemination in peer-reviewed academic journals (Holt 2003: 18-28). Indeed, although one would like to believe that evocative autoethnography is by now firmly established as a legitimate and meaningful research method, some writers are still criticised as insufficiently scientific or rigorous (Murray, Pushor and Renihan 2011: 46). Anderson is also, perhaps, trying to build cohesiveness in a notoriously fractured research field that some criticise as translating the political and the social into the merely personal (Atkinson 2005; C. Thomas 2010: 647-660).

While Anderson’s attempt to take autoethnography to a wider audience may be honourable, Carolyn Ellis and Arthur Bochner (2006: 433) voice several concerns. Firstly, they point out that Anderson does not need to appropriate autoethnography as a genre – if he wants to write a more mainstream type of ethnography he can just call it realist ethnography, which is already a recognised style. More importantly, though, Ellis and Bochner are concerned that Anderson wants to tame autoethnography:

Leon wants to take autoethnography, which, as a mode of inquiry, was designed to be unruly, dangerous, vulnerable, rebellious, and creative, and bring it under the control of reason, logic, and analysis. We want to put culture or society in motion; he wants to stop it, freeze the frame, change the context .... Autoethnography shows struggle, passion, embodied life, and the collaborative creation of sense-making in situations in which people have to cope with dire circumstances and loss of meaning. Autoethnography wants the reader to care, to feel, to empathize, and to do something, to act. It needs a researcher to be vulnerable and intimate. Intimacy is a way of being, a mode of caring, and it shouldn’t be used as a vehicle to produce distanced theorizing. What are we giving to the people with whom we are intimate, if our higher purpose is to use our joint experiences to produce theoretical abstractions published on the pages of scholarly journals? (C. Ellis and Bochner 2006: 433).

Norman Denzin (2006: 420) remarks that Anderson’s ‘analytic autoethnography’ has little in common with the ‘creative analytical processes’ advocated by Laurel Richardson and Elizabeth St Pierre: (2005: 962-963) the practices of poetry, performance, layered texts, allegories, storytelling, and other categories that I described earlier.

As Ellis and Bochner stress (2006: 431), the intention of writing autoethnography has always been to move ethnographic research away from the gaze of the detached and distant observer, and towards a connection with shared intimacy, embodied participation, and vulnerability; as they say: ‘[w]e think of ethnography as a journey; they think of it as a destination.’ This is, I admit, my own point of view. But my narrative, although profoundly personal, does not ignore the political or the social. Indeed, as Denzin (2006: 422) asserts, when we write about experiences of injustice, suffering, and pain, it is out of a commitment to a more just and egalitarian society:

We enact the worlds we study [and] [t]hese performances are messy and pedagogical. They instruct our readers about this world and how we see it. The pedagogical is always moral and political; by enacting a way of seeing and being, it challenges [and] contests ... the hegemonic ways of seeing and representing the other (Denzin 2006: 422).
Whilst self-exposure without a concomitant cultural analysis and interpretation may descend into memoir or bathos, or, worse, mere self indulgence (Sparkes 2002: 210), autoethnography must not just become an exercise in data collection, coding, and analysing: it needs a self-dialogue with a feeling and vulnerable self.

In another critique of autoethnography, Martin Tolich (2010: 1608) argues that ‘[t]he word auto is a misnomer. The self might be the focus of research, but the self is porous, leaking to the other without due ethical consideration.’ I have spent some time in this thesis arguing for the self as non-unitary, relational, and interactive; and I repeatedly noted my contention that the Western conception of the sovereign consciousness of the self is a socially constructed idea. Yes, autoethnography may therefore be inaccurate as terminology, but Tolich clearly regards the lack of boundaries in dialogical storytelling as problematic, and his description of the ‘leaky’ self, as an unethical, untrustworthy, and ultimately harmful phenomenon, seems to be begging for a return to the good old days of logical positivism and its pretence of objectivism. Carolyn Ellis is a particular object of Tolich’s (2010: 1608) ire, portrayed as ‘defiant’ when she argues (Ellis and Bochner 2006: 433) that the practice of evocative autoethnography should not be tamed. The word defiant implies a resistance to authority, and a kind of provocative challenge to the status quo. Tolich (2010) represents himself as an authoritative voice, as the detached and distant observer, against the multitude of qualitative researchers using more emancipatory, postmodern, feminist, and deconstructive methods to tell stories about embodiment, intimacy, emotion, and vulnerability.

Although to write work that resonates with another’s experiences one must be willing to be a ‘vulnerable observer’, this is a painfully isolating position to adopt. Some people respond in kind to this type of emotional opening; others, unfortunately, can wound. But not only is the observer vulnerable, so is the observed (Behar 1996). In this autoethnography I am both observer and observed; Django is also a major participant in this study, and the nature and sensitivity of the information divulged in my writings place my son and myself at risk. Django has given me his consent, but I have continually wrestled with this moral concern. Carolyn Ellis (1999: 672) notes that – of course – it is excruciatingly difficult to inscribe an honest autoethnography, especially when writing about family members. Indeed, says Sarah Wall (2008: 38-53), it is much ‘easier said than done’ to write an autoethnography: the writing experience is emotionally confronting, and there is constant negotiation between ethics, legitimation and issues of representation (Wall 2006: 146-160). Although autoethnography ‘by its nature involves the Self too intimately to ignore wounds, scars, and hard-won understandings that are to some degree part of our baggage’ (Etherington 2004: 82-83), this type of reflexive research raises several ethical dilemmas and needs to display an awareness of these issues as well as transparency in the research process. This is also why evocative autoethnography is a useful narrative framework for concealing information: I can omit or change identifying details, and I can fictionalise the story. And, I can try to create something valuable out of chaos, for telling a story about how I made difficult choices in ambiguous circumstances may show other people how these struggles can be meaningful: my autoethnography can ‘become a call to witness for both the author and the reader. The witness offers testimony to a truth that is generally unrecognised or suppressed’ (Sparkes 2002: 209-232).
The Ethics of Life Writing

Testimony sometimes offers the only, albeit slippery, witness to truth. I am convinced, following Arthur Frank (2000: 354-356), that this story about illness and trauma can be told as an ethical as well as an analytical act: ‘What makes an investigation principled is its advocacy.’ I have tried to tell my story for Django, in a responsible manner, trying to provide a therapeutic and emancipatory narrative (Frank 2000: 357-358). Since Michel Foucault’s presumption ‘that ethics and power relations are coterminous’ the demands of truth-telling are suspect as techniques of power, whether used in an illness narrative or in a confessional tale of the self (Frank 1998: 332). However, argues Frank (1998: 332-333), following Foucault, inscribing the self can move beyond subjection toward subjectification, an ambiguous term that can construct ‘the self as both object and instrument of power .... Practices of telling oneself still articulate with self-surveillance and self-regulation, but they also produce a self who may be ... ethical.’ With Foucault, there is always ambivalence: structures of power readily capture therapeutic narratives, as a ploy to control the subject by using that individual’s own voice. ‘Power operates by convincing us of the selves we want and need to become, in order to be “true” to ourselves’ (Frank 1998: 332-333). The techniques of therapeutic authority, as we have seen, operate most efficiently not through overt domination but through constructing the ways in which people can become self-regulating (P. Miller and N. Rose 1994: 31-35).

Power relations, though, are unstable, reversible, mutable, and can be re-framed (Foucault 1983a). ‘Power,’ says Foucault (1984: 287-299), ‘is not evil. Power is games of strategy.’ Foucault’s (2011) last writings and lectures took seriously the possibility that the care of the self, as an ethical act, also takes care of others. A speaker expresses his or her relationship to truth through frankness and moral duty: parrhesia, or ‘fearless speech’ takes a risk, but courage can reveal what is true (Foucault 2001: 11-16). The last words Foucault (in Gros 2011: 356) wrote, on the last page of his final lecture, state ‘there is no establishment of the truth without an essential position of otherness.’ Standing outside traditional social discourse – telling the truth slantwise – I can take a risk: I want people to read our story and connect with its events: to understand what harm results from child sexual abuse, to realise how it is hidden from view, to grasp how the psy professions (still) disregard its impact, to empathise with the twists and turns of psychiatric diagnosis and education for a young child damaged by a complex weave of traumatic injury and disability. Stories, says Frank (2010a: 666), ‘are “social facts”, in Durkheim’s sense of being external to humans but felt as coming from within, as one’s own sentiments ... “Stories go work on you like arrows.”’ This piercing witnessing is a way of talking back to Wolf, to Reynard, and to all other perpetrators of rape and child sexual abuse. My story takes back these traumatic tales, and makes them my own. Illness narratives offer readers an awareness of what goes on inside someone else’s body and psyche: conditions that are usually expressed only as external signs and symptoms. This story may perhaps provide resources for individuals who possibly could themselves one day become patients, or mental health service-users, or rape survivors, allowing them to ‘plug-in’, connect, and recognise what were previously disparate sites, discourses, and policies (Frank 2006: 421-440).

I strongly believe that all aspects of human life need to be talked about: indeed, threatening stories of illness, pain, and trauma should, especially, be exposed so that survivors can reclaim their own experiences from the narrative representations of others who tell them as allegedly objective, emotionless case studies (Frank 2009: 185-199). While writing my autoethnography, I was profoundly moved by reading the stories of others: I found that remembering and writing about childhood sexual abuse triggered flashbacks, feelings of rage, and anxiety attacks, and I was glad not to feel so isolated in horror and pain (Romo 2006: 81-94; Ronai
However, writing autoethnography does raise particular ethical issues over the rights of people who are characters in the text, and the necessity of requesting informed consent. And sometimes, surely, individuals would not give their consent, if asked. Could I have written my autoethnography if I needed permission from Wolf and Reynard? I gave them false names, and concealed and altered several things about them to make them difficult to identify, but I believe that this is my story, not theirs. Wolf is dead, but Reynard may read my thesis, and if this happens, and if he contacts me, I am not sure how I will react, although I have thought about this eventuality. I think issues of social justice are important, and how would it be possible to talk about trauma at all if the perpetrators had to have ethical clearance? When I wrote my autoethnography the ethical guidelines for autoethnographic research in academic practice were still relatively informal, although they are presently undergoing a rapid review that is resulting in stricter regulations (Tolich 2010: 1599; UAHPEC 2010).

Martin Tolich (2010: 1607-1608) describes ten guidelines that he argues should be foundational in the way autoethnography is practiced, covering aspects of consent, consultation, and vulnerability. In summary: participants’ autonomy must be respected, and informed consent process must be documented. During writing, ‘process consent’ must be practiced, ensuring that participants still want to be included in the story. The writer must be wary of conflict of interest or issues of coercive influence when seeking retrospective informed consent, that is, asking permission after the manuscript is written. Consultation must be performed; and authors ‘should not publish anything they would not show the persons mentioned in the text.’ Confidentiality is risky: especially between ‘insider’ participants, not only for the researcher disclosing information to ‘outsiders’. Stories will forever remain tattooed on the writer's curriculum vitae. Beware of using photographs; no image or story should harm others. Noms de plume should be used; and ‘assume all people mentioned in the text will read it one day.’ Tolich (2010: 1608) is particularly concerned with providing guidance for postgraduate students and I agree that supervision is important; my supervisors and I repeatedly checked my ethical responsibilities.

All of these matters are important, and I most certainly considered all of these strictures before, during, and after my research. Carolyn Ellis (2009: 303-318) draws attention to relational ethics: recognition of mutual respect between researcher and research participants, and the communities in which they work and live. It is important also to think about the impact of research on intimate others, and how relational situations come up during interviews, and during fieldwork, in ways that are unexpected and upsetting. It is impossible to plan ahead for all emergent complexities. Rhonda Shaw (2011: 62-63) determines that respect and care for participants, especially if they are in any way vulnerable, is a key principle in social research. Informed and uncoerced consent, minimisation of harm to participants (especially vulnerable ones), and to the researcher, are vital strictures. ‘Harm includes pain, stress, fatigue, emotional distress, undue embarrassment, cultural dissonance and exploitation. Without a doubt, social researchers need to be careful when interviewing around sensitive topics with vulnerable populations’ (Shaw 2011: 63), and an essential part of my research process was a continual monitoring and checking of Django’s safety and wellbeing.

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20 Romo writes about his suppressed memories of sexual molestation by his childhood Catholic pastor, and his attempts to deal with the re-emergence of these memories. Ronai writes a layered account of her experience of being sexually abused as a child. I found these autoethnographies intensely affecting.
While we may never be entirely able to understand or empathise with another’s suffering, there is a great deal of agreement that sensitively written illness narratives give voice to those in pain, providing understanding and hope, and sometimes catharsis. These stories involve therapeutic elements for the teller and for other people included in the tale, and the narrative can also help guide other people who may follow the same path of illness, disability, and suffering (Frank 1997: 17; Shaw 2011: 58-61). Attending to stories about other people’s illnesses teaches all of us something fundamental ‘about the human condition, with its universal suffering and death’ (Kleinman 1988: xiii). An ethics of compassion surely requires that we explore the violence of child sexual abuse, with its hidden victims and hidden pain: there is widespread trauma that still provokes much societal avoidance (Summit 1988: 39-60). Milan Kundera (1987: 31) writes that ‘there is nothing heavier than compassion. Not even one’s own pain weighs so heavy as the pain one feels with someone, for someone, a pain intensified by the imagination and prolonged by a hundred echoes.’ If forcing the researcher to suffer along with research participants is the true criterion for ethics of research with human subjects (Klockars in J. Johnson 2002: 116; J. Johnson in Shaw 2011: 67), then I have truly shouldered the burden of shared pain with Django and passed the test as an ethical researcher.

What kind of moral experience emerges from social science inquiries – the ethical dimensions of research – is a serious matter. Zygmunt Bauman (2005: 1096-1097) says that there is no ‘morally neutral way’ of practicing sociology, and the imperative is, always, to make the human condition intelligible: trying to reveal the truth of human suffering may at least bring the possibility of change. According to Bauman (2005: 1089-1090), there are three parallel streams of human creation that are able to ‘grasp and encapsulate the gist of the human condition’ – poetry, history, and sociology; they should all uncover hidden truths, and “‘crush the wall behind which something that ‘was always there’ hides”’ (Kundera in Bauman 2005: 1089). In my attempt to excavate the buried truths of psychological trauma, this thesis uses all three of these currents, weaving together history and sociology, and using poetry to emphasise emotional points I wish to make. My final social history chapter, on psychological trauma, has sub-headings borrowed from poems and the literature of trauma, a device intended to interrupt the dryness of academic discourse on human suffering, trying to jolt the reader into the shimmering realm of emotion, empathy, and compassion. Entwining poetry, history, and sociology, I try to reveal the uncanniness of existence, to make the wild being sing, reverberating in my reader’s consciousness as it resonated in mine.

Writing about this subject has been a gruelling experience. I still feel ambivalence over this revelation of Django’s and my own most intimate secrets, and I continue to suffer a profound sense of mourning and grief. I have lived this story for many years, and it is ‘a highly personal sedimentation of experience’ (Frank 1997: 24). Memory is a contested field, dominated by scepticism over the reliability of recollections of childhood sexual abuse. As Tessa Muncey (2005: 69) points out, telling a story about a taboo subject – and child sexual abuse is indeed still this – ‘require[s] legitimation not only for the text but also the method by which it is conveyed. This is particularly important if memory and its distortions appear to be critical features of the process.’ For now, I would merely like to note that our personal memories combine information from the past with perceptions arising in the present, mixing our imaginings and intuitions with the views of others and popular culture ‘to creatively reconstruct a rendering of our past experience’ (Campbell 2003: 4-5). I will address the topic of recovered memory in a later chapter. Memory is a palimpsest: present events are layered over past experiences, haunted by silences, forgetting, and implacable reminders.
Autoethnography does not claim to accurately reflect the past. There is, says Kristina Medford (2006: 853), a ‘mindful slippage between Truth and truthful’ in autoethnography; this means the essence of my experience is presented rather than an allegedly objective explanation of events. Memory is an active process, as we do not simply passively call on a depository of facts, but, rather, spontaneously compose and shape our remembrance in the light of subsequent experiences that are always in some sense articulated in the wider mix of social relations. Memory, it can be argued, is ‘necessarily relational: memories of the past are, like all common-sense forms, strangely composite constructions, resembling a kind of geology, the selective sedimentation of past traces’ (Popular Memory Group 2006: 46; emphasis in original). As Antonio Gramsci (in Popular Memory Group 2006: 46) said, ‘the problem is “knowing thyself” as a product of the historical process to date which has deposited in you an infinity of traces.’ As I stated previously, my autoethnographic writing slips away from the concept of a unitary self, building up a dialogue between inside and outside and between my self and Django. If a story is complex and fragmented, the method of narration needs to reflect these disjunctions, using tactics that draw attention to the very disintegration that the tale depicts as well as to the social formations and larger historical processes in which we are embedded (Muncey 2005: 70).

I have already alluded to my methodological approach several times in earlier chapters. I hope I have made it clear that I believe that the factual, disembodied, and objective accounts of much social science erase the complexity of social life, which, rather, demands an epistemology that can comprehend the fact that life is complicated, and an interdisciplinary line of attack that can reckon with the ambiguous dynamics of subjectivity. Exploring the Otherworld, where I, following Gordon (2007: 6-7), describe people denied personhood haunting the peripheries of society, requires a creative methodology that overlaps disciplinary rules and boundaries that are, after all, not fixed or rigidly ordered (Game and Metcalfe 1996: 6-25). My autoethnography tries to evoke resonant relational lifeworlds, but the next section of my thesis, my history of the present, takes a more analytical stance.

Subjugated Knowledges

In this thesis the history of psychiatry is examined as a way of understanding the present and its social arrangements. This is not so much a history of an era, as a history of several problems that attracted my attention while navigating the treacherous shoals of psychiatric diagnosis: Why do the psy disciplines privilege the inner world of fantasy and ‘broken brains’ and nearly always disregard the impact on consciousness of the outer world of traumatic events? How does a diagnosis of mental disorder fit an individual into a labelled category, a classification of how to be a certain type of person? How were these experiences of Otherness treated in the past, and in other cultures? How do the power relationships between psy professionals and their patients, the service-users, operate? And, how can the powerless subvert the dominant discourse of the psy professions: what tactics can they use, what loopholes can be exploited? Why is there such a widespread psychiatric denial of the sexual abuse of children, and why are the negative sequelae of this abuse so often misdiagnosed? And how can things be done differently here and now? This thesis traces a history not of inevitable progress, but, rather, as I will explain, a complex weaving of contingency.

One of the methodological weapons that I employ in this undertaking is that of genealogy, a tactic indissolubly linked to the work of Michel Foucault, although the term itself is borrowed from Friedrich
Nietzsche (1998). Foucault (2003b: 8) delineates the genealogical approach as a ‘coupling together of scholarly erudition and local memories, which allows us to constitute a historical knowledge of struggles and to make use of that knowledge in contemporary tactics.’ By ‘local memories’ Foucault (2003b: 7) means what he terms ‘subjugated knowledges,’ which he defines as both a return of historical knowledges that have been repressed or buried and the emergence of ‘a whole series of knowledges that have been disqualified as nonconceptual knowledges, as insufficiently elaborated knowledges: naïve knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition or scientficity.’ These types of knowledge belong to the marginalised: the delinquent, the psychiatric patient, the criminal, and those that simply fall outside the dominant discourse. Genealogies are, claims Foucault (2003b: 8-9; 1980: 81-83), ‘antisciences’, not because they contrast ignorance with unitary theories of knowledge, but because they represent an ‘insurrection against the centralizing power-effects that are bound up with the institutionalization and workings of any scientific discourse organised in a society such as ours.’

Subjugated knowledges are recognitions first and foremost of struggles, struggles that have been obfuscated by the tyranny of totalising discourses, especially that of science. To understand the operation of power, argues Foucault (1983b), a good starting point is to examine forms of resistance to power:

[U]sing this resistance as a chemical catalyst so as to bring to light power relations, locate their position, find out their point of application and the methods used. Rather than analyzing power from the point of view of its internal rationality, it consists of analyzing power relations through the antagonism of strategies (Foucault 1983b: 329).

The tactics of this thesis, therefore, utilise counternarratives of resistance to challenge the expert knowledges of scientific institutions, especially the institution of Western psychiatry. Nevertheless, as Foucault (2003b: 9) notes, genealogies are no celebration of ‘the lyrical right of the ignorant,’ nor do they reject ‘the contents, methods, or concepts of a science’ and this thesis does not desire to elevate the irrational; rather it seeks to remain necessarily outside the institutionalisation of scientific discourses. In agreement with Foucault (2003b: 39-40), this work challenges the ‘rise of [disciplinary] power that is bound up with scientific knowledge,’ contributing toward the struggle for a new right that is ‘both antidisciplinary and emancipated from the principle of sovereignty.’ Turning to the past in order to understand the present state of mental disorder and psychiatry by means of a genealogical study, is a way of disturbing the current conventions of ethics, of politics, and of truth; a way of examining the paths taken and not taken toward the values, subjects, and objects that nowadays seem so natural.

A History of the Present

Although Foucault’s critiques of the insidious operations of disciplinary power are certainly condemnations of particular kinds of modern discourse, Foucault was not merely a cynic denouncing the will-to-knowledge of the Enlightenments. The famous debates between Foucault and Jürgen Habermas on this legacy are outside the scope of this thesis. However, Habermas (1998: 103-108) concedes that Foucault, as well as criticising modernity, was also carrying on a tradition of an ‘ontology of actuality’ begun by Emmanuel Kant, in which modern consciousness examines contemporary historical actuality by investigating historical forces that are simultaneously concealed and have prevailed since the late eighteenth century. In an evocative phrase, Habermas (1998: 105) describes a person who works in this way as ‘an archer who aims his arrow

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at the heart of ... the present.’ In my explorations of the early forms and current practices of psychiatry my thesis has precisely this aim: it is a history of the present.

Along with Karl Marx, Friedrich Nietzsche and Sigmund Freud, Foucault as genealogist is a ‘master of suspicion’, who reveals the unsavoury underpinnings of ostensibly noble endeavours (Flynn 2005: 36-37). Furthermore, all of these authors, along with other ‘founding fathers’ of sociology such as Emile Durkheim, Max Weber, Georg Simmel, and, later, Norbert Elias and Erving Goffman, have questioned how human capacities, mentalities and psychologies have been socially determined, whether by religious morality, by capitalism, by the division of labour, or by the societal restraint of deviant conduct (N. Rose 1999: xvi-xvii). More recent academic studies, such as those written by Nikolas Rose (1999: xvii) and Ian Hacking (2006: 23-26), address the issue of how dominant ways of thinking contribute toward ‘making up people’, that is, how certain understandings of human nature shape human beings.

According to Hacking (2004: 279), new classifications create new ways for people to exist; a psychiatric diagnosis is a good example of this process. The people who are altered by being classified also change in ways that cause systems of classification to be modified in turn. Hacking terms this the ‘looping effect’ of classifying human beings. ‘Classifying changes people, but the changed people cause classifications themselves to be redrawn.’ Hacking’s work has always been Foucauldian in character, but recently he has acknowledged that much of his work on ‘looping effects’ parallels Goffman’s earlier research on face-to-face interactions. Hacking (2004: 279) recognises that Goffman is a counterweight to Foucault: Foucault’s work was ‘top down’ and directed at entire systems of thought, whereas Goffman’s research was ‘bottom up’ and always concerned with individuals in specific locations entering into or declining social relations with other people. This thesis is composed of both ‘bottom up’ – the autoethnography – and ‘top down’ research – the social history.

Foucault (2006a), whose History of Madness remains a seminal text on the matter (Porter in Gutting 2005a: 63), repudiates the possibility of splitting reason and madness into universally objective categories, and traces a history of how Western culture has conceptualised and treated mental disorder from the thirteenth to the early nineteenth century. Foucault’s work has been widely attacked by many historians, who critique the empirical basis of many of his assertions. Gary Gutting (2005a: 49-73) notes that Foucault has an idealist approach to history, using facts as illustration rather than support, but this does not weaken the interpretive faculty of his work. Roy Porter (1999b: 14), however, has serious objections to Foucault’s analysis of the so-called ‘Great Confinement’ of the insane during the Classical Age, and sharply criticised as ‘romantic primitivism’ Foucault’s notion that in medieval times madness was permitted to ‘utter its own truths.’ Porter’s (2004; 2002; 1987) own social histories of madness provide insight into how ‘mad-doctoring’ developed into the profession of psychiatry, as well as explorations of the thoughts and feelings of ‘mad people.’ Notwithstanding his critiques of Foucault’s work, Porter (in Gutting 2005a: 63) still admits to feeling a ‘bewitched, bothered, and begrudging,’ respect for Foucault’s work, a response that is shared by many historians who prefer to see more reliance on empiricist analysis than philosophising in their history. Andrew Scull (in Gutting 2005a: 50), whose work imparts similar views to both Porter and Foucault, nonetheless agrees with ‘the verdict of most Anglo-American specialists: that Foucault’s History of Madness is a provocative and dazzlingly written prose poem, but one resting on the shakiest of scholarly foundations and riddles with errors of fact and interpretation.’ Despite these cautionary words, Foucault’s history, which
Porter (in Gutting 2005a: 49) describes, despite its flaws, as ‘the most penetrating work ever written on the history of madness,’ has provided many challenging insights on the topics of psychiatry, mental disorder, marginalisation, and trauma.

The Modern Era
Michel Foucault (1994: 238-309) determines the birth of modernity to be around the beginning of the nineteenth century in Europe, a time when he argues that the forms of knowledge of the Classical Age shifted into that of the Modern Era. Foucault uses the term *episteme* to denote a hidden network of knowledge by which discourse is organised and that makes certain ideas unthinkable during different historical periods. The way individuals believe things to be connected to one another grounds an epoch’s understanding of knowledge, based on a set of assumptions that are so fundamental to that episteme so as to be invisible to those working within it. An *episteme* can therefore be regarded as the epistemological unconscious of an era (Smart 1995: 31-34). Gilles Deleuze (1999: 47-48) describes these historical formations as ‘sedimentary beds, made from things and words, from seeing and speaking, from the visible and sayable,’ emphasising that most of us can only see or speak about what is ‘visible’ in our current *episteme*. Foucault (1980: 197) came to believe that several *epistemes* could co-exist and interact simultaneously, being parts of various systems of power and knowledge. Tracing these transformations in systems of thought does not, to Foucault (1994), reveal the progressive refinement of reason, but, rather, mutations of epistemological organisation that permit hitherto unimaginable concepts to acquire the status of scientific knowledge, as well as the opposite effect in that theories once lauded slip into obscurity and disbelief, although they do not disappear (Smart 1995: 31-34).

Put briefly, Foucault asserts that in the Renaissance people thought in terms of similitudes: the world was ordered in terms of the resemblances between the properties and relations of things, by means of a continual exegesis of God’s creations and His word. Around the mid-seventeenth century, the advent of the Classical Age (a period sometimes known as the age of reason) ushered in a new *episteme* where the world came to be regarded as a set of elements ordered by specific identities and differences (Gutting 1999: 139-146). As Foucault (1994: 55; emphases in original) puts it: ‘The activity of the mind … no longer consist[es] in drawing things together … but … in discriminating.’ Just as the Renaissance *episteme* that preceded it was ordered by resemblance, the Classical *episteme* had its own particular rationale: the true subject is here not found in the classification of discrete and stable identities as an historical subject of labour, life and language, but appears in the mirror of representation (Foucault 1994: 3-16).

Foucault argues that in the beginning of the nineteenth century, with the new *episteme* of the Modern Era, came a fundamental reorganisation of reality whereby the order of tangibly existing things became determined by the historical forces hidden within them, rather than by their place in an ideal classificatory system. In the Modern Era, ‘Man’ for the first time becomes a subject, an agent capable of understanding and changing his or her worldly condition, as well as one obedient to physical laws (like any other thing in the physical world), and the object of modern scientific investigations (Hacking 1998a: 31). Man – and of course, Woman – as the fundamental point of reference for research in the new human sciences, therefore only came into existence when the classical field of representation, although still crucial to modern thought, was displaced, having ‘lost the power to provide a foundation … for the links that can join its various
elements together’ with its power to connect sought instead ‘outside representation ... in a sort of behind-scenes world even deeper and more dense than representation itself’ (Foucault 1994: 238-239).

The human sciences, such as psychology, sociology, and criminology, moved away from studying the nature of Man as a living, producing, speaking being ‘to what enables this same being to know (or seek to know) what life is, in what the essence of labour and its laws consist, and in what way he is able to speak’ (Foucault 1994: 353). Foucault argues, therefore, that by establishing these discourses the human sciences and their institutional apparatus of medical, psychiatric, juridical, penal and pedagogical systems create the very human subject that is the object of their investigations. Furthermore, persons who engage in serious research do so under an illusion, as, unknown to them, their thinking is coloured by the current episteme, a claim that implies truth becomes historically relative (Hoy 1998: 5). If an episteme can be regarded as the epistemological unconscious of an era, according to Foucault the Modern Era has invented for itself a depth in which hidden forces displace the surface regularities of the Classical Age. The Cartesian notion of cogito ergo sum, where Man is identified with the ‘sovereign transparency’ of a pure consciousness, has given way to the modern understanding that human awareness is inextricably tied to what is unthought (Foucault 1994: 322). The originality of psychoanalytic theory (and the psychodynamic approaches that developed from it) is located in the notion that it seeks the foundation of a person’s active role as a subject in this ‘unthought’: in what has come to be called the unconscious (Gutting 1999: 212).

One of the organising principles of the Modern Era, therefore, is a fascination with the inner life – the unthought, the unconscious, hidden not only to the beholder but also to the material form that enfolds this secret.22 This arena was the focus of many of the nineteenth century’s social interlocutors, but, as I mentioned, the beliefs of previous eras are not entirely superseded by the dominant discourses of a new episteme. Traces remain, spectrally interwoven with new certainties, and Michel de Certeau (1989: 179) argues that the past returns in different guises to haunt and unsettle the present, echoing Josef Breuer and Sigmund Freud’s (1893: 7-21) early acknowledgement that repressed traumatic experience is never destroyed. These ‘ghostly matters’ are marginalised, but never entirely excluded from social life (Gordon 2007: 6-7).

Indeed, one of the features of what Ian Hacking (1995: 209; emphasis added) calls ‘the modern sensibility’ is spectacularly implausible: ‘the idea that what has been forgotten is what forms our character, our personality, our soul.’ Forgetting and remembering, twin facets of traumatic memory, have polarised opinions between sceptics and believers in the so-called ‘false memory’ debates of the late twentieth century, with acrimonious legal struggles occurring over the reality of recovered memories in cases of child sexual abuse (McFarlane and van der Kolk 1996: 36-39). This subject, as I have already mentioned, will be explored in a later chapter, but there were similar debates in the late nineteenth century, from 1887, when Jean-Martin Charcot first suggested that the symptoms of his hysterical patients originated in long-buried memories of trauma.

The consolidation of psychiatric power rests on the political, economic, and social organisation of biopower, and to Foucault (2006b: 297-300) the emergence of the ‘neurological body’ during the late nineteenth century is one of the most important events in this process. At this time a new way of clinically capturing the

22 Biological psychiatry of course has a different focus to psychoanalysis, but is similarly fixated on the inner world, looking for the foundation of personhood in neuroscience, biochemistry, genetics, physiology, and psychopharmacology.
sick body of the patient was established: the clinician gazes at the surface of the patient's body with 'an almost impressionistic gaze' that reduces the person to a series of stimulus-responses, signs, and symptoms to be deciphered by the expert doctor. During the nineteenth century, when the discipline of psychiatry was becoming established and professionalised, mad-doctors, alienists, neurologists, and other researchers attempted to understand, name, and control many and various forms of abnormal behaviour, such as somnambulism, hysteria, and hallucinations. Methods that later fell into disrepute, such as mesmerism and hypnosis, were once commonplace medical techniques, and major figures such as Jean-Martin Charcot, Pierre Janet, Josef Breuer, and Sigmund Freud were all fascinated by these phenomena. Both Charcot and Freud are notorious for their domineering manner when interacting with their female patients, manipulating these women's hysterical symptoms to fit their grand theories of causation (Herman 1998: 10-20; Showalter 1997: 30-43). The men who established the dominant model of psychiatry and mental illness that we know today were all too frequently misogynists who used violence and coercion against the women in their care, while refusing to acknowledge the reality of the widespread child sexual abuse that was the major cause of these unfortunate women's symptoms (Masson 1998; 1992).

Dominant understandings of human nature shape human beings, as we can see by following Hacking's (2006: 23-26) discussion on 'making up people'. Hacking (1998b: 1) further argues that some mental disorders are candidates for a definition of 'transient mental illness', by which he means a malady such as hysteria that appears at a particular place and time, later disappearing. Hacking (1998b: 1-2) uses the metaphor of an 'ecological niche', within which what appears to be a mental illness may thrive; both psychiatric service-users and experts exist with a cluster of vectors, which include medical taxonomy, cultural factors, an observable suffering, and the fact that a diagnosis may provide some form of assistance and release for the ill. All of these ideas have influenced my exploration of the history of the present that follows on from this chapter. As Herbert Marcuse (2002: xlii) states: ‘Social theory is concerned with the historical alternatives which haunt the established society as subversive tendencies and forces.’ And in the chapters that follow, my history of the present will explore the emergence of psychiatric power in the nineteenth century and the construction of modern categories of mental disorder, seeking out these ‘subversive tendencies and forces.’ In the final part of this history I will investigate problematic behaviours that became labelled as diseases originating inside the brains of the individual that were in fact caused by events outside the person. As John Read and Nick Haslam (2004: 133) emphasise, ‘bad things happen and can drive you crazy,’ a perspective that a sociologist can comfortably support, and a statement that I will reiterate many times throughout this thesis.
A Klee painting named ‘Angelus Novus’ shows an angel looking as though he is about to move away from something he is fixedly contemplating. His eyes are staring, his mouth is open, his wings are spread. This is how one pictures the angel of history. His face is turned toward the past. Where we perceive a chain of events, he sees one single catastrophe which keeps piling wreckage upon wreckage and hurls it in front of his feet. The angel would like to stay, awaken the dead, and make whole what has been smashed. But a storm is blowing from Paradise; it has got caught in his wings with such violence that the angel can no longer close them. This storm irresistibly propels him into the future to which his back is turned, while the pile of debris before him grows skyward. This storm is what we call progress.\(^{23}\)

The Angel of History

Throughout human history and from all human cultures spill tales of primæval forces and devils – beings driven or possessed by supernatural energies, appearing as monstrous creatures or cataclysms of the natural world, sometimes inhabiting or devouring human bodies. Madness, dementia, pōrangi, lunacy, windigo, melancholia, possession, amok, mania, psychopathy: the labels of deviation a people create reflect the way the boundaries of its cultural universe are visualised; its marginal persons – outsiders, strangers, the mad – providing a touchstone for what is regarded as ‘normal’ (Erikson 1966: ix). The looking-glass world of madness holds up a dark mirror to sanity. As Michel Foucault (2006a: xxvii) insists, until distance is established between them by means of an organising principle, ‘madness and non-madness, reason and non-reason are confusedly implicated in each other’. Whether an individual consciousness becomes defined as ‘normal’ or ‘abnormal’ by socially invested expert authority is determined by the various ways in which different societies, separated in time and space, define and treat mental disorder and altered states of consciousness (Erikson 1966: 21).

The twentieth century, in its developed, liberal, democratic confines at least, has been widely regarded as ‘the psychiatric century’. It saw an enormous proliferation of new mental disorders labelled as diagnostic entities, the emergence and partial eclipse of psychoanalysis, key innovations in treatments through surgery and psychopharmacology, and the rise and fall of the asylum and its replacement by ‘care in the community’. As the century grew older, the conventional picture of heroic scientific progress and enlightenment was increasingly challenged and denied, with intense controversy and passionate arguments between the professions, academics, and pharmaceutical companies. Increasingly, the power of psychiatry has been defied by those individuals formerly banished to society’s exclusion zone, where they were silenced: the mad or otherwise ‘abnormal’, now known as mental health service-users or psychiatric survivors. Confidence that technological advance would result in improvements in the material welfare of all citizens in the developed world has dimmed, with the notion of progress problematised. Inexorable social change brings unequal benefits for different social groups; what counts as progressive is defined in variable ways; and who balances the benefits of progress with the costs? Rather than viewing progress as a teleological manifestation of technology, reason and knowledge, I follow Walter Benjamin’s (1999: 249) Thesis IX, quoted in the text which accompanies the Paul Klee painting heading this chapter – the angel of history, facing the past, does not see a chain of events but a catastrophic force piling wreckage before him as he is blown into the future: ‘This storm is what we call progress.’

This part of my thesis is a three-part history of the present that explores the development of the psy professions and the treatment of their patients, the mental health service-users. I acknowledge that the past haunts the present: that we are all bound to invisible historical and social effects, shadowed by echoes and murmurations that hint at the lost things that are still there behind dominant ways of knowing. ‘Social theory,’ asserts Herbert Marcuse (2002: xliii), ‘is concerned with the historical alternatives which haunt the established society as subversive tendencies and forces.’ Knowledge, people, and events that we think of as past disrupt and unsettle the present, subverting the order of things and making our certainties waver: linear time is jammed by these haunting presences (Gordon 2004: 24). Trying to capture what the dominant discourse has exiled, seeking ‘ghostly signals’ that illuminate hidden analogies and connections between events (Benjamin in Gordon 2004: 204), this history of the present takes a genealogical approach. To recapitulate on one of the theoretical underpinnings of this thesis, Foucault (2003b: 8) defined this method as
'a coupling together of scholarly erudition and local memories, which allows us to constitute a historical knowledge of struggles and to make use of that knowledge in contemporary tactics.' ‘Local memories’ are ‘subjugated knowledges’: intelligence that has been repressed, buried or disowned by the dominant discourse as inferior, naïve, or unscientific; information belonging to marginalised sections of the population such as the criminal, the delinquent, and the mentally ill (Foucault 2003b: 8-9). Genealogies, asserts Foucault (2003b: 8-9), represent an ‘insurrection against the centralizing power-effects that are bound up with the institutionalization and workings of any scientific discourse organised in a society such as ours.’ They are counternarratives of resistance to power (Foucault 1983b: 329).

My history of the present is divided into three chapters. This chapter, The Storm of Progress, is mostly focused on the nineteenth century, exploring the turbulent development of the Modern Era, specifically the often confusing and contested mass of phenomena that either became captured in, or discarded from, current categories of mental disorder. The following chapter, Classification and its Discontents, investigates the feuds between rival branches of the psychiatric professions as they attempted to gain control of the field in the twentieth century, and the struggles that later ensued as mental health service-users fought the therapeutic authority of psychiatric power. The third chapter, Trauma, turns away from the psychiatric fetishisation of the inner world of intrapsychic conflict and brain disease, instead exploring the issue of psychological trauma. When people experience terror, fear, and betrayal they are profoundly damaged by these events; I reiterate: ‘bad things happen and can drive you crazy’ (Read and Haslam 2004: 133). In turning to the past in order to understand the present, I am measuring the way that the psy professions are currently organised against historical alternatives, tracing contingent ways in which human life has been judged as worthy or unworthy of living. The human condition can, I believe, be improved by confronting society’s ‘used and unused and abused capabilities’ (Marcuse 2002: xl).

Psychology as Metaphor
Rhetorical strategies and metaphor are central to the work of establishing a convincing theoretical account of any scientific discourse, and in the field of medicine, investigations of physical and mental sickness have, for centuries, used metaphors to illustrate and explain human behaviour (Leary 1990: 1-78; Soyland 1994). Until the mid-seventeenth century, Hippocratic medicine, which originated in Greece in the fourth century BC, dominated Western understandings of health and illness in terms of the four ‘humours’. The vitality of the human body was determined by the variable balance of the fluids of black bile (melancholic or saturnine temperament), yellow bile (choleric or irritable temperament), phlegm (phlegmatic or lethargic temperament), and blood (sanguine or robust temperament); these paralleled the Aristotlean elements of earth, fire, water, and air. Astrological influences and the cyclical seasons of nature were interwoven in the Greek sciences, along with the colours attributed to each of the humours, which endowed people with their various complexions, whether swarthy, jaundiced, pale, or ruddy, as well as their temperaments (Arika 2007; Porter 2002: 36-40).

As human society changed, so did the analogies that illuminated the hidden workings of the human body and mind. Each era has its own cultural motifs that transform the prevailing discourse, overwriting earlier comparisons as a palimpsest. In the seventeenth century, John Locke famously discussed the mind as a blank slate, or tabula rasa, and René Descartes, believing that there must be more to the mind than mechanical function, imagined a ‘ghost in the machine’ of the physical brain (Pinker 2006: 1-8; 2002; Ryle
1949). By the eighteenth century, the principal model of the body was hydraulic: the nervous system was a network of hollow pipes, filled and pumped by subtle bodily particles. This model was in turn contested by a theory that regarded the nerves as wires infused by electrical impulses (Porter 2004: 180-181). By the nineteenth century, the human body was often depicted as an engine, its innards compared to the visible machines of the industrial age (Rabinbach 1992), and the brain as a piano, with the various keys representing the potential infinitudes of neurological connections (Leary 1990: 11). The railroad, the telegraph, and the telephone were other analogies that emerged, metaphors nowadays mutated into that of the Swiss army knife, equipped with specialised modules designed to solve specific human problems; or the computer, with brain functions compared to software, hardware, programming, and debugging, or to jargon internet terms such as downloading (Leary 1990: 12; Pinker 1997; Turkle 2011: ix-x).

The importance of these metaphorical frameworks is that they direct the gaze, as the workings of the brain are conceptualised differently depending on the favoured model, so as the metaphors for the mind have become increasingly scientific, it has nowadays come to seem like the computer technologies used to describe it (Draaisma 2001: 230-231; Leary 1990: 12). As people experience more face-to-face interaction with computers, reflected in ‘the mirror of the machine’ they see themselves differently: their minds, suggests Sherry Turkle (2011: x-xi), seem more like programmes, with free will appearing more illusory. As we will see, the descriptions of consciousness and the mind formulated during the period when the psy disciplines were being formed have remained highly influential, with the Freudian vocabulary in particular having a profound impact on psychological language (Soyland 1994: 138-140). The question of the mind is inexorably bound up with analysis of the self. From the Greek notion of humanity as playthings of the Fates, through Christian belief in a unique immortal soul, to the Renaissance perceptions of mankind’s perfection (at least, as applied to white, elite, and educated males) and the sixteenth century’s impulse to self-examination, in Western thought the individual is increasingly highlighted. What, then, is the consciousness of a human being, the entity William Shakespeare (1994: 70) described as ‘this quintessence of dust’?

The Sovereign Consciousness of the Self

The notion of the sovereign consciousness of the self, a vision set out by classical philosophy and taken for granted in everyday existence, was profoundly disturbed by the time of the nineteenth century. Questions of human identity have troubled Western thinkers for millennia, and the story of the self is often told as a progressive teleological drive toward individuality and authenticity. However, anthropological studies suggest that human nature is never independent of its cultural matrix, and according to Clifford Geertz (1993: 49-50) ‘[o]ur ideas, our values, our acts, even our emotions, are, like our nervous system itself, cultural products.’ Examining the modernisation of the Western world, Max Weber (2001) famously argued that thanks to the Protestant doctrine that individual salvation must not be gained by priestly intercession, a new individuality was born during the Reformation. By the seventeenth century, Descartes was proposing that the conscious self, not nature or God, was the source of all understanding: cogito ergo sum. Locke argued that the mind is not crammed with ideas from birth, but is a ‘blank paper’ written on by education and experience: individual identity was becoming a matter of intellect. Man was no longer envisaged as an Adam created by God, but as the Enlightenment ideal of the self-made man (Porter 1997: 1-5).

The notion of selfhood as unified, rational and autonomous is a uniquely Western approach, but there have been dissenting voices. In the early eighteenth century, David Hume (1985: 299-301) compared the soul to
a commonwealth, which maintains its identity by being arranged from diverse, constantly changing, yet interrelated elements, not by virtue of some stable essence at its heart. The question of personal identity becomes, to Hume, a matter of differentiating the loose coherence of one’s personal experience: ‘Man is a bundle or collection of different perceptions, which succeed one another with an inconceivable rapidity and are in perpetual flux and movement.’ If all our knowledge is based on sense impressions, we cannot have an idea of self; therefore there is no ‘self.’ To Hume, humanity’s propensity to imagine an enduring identity is a fiction; we have, rather, a mind constituted of successive perceptions (Hodgkiss 2001: 24-25). Friedrich Nietzsche rejected the notion of the self as a metaphysical being, claiming that the self is not given but – like Hume’s ‘bundle of the self’ – is created into a coherent character from the incorporation of experiences. To Nietzsche, different types of self emerge under different material conditions: ‘the social straitjacket’ can develop the self in variable ways (Schacht 1995: 104-107). Actions create the true self, not the other way around: ‘There is no “being” behind the deed … the “doer” is invented as an afterthought’ (Nietzsche 1998: 28). There are different types of humans; ‘herd animals’, and ‘masters’ and ‘slaves’, with only the aristocratic ‘higher’ human being, the Übermensch, able to achieve a unity of the self, and become what we are capable of being (Schacht 1995: 110). To Nietzsche, this true self is not hidden within, and is something other than one’s personal, social, and biological identity; achieving self-realisation involves sacrifice and supreme effort, and only with the instrumental genius of artistic and cultural transfiguration can human animality become transformed (Schacht 1995: 158-159).

Notwithstanding Nietzsche, modern Western identity is constituted by a sense of inwardness. We believe that emotions and thoughts originate inside us, as opposed to the physical world outside us, which we act on. We also have inner potential, which we can develop and manifest in the outside world. In short, we are beings with powerful, inchoate feelings, as well as untapped abilities, which we regard as dwelling deep inside us. As Charles Taylor (2001: 111) points out, this binary opposition of ‘inside-outside’ seems self-evident to us, but in reality it is an artifact of modern Western thought:

But strong as this partitioning of the world seems to us … and anchored in the very nature of the human agent, it is in large part a feature of our world, the world of modern, Western people. The localization is not a universal one … [r]ather it is a function of a historically limited mode of self-interpretation, one which has become dominant in the modern West … which had a beginning in time and space and may have an end (Taylor 2001: 111).

Other cultures and other times have had different concerns about how ‘essential’ humanity is defined. Interestingly, neuroscience in the early twenty-first century is now affirming that the ‘self’ may be an illusion formed not only from the interaction between areas of the individual’s brain, but, furthermore, a product of biological and social forces as our brains interact with each other and our wider social system; individual consciousness is not a closed system (Zeman 2002: 291). This notion of the ‘extended mind’ was defined in the 1930s by Alexander Romanovich Luria, a Soviet neuropsychologist, in his studies on the sociohistorical determination of the human psyche, but is only recently being investigated by Western cognitive science (Homskaya 2001: 84-86). However, the relationship to self that the ordinary modern person in the West has developed has been overwhelmingly formed by what Nikolas Rose (1997: 226) calls the ‘psy disciplines.’

Nikolas Rose (1997: 226-227) maintains that in North America and North Western Europe, between 1875 and 1925, the birth of the scientific discipline of psychology, both as a profession and as a subject matter, had a profound effect on ‘the kinds of persons we are able to be.’ Psychological techniques, norms, and
beliefs about issues such as emotions, personality, intelligence, relationships, and desires and fears, rather than being either illuminating or mystifying, in fact mould us:

[They have become woven into the practices that fabricate and sustain the ‘psy’ interior that has been hollowed out within us as our truth, this psychological being which has been placed at the origin of our passions, our speech, our ills, our wants and our conduct. We need to abandon the belief that we are ‘in our very nature’ discrete, bounded, self-identical creatures, inhabited and animated by an inner world whose laws and processes psychology has begun to reveal to us. On the contrary, we are ‘assembled’ selves, in which all the ‘private’ effects of psychological interiority are constituted by our linkage in to ‘public’ languages, practices, techniques and artifacts (N. Rose 1997: 226-227).

As we have seen, Foucault argues that the episteme of the Modern Era brought a fundamental reorganization of reality, whereby the order of tangibly existing things became determined by the historical forces hidden within them. To Foucault (1994: 322-353), ‘Man’ was an invention of the nineteenth-century human sciences, which both create and study an individual’s inner life through the institutional apparatus of psychiatric, medical, juridical, penal, and pedagogical systems, the technologies of social power that Foucault termed biopower and biopolitics (Foucault 2003b: 242-244; Foucault 1990: 135-159; Hacking 1998a: 31; Hoy 1998: 5; Rabinow and N. Rose 2006: 195-196).

Foucault (1994: 387) concludes that when the arrangements of knowledge of the modern episteme collapse, our current definitions of humanity will dissolve: ‘then one could certainly wager that man would be erased, like a face drawn in sand at the edge of the sea.’ Foucault renounces the ‘deep truth of the self’, which the guidance of science, law and religion fosters, writing that:

[Modern man … is not the man who goes off to discover himself, his secrets and his hidden truth; he is the man who tries to invent himself. This modernity does not ‘liberate man in his own being’; it compels him to face the task of producing himself (Foucault in Dreyfus and Rabinow 1998: 112-115).

Following Foucault, Nikolas Rose (1998: 24) argues that a ‘continuous history of the self’ is impossible; echoing Hume and Nietzsche, he maintains that it is the practices that human beings engage in, and the relation we have with ourselves, which shapes our ways of understanding our existence. This perspective is further endorsed by Hacking (2006: 23-26; 2004: 279), who asserts that new classifications of human nature create new ways for people to exist; ‘making up people’ also has a ‘looping effect’ as classifying changes people, but the classifications are redrawn by the individuals changed by this labelling. Contemporary analytic thought, at a time when all ideas are being rapidly deconstructed, may now question the existence of a unified sense of self, ‘quaintly Latinized as [the] ego’ (Bach 2011: 52). But there is, nevertheless, still a desire to construct a self that feels integrated and authentic, rather than false or fragmented (Druck, Ellman, Freedman and Thaler 2011: xix). Rose (1998: 25-26) stresses that the development of what is considered the typical modern self has materialised out of a fascination with kinds of appearance, expression, thinking, and behaviour considered dangerous or disorderly: the pathological self defines the normal self.

Degeneracy

In the nineteenth century, alienists and mad-doctors working in German universities and institutes attempted to map the genetic roots of mental illness. These researchers in the first biological psychiatry were not asylum-based, and performed postmortem examinations of the brains of severely mentally disordered human subjects, as well as experiments on living animals and humans. The clinical-pathological method so
THE STORM OF PROGRESS

A particular stream of thought typified the nineteenth century, linked to a naturalistic, anti-metaphysical, pro-materialist point of view, with an associated questioning of traditional morality. One of the most influential exponents of this perspective was Charles Darwin. Before Darwin, most naturalists believed that species had been separately created and were immutable. Rather than all life descending from a common ancestor, Man existed at the pinnacle of a divinely ordained ‘great chain of being’ and was thus the end-point of terrestrial perfection: from this perspective, madness was readily interpreted as a fall from grace. Darwin, however, insisted that the potentials for evolutionary change derive from the individual organism: no virtue is involved, simply a process that favours those individuals most suitable to a particular environment – an amoral, non-teleological world-view that argues for a material (rather than divine) origin for all life on earth. Despite Darwin’s (1998: 396) insistence on the survival of individuals and species well adapted to their contemporary surroundings, the notion of ‘improvement’ still haunted his work, as he emphasised: ‘[A] struggle for life entail[s] … the Extinction of less-improved forms …. Thus, from the war of nature … the production of the higher animals directly follows.’ In the fifth edition of his work, in 1869, Darwin used an idea taken from the philosopher and sociologist Herbert Spencer and re-titled his fourth chapter ‘Natural Selection; or the Survival of the Fittest.’ This notion, which implies that the ‘fittest’ are superior rather than merely better adapted, fed directly into the notion of ‘degeneration.’

After Darwin, degenerates were portrayed as a social menace: these losers in an epochal battle for survival would bring down any society that did not impose constraints on its own population of degenerates. With its references to ‘hereditary taint’, degeneration theory also harked back to pre-Darwinian notions, hinting at the concept of original sin. In Italy, Cesare Lombroso proposed a theory of evolutionary atavism, which stated that criminals were ‘throwbacks’ to a primitive stage of development. Lombroso, in a search for the causes

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24 Krafft-Ebbing’s major work, Psychopathia Sexualis, was published in 1886. Until Freud published his works on sexuality, Krafft-Ebbing’s text was the forensic authority on psychosexual diversity, and popularised the terms sadism and masochism.
of crime, emphasised physical and biological abnormality – following Morel – as the distinguishing marks of the criminal. This belief in stigmata that denote evil is as old as recorded history, but a new ‘science’ of phrenology which claimed that the shape of the skull, especially bumps on the cranium indicating special faculties of the brain, had gained some credibility at this time (Vold and Bernard 1986: 37 and 47-50). Lombroso’s theory of atavism, added to phrenology and degeneracy theory, argued that five or more anomalies – such as an asymmetrical face, large ears, abnormal teeth, too many wrinkles, or a hairstyle too similar to that of the opposite sex – would indicate that an individual was a ‘born criminal.’ Although Lombroso’s theory was challenged, it was agreed that criminals were consistently about two inches shorter and weighed up to seven pounds less than non-criminals (Vold and Bernard 1986: 51-53). These differences were regarded as evidence of hereditary vice, not as deriving from social or economic factors such as a deficient diet. Since the mad and the criminal were believed to be identifiable through their physiognomy, such ‘monstrosities’ were easily recognizable, readily sequestered, and, happily for degeneration theory, regarded as being afflicted with a short lifespan (Shorter 1997: 66).

In England, Henry Maudsley, founder of the Maudsley Hospital, had established himself as one of the most influential alienists of the late-nineteenth century. He denounced the psychological view of the mind, insisting that it could only be studied inductively from a pathological and physiological basis. That Maudsley’s own allegedly scientific views were themselves purely speculative was, however, seldom acknowledged (Scull, MacKenzie and Hervey 1996: 232-237). Often remembered for his insistence that lunatics should be treated humanely and with kindness, Maudsley’s ‘scientific’ approach paradoxically recast the shame and horror of madness into a new and still more derogatory language. Maudsley, searching for the ‘stigmata of degeneracy’ in malformations of facial features and expressions, tics, stammering, and spasmodic movements, believed that his science showed that madness was the penalty to be paid for vice and immorality: degenerate activities wrought physical changes on the bodies of offenders, and this ‘evil heritage’ was transmitted to their descendants. Maudsley (in Scull, MacKenzie and Hervey 1996: 237) described his asylum patients as ‘the waste products of the evolutionary process, “morbid varieties fit only for excretion” from the social fabric.’

The behaviour of mentally and emotionally disturbed people can be both dangerous and outrageous, and historically it has often been regarded as indistinguishable from the behaviour of violent criminals, with both lunacy and crime at times viewed as influenced by the forces of evil (Vold and Bernard 1986: 109). I reiterate, every culture has a zone where individuals are marginalised and denied personhood (Gordon 2007: 6-7), and in the nineteenth century, degeneracy theory provided the rationale for the existence of this space of deviancy. Moral judgements on persons considered deviant, such as prostitutes, delinquents, criminals, the insane and the dissolute, could now use this discourse (and, indeed, this taint still exists today). Problematic behaviour previously viewed as the unfortunate consequence of exposure to a harmful environment was now regarded as the result of the irremediable inheritance of a degenerate nature. Forms of abnormality, whether madness, deviance, backwardness or difference, all became medically classified as hereditary, and were therefore incurable: psychiatry could dispense with its notion of cure, instead intervening to protect society from the dangers that undermined it from within (Foucault 2003a: 315-317).

As this hereditary weakness was believed to be cumulative, with each generation inheriting characteristics from its parents, as well as the feeble-minded tending to interbreed profligately, the wellbeing of the state
itself was threatened by the taint of degeneration. In an exercise of biopolitics, strategies of defining and detecting degenerates, and restricting their breeding were devised by the new disciplines of psychiatry, psychology and criminal anthropology. By the end of the nineteenth century in Europe and the United States, the doctrine of degeneration was influencing social policies such as slum clearances, the sequestering of degenerates, euthanasia, and mass sterilisation programmes of the mentally ill and of the criminally insane (N. Rose 1998: 71; Shorter 1997: 93-96 and 353f).25 This so-called ‘social hygiene’ role of psychiatry fed into to new forms of racism, acting against all individuals who carried defects that may pollute the purity of normal society and the human species itself. The targeting of abnormal individuals eventually grafted German psychiatry onto ethnic racism, with its organised programmes of pseudo-scientific ‘racial hygiene’ in Nazism (Foucault 2003a: 315-317).

The degenerationist school became, above all, fearful about the dangerous tendencies of the masses: if degenerate families were permitted to breed unhindered, their idiocy would ruin civilisation just as Darwin and Spencer were warning that only the fittest would survive. In Germany, this fear eventually coalesced with the early twentieth century’s catastrophic upheavals of world war, revolution, and economic crises, and with Friedrich Nietzsche’s exultant predictions of the Übermensch, superior individuals who could seize the magnificent possibilities of the modern world and discard the values of the past (Berman 1999: 21-23). In the 1930s the biopolitics of Nazi Germany attempted to compulsorily sterilise all non-Aryans, and to exterminate the mentally ill and physically disabled Lebensunwertes Leben (‘life unworthy of life’) in order to purify Aryan racial fitness. This ‘euthanasia’ programme ‘disinfected’ (murdered) around 200,000 people in mental asylums, many of them children, to save money and resources for those deemed more worthy, and provided a model for the death camps of the Holocaust (Burleigh 1995). As developed by Nazi physicians, Rassenhygiene (racial hygiene) medicalised anti-Semitism; Jews, along with the ‘health hazards’ of Gypsies, homosexuals, communists, and other deviants, were ‘quarantined’ and exterminated in their millions during the Third Reich (Proctor 2000). After the Second World War it became taboo for several decades in medical research to make any public reference to the genetic transmission of psychiatric illness (Shorter 1997: 69-99), and although after the war many of Germany’s racial hygienists did continue their careers in the human genetics field, all mention of Nazism was carefully expunged from their records (Proctor 2000: 298-312).26

From the nineteenth century onwards, in order to avoid the stigma associated with degenerative madness, wealthier patients attending the offices of private physicians were permitted to hide their affliction under the more genteel euphemism of ‘nervous illness.’ This pretence enabled doctors to establish lucrative private practices away from the asylums, and patients and their families could escape the shame of ‘tainted blood’, since nervous illness was said to be non-inheritable (Shorter 1997: 113). Nervous disorders were a sign of social superiority from the eighteenth century onwards: the lower classes could descend into idiocy, but only those with a highly-strung or refined temperament could suffer from ‘nerves.’ The asylum was regarded, and

25 Shorter says that in the 1920s it was at first suggested that individuals with terminal medical illnesses should be euthanised if they so desired, and this recommendation was then extended to include institutionalised people with severe mental retardation – but this was euthanasia without consent. The Nazi legacy of degeneration, genetics, and eugenics cannot all be blamed on psychiatry. However, many of psychiatry’s social hygiene tenets, particularly the mass sterilisation of the mentally ill and the criminally insane enacted in the United States between 1907 and 1939, alarmed German racial hygienists who believed that the United States would in this way surpass the Fatherland in the health and fitness of its population. American and English achievements in this field were regarded as a goal to be pursued if Germany was to catch up with the state powers that had so crushingly defeated them in the First World War. See Proctor 2000: 97-100.

26 Attempts to develop a science of human and animal ‘sociobiology’, where it is argued that genes play an ultimate role in determining human behaviour, including aggressiveness, have been successfully established since the 1960s, although often criticised as biological determinism; see Gould 1996.
not without justification, as a place of abuse and horror, despite the protestations of the alienists and mad-
doctors who ran them. After the 1860s, when degeneration theory was in its ascendancy, a family with a
member suffering from a major psychiatric disorder was filled with dread over the notion of a poisoned
heredity. The press was full of stories of madmen switching places with sane citizens and of persons
tortured in asylums, so for psychiatry to have a professional future it had to reassure its paying clientele that
‘insanity’ meant only ‘nervous illness’ (Shorter 1997: 116). This duplicity was so successful that by Victorian
times it was fashionable to be ‘neurasthenic’, or to suffer from hypochondria or, sometimes, even hysteria,
and nerve clinics and hydrotherapy centres for wealthy patients appeared all over Europe and the United
States (Porter 2002: 87).

By the late nineteenth century the language of mental and nervous pathology had infiltrated Europe’s social
and political spheres, with the perceived cultural malaise of the fin-de-siècle explained in frankly medical
terms. The widespread feeling of dissatisfaction and melancholy believed to be afflicting Europe in the dying
years of the century became tied to the diagnostic categories of degeneration and hysteria. Writers and
intellectuals were affected with a literary sensibility that explicitly noted the equivalence between the qualities
of fin-de-siècle Europe and the enormous increase in cases of individual hysteria. Artists in the
Impressionist school and other avant-garde painters were described as unintelligible and ‘hysterical’, as were
many modernist writers. Hysteria and degeneration became regarded as closely, albeit confusedly, related.
Collectives, not only individuals, could lapse into uncontrollable occurrences of hysteria, and the dreadful
events of the Paris Commune of 1870-1871 were critiqued in medical and psychological terms, as ‘nothing
else than Paris having an attack of hysteria’ (Micale 2004: 77-79). Psychological modes of explanation
increasingly became the dominant way in which individuals were regulated by the state, and the way in
which the modern human being related to him or herself. Hysteria was for many years the central concern of
French psychiatry, along with bizarre forms of behaviour termed ‘double consciousness’ and ‘alternating
personality’ (Hacking 1995: 132-133).

**Hysteria**

Although hypnosis is now regarded as pseudoscience and hysteria an archaic diagnosis in mainstream
psychiatric thought, the founding fathers of psychiatry and psychology made their reputations working in
these fields. In the eighteenth and nineteenth centuries, hysteria was the paradigmatic female mental
illness. First described over two thousand years ago, hysteria was believed to originate from the womb,
imagined as a tiny animal that wandered around inside a woman’s body causing pathogenic symptoms.
Then termed ‘suffocation of the womb’, the condition was most often diagnosed in ‘wayward’ women;
treatment ranged from ‘fumigation of the vulva’ to tight bandaging of the sufferer’s body (King 1995: 443;
Trillat 1995: 433). Later called ‘the vapours’ because by the seventeenth century the cause was believed to
be a gas produced from ‘fermentation of the female semen … or … decomposition of animal spirits’ (Trillat
1995: 433-436), eighteenth century physicians defined hysteria as a neurosis, and symptoms could consist
of anything from headaches, weakness, or mood swings, through to double consciousness, delusions, and
hallucinations.

Medical opinion emphasised that hysteria was physical in origin – despite the fact that putative brain or
spinal lesions causing the disease were never located – with its symptoms aggravated by dramatic outbursts
of emotion (Trillat 1995: 436; Showalter 1985). By the 1850s in France it was concluded that hysteria was
hereditary, with the mothers and sisters of hysteria patients being especially susceptible. Familial unhappiness or stresses were not considered as possible causes (Shorter 1994: 9-13). Although male hysteria also existed it was usually defined as hypochondria, and by the end of the nineteenth century the words ‘feminine’ and ‘hysterical’ were virtually synonymous (Busfield 1996: 16-17). It was during this historical period that hysteria moved into the spotlight: its diagnosis and treatment making the names of famous medical figures such as Jean-Martin Charcot, Pierre Janet, Josef Breuer, and Sigmund Freud. Charcot and Freud were both consummate showmen who hypnotised patients for self-aggrandising public performances – indeed twentieth century feminist scholars vilify Freud as ‘a stubborn, bullying interrogator of hysterical women’ (Showalter 1997: 30-43).

The Hôpital Salpêtrière in Paris was by the late nineteenth century home to about five thousand female patients, of whom a large number were diagnosed with incurable diseases of the nervous system and locked up for life. In 1862, Charcot was appointed Director of what he called this ‘great emporium of human misery,’ becoming the most celebrated doctor of his time (Didi-Huberman 2003: 15-17). His studies on hysteria, although controversial, brought him triumph, and he was likened to the Sun King, Caesar, Napoleon, and, above all, to Dante, who had recorded a descent into hell. The Salpêtrière, says Georges Didi-Huberman (2003: xi), was a nightmare: ‘a kind of feminine inferno’ where hysteria became a spectacle, with photography crystallising the images performed for the public gaze.

Charcot's investigation of hysteria fascinated an audience far wider than the medical world in which he was so renowned. Public lectures were held every Tuesday, theatrical events that were attended by doctors and literary writers, as well as by fashionable men and women curious to witness the performances. In these public demonstrations, Charcot used hypnosis to induce the displays, asserting that hysteria and hypnotism were essentially identical. Hysteria was a physiological condition whereas hypnosis was an artificially created neurosis, which presented in three organically determined states: cataleptic, lethargic, and somnambulistic (Crabtree 1993a: 166-167). The patients demonstrated vividly theatrical movements and grimaces in la grande attaque hystérique, during which the women’s bodies moved through florid epileptic seizures, contortions and attitudes passionelles, including an arc-de-cercle, in which they arched their body backwards, supported merely by their head and heels, to a final period de délire. Some hysterics, Charcot’s star performers, became celebrities, with their convulsions recorded in paintings and, especially, photographs (Melechi 2003: 32). Charcot coached his models how to behave, and it is argued that Charcot’s images were so widely publicised that they constituted, in both pictorial and verbal form, ‘for that historical moment a reigning “cultural preconception” of how to act when insane’ (Jan Goldstein in Showalter 1997: 36).

The patients performing for Charcot were young women who had been admitted to the asylum after suffering lives of unremitting exploitation, violence, and rape (Herman 1998: 10). These traumatised victims were banished to the periphery of society, ghostly presences that no longer had rights of personhood but were instead diagnosed, treated, and made to display their abnormality. Charcot was silent on sexual trauma as a precipitating factor in his patients' illness, believing instead that fear was the most potent destructive force, and even that unrequited love could damage a woman’s psyche (Micale 2001: 124-126). Charcot concluded that many of these women were suffering from a form of hysteria provoked by their emotional reaction to incidents in their past: erotic encounters, or perhaps some kind of frightening accident. The women suffered
from a conversion of this painful shock and terror into unusual physical symptoms, but this was not at first regarded as a psychological problem: Charcot believed that hysteria was an organic nervous disease (Melechi 2003: 32-33). Just how the idea or emotion was transformed into a somatic symptom was a question that Charcot seems to have found too uncomfortably speculative, although he did struggle to explain the process by comparing it to intoxication with drugs or alcohol, and to somnambulic or hypnotic trance (Micale 2001: 124). But Charcot was not interested in the emotional lives of his patients, whose painful feelings he merely regarded as symptoms to be noted and catalogued (Herman 1998: 10-11). An excerpt from a transcript of one of his public case presentations from around 1887 or 1888 demonstrates Charcot’s lack of empathy:

CHARCOT: Let us press again on the hysterogenic point. (A male intern touches the patient in the ovarian region). Here we go again. Occasionally subjects even bite their tongues, but this would be rare. Look at the arched back, which is so well described in textbooks.

PATIENT: Mother, I am frightened.

CHARCOT: Note the emotional outburst. If we let things go unabated we will soon return to the epileptoid behaviour … (The patient cries again: “Oh! Mother!”)

CHARCOT: Again, note these screams. You could say it is a lot of noise over nothing (Goetz in Herman 1998: 11).

The hysteric’s body offered endless creative possibilities, and some physicians literally moulded women’s flesh to respond to their hands. In a bizarre medical art called ‘dermagraphism’ doctors traced words or images on the hysteric’s back, abdomen, or breasts, using a rubber stylus – many hysterics had extremely sensitive skin (Hustvedt 2011: 55). Sometimes a medical label like démence précoce (dementia præcox) was inscribed, or the name of the hospital, Salpêtrière; and even words drawn from the vocabulary of demonology: Satan and démoniaque. Doctors often signed their names and dated their drawings, which could remain visible as red welts, sometimes bleeding, for more than three months. The sadism of Charcot and his colleagues could hardly be better demonstrated than in this grotesque performance (Hustvedt 2011: 55-58).

Charcot, profoundly influenced by degenerationist theory, was certain that his patients had an inherited flaw, an organic weakness such as a spinal lesion or a brain tumour, although this actual anatomical abnormality was never found in postmortem examinations; this underlying hereditary weakness was, he believed, triggered by fear or shock, causing neurological disease. This theory would, however, mean that men were also at risk of developing the malady, an idea rejected by centuries of medical opinion (Micale 2008: 134-135). Charcot, having proposed that female hysteria had its origins in traumatic experiences, experimented with male hysterics, finding that by administering small shocks while they were in a hypnoid state he could trigger a paralysis that endured into the waking state. Later, these experiments gave rise to the idea that les névroses traumatiques in men could be due to what Charcot termed auto-hypnosis; in a state of modified consciousness the notion of trauma could take hold in an individual’s mind like a parasite (Trillat 1995: 438). Charcot was, however, careful to point out that symptoms of hystérie virile were not as debilitating as those of female hysteria, and he argued that male sufferers never developed feminine traits (Mosse 2000: 102-103). Despite these assurances, it was popularly held that men who could suffer from these floridly emotional states must be homosexual, effeminate or in some way unmanly, and Émile Batault (in Showalter 1997: 65), one of Charcot’s interns, spoke for many, when he said: ‘One can imagine a perfumed and
pomaded femmelette suffering from this bizarre malady, but that a robust working-man should have nerves and vapours like a society woman, that’s too much!’ It was not until shell-shock became a military problem during the First World War that interest in les névroses traumatiques in men was revived (Showalter 1997: 63-66), and I will return to this issue in a later chapter.

**Psychogenic Theories of Hysteria**

As I mentioned earlier, one of features of the Modern Era is the strange notion that ‘what has been forgotten is what forms our character, our personality, our soul’ (Hacking 1995: 209; emphasis added). The roots of this notion lie in Breuer and Freud’s (1893: 7-21) acknowledgement that traumatic experience is never destroyed, only hidden from consciousness. Soon after Charcot’s death in 1893, Freud and his collaborator Josef Breuer speculated that some hysterical symptoms could be an acting-out of unconscious memories of trauma. All of the case studies presented in their book, *Studies in Hysteria*, are of women (Freud and Breuer 2004). I will examine the controversy over Freud’s investigations into the traumatic origins of hysteria in a later chapter; suffice it to say here that Freud rapidly abandoned this notion, in which he asserted that hysteria was caused by repressed memories of childhood or infantile sexual abuse, developing instead a fantasy-driven model of hysteria (Masson 1998). Turning away from exploring a mind damaged by forgotten traumatic events towards analysing a mind damaged by forgotten fantasies of sexual trauma, Freud developed Charcot’s theory of auto-hypnosis into that of the ‘conversion disorder’, where intrapsychic distress, rather than physical trauma, is converted into apparently neurological symptoms (Melechi 2003: 32-33). This notion of ‘conversion’ is crucial to the Western division of mind and body, and it is important to note that somatic and physical notions of disease, such as Charcot’s earlier insistence that hysteria was an organic nervous disease, are not inevitably more stigmatising than psychologising an illness. Psychologising hysteria denied its authenticity as an illness, and, says Roy Porter (1990), the first psychogenic theory was misogynist and victim-blaming.

Freud’s new approach was described in a case history of his young patient, ‘Dora’ (Ida Bauer), in a famous story that perfectly illustrates how the power dynamics in a therapeutic relationship are weighted in favour of the clinician. The case of Dora is important, and not only because Freud acknowledged her treatment as a breakthrough in his psychoanalytic project. The case is still used as a model for students of psychoanalysis, as it not only shows Freud’s ingenuity in dream interpretation and how significant dreams are in therapy, but it also reveals a great deal about Freud’s own compulsions and his bullying methods (Storr 2001: 125). In a complete reversal of his previous theory – that experiences in adolescence are repressed, becoming harmful because they stir up earlier unconscious memories of actually occurring childhood sexual abuse – he now postulated that because ‘the “neurotic” adolescent does not want to acknowledge her own sexual desires, and in order to cover them up, she “invents” sexual tales of seduction from her early childhood’ (Masson 1998: 122). Freud’s repudiation of his so-called ‘seduction theory’ will be examined in detail in a later chapter, but for now it will suffice to say that much of Freud’s new intrapsychic conflict model of neurosis was based on insights gleaned from treating Dora. Freud’s analysis of Dora has provoked a storm of debates, as well as examinations of his prejudices and motives, which I will briefly summarise.

Dora, brought against her will to Freud’s consulting rooms when she was eighteen, had informed her father that his close friend, Herr K., had made explicit sexual advances to her. Herr K. insisted that Dora had imagined the situation, and her father, hoping to ‘bring her to reason’ and cease what Freud immediately
decided were neurotic symptoms, forced Dora into analysis. However, it transpired that, as she well knew, Dora's father was having an affair with Herr K.'s wife. As Roy Porter (1999b: 113) says, 'Dora was the price of silence.' The events were quite straightforward, but Freud interpreted everything in accordance with his new theoretical approach, a shift towards invisible, internal dramas, a hidden world almost utterly unconstrained by empirical reality (Showalter 1997: 42).

Dora's rather mild symptoms; depression, language impairments, a nervous cough, and a soured relationship with her parents, were interpreted through the analysis of two dreams. Dora, an intelligent, wealthy young woman trapped in an adulterous conspiracy in which her father and Herr K. gave no regard to her autonomy, was subjected by Freud to several indignities: he insisted that Dora was sexually attracted to Herr K., in love with her father, in love with Freud himself, and, later, in his notes, claimed Dora was actually repressing the fact that she had, all along, been in love with Frau K. (Showalter 1997: 43). Freud (1901: 172-239) proposed that Dora's hysterics had a sexual-organic basis, in fact that the symptoms of hysteria are 'nothing else than the patient's sexual activity.' Dora refused to collude, disagreed with Freud's arguments throughout three months of analysis, and then she walked out – or, as Freud put it, 'deserted me' (Porter 1999b: 116). Despite the failure of his treatment, Freud was convinced of the correctness of his theories, especially in the role of transference in analysis (Storr 2001: 125). As Jeffrey Masson (1992: 108) remarks, 'the Dora case marks Freud's first muted message ... that from now on he will seek for the cause of mental suffering in the person, not in the external world.'

Freud's transition towards a hidden world, where repressed and unconscious forces shape humanity's external relations to themselves and others, was part of the historical transformation in thought in that altered the very nature of observation during the modern episteme. The scientific revolution was originally supposed to have eliminated intangible entities from rational discourse: those inexplicable phenomena that throughout the medieval era had still been the realm of spirits and gods. However, in the nineteenth century, materialist science, despite its enormous discoveries, still ran up against the limits of direct experience. Scientists, to many of whom supernatural or metaphysical thought was anathema, were trying to find evidence that lay beyond what was visible, evidence that remained tantalisingly invisible (Panek 2005: 168-178).

The nineteenth century's fascination with the invisible underpinnings of material life produced insights and discoveries that have continued to shape our modern world: for example, Darwin's transmutation of species, Albert Einstein's theory of relativity, Karl Marx's commodity fetishism, and Freud's unconscious. The Modern Era's focus on inwardness can be examined further by exploring the history of hypnosis, a controversial technique with connections to religious practices of exorcism; and phenomena such as 'alter' personalities and dissociation, later classified as mental disorders. Hysteria as a medical diagnosis had vanished by the early twentieth century, with its symptoms submerged in the catch-all label of the psycho-neuroses. The practice of hypnosis, inextricably linked to the treatment of hysteria, became discredited, rejected by nearly everyone in mainstream psychiatric practice (Trillat 1995: 439).

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27 Sometimes this inability was purely technological: when William Röntgen first noted the mysterious fluorescence produced as an electrical current passed through a gas his response was purely speculative: it was not until 1895 when he built a cathode ray tube and directed it at his wife's hand that he could actually see and describe the x-rays that so thrillingly revealed the bones in her hand.
Hypnosis

Medical speculations over the cause and cure of hysteria were intertwined with the practice of hypnosis, which itself developed from an earlier healing method termed mesmerism, devised in the late eighteenth century by Franz Anton Mesmer. Based in Paris, Mesmer revolutionised the tradition of religious healing in Europe, arguing that the miraculous cures performed by priests using exorcism were actually using an unrecognised form of what he termed ‘animal magnetism’, a process by which bodies materially influence each other through the medium of a universal and superfine fluid, in the same way that light travels through ether and sound travels through air (A. Gauld 1995: 11). Mesmer argued that exorcism was actually an unrecognised form of animal magnetism, a claim acknowledged by the Munich Academy of Science, which strengthened his claim that natural power was more therapeutic than any supernatural force (Crabtree 1993a: 9; Trillat 1995: 437). Magnets had been used to treat illness for some time, but Mesmer believed that these mineral magnets were not the therapeutic agent. Instead, Mesmer claimed that healing magnetism emanated from his body, and that he could channel this energy and transfer it to his patients. Healers with this power had to establish a rapport with the patient, perform ‘magnetic passes’ of gestures with the hands, and provoke a ‘crisis’ in which the symptoms of the specific disease were dramatised prior to the cure (Braude 1995: 9-10).

Mesmerised patients – often young and vulnerable women – fell into a state of artificially-induced somnambulism, or ‘magnetic sleep’, in which they could answer questions about their illness, and even predict its course; they obeyed commands, performed vigorous physical movements, and remembered nothing of their experience once they were awakened (Ellenberger 1970: 70-71). As well as individual treatment, Mesmer devised a collective cure in which a number of patients sat by a tub filled with water and magnetised iron rods. This magnetic baquet was placed in a darkened room; patients sat on chairs and held hands, iron rods touching the afflicted parts of their bodies, while Mesmer moved among them touching them or fixing them with his mesmeric gaze. By a kind of psychic contagion, convulsions and violent crises swept from individuals through the rest of the circle (Crabtree 1993a: 13-15). Mesmer became enormously successful, but his egotistical belief in his own power and abilities, his vanity, rumours of sexual impropriety, and his unconventional methods resulted in the disapproval of orthodox medicine; in 1784 he was discredited by two successive Royal Commissions set up on behalf of the Paris medical community (A. Gauld 1995: 16-17).

Animal magnetism as an idea, however, survived, and profoundly influenced the development of Western psychology. One of Mesmer’s students, the Marquis de Puységur, developed a new approach, interpreting rapport as psychological intimacy rather than as a means of transferring magnetic fluid (Braude 1995: 10-11). Puységur explored the phenomenon of mesmeric trance, developing a ‘magnetic rapport’ between subject and magnetiser in his practice (Crabtree 1993a: 78-79). Puységur devised a theory of mental illness, arguing that most disturbances involving strange changes in personality were forms of ‘disordered somnambulism.’ The convulsions of madness were, to Puységur, due to the disturbed person being trapped in a magnetic rapport established in the past, with someone no longer present – this could appear to be like a second personality – and the disorder could be cured by repeated bouts of ‘ordered’, or ‘magnetic’, somnambulism, which removed the strength of the hidden bond. Puységur was struck by the remarkable changes in the character of his subjects while in a state of magnetic somnambulism, a phenomenon that later gave birth to theories of divided consciousness (Crabtree 1993a: 82-84).
There is clearly an affinity between exorcism, magnetism, and hypnosis, but although many practitioners tried to distance themselves from the taint of occultism, sensational stage performances by hypnotists drew huge audiences in Europe, the United States and throughout the British Empire, and the practice retained its mysterious reputation. The ‘artificial’, ‘lucid’, or ‘clairvoyant somnambulism’ that occurred during magnetic sleep frequently induced spectacular cures of what would later be termed nervous disorders, and by the early nineteenth century a derivative of mesmerism was named ‘hypnosis’ by an English surgeon, James Braid, who produced the same state of simulated sleep by flashing lights or by staring intently at his subjects. Braid, trying to gain scientific respectability for hypnosis, theorised that the rapport between hypnotist and patient created a type of modified consciousness in the patient, and during this trance state or somnambulism, their unconscious mind could be accessed and manipulated. Not only could healing be performed under hypnosis, but also hysterical symptoms such as paralysis, analgesia, and catalepsy could be replicated in a healthy subject (Trillat 1995: 437).

The Enchantments of Modernity

There is a long-standing sociological opinion that modernity is characterised by ‘disenchantment.’ Max Weber’s famous discussion on *Entzauberung* in 1917 describes a process of de-magicalisation in the modern world, as the forces of scientific rationalisation diminished the strength of spiritual explanations and animistic connections: human recourse to numinous powers was, it was claimed, demystified. Weber’s account resonated with the enlightenment elevation of positivist science and reason over marvels and wonders – enchantments that had become negatively associated with popular culture and persons deemed inferior, such as women, children, the lower classes, and ‘primitives’ (Saler 2006: 695). Everything, declared Weber (2004: 274), could be mastered by technology and calculation: ‘But that means the disenchantment of the world.’ Notwithstanding these assertions, the modern world remained enchanted in historically contingent ways. Mesmerism and hypnotism were not regarded as fringe sciences; lecturers extolling the virtues of mesmeric trances were given attentive hearings, particularly in debates concerning the use of anaesthesia in medical operations (Winter 1998: 165-169). It was not until the mid-to-late nineteenth century that mesmerism and other vitalist currents began to be clearly demarcated from a narrowly construed positivist science, and even so, many rejected this view of science as too limiting, offering alternative definitions that incorporated nonmaterial agents. The wonders of the occult became rivalled by the new probabilistic explanations of the physical world that science was beginning to explore.

Other techniques to access the unconscious mind emerged later in the nineteenth century, and the fin-de-siècle fascination with occultism is an instance of another modern form of enchantment. The occultists' emphasis on human potential and spiritual growth was well suited to the marketing imperatives of mass culture, and indeed, occultism flourished because mass culture was able to bring it to the attention of a wide audience. During the wave of popular interest in spiritualism that swept through Europe and North America, it was common practice for mediums to claim that they were receiving messages from spirits, which they wrote down during a trance state – a technique termed automatic writing. Madame Blavatsky, of the Theosophical Society, claimed to have received psychic messages in this manner from her spiritual guides, Tibetan Masters who revealed esoteric occult knowledge to her, later published in several large volumes (A. Owen 2004: 30-33). Some psychologists realised that automatic writing allowed access to the unconscious, and the technique became systematically used by William James and Pierre Janet, among others. Ancient divinatory methods of gazing into crystal balls, mirrors, and reflective water, which became fashionable
during the popular craze for visiting spiritualist mediums, also came to be regarded as a means to access unconscious mental states (Ellenberger 1970: 83-85 and 121).

Public displays by mesmerists and hypnotists fascinated the general public, and hypnotised, possessed, charmed, and sleepwalking heroines began haunting literature and art; this intense interest in phantasmagoria enabled a new historically contingent way to describe aberrant mental states to develop. George Du Maurier’s novel *Trilby*, published in 1864, tells the story of Svengali, a malevolent Jewish musician who transforms a young woman into a great singer through his hypnotic powers. The popular mania for *Trilby*, claims Daniel Pick (2000), reflected not only prevalent anti-Semitic prejudices, but also a widespread anxiety about the ‘unconscious’ forces that affected individuals and groups, which contemporaries believed to be an outcome of the rapid spread of the social changes of modernity. The period was preoccupied with fears and fantasies of racial hypnosis and psychic invasion, and despite the pretensions of materialist science, invisible forces remained an almost palpable presence in modern life.

Vincenzo Bellini’s opera, *La Sonnambula*, first performed in 1831, was a great crowd-puller. The phenomenon of trance held a wide voyeuristic appeal, with the sleepwalking heroine encapsulating wide-ranging contemporaneous notions about the relationship between madness, mesmerism, the supernatural and somnambulism (Hibberd 2004: 107-132). Running alongside elite interests in gaining scientific status for inquiries into trance states was a parallel cycle of religious revival, with instances of somnambulism cited as evidence of a heightened spiritual awareness, such as the case of Jane C. Rider, the nineteen-year-old ‘Springfield Somnambulist’, in 1833 in the United States (Reiss 2004). Involuntary experiences such as fits, convulsions, and catalepsy; spontaneous vocalisations such as speaking in tongues; unusual sensory impressions such as clairvoyance and hearing voices; trances and out-of-body experiences; and altered states such as somnambulism, possession, dreams, and double consciousness had long been explained in religious terms. The rise of psychological interpretations of mental states during the nineteenth century led to these acts more often being explained in secular terms, but there was much interplay between popular psychology and movements in popular religion (Taves 1999).

Whether displays of mesmerism and hypnotism were fraudulent or real phenomena is not the issue here, and without doubt the practice attracted many charlatans as well as elite scientific figures. Contemporary audiences certainly wanted proof that experiments were not fakes, and performed cruel tests to check that the (usually female) subject was genuinely entranced and unresponsive to stimuli: the subject’s skin or under her fingernails was pricked with needles, pistols fired near her ears, and noxious chemicals placed in her mouth. Persons of any class could yield to the power of the mesmerist or hypnotist, and behaviour displayed during altered states could offer challenges to the social standing of participants: it is as though they were in a liminal zone where they were immune from censure. Female subjects frequently switched from conventionally demure behaviour to a personality that was bolder and more disrespectful; for example, in 1838, in front of a large audience, a timid maidservant in a state of ‘magnetic sleep’ accused her eminent doctor of being ‘a pathetic fool’ (Winter 1998: 4). Alison Winter (1998: 4-5) suggests that it was not only the authenticity of mesmeric sleep and the integrity of hypnotist and subject that was being tested in the nineteenth century, it was, rather, an experiment undertaken on the nature of society itself, for rather than being a marginal activity, mesmerism and hypnotism reveal insecurity in the midst of the medical, scientific and intellectual life of the period.
Henri Ellenberger (1970: 53) asserts that all modern psychological theories based on the notion of dynamic unconscious mental activity are rooted in the phenomenon of magnetic sleep, which revealed a realm of cerebral agitation not available to the conscious mind. A new alternate-consciousness paradigm evolved, which displaced the two earlier explanations, that of possession or intrusion by demons or sorcery, and that of physiological dysfunction, with the possibility that mental disturbance may be precipitated intra-psychically (Crabtree 1993a: vii). As Hacking (1995) suggests in his study of the origins of multiple personality disorder, prevailing linguistic convention and cultural images shape the way madness is expressed, made sense of, and, perhaps, even how it is experienced. There is not necessarily an essence of a specific type of psychopathology that is gradually discovered, but, rather, a symptom language develops in a particular society, that then becomes available for interpreting social action (Eigen 2003: 153). Just such a shift in language occurred as a result of the popular craze for mesmerism and hypnosis, where everyday cultural understandings of alterations in consciousness influenced medical, psychiatric and legal opinions. In the mid-nineteenth century the legal concept of a person as a rational actor with a clear understanding of consequences was repeatedly challenged by crimes committed by alleged somnambulists, ‘alter’ personalities, and ‘unconscious’ persons.

**Unconscious Crime**

Prior to 1843, the conceptual tools by which the law could interpret a defendant’s action were few. Action could be found intentional, and therefore the person culpable; accidental, and consequently the person not culpable, or guilty of a lesser crime; the crime could be the result of mitigating circumstances and perhaps not punishable; and defendants who were acquitted on the grounds of insanity were deemed nonresponsible due to their distracting mental state. Judicial anxiety increased as medical witnesses with opinions of defendants’ lack of accountability described new types of derangement: ‘moral insanity’, ‘irresistible impulse’, and a ‘lesion of the will’ – a supposed invisible black spot on the brain that could only be inferred by the expert gaze of a mad-doctor observing an individual’s behaviour (Eigen 2003: 6-7).

The number of criminal cases claiming a derangement of moral feeling was growing alarmingly in Britain. The law could not sanction a concept such as moral insanity, which permitted an impulsive will to dominate human accountability and a consequent reduction in the suspension of human agency. In 1843 a new set of guidelines for prosecution was devised: the McNaughtan Rules. This was the first serious attempt to rationalise the attitude of criminal law towards mentally incompetent defendants. The Rules sidestepped contemporary medical opinion, which argued for the existence of a derangement of the passions distinct from intellectual disorder, and restricted courtroom enquiry to the impact of a pathological state on the cognitive capacity of the defendant. The Rules permitted sharp judicial reproof if medical testimony deviated from legally relevant madness, with moral feeling deemed to no longer be a medical question at all. The allegedly insane could still, therefore, be prosecuted (Eigen 2003: 6-7).²⁸

Notwithstanding this attempt to narrow the legal definition of insanity, an increasing number of persons on trial continued to claim that a ‘second self’ committed their crimes, during a blackout of normal awareness. Indeed, following 1843, a new state of being entered the testimony of medical witnesses, one used to

²⁸ These guidelines (alternately known as the M’Naghten Rules) were named after the case of Daniel McNaughtan, who in 1843 killed a man he believed to be Robert Peel, Britain’s Prime Minister (McNaughtan shot Peel’s secretary). At his trial, medical experts testified that McNaughtan had so little ‘moral restraint’ that his violent act flowed uncontrollably out of his delusions – he was found not guilty due to an insanity plea of ‘irresistible impulse’.
describe defendants who often had no history of madness or time spent in an asylum, but nevertheless were not responsible for their actions. These defendants were characterised as ‘quite unconscious of the act’, and in this description forensic psychiatry was clearly influenced by common cultural understandings of altered states of consciousness (Eigan 2003: 153-155). In 1859 a father was acquitted of the brutal slaughter of his young son on the grounds of somnambulism: the judge determined that this was a separate state to insanity, and that the accused was not responsible for his crime due to a second unconscious persona which existed in the same body. Attempts to name this condition led to the belief that it was a type of dream state, where an epileptic-like seizure led to an absence of consciousness. By the end of the nineteenth century French clinicians were referring to a variant of epilepsy termed vertigé épileptique where, between two convulsive seizures, the individual returned to apparent recovery, during which strange and violent behaviour sometimes erupted, and of which the person later had no memory (Eigan 2003: 135-149). Somnambulism and vertigé épileptique suggested more than amnesia: the individual seemed like an automaton, appearing “as a person might be supposed to do who had two souls” (anonymous account from 1834 in Eigan 2003: 133; emphases in original).

The Double

Every important nineteenth century medical description of states of absent consciousness tells of subjects who act in unexpected and atypical ways, exhibiting attitudes and behaviour radically at odds with that of the conscious individual, or ‘host’ personality. In mesmerism and hypnotism, somnambulism and vertigé épileptique, an alternative presence emerges: the weird spectre of the double (Eigan 2003: 17). As Hacking (1995: 149) points out, the new terms ‘double consciousness’ (used in England) and ‘alternating personality’ (used in France) permitted a new way of theorising mental states, with the discovery of mesmeric and then hypnotic sleep directly linked to the form of what later became labelled multiple personality disorder. As mentioned earlier, until Puységur’s discovery that magnetic somnambulism could help in the treatment of disturbances involving switches between two apparently different personalities, thus revealing a second consciousness hidden from the host personality, two frameworks existed to explain mental disturbance (Crabtree 1993a: 86-88). The supernatural ‘intrusion paradigm’, where a demon, a witch, or the devil invades a person and causes strange behaviour, or even, in the extreme case of possession, inhabits the body of the victim, has in many times and cultures been – often successfully – remedied by the intervention of spiritual experts such as exorcists, sorcerers and shamans (Crabtree 1993a: 86-88).

The second explanation, the ‘organic paradigm’, appeared in the West in the sixteenth century, with practitioners asserting that madness resided in the body of the victim, and was thus a physical rather than a moral or spiritual dysfunction, curable by medical treatment of the diseased brain or rebalancing of the humours. Over time, the organic paradigm steadily eroded the dominance of the intrusion paradigm, and although Mesmer regarded himself as an advocate of the scientific organic paradigm, fighting the superstitions of the intrusion paradigm, Puységur’s further research into magnetic sleep introduced a third explanatory framework, the ‘alternate-consciousness paradigm’. According to this new model, human beings consist of divided selves, a revolutionary idea that did not reach its full potential until the late nineteenth century. In the intrusion paradigm, an alien force invades the self, producing inexplicable behaviour, feelings or ideas; in the organic paradigm the source of the aberration is one’s own body; in the alternate-consciousness paradigm the alienation derives from an inner division, where part of one’s mind is dissociated from conscious control. It was now possible to envisage that human beings had an unconscious

The Unconscious

Blaise Pascal's (1999: 243-244) observation 'le Coeur à ses Raisons, que la Raison ne connaît pas' (the heart has its reasons which reason itself does not know) was an early critique of the conscious heroic self, as from the seventeenth century onwards scientific and rational thought increasingly had less interest in humanity's creative processes of imagination and symbolism. This idealised and simplistic regard for reason led to an increasing philosophical interest in what underpins consciousness: 'unconscious' being. Consciousness was, therefore, for many years the province of philosophers rather than psychologists. In the early eighteenth century, Gottfried Leibniz (1996: 53 and 166) speculated that:

> There are hundreds of indications leading us to conclude that at every moment there is in us an infinity of perceptions, unaccompanied by awareness or reflection .... That is why we are never indifferent, even when we appear to be most so, as for instance over whether to turn left or right at the end of a lane. For the choice that we make arises from these insensible stimuli, which, mingled with the actions of objects and our bodily interiors, make us find one direction of movement more comfortable than the other.

Leibniz was one of the first philosophers to analyse the significance of unconscious processes in mental life. According to Leibniz, minute perceptions, as they gradually and continuously accumulate, completely bypass the conscious will, with these sub-threshold perceptual processes playing a role in directing behaviour. Moreover, he argued that when these submerged experiences later become conscious, we might not recognise them as arising from the unconscious, instead misidentifying them as our own creations. Anticipating Freud, Leibniz declared that these forgotten memories often become conscious in dreams (Gomez 2005: 111). Indeed, by 1814, Gotthilf Heinrich von Schubert was asserting that dream images often have an amoral or horrific aspect because forgotten thoughts rise to the surface at night, with hieroglyphic pictures replacing the verbal language of the daylight hours (Ellenberger 1970: 205-206). By the end of the eighteenth century, Immanuel Kant (1996) devoted a section of his last work to a discussion 'On the Ideas We Have Without Being Aware of Them':

> To have ideas, and still not to be conscious of them seems to be a contradiction; for how can we know that we have them unless we are conscious of them? ... Nevertheless, we can be indirectly conscious of having an idea, although we are not directly conscious of it. Such ideas are called obscure, the others are clear (Kant 1996: 18).

Due to the problematic condition of introspective thought, Kant doubted that a natural science of the mind was in fact possible (D. Jones and Elcock 2001: 37).

Throughout the nineteenth century interest in unconscious influence on conscious perceptions continued to proliferate. Johann Friedrich Herbart believed that once ideas entered the mind they were never completely forgotten or destroyed. Similar ideas attract and form an 'apperceptive mass', and ideas incompatible with the mass are repelled by it and relegated to unconsciousness. Herbart devised the term 'limen' to describe the border between the conscious and unconscious mind, a term which later evolved into the concept of 'subliminal' (Ellenberger 1970: 209-210). At the same time, Hermann von Helmholtz proposed that ordinary conscious perceptions are determined by unconscious conclusions. By 1868, Eduard von Hartmann asserted that everything, from the physical universe and all mechanisms of life, down to human mental life,
was ruled by a dynamic form of unconsciousness, which possessed powers far superior to that of conscious reason. Hartmann's three-volume *Philosophy of the Unconscious*, which went through twelve editions, was enormously popular and was hugely influential on the romantic notion of the untapped well of humanity's unconscious creativity (Ellenberger 1970: 209-210).

The nineteenth century saw a struggle between two approaches to psychology: that of a Romantic natural philosophy and a new materialistic scientism. Gustav Theodor Fechner's career spanned both approaches, with his later work influencing his follower Wilhelm Wundt, who in 1879 established the first institute of experimental psychology in Leipzig. Ironically, it was from Fechner's earlier philosophy of nature that Freud later borrowed several key concepts that become incorporated into psychoanalysis, one of which was a 'topographical' concept of the mind, whereby unconscious sensations existed beneath the threshold of consciousness (Ellenberger 1970: 215-218).

Sigmund Freud and his contemporary, William James (often cited as the 'father' of American psychology) were both working in the period during which the psy professions were formed, and the metaphorical language both men used to describe the human psyche remains a powerful force. James believed that all scientific thinking rests on analogy, a belief illustrated in his own writings, where he describes consciousness as a 'stream,' or a flow of 'waves' that constitute inner life (Leary 1990: 19-20). James does not, however, unlike Freud, postulate an *unconscious* stream in his account of the mind (Soyland 1994: 141). Freud was suspicious of the surface manifestations of human nature; he described the mind as consisting of many deep layers hidden from an individual's own consciousness, claiming that only psychoanalysis can excavate these buried fragments of memories, feelings, and thoughts. To Freud (2002a: 7-10), using an archaeological metaphor, the mind is like ancient Rome, with the lowest strata continuing to affect the structure of the highest levels. The long-forgotten memories of childhood return in symbolic form in dreams, neuroses, and physical illness:

> [The] mind is not a simple thing; on the contrary, it is a hierarchy of superordinated and subordinated agencies, a labyrinth of impulses striving independently of one another, corresponding with the multiplicity of instincts and of relations with the external world, many of which are antagonistic to one another and incompatible (Freud in Soyland 1994: 142).

Freud acknowledged the role of literary imagination in his theoretical speculations, and there are scores of metaphors in his work. He draws on mythology for theories such as the Œdipus and Electra complexes; his descriptions of the id, as 'a pot full of seething excitement', and of the libido, building up pressure and draining away, both draw on hydraulic theory; and he used military language to describe the way unconscious material invades consciousness in dreams (Draaisma 2001: 8-9). When reviewing theories of consciousness it is evident that they all rest on varied and often wildly exuberant metaphors (Bruner and Feldman 1990: 230), but Freud's hidden forces of warring libidinal and death drives that can sabotage civilised behaviour resonated with a emergent cultural suspicion of noble endeavours, and his analogies have endured in our contemporary popular culture as well as in psychological theory (Flynn 2005: 36-37).

Freud, along with his collaborator, Josef Breuer, drew on a number of major nineteenth-century ideas about unconscious processes (D. Edwards and Jacobs 2003: 28-30). Firstly, mental activity divides into parallel streams, of which only one can be conscious at any given time; this 'splitting' commonly occurs when people
perform mechanical activities without giving them their full attention. Secondly, cases of ‘double consciousness’, or uncharacteristic behaviours, can transpire when a there is an abrupt change from one parallel mental stream to another. (Both Freud and Breuer described these events as a splitting of the personality or consciousness). Thirdly, Freud refers to the way in which irreconcilable thoughts are repudiated, become repressed, and are then unavailable to consciousness. Fourthly, the unconscious influences conscious activity, and, finally, Freud uses metaphors of depth and excavation to describe his psychoanalytical approach (D. Edwards and Jacobs 2003: 28-30). Freud relied heavily on multiple allegories in his theoretical ruminations on the psyche (Leary 1990: 18), and as Roy Porter (1993: 234) points out, ‘the “unconscious” is not a place or an organ but, at most, a metaphor,’ and in his descriptions Freud reifies a ‘fictive substance’ in terms of actual, substantive electrical and hydraulic expressions.

At the centre of Freud’s (in D. Edwards and Jacobs 2003: 31; emphases in original) theories and therapeutic methods is the interpretation of dreams: the much-quoted ‘royal road to a knowledge of the unconscious activities of the mind.’ According to Freud (1999: 211-239), in dreams the dreamer’s unacceptable – and to Freud, this inevitably meant sexual – unconscious desires are censored and subjected to coding through layers of condensation and displacement, emerging in a ‘picture-puzzle’ in the ‘dream-work’ itself. In dream-work, Freud unveiled the relationship between the conscious and unconscious mind; painful and threatening memories repressed from consciousness carried an emotional charge, and could transform into somatic symptoms and slips of the tongue as well as appearing in symbolic form in dreams (D. Edwards and Jacobs 2003: 30-31). Ian Craib (2001: 32) states that ‘[u]nconscious processes are timeless, do not obey the laws of formal logic, and involve processes of constant re-symbolization.’ Freud considered repression to be the key instrument of psychic defence, and the ‘return of the repressed’, where unconscious emotion or knowledge gathers subterranean energy and erupts into consciousness is a fundamental feature of Freudian dream-work (Clemens 1999: 3-4). In Freud’s ‘topographical’ model of the human mind, three interacting systems control and censor what is permitted to enter awareness (D. Edwards and Jacobs 2003: 32).

Freud’s theories assert that rather than straightforward agents, we are divided in, and against, ourselves. He devised a complex dynamic relationship between what he termed unconscious, preconscious, and conscious levels of the psyche, which gradually evolved into what we now know as the ‘internal agencies’ of the id, ego, and super-ego. Briefly, the id is a chaos of repressed primitive drives that incessantly goads or seduces the ego in attempts to assert its desires. The ego develops as a means to balance the demands of the id with the constraints of the outside world, and in its conscious part is what we identify as ‘I’. However, there is also an unconscious component of the ego, which is the mechanism for repression and defense. Says Craib, the ego can be regarded as the point where all disquiet originates, and thus the price we pay for selfhood is anxiety. The super-ego is an internalised agency, which develops to manage the drives, sometimes resulting in severe guilt and self-criticism (Craib 2001: 32-36).

Freud’s creation of what later became termed depth psychology drew together, as we have seen, many strands of knowledge gleaned by others working in the field of hypnosis and hysteria, as well as his own observations. His innovation lay in introducing new techniques, where the patient relaxed on a couch and spoke of whatever came to mind in the process of ‘free association.’ The ‘resistance’ to recounting embarrassing or traumatic thoughts, and the ‘transference’ of amorous or hostile feelings from the patient towards the analyst that emerged in therapy sessions, first noted by magnetisers and hypnotists, were now
used as a therapeutic tool and analysed to discover hidden yearnings and forgotten terrors (Ellenberger 1970: 490).

Freud also drew on literary works to enhance his descriptions of the psyche. With his claims that ‘everything past survives,’ and ‘in mental life, nothing that has ever taken shape can be lost,’ Freud (2002a: 7-9) found resonances between psychoanalysis and Gothic literature. Both feature individuals trapped by a powerful and mysterious past, which unconsciously drives their present-day actions. Indeed, psychoanalysis itself can be regarded as a kind of Gothic narrative, devised to help understand and manage the symptoms of alienation saturating modern bourgeois society, with individuals both estranged from each other, and simultaneously fearful of the isolation this brings (Kilgour 1995: 220-221). E. T. A. Hoffman’s (1815) ‘The Sandman’, a Gothic fairy tale of hallucinatory terror, inspired Freud’s (1919) essay ‘The Uncanny’, and it has even been suggested that The Interpretation of Dreams is best read as a Gothic novel (A. Smith and Wallace 2001: 3-4). Indeed, it has been argued that after the First World War, as psychoanalysis began ‘to report back from the psychic underworld of the death drive’, it was tracing itself as an ever more Gothic tale, ‘an uncanny double, at the heart of modernity’ (Hugh Haughton 2003: xlii).

The Gothic

The episteme of the Modern Era, whereby the order of tangibly existing things became determined by the historical forces hidden within them – rather than by their place in an ideal classificatory system – built strains between the valorisation of reason and consciousness and ideas about the unconscious mind. These tensions were worked out and displaced into popular novels of the period, especially the genre later identified as ‘Gothic’ literature. Gothic, then, can be regarded as a kind of cultural threshold, a repertoire of images that undercut the rational surface of society. Gothic literature can be employed as a prism by which to view the values and mores of the eighteenth and nineteenth centuries, a use suggested by Fred Botting: in the Gothic, the past is reconstructed as the inverted mirror image of the present, and its darkness allows the virtue and reason of the present a brighter reflection (Botting 2000: 5). The reflection of the past that Gothic revels in preserves an imagined and ideal continuity with the past. Gothic is a trope of the history of the present, a screen for the consumption and projection of the present onto a past at once distant and close by (Foucault 1986: 22-27).

Gothic storytelling first gained public popularity coincident to the revolutionary upheavals in France and the concurrent threat to other monarchies in Europe. This historical period of violent social upheaval is tied to the enlightenment ideals of the eighteenth century – reason, humanism, progress, liberty, fraternity, equality, and the pursuit of happiness. Those who had faith in progress – revolutionaries and bourgeois liberals alike – believed that individuals and human society could be perfected by the application of reason, and were destined to be so transformed. But the age of reason, which produced all these notions of perfectibility, also invented the Gothic (Botting 2000: 3). Indeed, Gothic novels so sensationally reflected contemporary fears and political turbulence that their efflorescence in the 1790s was commonly referred to as the ‘terrorist system of novel writing’ (Miles 2003: 41-43).

Gothic novels defy the dominance of enlightened scepticism, underlining the tenuous hold of civilised limits on human behaviour, and showing that an older world of dangerous brutality continues to shape the psychic realities of the Modern Era. The enlightenment’s assumptions about the powers of the rational mind, the
march of progress, and civilised superiority were all undermined by the popularity of Gothic novels, which suggests that the progressive thinking embraced by elite intellectuals was a veneer concealing the prejudices, superstitions and ideas held by the vast majority of the population of eighteenth and nineteenth century Europe. The genre of Gothic fiction continued its popularity throughout the nineteenth century. I do not intend to examine the Gothic as a literary form, rather, I wish to make use of the way the genre explores the notion that the subject is not in control of his or her self; its images of transgression, the forbidden, and the monstrous; and its influence on thinkers regarded as more serious than writers of fiction.

In the early eighteenth century, the notion of the sublime became a catch-all for both the aims of Gothic literature and as a description for any sensation unacceptable to the prevailing neo-classical virtues of rationality, order, and balance. An emphasis on the aesthetic qualities of the sublime emotions of melancholy, joy, horror, and terror gradually became fashionable, and by mid-century Edmund Burke was attempting to construct a psychology for the passions of the sublime (Milbank 1998: 227). Burke (in Stevens 2004: 50) defines the sublime primarily in terms of fear, emphasising the source as the indirect threat of Death, the ‘king of terrors’. Burke (in Stevens 2004: 50) examined the human reaction to an overwhelming experience that transcended everyday normality: ‘Whilst we contemplate so vast an object, under the arm, as it were, of almighty power, and invested on every side with omnipresence, we shrink into the minuteness of our own nature, and are, in a manner, annihilated before Him.’ Burke also notes a link between ‘some degree of horror’ and this ‘engulfing, oceanic sensation’.

According to Burke, the sublime is a separate category from the beautiful, which he regards as more gentle and thus feminine in its qualities. The sublime acts viscerally and directly upon the body, experienced as a powerful emotional effect that operates against our will (Milbank 1998: 227). The body, in Gothic literature, is portrayed as suffering brutality and extreme pain, the victim of political, religious, or social tyranny (Bruhm 1998: 267). Indeed, Kelly Hurley (2004: 3) argues that by the end of the nineteenth century, Gothic fiction was offering the spectacle of ‘the ruination of the human subject …. figured in the most violent, absolute and often repulsive terms.’ As human identity changed from a secure and stable construct to a more permeable and fragmented subjectivity, the Gothic body became a site for displaying the destruction of ‘the human’ and its metamorphosis into the ‘abhuman’. The abhuman is Hurley’s (2004: 3) term, derived from Julia Kristeva’s (1982: 4-5) notion of abjection, for the not-quite-human subject, in the process of becoming something monstrous: ‘continually in danger of becoming not-itself, becoming other.’ Gothic literature reveals a cultural fear of the dissolution of human identity.

It is commonplace in literary criticism to assert that the appearance of psychoanalysis at the end of the nineteenth century was foreshadowed in the images of transgression in Gothic fiction, and certainly Burke’s writings on the sublime hint at the psychological basis of the attraction of the Gothic: horror and supernatural literature enable the individual psyche to encounter something more numinous than normal consciousness. Gothic texts also contain a frequently lurid and perverse sexuality, which resonates with the emphasis on repressed desire in psychoanalytical theory. Freud was certainly aware of the importance of the Gothic in this respect, believing that literature and other artistic creations, especially art on the extremity of human experience, can reveal more about the subconscious workings of the psyche than rational explanations, although Freud’s theories were heir to more than Gothic literature. Freud believed that artistic creativity
derives from the repression of desire, especially sexual desire, arguing that these ‘primitive’ tendencies can be sublimated into a more socially agreeable form as works of art (Guimón 2006: 73).

From its beginnings, Gothic literature catered to a fascination with terror and the uncanny, with monsters, malevolence, madmen and madwomen. At a time when scientific rationalism was struggling to make sense of insanity, the Gothic provides a way of looking at madness at the birth of modernity. Gothic writing, as many theorists have noted, is haunted by an awareness of the weight of a history, just behind its shoulder, which proves resistant not only to understanding but, more importantly, to change. Gothic literature not only points to a dialectic of civilisation and barbarism, but also to ‘a phenomenon of inner exile’ whereby in certain cultural circumstances what is repressed can be acted out by the repudiated personality (Clemens 1999: 1-13). Things emerge from the unconscious, the repressed returns, and it is at the point when ‘human reason loses control that the most profound emotion of the individual has the fullest opportunity to express itself’ (André Breton in Kilgour 1995: 220).

This ‘return of the repressed’ was part of Freud’s theory of psychoanalysis from the outset (Freud 1999; 1920). Unconscious material is indestructible and memory traces irreducible, forever re-emerging, erupting into consciousness in unrecognisable ways. Repressed memories and motives are revealed, speculated Freud (2002b), through parapraxes: slips of the tongue, misreadings and mishearings. These stumbles and muddles are the surfacings of distorted forms of repressed material sunk in the unconscious. Gothic literature, like the parapraxes, unsettled assumptions about civilised superiority and the power of rationality. Valdiné Clemens (1999: 4-5) says that the tension in Gothic tales often takes the form of a widening disparity between the reader’s awareness of a lurking terror, and a more rationally inclined protagonist’s refusal to accept the truth: ‘Goya’s eighteenth century dictum that “the sleep of reason breeds monsters” could be rephrased into the Gothic recognition that reason (or excessive rationality) itself is a form of sleep or unawareness, which breeds monsters.’ Things that have been buried grow in force until release occurs, bursting into manifestation where they must be acknowledged. The approach and the appearance of the repressed creates an aura of menace and uncanniness, both in the sense of something possessing a numinous quality and in Freud’s sense of Unheimlich – something that feels as though it should not be brought to light.

The Uncanny
Burke’s eighteenth century writings on the aesthetic of the sublime examined experiences of horror, dread, and awe. Freud, like Burke, believed that the theory of aesthetics was compromised by examining only things of beauty, and moved beyond these restrictions in order to investigate the aesthetics of anxiety. In his essay ‘The Uncanny’, Freud (1919: 123) explicitly acknowledges the lure of the Gothic, stating that the aesthetic of the uncanny undoubtedly ‘belongs to the realm of the frightening, of what evokes fear and dread.’ Freud (1919: 148) proposes that the uncanny, or das Unheimlich, is not something unknown, but rather, that the alien resides in the homely, or das Heimlich: ‘something that was long familiar to the psyche and was estranged from it only through being repressed.’ With modernity’s denial of the transcendent, we are haunted by our own and our culture’s disowned past: we all bear ‘residual traces … corresponding to the animistic phase in the development of primitive peoples’, said Freud (1919: 147), and these ancient revenants bestow the gooseflesh of encounters with the uncanny. To Freud, the pre-enlightenment era of atavistic supernaturalism is akin to the individual’s forgotten childhood fears and fantasies: the primitive and
the repressed perpetually return, nightmarishly erupting into an apparently rational modern consciousness (Haughton 2003: xlix).

In E. T. A. Hoffman’s (1815) ‘The Sandman’, reality is defamiliarised, the tale suffused with supernatural interpretations. The protagonist, Nathaniel, describes the traumatic fears of his childhood when he was terrified of his father’s colleague, Dr. Coppelius, who becomes identified with the nightmare figure of the Sandman, who plucks out sleeping children’s eyes to feed to owls on the moon. Nathaniel blames Coppelius for the death of his father, and grows up ‘neurotically haunted … with a taste for the supernatural, the melancholic, and the dæmonic’ (Haughton 2003: xlv). His sensible and rational fiancée, Clara, dismisses Nathaniel’s premonitions that Coppelius would return to ruin his happiness in terms presaging Freud; in a letter she argues:

All the terrible things of which you speak occurred merely in your own mind, and had little to do with the actual external world … the frightful Sandman in the nurse’s tale was naturally associated with old Coppelius [who] seemed to you a monster, especially dangerous to children … If there is a dark and hostile power, laying its treacherous toils within us, by which it holds us fast and draws us along the path of peril and destruction … it must form itself inside us and out of ourselves … It is the phantom of our own selves, the close relationship with which, and its deep operation on our mind, casts us into hell or transports us into heaven (Hoffman 1815: 118-120).

Hoffman’s tale is told through a series of dialogues and letters, telling unreliable versions of Nathaniel’s present by way of his past, as well as his obsessional interpretations of his life in terms of dreams and unconscious fate. Nathaniel, believing that ‘it is foolish to think that we do anything in art or science according to our own independent will’ (Hoffman 1815: 125), purchases an eye-glass from a salesman who has been haunting him: a man he identifies, perhaps erroneously, as the repulsive Sandman. Through the glass, Nathaniel spies a beautiful young woman, Olympia, and, ‘filled with a longing and a burning desire,’ he gazes into her eyes, becomes ‘enraptured’ and forgets Clara (Hoffman 1815: 133-134). Nathaniel describes Olympia as an inanimate mechanical doll, although it is never entirely clear if this is actually the case; but she is certainly ‘uncanny’ in her passivity. Olympia is gruesomely destroyed by her father and the monstrous Sandman, and then becomes, as Nathaniel describes, ‘a lifeless doll’ with ‘no eyes, but black holes instead’ (Hoffman 1815: 137-141). After apparently waking from this nightmare, Nathaniel finds the eye-glass in his pocket while climbing with Clara to the top of a tower. Plunged into madness as he looks through the glass, he believes that Clara has become a wooden doll, tries to murder her, fails, and jumps to his death, shouting ‘Ah, pretty eyes – pretty eyes!’ (Hoffman 1815: 143-144).

In ‘The Uncanny’, Freud (1919) treats Hoffman’s tale very much as one of his own case histories. Freud interprets ‘The Sandman’ in terms of Nathaniel’s relationship with his father; relating the recurrence of eyes and eyelessness, vision and blindness, to Freud’s own theories of Œdipus and the castration complex. However, says Hugh Haughton (2003: xlii-xlili), ‘unless we choose to see the Freudian case-history as a transportation of a Gothic tale into everyday Vienna life,’ nothing else really explains the eerie likeness between the story and Freud’s work. What is this haunting presence of the ‘uncanny’ that by the mid-nineteenth century had crept into Europe’s cultural vocabulary? Terry Castle suggests that:

[T]he eighteenth century in a sense ‘invented the uncanny’ … the very psychic and cultural transformations that led to the subsequent glorification of the period as an age of reason or enlightenment – the aggressively rationalist imperatives of the epoch – also produced, like a kind of toxic side effect, a new
human experience of strangeness, anxiety, bafflement, and intellectual impasse (Castle in Royle 2003: 22).

Representations do not stick in the cultural psyche unless they find an answering resonance; modernity brought with it a train of new anxieties and types of estrangement, as familiar terms of behaviour, language, the self, relations to others, and economic situations changed and became unfamiliar. The depersonalisation so unsettlingly portrayed in ‘The Sandman,’ as Nathaniel, Olympia, and Clara become automatons, was examined by many of the nineteenth century’s social theorists, as well as by Freud and his fellow investigators into the depths of the human mind: a sense of uncanniness began to manifest across a range of political and social issues.

The Vampire

Karl Marx’s writings, replete with supernatural metaphors to describe the inner workings of capitalism, also employed explicitly Gothic tropes (Houston 2005: 25 and 34-35; Wheen 1999: 305). Capital: Volume I, first published in 1867, introduces the reader to a world of phantoms, spectres and apparitions, and Marx’s assertion that capitalism’s relations of production distort a worker’s labour into an external, alien and hostile power sometimes reads like Frankenstein (Shelley 1992) one of Marx’s favourite books (Wheen 2006: 15). Marx describes an economic system whereby the commodity is fetishised, using the language of religion to illustrate how the outward economic forms of capitalism conceal underlying social relationships. Marx (1990: 342) portrays the capitalist as a kind of demon: ‘Capital is dead labour, which, vampire-like, lives only by sucking living labour, and lives the more, the more labour it sucks.’ The worker in the industrial factory – a “‘House of Terror” for paupers’ (Marx 1990: 389) – is drained of power and vitality by the capitalist: ‘in fact the vampire will not let go “while there remains a single muscle, sinew or drop of blood to be exploited”‘ (Marx 1990: 415-416). Furthermore, Marx (1990: 926) asserts, capital comes into the world ‘dripping from head to toe, from every pore, with blood and dirt.’ British industry is, he says, in its endless demands for more labour and longer working hours, ‘vampire-like, could but live by sucking blood, and children’s blood, too’ (Marx in M. Ellis 2003: 168).

Michel Foucault (1994: 250-251) argues that the fields of labour, life, and language each became obscure during the nineteenth century, with their essential nature hidden behind the veneer perceived by the conscious mind, a façade that had long been regarded as illuminated by reason. To Marx (1990: 163-177, the question of false consciousness, or ideology, which he asserts arises from the distortions of thought that stem from, and conceal, the social contradictions peculiar to the capitalist mode of production, is central. Marx, in Capital: Volume III, published in 1894, writes:

Capital-profit (or better still capital-interest), land-ground-rent, labour-wages, this economic trinity as the connection between the components of value and wealth in general and its sources, completes the mystification of the capitalist mode of production, the reification of social relations, and the immediate coalescence of the material relations of production with their historical and social specificity; the bewitched, distorted and upside-down world haunted by Monsieur le Capital and Madame la Terre, who are at the same time social characters and mere things (Marx 1991: 968-969).

This topsy-turvy consciousness arises when human beings are alienated from the products of their labouring activity; the commodities they produce become part of a powerful realm of things to which humanity is enslaved. As a consequence of this, people also become alienated from their actual active lives, from the natural world they live in, and from other people. Marx claimed that society, which was in earlier times an
extension of humanity, a form of shelter reflecting human nature, becomes in the Modern Era something that stands apart and is alien, transformed as a consequence of the hidden workings of capitalism (K. Morrison 2005: 91-98).

As Marx’s (1990) writing in Capital I shows, the vampire is an apt metaphor to employ when describing the plight of workers preyed on by unfettered capitalism, and it was an image widely used to satirise public figures throughout this period. Rather than being an ancient and ubiquitous myth, as usually believed, the notion of the vampire originated in the mid-eighteenth century, first recorded in English in a newspaper in 1732. Says Markman Ellis (2003: 161-162), ‘the vampire has a perverse modernity: a terror of recent invention manifested as a monster from time out of mind, from deep history.’ Bram Stoker’s (1998) Dracula, which partly takes place in an asylum, describes vampires in language taken from mad-doctoring, degeneration theory, and criminal anthropology: socio-medical discourses aiming to classify and understand the abnormal human being (Hurley 2003: 92). Gothic literature frequently used society’s fear of madness as a source of terror, with insanity usually employed as little more than a cypher for evil and immorality. In Dracula, Dr. John Seward writes case-notes as he observes his lunatic patient, Renfield. In his attempts to advance medical knowledge of the brain, Seward finds Renfield ‘a wonderfully interesting study.’

My homicidal maniac is of a peculiar kind. I shall have to invent a new classification for him, and call him a zoophagous (life-eating) maniac; what he desires is to absorb as many lives as he can, and he has laid himself out to achieve it in a cumulative way. He gave flies to one spider and many spiders to one bird, and then wanted a cat to eat the many birds. What would have been his last steps? It would almost be worth while to complete the experiment (Stoker 1998: 70-71).

Although the vampire is destroyed at the conclusion of Dracula, he is not defeated by the reason and scientific method that so prominently defines the narrative. Vampirism is not caused by the psychiatric disturbances scientifically recorded by Seward, but is an atavistic regression from the supernatural past: vampires can only be killed by a wooden stake thrust through their dead hearts (M. Ellis 2003: 189-198).

Other vampire stories proliferated throughout the late-eighteenth and nineteenth centuries, often as ways of articulating concerns over codes of social behaviour. During the French Revolution, for example, the aristocracy was described as ‘blood-sucking vampires.’ Marx was only one of many writers on political economy who used the vampire as a grisly metaphor: the figure of the vampire was also used to satirise the rulers of the new commercial society – industrialists, financiers, magistrates, excise men, politicians, and stockbrokers – and in both moral and economic dimensions they are exposed as corrupt, venal, tyrannical and sexually perverse (M. Ellis 2003: 167-168). The mid-nineteenth century also saw a progressively more scholarly collection and classification of folk tales, and so-called primitive beliefs. With the vampire increasingly located in antiquarian speculations, vampirism became subjected to scientific explanations that described it in medical terms, such as ‘death-trance’ and ‘suspended animation.’ On the pan-European fascination with vampires, it was proposed that resorting to superstition was a type of atavism, ‘a return to barbarous ancestral beliefs, a falling back from modernity into deep gothic history’ (M. Ellis 2003: 188).

The vampire has been variously construed as a symbol of venereal disease, female sexuality, male homosexuality, perversion, capitalism, and the feudal aristocracy; and he or she has been variously presented as a persecutor or as a victim, especially in the twentieth century. As Maud Ellmann (1988: xxviii) asserts: the vampire ‘is all these things and more: he stands for the return of the repressed, the contents of
which are forever shifting.’ More than anything else, though, tales of vampires are allegories about blood. Foucault (1990: 147; emphases in original) argues that blood is ‘a reality with a symbolic function’, and in a society ‘where power spoke through blood’ – as in descent through the bloodline, the status of class, the frequency of violence and disease, and the pervasiveness of war, execution, and death – it represented a fundamental value. Blood is a guarantee of purity, but its vulnerability makes it a source of anxiety: in that it is easily contaminated, drained, diluted or mixed, blood can symbolise moral, familial, or racial degeneration, weakness, and decline.

French psychiatry, trying to delineate the biological and genetic roots of mental illness, remained bogged down in the spectre of degeneracy. Freud’s theory of the psyche, synthesising complex discourses drawn from mythology, archaeology, psychology, psychopathology, perversion, neurosis, and debates over nature and nurture, the mind and the brain, evolution, desire, and fear, could be encapsulated in one word: psychosexuality (Makari 2009: 122-123). Freud’s work became a nexus linking evolutionary biology, sexology, psychology, and psychopathology, as well as studies of dreams, symbolism, and memory (Makari 2009: 124-125). But despite Freud’s enormous influence on the Modern Era’s thought and culture, Freudian psychoanalysis is now often regarded as a detour in the development of modern psychiatry, which became by the end of the twentieth century unequivocally biologically and genetically based (Shorter 1997: 145-146). A different current of European thought, contemporaneous with Freud, saw alienists and mad-doctors working in the organic paradigm and developing what is frequently termed ‘the first biological psychiatry.’ These proto-psychiatrists attempted to map the genetic roots of serious conditions like dementia praecox (later re-named schizophrenia) and manic depression (bipolar disorder): the overt psychoses. Although psychoanalysis and biological psychiatry are often portrayed as monolithic opposing forces, there were however many connections between them, associations that I will explore in my next chapter.

The Storm of Progress Moves On

This chapter, The Storm of Progress, was an investigation of the currents of thought that have been repressed or disowned by contemporary psychiatric discourse as inferior, naïve, or unscientific. Yet, as I argue in this and the following chapter, without these subjugated knowledges the psy disciplines that are dominant in the twenty-first century could not have arisen. As a genealogy of psychiatric knowledge, then, this chapter does not trace a history of triumphant advancement, but maps some of the areas once deemed significant by medical science that slipped into disrepute and obscurity as the storm of progress moved on. The nineteenth century is not unusual in this respect; although many of the phenomena explored, such as somnambulism, magnetic sleep, and hypnosis are now judged outside the remit of the mainstream psychiatric gaze, the twentieth century has plenty of tales that the rhetoric of progress prefers to sweep aside. Scientific judgement is unstable: as an historical occurrence, scientific standards are not fixed, but evolve. When scientists, physicians, psy professionals, or other researchers, choose to investigate a line of reasoning, information is always incomplete: as well as their own intuition and the guidance of their peers, their choices are underpinned by the multidimensional filter of their current episteme.

In Classification and its Discontents, my next chapter, I look at the establishment of biological psychiatry, the feuds between rival branches of the psychiatric professions as they attempted to gain control of the field, and the struggles that later ensued as mental health service-users fought the therapeutic authority of psychiatric power. Subjugated knowledges – those histories and phenomena that, as Foucault asserts, are made
inferior to the discourses of the presently powerful and therefore rendered invisible – cluster particularly
around the marginalised sections of any population. This thesis is concerned with these ghosts haunting the
margins of psychiatric power, and in the next chapter psychiatric survivors will begin to emerge from their
exclusion zone.
CHAPTER 5. A History of the Present, Part II: Classification and its Discontents.

“Psychiater Europas! Wahret Eure heiligsten Diagnosen!”
(Psychiatrists of Europe! Protect your sanctified diagnoses!)  

They are playing a game. They are playing at not playing a game. If I show them I see they are, I shall break the rules and they will punish me. I must play their game, of not seeing I see the game.  

**Power and Resistance**

This is the second part of my history of the present, focussing mostly on the twentieth century and early years of the twenty-first century. While the previous chapter explored the formlessness of eighteenth and nineteenth century investigations of the psyche, this chapter is, rather, a description of what happened when this chaotic flux was tapped into neater classificatory boxes. As we will see, not all psychic phenomena fits neatly into these systems of thought, frequently roiling out of the diagnostic straitjackets meant to categorise them. It is beyond the scope of this thesis to examine this issue across the entire field of mental disorder, so I will focus on schizophrenia, the paradigmatic disease of the Modern Era, and due to my particular interest, I will also explore the topic of childhood psychiatric care with special reference to the autistic spectrum disorders. In this chapter, *Classification and its Discontents*, we are still concentrating on the inner world as the locus of mental disorder, but moving away from the uncanny world of Freudian psychoanalysis to look at the development of the first biological psychiatry, at the end of the nineteenth century, before continuing with the contested development of the psy professions as we know them today. How European and American military psychiatrists diagnosed, treated, and managed their shell-shocked and traumatised casualties during the First World War and in later twentieth century conflicts had a profound impact on the profession. Although I will touch on the issue of traumatic injury and disorders such as shell-shock and post-traumatic stress disorder that are caused by exposure to terrifying events occurring externally to the victim, these will be dealt with in more depth in my next chapter.

Many cultural and scientific factors have contributed to the shape of modern psychiatry, which became a more unified profession in the United States during the 1920s. Criticism and opposition have been fundamental to the psychiatric field since its earliest days, driving many of its transformations (Scull 1993). In the contentious field surrounding psychiatry in the later part of the twentieth century, the competing and often conflicting points of view termed ‘anti-psychiatry’ mostly focused on an analysis of power and social control. Until recently, less has been written about resistance to this power and social control, but a more organised radical voice has emerged from ex-patients involved in the service-user / survivor movement, providing a counternarrative to mainstream psychiatric discourses (N. Crossley 2006a: 1-4). Psychiatric survivors are an exemplar of what Avery Gordon (2007: 4-7) terms ‘complex personhood’, as they are marginalised within a dominating system, ensnared by their symptoms, yet sometimes able to weave their own stories and, as we will see, able to transform psychiatry itself. These ghosts are no longer merely haunting social life, but reclaiming their right to personhood. However, before addressing these topics I will trace a brief history of the asylum, where the practice of treating the mentally disturbed was pioneered by specialist mad-doctors and alienists working in what Roy Porter (2004: 178-179) calls ‘the lunacy trade.’

**The Asylum**

Before modernity, and prior to the advent of the asylum age, family members cared for most lunatics – although this did not guarantee humane treatment, especially if the sufferer was poor as well as mad. Far from wandering around the countryside in the company of a ‘brotherhood of fools,’ as Michel Foucault (2006a: 42) describes them, before therapeutic asylums were established in the seventeenth century the mentally ill were mostly treated with unfeeling brutality or abandoned to a life of vagrancy. Contemporary accounts from the eighteenth and early nineteenth centuries describe unfortunates in rural areas condemned to a horrible existence, chained in filthy rooms, fettered in pigpens or stables, or restrained in a hole in the floor, until relieved by death (Shorter 1997: 1-5). In the cities, most psychotic individuals were locked up in
jails or workhouses with criminals and beggars, although a few, mostly wealthy private patients, were manacled in barbaric hospices such as the notorious ‘Bedlam’ – as Bethlam Hospital in London, founded in the thirteenth century, was known. ‘Bedlam’ has become a synonym for madness, but for centuries the hospital accommodated few inmates: in 1814, only 119 lunatics were held within its walls. Most asylums were private establishments for members of the propertied classes, and it was not until 1848 that Britain provided county asylums funded by the state (Porter 2002: 94; Scull, MacKenzie and Hervey 1996: 15-19).

In colonial North America, as in Britain, the numbers incarcerated were few, with most ‘distracted persons’ dealt with by family members or, occasionally, locked in ‘little strong-houses’ purpose-built for confining the mentally ill. Before 1800, there were only three facilities, with small psychiatric wards – in Boston, Pennsylvania and New York – and it was not until 1773 that the first hospital for ‘Idiots and Lunatics’ was founded, in Williamsburg, Virginia. Central Europe, like Britain, relied on small asylums and jails, with many lunatics in these Tollhäuser (‘fools’ houses’) locked in cages, in filthy cellars or desolate attics (Shorter 1997: 6-7).

Only in France did a larger-scale institutionalisation of the insane occur earlier than the nineteenth century. Sanctioned by the autocratic state of the ancien régime, the Hôpital Général (the Bicêtre for men and the Salpêtrière for women) was founded in Paris in 1656 by royal decree, as a way of quarantining, as Foucault (2006a: 48-49) comments, degenerates ‘emanating from the depths of civilisation.’ Some 6,000 representatives of this ‘social garbage’ were restrained in the Hôpital Général by the 1660s (Porter 2002: 92-93), but most of these troublesome denizens were not insane: in 1788, for example, Bicêtre held only 245 lunatics among its total population, and all other institutions were similar (Shorter 1997: 6). Most of the people locked up were beggars, criminals, prostitutes, the elderly, and patients suffering from physical diseases. France had a population of almost thirty million people by the late-eighteenth century, so the number of the deranged and psychotic held in the hôpitaux can hardly be described, as Foucault (2006a: 43-77) famously insists, as a ‘Great Confinement’ (Shorter 1997: 6).

At the end of the eighteenth century there was no such thing as the discipline of psychiatry, despite the longstanding medical familiarity with the mental disturbances that afflict humanity. Along with the advent of other medical specialities, psychiatry came into being during the nineteenth century in Europe and the United States, although it was not unified under this term until the early twentieth century. It was alienists and mad-doctors who controlled the asylums, staking their claim as experts in the ‘trade in lunacy’ by segregating the mad into institutions, where they could be subjected to therapeutic or ‘moral’ regimes devised by the skills of the new profession of psychiatry (Porter 2004: 94; Scull, MacKenzie and Hervey 1996).

Rival physicians had always employed their own remedies and therapies. Drug therapies were common, mostly narcotics such as opium and cannabis, and potassium bromide, a sedative; these were used to quieten the patients, and most mad-doctors recognised that these drugs did not aid recovery but were, rather, a ‘chemical restraint’ that could even result in worsening the patients’ conditions (Scull, MacKenzie and Hervey 1996: 240-241). Other popular treatments were bitter drinks such as quinine, infection with skin pustules to draw out inner poisons, sweats, vomits, laxatives, bloodletting, immersion or showers in very cold or very hot water for up to six hours, solitary confinement in dark rooms, restraining chairs, straitjackets,

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31 Alienists and mad-doctors were essentially the same thing: the words are just derived from different etymological roots. *Alienare* (to make stange) and *alius* (other) are Latin, whereas *mad* is Germanic in origin.
manacles, and whippings; another method chained the patient to a rotary machine which forced the sufferer to run around a pillar. All of these procedures were designed to pacify the body, tranquillise the agitations of frenzied constitutions, and, ultimately, to calm the mind and make it more susceptible to the power of reason (Foucault 2006a: 297-339; Porter 1999b: 18-19).

By the end of the eighteenth century radical critics denounced restraints and whippings as cruel, and advocated new ‘moral’ regimes, whereby a charismatic mad-doctor would deploy psychological methods in a kind, reasonable, and humane manner. These reformers, such as the Tukes at the York Retreat and Philippe Pinel in Paris, aimed to treat their patients as human beings who could be cured – after, of course, their passions had been subdued. The mad were here regarded as reasonable people trapped in a world of delusions. Since these delusions were believed to be similar to childhood fantasies, the asylum was structured like a reform school, the mad segregated from bad influences, and restored to reason by the enlightened progress of science (Porter 1999b: 18-19; Shorter 1997: 37-45). The function of the new ‘moral’ asylums was to cure, not merely to incarcerate: if the psychotherapeutics worked, then surely it was the duty of society to institutionalise the mad and redeem them from their unreason. This was initially a cause of great optimism, and since most patients tend to naturally remit from such disorders as mania and depression, and even from some forms of psychosis, under a quiet and regular routine, the first three decades of the nineteenth century saw the efflorescence of moral therapy in therapeutic asylums all over Europe and the United States (Shorter 1997: 41). However, the norm increasingly became for those certified as mad to be compulsorily locked away, for security as much as for curative reasons, and the asylum populations surged.

In the late-eighteenth and early nineteenth centuries, the confinement of the mad had only occurred in cities and was an unusual procedure; as we have seen, even famous asylums like Bethlam and the Bicêtre held only a handful of patients. By the late-nineteenth and early twentieth centuries, however, these numbers had skyrocketed, as asylums became society’s first response to mental illness. Society’s mad were banished, no longer permitted to haunt the streets: they were incarcerated in asylums, rapidly built for this purpose. In England, the number of patients confined grew from perhaps 5,000 in 1800 to over 100,000 by 1900, and numbers kept expanding, up to around 150,000 by 1950 (Porter 1999b: 20). By 1900, London alone had sixteen asylums, several with over two thousand beds; the United States held 150,000 patients in mental hospitals, increasing to 500,000 by 1950. By 1900, German-speaking Europe had over four hundred public and private asylums, and French institutions housed twice as many inpatients as they were designed to hold (Porter 2002: 112; Porter 1999b: 20; Shorter 1997: 34). At this time, professional and political thinkers vested great faith in institutional solutions to social problems: asylums, prisons, hospitals, and schools proliferated, and were all believed to alleviate the disruptions of urbanisation and industrialisation. But as soon as one asylum was built, another was needed; the dream of the pioneer psychiatrists – to provide an environment in which to diagnose and treat mentally ill patients – unquestionably failed, as drastic overcrowding swamped the system. Asylums founded in the mid-nineteenth century with the noblest therapeutic visions, had fifty years later become custodial hellholes with no pretence of cure.

Patients with severe mental disorders are indeed helped by being sheltered in quiet environments with regular routines, and by the careful administration of some forms of medication: it was not the methods of the

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32 The figures are inexact, but the vast increase in the numbers of patients locked up in mental institutions is without doubt.
new ‘moral’ asylums that were at fault, but the sheer pressure of inmate numbers that crushed the ability of the doctors to provide any rehabilitative treatments. In the Worcester Asylum in the United States in 1895, there were only five physicians attending 1,200 patients, with 600 new admissions every year. Institutions were being built especially to house chronic patients, with no notion of therapy or eventual discharge for the inmates, and this situation was becoming the norm all over Europe and the United States (Shorter 1997: 46).

Why the numbers of those deemed insane rose so steeply and so rapidly in the late-nineteenth and early twentieth centuries, and why so many people were committed to institutions is highly controversial, but there are basically three arguments. Firstly, some scholars insist that all mental illness is socially constructed, and since the agents of social control have become increasingly powerful in the modern world, those labelled as insane or who in some way deviate significantly from ‘normal’ behaviour, can be banished, sedated, or incarcerated in larger numbers (Becker 1991; Erikson 1962: 307-314; Szász 1972). Secondly, psychiatric illness is real, but its incidence probably does not change much over time. Therefore the huge increase in asylum populations must be explained by social causes, such as the establishment of professional clinics with captive clients. The rise in patient numbers could furthermore be partly a result of the redistribution of the mentally ill from the family home or the workhouse to the asylum (Scull, MacKenzie and Hervey 1996). Thirdly, psychiatric illness is real, and changing social circumstances can affect the human brain, body, and psyche to the extent that certain mental disorders increase or decline along with changes in society (Bentall 2003).

All three arguments have validity, and it seems likely there is a complex interweaving between all of these situations. However, by whatever means (and the resolution of these issues is beyond the remit of this thesis), the end of the nineteenth century saw a huge increase in the diagnosis and institutionalisation of the insane, with concomitant pressure on the psy professions to classify and control, if not cure, asylum patients. In the preceding chapter, the first part of my history of the present, we saw how at the end of the nineteenth century French psychiatry was still mired in the notion of degeneracy, but the German states, with their state-sponsored universities emphasising academic structures of teaching and research in anatomy and psychiatry, provided the ground for a different approach.

The First Biological Psychiatry
The first biological psychiatry attempted to harness neuroscience to therapeutic treatments, and was based on research undertaken in universities and institutes, not in the asylum. For centuries, physicians believed that psychiatric illness resulted from an imbalance of the humours, or from a disease of underlying neural or organic physical structures, but in the nineteenth century doctors began to use new research methods. The clinical-pathological method, which cross-reasoned between symptoms exhibited by a patient and the subsequent findings at autopsy, became standard practice. This kind of systematic research was new, and consisted of human and animal experiments that could be validated by repeated testing, pharmaceutical experiments, and post-mortem examination of brains. Research was driven by the demands of new university teaching posts in psychiatric medicine, which became established across Europe and in the United States simultaneously (Shorter 1997: 69-71). The diagnostic classifications that are now used to describe psychiatric disorders date back to the final decades of the nineteenth century, when it was recognised that the field of psychiatric knowledge could not claim the status of scientific progress until a reliable and valid classificatory system was devised that could categorise the confusing array of symptoms and behaviour...
exhibited by the mentally ill. Diagnostic validity, states Richard Bentall (2009: 93), ‘lies at the heart of modern psychiatric theory.’ However, these concepts were not discovered, as if they were natural kinds: they were invented, in a highly contested field.

The founding father of modern biological psychiatry was the German physician Emil Kraepelin, an exponent of the new evolutionary approach synthesised by Darwin in 1859. To Kraepelin, man was part of nature, and morality as a concept was a product of the cultural and historical development of society, not a force external to humankind (Hoff 1995: 261-279). From the 1880s onwards, Kraepelin incorporated anatomical psychiatry with carefully observed data on the trajectory of patients’ mental disorders. Kraepelin’s ambition was to unify psychiatry clinically and scientifically by applying the quantitative methods used by the natural sciences to psychiatric research. His neurological model was so influential that it is generally agreed that an epistemological shift occurred in the conceptualisation of psychotic disorders (Kendler 1995: 364-367). Successive editions of his textbook manual had a global distribution, and were followed by the entire psychiatric field. The 1893 edition gave a careful account of *dementia praecox* (later re-named schizophrenia), which included three subtypes of *hebephrenia*, *katatonia*, and *dementia paranoides*, and classified them as a form of neurodegenerative disease, the result of an inherited cerebral pathology. By 1899 Kraepelin had split the large and diagnostically unwieldy amount of psychotic illnesses which had no obvious organic cause into two groups: illnesses that involved moods, such as depression, mania, anxiety (‘manic-depressive psychosis’), and those that were psychotic but displayed no affect (‘*dementia praecox*’). The first category he determined would probably recover; the second probably would not. Although a diagnosis of *dementia praecox* terrified patients and their families, it was not necessarily chronic: around a quarter of these patients recovered, despite Kraepelin’s pessimism (Shorter 1997: 100-109). These two types of psychoses – the manic-depressive type, now known as bipolar disorder, and *dementia praecox*, later re-named schizophrenia – are still the focus of serious psychiatry.

Kraepelin’s classification of mental disorders has provided the basis for the most authoritative text in modern psychiatry, *The Diagnostic and Statistical Manual of Mental Disorders* (DSM) published in successive editions and revisions since 1952 by the American Psychiatric Association, and currently in its fourth revised edition (APA 2000; Shorter 1997: 105-107)). Kraepelin’s legacy is also evident in the diagnostic criteria of the World Health Organisation’s (2007) regularly updated *International Statistical Classification of Diseases and Related Health Problems* (ICD). I will return to both of these publications later in this chapter. Suffice it to say for now, that until after the First World War, psychiatry was a divided domain, scattered between neurologists working in private practice, asylum-based alienists, academic psychiatry, and general medical practitioners, all of which utilised a disparate cluster of therapeutic interventions drawn from both Kraepelian and Freudian frameworks.

**Schizophrenia**

Schizophrenia is perhaps the quintessential form of madness in the Modern Era, and its history is practically synonymous with the history of modern psychiatry. It has been over a hundred years since the modern concept of the disorder was first described, and schizophrenia, both as disease entity and as diagnostic construct, has been extensively studied and questioned. Even though it has been argued since the mid-nineteenth century that schizophrenia’s cognitive, emotional, and behavioural features must be rooted in the brain of individual sufferers, its neurobiological underpinnings have remained elusive. As a recent
psychology text on the subject deadpans: ‘100 years of schizophrenia research has yet to produce a coherent and agreed-upon account of necessary and sufficient neurobiological factors and processes that distinguish individuals with schizophrenia from individuals who do not develop the disorder’ (Beck, Rector, Stolar and Grant 2009: 14). Schizophrenia is a mysterious condition, and its aetiology and treatment remains controversial, a topic I will return to later in the chapter, but now I will examine the theoretical frameworks established in the late nineteenth century.

In 1880, John Hughlings Jackson classified madness as a brain disease that is caused by a specific pathology located in certain neurological centres. Disease, argued Hughlings Jackson, causes ‘negative mental symptoms’ such as deficits in pleasure, emotion, motivation, and speech, as the most evolved regions of the brain are damaged. All ‘positive mental symptoms’ such as hallucinations, delusions, and extravagant beliefs and behaviours are the result of the release of primitive functions once the ‘higher’ levels of thought are destroyed. Recovery seemed unlikely for these degenerate individuals with ‘broken brains’ who were both diseased, and, in evolutionary terms, on a ‘lower’ level to ‘normal’ people (Beck, Rector, Stolar and Grant 2009: 4-5). Before Kraepelin adopted the term, Augustin Morel, who had also introduced the concept of degeneracy, coined the name dementia praecox. As we saw in the previous chapter, degeneration theory had religious aspects: the successive worsening of illness and idiocy over generations mirrored the biblical fall of Adam and Eve. This descent into corruption and extinction clung to the notion of dementia praecox, along with the idea of heredity (Hoenig 1995: 336-339).

Kraepelin devised the Modern Era’s nosology for what was later called schizophrenia, but he was uneasy with the diverse nature of the clinical types that he had put together as one distinct disease entity (Healy 2002: 21-22). Trying to make sense of a very diverse clinical picture, he eventually split dementia praecox into ten different types (Hoenig 1995: 339). The field of psychiatric research was very broad, and another of biological psychiatry’s innovators, Eugen Bleuler, a Swiss contemporary of Carl Jung, was originally a member of the International Psychoanalytical Association (IPA), defending Freud and his theories from critics (Makari 2009: 254-255). Bleuler, who like Kraepelin had trained in academic psychiatry, had studied dementia praecox with Jung and initially thought that Freud’s new technique of psychoanalysis could help these patients (Bentall 2003: 21). Freud, incidentally, rarely treated psychotic patients, believing that neurotic patients, although often unwilling to alter their behaviour, are aware that their symptoms are problematic, whereas psychotic patients, experiencing hallucinations as a lived reality, are not troubled with fantasy and are generally unwilling to be ‘cured’ (McCabe 2002: ix-x).33

Bleuler’s academic status forced German psychiatry to take Freud’s work seriously, but Bleuler’s stance, questioning Freud’s theories and trying to anchor them in scientific rigour, led to a falling out. To Freud, legitimate scientific questions merely revealed the interrogator’s unconscious motives: Bleuler, accusing Freud of behaving like the leader of a religious sect, resigned from the IPA (Makari 2009: 255-256). Bleuler, shifting his focus away from psychoanalysis and more towards clinical study, recognised that dementia praecox was a misnomer: patients retain their intelligence and do not become demented, and the onset of

33 Freud’s (2002c) famous case study of Daniel Paul Schreber, first published in 1911, was, crucially, an attempt to defend the centrality of sexuality to psychoanalytic theory, rather than an account of a therapeutic regimen. Schreber, a highly intelligent German lawyer and judge, suffered from hallucinations and paranoia, and was convinced he was to be transformed into a woman by God, who needed to impregnate Schreber and thus save the world. Schreber’s book, a lucid description of his experiences, was widely read by contemporary professional psychiatrists.
the disorder is not necessarily early (Bentall 2009: 93). Bleuler therefore renamed Kraepelin’s *dementia praecox* as schizophrenia (Makari 2009: 254), and specifically rejected Kraepelin’s adherence to the concept of degeneration (Bentall 2009: 93). Bleuler was fascinated by schizophrenics’ strange alterations of thinking and the way that they seemed to live in a different world. There was no sense of a shared humanity, he felt, and in any encounter with a schizophrenic there was a sense of meeting something alien, uncanny, even sinister, and incapable of empathy: it seemed like they had lost their soul (Sass 1998: 14). Bleuler’s investigations were concerned with the unveiling of consciousness, and he came to regard schizophrenia as a form of death-in-life: sufferers experienced feelings ‘of being alive but feeling dead, blunted, stunned, or cut off’ (Morgan 2010: 177).

Much of Bleuler’s work contained remnants of the ideas gleaned from Freud – indeed he claimed a dual allegiance to both Freud and Kraepelin – blending his training in biological psychiatry with an interest in the psychology of his patients, as well as insights from French research into psychopathology, arguing that although a brain disease seemed the most likely cause, schizophrenics were ‘people with split mental associations’ (Makari 2009: 254), by which Bleuler meant not a split personality, but that cognition and affect were disrupted as mental functions become disorganised (Bentall 2009: 93). Bleuler’s eclectic work was thus an influential alternative to both psychoanalytic and medical model assumptions of psychiatric thinking, although even after a lifetime of working with schizophrenics he admitted that ‘they remained as strange to him as the birds in his garden’ (Sass 1998: 19).

Kraepelin’s approach had been empirical and observational, but Bleuler speculated on the existence of a hitherto unknown brain disease process that, like Hughlings Jackson’s ‘broken brain’ theory, caused the primary symptoms (the so-called negative symptoms such as loss of affect and social withdrawal, necessarily always present for diagnosis), whereas the secondary symptoms (the so-called positive symptoms such as hallucinations, delusions, and abnormal affects) were not directly linked to the disease. Bleuler also expanded the concept of schizophrenia to include what are now termed schizoid and schizotypal traits, and argued that Kraepelin was wrong to divide schizophrenia and manic depression, an idea that eventually led to what research in the last forty years has termed the ‘schizophrenia spectrum’ (Beck, Rector, Stolar and Grant 2009: 8-9; Bentall 2003: 24-25; Hoenig 1995: 342-343). Bleuler was impressed by the extent of variation in his patients’ symptoms, and he theorised that there was an inner unity underlying the disease, a concordance that he characterised by identifying four subtle markers. These are associations, which are loosened, so that the sufferer could no longer reason coherently and often spoke in a jumbled ‘word salad’; ambivalence, where attitudes and emotions towards others are conflicted and ambiguous; autism, where patients withdrew into a solitary fantasy world; and affect, in that emotions displayed by the patient were inappropriate to their circumstances (Bentall 2003: 21-24).

To Bleuler, these ‘four As’ revealed the underlying disorder, regarding the bizarre manifestations of hallucinations and delusions as merely psychological reactions to the disease. However, the broadening of conceptions of schizophrenia to include individuals who did not suffer from these florid symptoms meant that it was difficult to differentiate between people who had schizophrenia and those who did not (Bentall 2003: 24). Karl Jaspers, bringing together biological and psychological approaches to psychopathology in 1913, tried to make the borderline between madness and normality more objective. Jaspers stressed that doctors should develop empathy with their patients’ delusions – which were of course very difficult to understand.
That clinicians tended to come from radically different social backgrounds to asylum inmates was an inherent problem when ‘un-understandability’ was what distinguished the psychoses from the neuroses. Jaspers’ explanations of ‘abnormal beliefs’, trying to account for the un-understandability of some delusional perceptions, unintentionally deterred further psychological studies of the psychoses, as psychiatrists were much more comfortable with the biological approach which avoided the frighteningly subjective boundary between madness and reason (Bentall 2003: 28).

It was not until 1959 when Kurt Schneider identified what he believed to be the ‘first-rank symptoms’ of schizophrenia that it became easier for psychiatrists to diagnose the disease, as the negative symptoms have always been tricky to evaluate. Indeed, this difficulty is still acknowledged by the current DSM (APA 2000: 301). For Schneider the meaning of the symptoms was irrelevant: it was the behavioural form that the symptoms took that was important. There was no need, thought Schneider, for the clinician to try to empathise with the delusions: it was enough that the patient heard voices and held strange beliefs. Following Schneider, as psychiatrists in Britain and the United States tried to find more reliable ways to define schizophrenia, all diagnostic criteria emphasised the positive symptoms of delusions and hallucinations rather than the negative symptoms of flattened affective states that Kraepelin and Bleuler believed were fundamental to the disease (Bentall 2003: 29-34).

The five Criterion A symptoms in the diagnostic criteria for schizophrenia, as listed in the APA’s (2000) current manual of mental disorders, DSM-IV-TR, are delusions, hallucinations, disorganised speech (that is, incoherence), grossly catatonic or disorganised behaviour, and, lastly, negative symptoms, such as flattening of affect, lack of speech, and lack of motivation or desire. If the hallucinations consist of a voice providing a commentary on the person’s thoughts or behaviour, or of voices conversing with each other, or if the delusions are ‘bizarre’, then only one symptom is required for diagnosis, otherwise two are required. Other criteria exclude the effects of other medical and psychiatric disorders, and specify that the sufferer has experienced disturbance for at least six months, and that at least one ‘area of functioning’ such as self-care, relationships, or work is dysfunctional (APA 2000: 312).

It is clear that the concept of schizophrenia has gone through a series of radical transformations since Kraepelin outlined dementia praecox. Kraepelin believed the most important features of the disease were intellectual; for Bleuler, they were emotional and cognitive; Jaspers argued that the contents of delusions needed to be understood by empathic clinicians; Schneider focused on the outward forms of delusions and hallucinations. This has led many critics to doubt the robustness of the concept: were these famous giants of psychiatry even writing about the same disease? (Bentall 2003: 37) Mary Boyle (1990: 66), for example, suggests that many of Kraepelin’s patients were in fact suffering from a type of encephalitis, a viral illness that resulted in death or a movement disorder similar to Parkinson’s disease. Boyle shows that schizophrenia research, and the diagnoses that result, is conceptually confused and misleadingly presented. Although people experiencing the bizarre behaviours categorised by the diagnosis suffer great distress, the scientific status of ‘schizophrenia’ is questionable.

Indeed, the diagnostic criteria for schizophrenia have long attracted criticism. Individuals diagnosed with the disease can be totally different in their symptom presentations; any two out of the five DSM-IV-TR Criterion A symptoms will result in a diagnosis. One person can manifest characteristics 1 and 2, another person
characteristics 3, 4, and 5 – neither of these two people share any common characteristic, but both become grouped in the same category: ‘[d]isjunctive categories are logically too primitive for scientific use’ Don Bannister in Read 2004a: 46). That the five criteria are disjunctive categories leads to an illogical situation where ‘there are fifteen ways … in which two people can meet DSM-IV’s criteria for schizophrenia without having anything in common’ (Read 2004a: 46).

As mentioned, if delusions are defined as bizarre – a subjective evaluation – or involves hallucinatory self-reports such as ‘hearing voices’, this single characteristic is enough to meet the criteria for a diagnosis. Diagnosing a person with schizophrenia merely by observing presenting symptoms is flawed, and can lead to absurd situations. In a famous 1972 research project led by David Rosenhan (1973: 250-258), eight ‘normal’ people were admitted to different psychiatric wards after claiming to hear voices (specifically the words ‘hollow’, ‘thud’ or ‘empty’) and all of these impostors were diagnosed schizophrenic by the admitting psychiatrists. Although none of the staff recognised the trick, many of the other patients did, suspicious that the ‘pseudopatients’ were academics or journalists checking up on the hospital. The ‘pseudopatients’ remained hospitalised for seven to fifty-two days, and were eventually discharged with a diagnosis of schizophrenia in remission. When Rosenhan reported this experiment there was huge indignation, and he was accused of fraudulent practice. One asylum challenged him to send them more pseudopatients, assuring him that this time they would be spotted. Rosenhan agreed, and after a month the hospital announced that its psychiatrists had discovered forty-one fakes. Rosenhan then revealed that he had not sent any pseudopatients to that hospital (Ronson 2011: 248).

Because of this heterogeneity in its symptoms and longstanding disagreements over its aetiology, in the early twenty-first century schizophrenia remains an enigmatic disorder. Indeed, schizotypal tendencies, the experiences and traits that are regarded as central to schizophrenia and the dissociative disorders, are present in non-pathological forms in the general population, with many researchers now assuming that these predispositions are transformed into problematic disorders only under certain adverse conditions (Lenzenweger 2006: 162-166; Startup 1999: 333-344). I will return to schizophrenia later in this chapter, as the disorder is central to the anti-psychiatry debates that raged from the 1970s onwards. Research that links schizophrenic traits and dissociative experiences to a history of childhood abuse will be further explored in my following chapter. Now we need to revisit the early years of the psy professions, firstly to the harrowing experiences of the First World War.

**Early Military Psychiatry**

Although the American Civil War is arguably the first instance of industrialised warfare that, along with massive physical carnage and disability, caused widespread psychological trauma in soldiers (Dean 1999: 46), the First World War is the earliest stage where military psychiatry participated in campaigns in an organised manner. Many traumatised men at the front were treated as deserters and shot, but the sheer numbers of shell-shocked soldiers forced the military, with mixed feelings, to turn to psychiatric experts for help in conserving manpower (Dean 1999: 30). The number of casualties in the Great War was enormous. After the Battle of the Somme, which killed around one million British, French, and German soldiers in the four months ending 1916, cases of shell-shock in the British army jumped from 3,000 or so to around 17,000 (Merskey 1995: 491-493).
British military authorities abolished the use of the term shell-shock, trying to play down the cause of the problem. Other physiological terms were available, such as ‘soldier’s heart’ and ‘disorderly action of the heart’, but medical officers were instructed to employ the more ambiguous psychological label ‘Not Yet Diagnosed – Nervous’ as a way of preventing soldiers from avoiding battle under the more robust shell-shock diagnosis. As a way of integrating doctors more closely into the military, triage stations were moved to the front line to enable a more rapid return to fighting for these men (E. Brown 1995: 505-506). Shell-shock was initially believed to be caused by physical damage, especially to the brain, but as a means of reducing casualty numbers the British military re-categorised the problem as a psychological illness, defining it as a type of male hysteria (Merskey 1995: 492-493). The actual numbers of British war neurosis cases are difficult to quantify accurately because of these varying definitions of the disorder, but Peter Leese (2002: 10) accepts a total of around 200,000 men as a reliable estimate of shell-shock cases in each of the three main combatant states; Britain, France and Germany. Post-war this became exorbitantly expensive for the state: by 1921 in Britain 65,000 men were drawing pensions for conditions related to shell-shock, by 1939 the number of pensioners was 120,000 (Merskey 1995: 493).

The psychiatric community struggled to understand and treat battle-related mental breakdown, and there was confusion, political bias, and turf wars between the various factions within it. There were three medical perspectives: one group, which included many military doctors, concentrated on hereditary weaknesses, concussion, and physical shock, falling back on moral degeneracy explanations when all else failed. The second and third schools of thought were both influenced by psychological theories – one was psychoanalytically oriented, and the other stressed a pragmatic approach that encompassed both progressive and disciplinary techniques, from sympathetic rehabilitation to electric shock therapy (Leese 2001: 217-218). Associations with malingering, cowardice, hysteria, and madness tainted combatants labelled as shell-shocked, and Charcot’s investigations of male hysteria were revived, along with allegations of degeneracy, effeminacy, and homosexual tendencies; shell-shock came to be regarded as a crisis of male identity (Showalter 1997: 72-73).

The evidence of male combat neurosis in the First World War undermined psychiatry’s assumption that men and women were naturally different, and Leese (2002: 3) states that to understand the history of the traumatic neuroses in wartime is to understand the cultural shaping of a mental condition. The stresses and anxieties endured by urban dwellers of industrial modernity, described by Georg Simmel (1903: 47-60) as the twentieth century began, seemed to be transforming human experience. Simmel believed that a new psychological condition was appearing in men and women, and due to the ‘intensification of nervous stimulation’ associated with modern metropolitan life: agitated emotional states were altering consciousness. Following Simmel, Leese (2002: 1-2) proposes that an intersection of urban modernity, industrial technology, and medical knowledge – along with an additional modern need to withdraw from the stressors of everyday life – created an epidemic of hysteria in the late-nineteenth and early-twentieth centuries. The manner in which hysterical women were treated in the Hôpital Salpêtrière in Paris was explored in my previous chapter, and Leese (2002: 2) points out that mental and emotional disturbances were not generally acceptable reasons for abandoning societal roles, especially for men in the armed forces, and were accordingly masked by physical symptoms such as paralyses, fainting, and fits: ‘These symptoms constitute an idiom of suffering and sickness: a physical style for expressing inner pain, which was bound in time and culture.’
For combat soldiers in the First World War, it was important to ascribe an organic origin to the traumatic neuroses. The notion of courageous soldiers breaking down under the stress of the war effort was abhorrent to the military authorities, which needed to justify unprecedented levels of slaughter in the trenches; desertion, low morale and cowardice, were other problematic issues. Men who could not behave aggressively, and who were disgusted by the brutality of combat, were generally regarded as psychologically ‘abnormal’ and in need of a ‘cure’. The shell-shocked soldier was ‘unmanly’, ‘infantile’, and believed to be effeminate in his revulsion over violence and killing; consequently, the harsh treatment of those who suffered from shell-shock was meant to cure men of their weakness and get them back to the front (Bourke 2000a: 57-59). The scale of the phenomenon resulted in a crisis in Europe’s military, as by late 1916 up to forty percent of casualties from intense combat zones were shell-shock cases (Pick 1989: 231-232).

The outbreak of shell-shock profoundly destabilised Western ideals of masculine behaviour. The manly archetype in modern Western Europe was ‘a man of action who controlled his passions’, and the menace to society’s norms of manhood were held to only come from ‘outside’: from homosexuals, the insane, criminals and marginalised ethnic groups. It was argued up to 1917 that officers were less likely to suffer shell-shock than young conscripts; as the products of English public schools, officers had developed ‘manliness’ in tandem with their academic studies (Mosse 2000: 101-102). In fact, officers were four times more likely than enlisted men to suffer from war neurosis, perhaps because officers were under more pressure to conform to masculine ideals of emotional repression (Showalter 1985: 174). However, all sufferers of shell-shock were regarded as weak, passive, emotional, suggestible and dependent, traits that recall definitions of hysterical women; furthermore, hysterical men were said by Charcot to be uninterested in sex, a characteristic that was regarded as ‘unmanly’ (Showalter 1985: 172-175).

The notion of ‘enfeebled manhood’ had first appeared in 1888 in the American Civil War; young men with highly developed imaginative abilities were said to be unable to adjust to the suffering of war. As we have seen, at the same time in France, Charcot discovered that men as well as women develop hysteria, but he was careful to point out that symptoms of hystérie virile were never as debilitating as hysteria in women, and male sufferers never developed feminine traits. However, bourgeois social prejudice widely held that hysteria and nervousness in men were racial and class characteristics, and that the Irish, the Jews, the lower classes and other ‘outsiders’ were especially prone to these debilitating afflictions. The spectre of degeneracy was again emphasised, since it was linked with an inclination to suffer from psychoneuroses, and ethnicity was regarded as crucial. During the First World War, it was widely held that the Southern Irish were disproportionately predisposed to insanity and therefore shell-shock, as they were believed to be degenerate due to the widespread ‘cerebral excitement’ caused by centuries of debate over politics and land – a cruel irony, as these men had volunteered to fight for Britain, the very force occupying their own homeland (Bourke 2000a: 59-62).  

The clear demarcation between genders was seen as a bastion of society, and ‘effeminate’ men were thought to threaten the very foundations of society; control of the emotions and thus will-power was equated with courage, and the necessity of this virtue was taken for granted by the bourgeoisie all over Europe.

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34 The Irish experience in the Great War was complex: A radical group of Irish nationalists launched an armed insurrection against British occupation in Dublin in 1916 (the Easter Rising), with German help, but in fact both Catholics and Protestants served extensively in the British forces, with over 300,000 men deployed. All were volunteers, as the notion of conscription provoked widespread resistance in Ireland. Ireland was not partitioned until after the Irish War of Independence, 1919-1922 (Fitzpatrick 1997: 379-406).
CLASSIFICATION AND ITS DISCONTENTS

(Mosse 2000: 102-103). Late-nineteenth and early-twentieth century culture was, as we have seen, haunted by the menace of degeneracy, which was believed by some to be contagious, spread by contact with unmanly sufferers of nervous disorders. This fear was so prevalent, asserts George Mosse (2000: 104-105), that 'shell-shock was regarded in much of the literature as a mental state which mirrored a social disease and national degradation.' Indeed, some commentators argued that the First World War revealed the degeneration of European culture, as the brutish nature of human beings was all too clearly visible through the frail veneer of civilisation (Pick 1989: 232). The very notion of ‘progress’ became overturned, as Henry James (in Fussell 2000: 8) says, when ‘civilisation [plunged] into this abyss of blood and darkness.’

In the British armed forces, the class politics of medical diagnosis was evident; officers demonstrating emotional symptoms such as nightmares, insomnia, depression, and anxiety were viewed with less suspicion than the lower ranks, and were more fortunate in that their treatment was considered a high priority (Leese 2002: 103-104; Showalter 1997: 72-73). Despite being shielded from the worst taint of dishonourable behaviour, and generally receiving more sympathetic treatment than the harsh disciplinary methods used to rush lower ranking men back to the front line, officers were still shamed by the social stigma of shell-shock (Leese 2002: 103). Some psychoanalytically minded physicians, such as the neurologist W. H. R. Rivers, developed psychotherapeutic techniques to treat traumatic neuroses in convalescent hospitals such as Craiglockhart in Britain, but these methods could only deal with a relatively small number of the élite. Treatment was a long, complicated process, not usually possible in wartime conditions (Leese 2002: 82-83).

Many casualties, though, were not officers. The British army high command quickly became concerned over the increasing numbers of combatants with war-related mental disorders, and it was evident that courts martial and the firing squad were no solution, especially as the public and the British Government began asking embarrassing questions about military psychiatry’s ignorance of psychopathology (Leese 2002: 88). The major concern was with treating physical wounds, and it was considered damaging to mix these patients with psychological casualties, for whom there was much less funding and facilities (Leese 2001: 214-215). The mind’s ability to convey through the body what words could not express was startlingly evident in the symptoms manifested by the less educated and articulate lower ranks; paralysis, stuttering, hobbling gaits, misshapen torsos, and, most commonly, mutism were all evident. Indeed, all ranks suffered from delirium, amnesia, hallucinations, nightmares, vomiting, and diarrhoea, with many medics observing that the symptoms of wartime psychoneuroses were similar to those seen in civilian life (Cox 2001: 289).

Some of the British lower ranks were fortunate and were sent home to Maghull Hospital in Merseyside which provided humane treatment based on the work of Freud and Janet, but there was a shortage of qualified therapists as well as a scarcity of funding, and it was not possible to adequately treat the increasing numbers of shell-shock casualties (Leese 2001: 216-217). Doctors lacked specialist training, and treatments tended to be pragmatic and short-term, usually a mixture of psychotherapy, sedation, hot baths, physiotherapy, and electric shock treatment, sometimes punitively applied (Leese 2001: 217-220; Showalter 1985: 178). Faradism, as electroshock aversion therapy was termed, was claimed to successfully cure paralysis and mutism, and there are recorded cases of patients strapped to chairs enduring four-hour sessions of electric shocks. There are also reports that describe doctors applying lighted cigarettes to men’s tongues (E. Jones and Wessely 2005: 38-39).
However their symptoms were categorised, the central issue for military authorities was that men with shell-shock could not fight. Indeed, after the huge losses incurred on the Somme in 1916, the increasing number of shell-shock cases resulted in a drastic shortage of combatants in the British army (E. Jones and Wessely 2005: 21). Army hospitals and medics were not established for the well-being of the patient but to protect the manpower requirements of the Western Front. There was a great deal of tension between medical and military imperatives, as the military wanted to motivate soldiers to return to the front line as soon as possible: battle fatigue and breakdowns needed rapid and successful treatments, not lengthy analysis. Alarmed by the enormous loss of military manpower, the armed forces rejected Freudianism and instead adopted a practice of front-line therapy, where the soldier was treated as close to his unit as possible (Dean 1999: 31). Forward psychiatry was originated by the French military, which claimed that their neurologists could cure 91% of patients using brief psychotherapy and, frequently, electric shocks to paralysed body parts, although they were accused of not curing, but merely ‘whitewashing’ the trauma (E. Jones and Wessely 2005: 25-26). The so-called PIE system of frontline treatment (Proximity, Immediacy, Expectancy) involved treating the soldier with combat exhaustion at the battalion or regimental aid station: treat immediately (reassure, feed, sedate, assure one or two nights sleep); and reinforce in discussion that he was expected to return to his unit as soon as possible. This system, incidentally, was used throughout the twentieth century, and is still the favoured doctrine in the armed forces (E. Jones and Wessely 2005: 21). The American Expeditionary Force, concerned to avoid the shell-shock casualties suffered by the French and British armies, also set up a version of forward psychiatry, but tried to offer more humane clinical interventions such as occupational therapy, although these methods returned fewer soldiers to combat (E. Jones and Wessely 2005: 31-33).

In Germany, where medicine was imbued with approaches drawn from degeneracy theory, eugenics, and notions of sexual continence, it was believed that there was a link between mental health, obedience, and military discipline: willpower and strong nerves would protect the Fatherland (Lerner 2003: 40-43). Many physicians regarded war as not only an opportunity to advance psychiatric and psychological knowledge, but also a way of purifying the nation of degeneracy, hypochondria, and deviance. The allegedly weak nerves of Teutonic men were because they had become feminised during peacetime: war was a masculine regeneration of the German state (Lerner 2003: 44-47; Mosse 1994: 134-157). This greater goal of the collective was seen as paramount, with medics and the military believing that the individual soldier must be trained so his body and mind were entirely dominated by his will. As the war brought epidemics of neurosis, shell-shock, and psychopathology, sufferers were treated as not only inferior and weak-willed, but also as threats to the power of Germany itself. The German medical corps was unprepared for the hundreds of thousands of traumatised soldiers flooding into field hospitals; many patients were sent back to German territory for rest cures, but few recovered.

As psychological casualties grew, the economic implications of diagnosing so many men with traumatic neurosis became apparent, and many were instead labelled as hysterical, which meant they were not eligible for military pensions (Lerner 2003: 54-74). Returning to Charcot’s work on hysteria, medics attempted hypnosis but found it ineffective on large numbers of patients, so new electric shock treatments were developed. Although French, British, and American medics also employed electrotherapy – indeed, some British treatments were dramatically sadistic – German therapies using powerful currents were brutally painful, leading in some cases to death and suicide (Lerner 2003: 102-113; Shephard 2003: 76-101). These
treatments, though, did nothing to stem the flood of psychiatric casualties away from the front (Shephard 2003: 103).

Most army physicians were civilians untrained in military thinking, and faced an ethical dilemma as they were required to heal traumatised men who were terrified of mutilation and death, fears very likely to be realised when they were returned to the hellish conditions of battle by the military authorities – these were not the neuroses of civilian life, imaginary fears, or social phobia (E. Jones and Wessely 2005: 21-22). As Sigmund Freud (in E. Jones and Wessely 2005: 22) observed, ‘the physicians had to play a role somewhat like that of a machine gun behind the front line, that of driving back those who fled. Certainly, this was the intent of the war administration.’ Medics often found this kind of treatment perverse, but it was unfair to abandon soldiers who remained at the front, and doctors with first-hand experience of battle were likely to appreciate this point (Shephard 2003: xvii-xxiii). The so-called ‘forward treatment’ was highly effective: only about 5% of shell-shock cases evacuated to base hospitals in Britain and around 30% to 40% of men hospitalised in France ever returned to combat; in marked contrast, if treated at the front, as many as 91% of men were returned to battle (E. Jones and Wessely 2005: 24-25).

Freud had little to do with the war directly, but those of his followers who worked with soldiers afflicted by traumatic neuroses did develop a psychoanalytic perspective. Like Rivers in Craiglockhart hospital, therapists influenced by Freudian ideas combined dream analysis with ‘hypnotic abreaction’, a way of becoming conscious of repressed traumatic experiences. Skillful therapists were able to achieve impressive numbers of cures, although far from the scale required by the military authorities that were nevertheless interested in their methods (Shephard 2003: 105-106). After the war ended, there was much debate in psychoanalytical circles over whether neurosis always had its origins in sexual repression, as surely traumatic neuroses could not all be explained by recourse to narcissism or the libido? When Freud attempted to understand war neurosis he developed an entirely new idea that returned to his early research into the causes of hysteria: that actual traumatic shock, rather than fantasy, could damage the nervous system. Freud (1920: 50-51) suggested that shock is devastating because the suddenness of its attack far exceeds the moderate amount of anxiety the human psyche is able to withstand, and the traumatic experience is continually repeated in terrifying nightmares, upsetting the normal wish-fulfilling function of dreams.

According to Freud (1920: 45-48), in the human psyche there is a tendency for what he terms the ‘pleasure principle’ to exist; a notion he defines as a propensity to avoid unpleasure and encourage pleasure by the immediate gratification of needs and desires. The ‘pleasure principle’ is thus more concerned with the avoidance of pain than with the seeking out of pleasure. Obstacles in life inhibit the effectiveness of the pleasure principle, especially in dangerous situations where self-preservation is involved. It is then displaced by a ‘reality principle’ that enables a tolerance of delayed gratification. Freud was intrigued by the intrusive and repetitive nightmares suffered by traumatised soldiers, and in a highly speculative exploration of life and death, he searched for an explanation. Hitherto privileging the role of the sexual drive (the libido), Freud considered that the phenomenon of traumatic neurosis was evidence for a human impulse toward destructiveness that he termed the ‘death instinct’: this new dual-drive theory granting aggression equal status to sexuality (Mitchell and Black 1995: 18-19). Although Freud here returned to real-life trauma in his
examination of the war neuroses, he did not, however, integrate his observations with his seduction theory of childhood sexual abuse undertaken and repudiated twenty years before.

Before the First World War, biological and biochemical theories of mental disorder had gained favour in Europe and America, and although empirical evidence was weak, most physicians, mad-doctors, and alienists were obsessively focused on theories of degeneration as the cause of human mental disorder, as well as preoccupied with the admission and control of lunatics in the asylum (Pilgrim and Treacher 1992: 6-7). However, the Great War, with its military violence and unprecedented numbers of psychiatric casualties, profoundly destabilised the theoretical framework of inherited biological weakness. Asylum alienists, clinicians who had no previous interest or expertise in nervous illnesses, were unable to solve the problem of shell-shock. Furthermore, the hundreds of thousands of men who were struck down with these traumatic neuroses were not the degenerate detritus of the workhouse or the slum, they were heroes: soldiers and officers serving King and Country (Pilgrim and Treacher 1992: 8). A psychological explanation of mental disorder suddenly gained legitimacy, along with the psychoanalytical psychotherapies successfully used to treat repressed traumatic experiences. Psychiatry, until now, had been focused on the functional psychoses, with little or nothing to say on the neuroses, the province of neurologists and the Freudian psychoanalysts. After the First World War, the field of psychiatric jurisdiction dramatically expanded to include the neuroses as well as the psychoses, integrative models in which psychological and medical reasoning coexisted were developed, and attempts to consolidate the power and status of psychiatry were set in motion (Pilgrim and Treacher 1992: 8-10).

**The Profession of Psychiatry**

The formal profession of psychiatry has a relatively recent origin. Until the 1920s there were three groups working with mentally ill patients: the asylum-based physicians known as alienists and mad-doctors; neurologists in private practice – a category that includes Freud and the psychoanalysts; and general practitioners of medicine (Pressman 2002: 18-19). Adolf Meyer, who trained in Switzerland, had by the 1930s united the profession under the name ‘psychiatry’ in the United States. An advocate of ‘psychobiology’, Meyer considered psyche and soma different parts of the same thing, and mental illness as brain disease (Pressman 2002: 20). However, Meyer, influenced by the Chicago school of sociology, also determined that the health of each individual was embedded in a social web. To Meyer, mental illness was also a social failure on the part of the individual who failed to adapt to his or her environment. His notion of mental maladjustment ‘combined the troublesome as well as the troubled into a single medical framework,’ in the mental hygiene movement, which was originally formed to regulate sexual issues and family planning, as well as to control venereal disease and prostitution. Maladjustment became the master paradigm of mental disorders, with the mentally ill categorised as social deviants (Pressman 2002: 20-21).

Nevertheless, in the 1930s most psychiatrists in the United States worked outside the asylum in private practice, running clinics where the unhappy middle classes paid large fees to have neurotic illnesses analysed. These men were often originally trained in the asylum but abandoned the grim work of institutional care of the psychotic, preferring instead to communicate with their patients, and getting well paid to do so (Shorter 1997: 156-157). As Edward Shorter (1997: 165-181) shows, the American Psychiatric Association (APA) and the American Psychoanalytic Association had overlapping memberships, and the trend towards working in the more lucrative private practice field became well established. The mass migration of
European analysts driven from Europe by fascism gave psychoanalysis more intellectual weight, and by the end of the Second World War it was psychoanalysts who ran psychiatric training in the United States, a situation that continued until the 1970s. The biopsychosocial blend of Meyerian psychobiology and Freudian intrapsychic conflict dominated psychiatry for several decades, but it did not clearly define the boundaries between the mentally ill from the mentally well. After the 1960s this style of thinking about mental disorder came under increasing attack from several professional fronts, a situation that led to a crisis in the legitimacy of psychiatry. The focus of psychiatric knowledge then shifted back to the medical model, a change consolidated by the 1980 edition of the APA manual of mental disorders, DSM-III (M. Wilson 1993: 399). I will return to this below, when I explore the role of the DSM and its task force in the diagnosis, assessment, and treatment of mental disorder.

Psychiatrists are trained to identify sick people, calculate the course of the illness, speculate on its cause, and cure or palliate the symptoms: diagnosis, prognosis, ætiology, and treatment (Rogers and Pilgrim 2005: 2). As we have seen, the ætiology of various forms of mental illness have long been disputed between professionals holding to biological, degenerative, or intrapsychic causes; all three of these possible causes are located within the sufferer. Another aspect of psychological thought, behaviourism, is however based on the positivist proposition that subjective states of mind can be disregarded: only observable and measurable processes are important, such as the acting out of behaviour. This attempt to make psychology more scientific, reducing complex human motivations to stimulus-response patterns, began in the first half of the twentieth century, mostly flourished in the United States, and was based on animal studies (Harré 2006: 7).

One of the most famous practitioners of behaviourism was B. F. Skinner, the originator of operant-conditioning, which uses consequences such as reinforcement and punishment to modify unwanted behaviours. Skinner’s techniques were developed using pigeons and rats, and he had no interest in the mental states of human subjects (Harré 2006: 15-23), arguing that: ‘[s]tates of mind may be interpreted as collateral products of the contingencies which generate behavior’ (Skinner in Harré 2006: 23).

The present-day technique of cognitive-behavioural therapy is a legacy of behavioural theory, as is an intensive behavioural intervention carried out on autistic children, applied behaviour analysis (ABA), developed by Ivar Lovaas (Schreibman 2005: 135-136). While there is no doubt that behavioural techniques can be dramatically effective in some cases, many of the methods of punishment, such as electric shocks and inhalation of ammonia, were cruelly used, and the long-term effectiveness of ABA is disputed. These practices are reminiscent of the electrotherapy treatments used on shell-shocked soldiers during the First World War, and it hardly needs to be said that practitioners are placed in a powerful position: many in the autism rights movement criticise ABA as unethical. Indeed, electric shock as an aversive is still used in some special schools and is currently protested by the rights group Aspies For Freedom. I will explore the topic of autism in more depth below, but of course autistic individuals are not alone in suffering painful treatments that attempt to alleviate their symptoms.

Psychiatric care has a long history of unethical treatments. Too often, chronological accounts of the development of psychiatry are written in terms of progress, overlooking the fact that many medically therapeutic interventions have proven less than efficacious. This is not to suggest wilful harm: when the psychiatrists of the 1930s introduced new physical treatments into the asylum, they were attempting to bring humane, scientific therapeutics into institutional practices long regarded as barbaric (Pressman 2002: 402).
We have already seen how the numbers of mentally disordered people committed to asylums skyrocketed in the late nineteenth and early twentieth centuries, and how physicians struggled to treat chronic patients in their care; new treatments were seized on enthusiastically after all else had failed. Some of the unfortunate inhabitants of the asylums were probably suffering the symptoms of brain lesions, from the ill-effects of ingesting environmental toxins, or from illnesses such as syphilis, encephalitis, and epilepsy, but until neurological evidence of these conditions was demonstrated as causal they were not able to be accurately diagnosed or treated. Many of these problems can now be corrected by drugs and are considered medical rather than psychiatric disorders (Rogers and Pilgrim 2005: 2-3). Some of those deemed ‘mad’ were, like Charcot’s female patients in the nineteenth century, very likely suffering from unusual physical and emotional symptoms brought on by experiences of violence, abuse, and rape (Herman 1998: 10), and this is arguably still the case – although it is now known that patients are much more likely to regard their trauma history as a causal factor in their psychosis than their clinicians are (Geekie and Read 2009: 31).

Just over a century ago, the patient and the physician were considered to possess equal powers of observation of symptoms, with the doctor just having a more informed interpretation that allowed for the identification of disease. Foucault (2006b: 297-300) argues that this state of affairs changed in the late nineteenth century, when clinicians first began examining the surface of the patient’s ‘neurological body’ with an ‘impressionistic gaze’ that reduced the person to a series of symptoms to be observed and deciphered by the expert doctor. Symptoms, which are subjective experiences reported by the patient, have become divided from signs, which are medical facts or characteristics detected by a physician. However, psychiatry, unlike medicine, still has unresolved problems with the aetiology of pathological conditions, and although modern psychiatric thought is dominated by the empirical Kraepelian view that diseases of the nervous system or the brain underpin all mental illness, there is still limited evidence that this is the case (Pilgrim 2009: 7). In medical diagnostics, symptoms are interpreted as signs that point towards an underlying disturbance, but as Rogers and Pilgrim (2005) point out:

A fundamental problem with the illness framework in psychiatry is that it deals… with symptoms, not signs. That is, the judgements made about whether a person is mentally ill or healthy focus mainly (and often singularly) on the person’s communications. This is certainly the case in the diagnosis of neurosis and the functional psychoses (Rogers and Pilgrim 2005: 3).

Medical diagnostics move from the particular to the general, with a doctor observing a patient, and interpreting a number of physical symptoms that are identified as an illness, then a prognosis is made, and a treatment recommended. This process holds for a wide range of cases from mild viruses like chicken pox to potentially fatal diseases such as cancer.

Psychodiagnoses operate differently to medical diagnostics: a number of isolated psychological symptoms cannot logically be bound together and generalised into a syndrome that fits more or less every case, despite psychiatry’s claims to truth (Verhæghe 2008: 3-5), as is revealed in, for example, the increasingly strained disjunctive categories of schizophrenia diagnosis. As Paul Verhæghe (2008: 5; emphasis in original) points out, ‘[i]n clinical psychodiagnoses we are confronted with signifiers that carry endlessly shifting meanings in any given interaction between the patient and the Other.’ Indeed, most diagnosed mental disorders are still termed ‘functional’, which means that ‘they are based upon symptoms of speech and action, not on bodily diagnostic signs’ (Pilgrim 2009: 7). This unresolved problem means the DSM is
silent on aetiological claims, instead emphasising behavioural descriptions of the mental disorders listed within its pages (APA 2000: xxx; Kutchins and Kirk 1997; Pilgrim 2009: 7). Applying medical diagnoses to psychological problems has now survived longstanding criticism, but professional understandings are still evolving, with the Kraepelalian ‘brain disease’ model being eroded by the Meyerian psychobiological approach, that recognises the impact of environmental events influencing modern ‘biopsychosocial’ models of mental disorder (Pilgrim 2007: 537-538). This is a debate we will return to below when I explore the legitimacy of modern diagnostic systems.

Psychiatric care, as Meyer believed, and as intimated in the work of Foucault, is a socio-medical discipline, and until the 1920s, psychiatrists in the public asylums relied to a large extent on techniques of management, based on suppositions from degeneracy theory and eugenics. This psychiatric social Darwinism persisted in both the United States and Europe, with forcible mass sterilisations of ‘feeble-minded’ female inmates continuing into the 1950s (Samson 1996b: 62-63). Since the 1800s, morphine use in the asylum was routine, especially for subduing psychotic patients. Asylum psychopharmacology really began, however, with hyoscyamine ‘cocktails’, often mixed with morphine and atropine, to relieve symptoms of aggression. As psychiatry began its long association with the pharmaceutical industry in the 1830s, sedatives poured into the asylum, not to cure, but to subdue. Chloral, the first major success in 1889, was used for decades, and the plots of detective stories were full of stories of ‘knock-out drops’ (Shorter 1997: 196-199). Some asylum patients having manic episodes would rage and fit until they died, and the administration of powerful emetics, although they calmed the patient, would literally turn them green and make them vomit for up to an hour (Shorter 1997: 199).

The first attempt to ‘cure’ a psychotic patient took place in 1899, when bouts of acute mania and delusions were quelled by the administration of enormous consecutive doses of potassium bromide. Patients were effectively put into a coma, or ‘bromide sleep’ as it was called, for up to two weeks: inexplicably, the treatment worked for several patients (although they later relapsed), but several died. Various sedative and hypnotic drugs were developed – later called barbiturates, a class of drugs that exemplified psychiatry before the advent of the benzodiazepines in the 1960s – and these became widely used, not just in asylums but also within medicine generally (Shorter 1997: 200-203). The first widespread attempts to cure psychotic patients with barbiturates began around 1920, in Europe, using ‘prolonged sleep therapy’ (actually profound narcosis), and the patient was typically unconscious for around six days. Tested on female patients, it was found that some responded well, awakening to be more receptive to psychotherapy, although mortality rates were about five percent. Deep sleep therapy was adopted throughout European psychiatry, and spread to the Americas (Shorter 1997: 203-206). By the 1950s Ewen Cameron, the president of the American Psychiatric Association, and an avowed enemy of psychoanalysis, seized upon these new physical therapies, and added what he termed ‘depatterning’ techniques. Cameron tried ‘psychic driving’, forcing his female psychotic patients to listen incessantly to tape loops of propagandistic messages, or ‘brainwashing’, as he called it, with simultaneous applications of electroshock. All of these ‘depatterning’ procedures were unscientific and experimental, and performed on patients without their consent (Shorter 1997: 200-207).

Why convulsions and dangerous drug-induced comas should sometimes improve the condition of psychotic patients is still not understood. However, nothing at all had worked before these treatments, and the asylums were full of ‘incurables’. Asylum-based psychiatrists, and neurologists and psychoanalysts based
outside these institutions competed over diagnostic territory, and this inter-professional rivalry drove much experimentation and research (Samson 1995b: 63). The next innovation, insulin shock coma, was regarded as providing ‘astonishing’ cures, and the procedure spread throughout Europe and the United States: by 1960, there were insulin units in over one hundred American asylums, despite the procedure being highly dangerous and killing one patient in a hundred (Shorter 1997: 209-214). Another kind of shock therapy, using the drug Metrazol, which induced convulsions but no coma, was the next contender. Patients dreaded the fits, the pain, and the vomiting, but until the introduction of electroconvulsive therapy (ECT), giant American asylums depended on it to subdue difficult patients. ECT passes electricity through the brain with enough current to cause a grand mal seizure. It was received very favourably by asylum psychiatrists, as they no longer had to chase patients and hold them down to inject Metrazol, and only the agitations of the anti-psychiatry movement during the 1960s and 1970s ended the dominance of this practice (Shorter 1997: 218-223). Patients fared rather less well, since electroshock caused such severe convulsions that limbs broke and spines fractured; in later years, muscle relaxants and anaesthetics were used to minimise this danger (Bentall 2009: 36-37). ECT has seen rather a revival of interest in the late twentieth century (Shorter and Healy 2007), but it is still a controversial treatment with critics pointing to a disproportionate number of female recipients, and the danger of profound memory loss and brain damage after ECT (Read 2004b: 85-99).

Psychosurgery
The next physical therapies to be developed, lobotomy and leucotomy, were even more frightening. These methods excised portions of the brain and severed neuronal connections, with the inventor of the frontal leucotomy, Egas Moniz, awarded the Nobel Prize in Medicine in 1949 (Samson 1995b: 64), a reward that seems very undeserved to modern sensibilities. Psychosurgery is now denounced, as the most evil of scientific aberrations, turning individuality into vegetable conformity, but in its heyday it was not a marginal procedure performed by a few sinister mad-doctors. Lobotomies were indeed carried out on incurably psychotic patients in the back wards of state asylums, as at the time this was where the majority of the seriously mentally ill were housed; but elite research institutes also performed lobotomies, as did wealthy private asylums. Says Jack Pressman (2002: 1-4), ‘the psychiatrists who recommended the procedure, the neurosurgeons who performed the operations, and the scientists who justified it, all came from the highest ranks.’ Patients from socially powerful families were as likely to be lobotomised as those from poor and marginalised backgrounds: the operation was, for a time, a mainstream procedure, and one could say it was at ‘the cutting edge’ of scientific innovation.

These interventions were violently invasive, and most were frankly experimental. Serious mental illnesses were still regarded by asylum psychiatrists as degenerative hereditary diseases and thus incurable, and the mentally ill were, believed contemporary physicians, like cancerous cells weakening the host body of society. This way of conceiving these individuals as defective and abnormal led to an end consistent with eugenic beliefs: the patients’ rights were over-ruled, and without consent their memories were erased and their intellectual abilities destroyed (Whitaker 2003: 136-137). Although it is often believed that psychoanalytic psychotherapy and psychiatry inevitably held to radically different theories, they created and shared an eclectic discourse on psychosurgery. Many clinicians believed psychoanalysis, psychotherapy, and psychosurgery to be complementary practices with common goals, and this endorsement contributed to the professional popularity of lobotomy and leucotomy (Raz 2008: 387).
Lobotomy’s capacity to make ‘the unmanageable more manageable’ was not regarded by the psychiatric profession as mere expediency, but as a clinical gain that could restore mentally ill patients to a form of citizenship, although clearly some patients did receive the operation because their behaviour was too intolerable to deal with in stressed institutional settings (Pressman 2002: 11). Most clinicians were well-intentioned, trying to do something to alleviate the suffering of forgotten patients warehoused in asylums. Even so, it is chilling to see how easily these patients became the mostly unwilling subjects for experimentation, and as Roy Porter (1999a: 520) points out, the development of such abusive techniques reveals the powerlessness of patients in the face of the radical and reckless interventions of doctors. Lobotomy’s use accelerated as its efficacy on psychotic patients was established, and its use widened to include those suffering only from mild intellectual impairment, ‘maladjustment’, and eventually to the control of troubled children. The techniques rapidly spread throughout the world.

Surgeons became quite evangelical, demonstrating their technique to other doctors, with some peripatetic American neurosurgeons travelling across the continent and performing operations like a ‘one-man medicine show’ (Shorter 1997: 225-229). Walter Freeman, an American neurosurgeon who drove a mobile clinic he named ‘the lobotomobile’ around the United States, favoured the transorbital lobotomy: he stunned his patients with electroshock, then hammered an ice-pick through the orbital bone above the eyeball, severing nerve fibres in the frontal lobe of the brain, a very imprecise operation. The result, said Freeman, who in 1960 operated on a twelve year old boy whose stepmother complained that the child was defiant, was to reduce intellectual capacity to that of ‘a household pet’ Bentall 2009: 37-38). However, when the new anti-psychotic drug chlorpromazine was introduced in 1954 the practice of lobotomy dramatically declined, and by the 1960s, it had become redundant (Pressman 2002: 401). The effectiveness of these new drugs astounded psychiatrists, and the reputations of all associated with lobotomy, including Freeman, underwent a rapid reversal. By then, however, tens of thousands of lobotomies had been performed in the United States alone (Raz 2008: 387; Shorter 1997: 225-229).

According to Pressman, psychosurgery’s dramatic rise and fall reveals the lack of determinative data in medical science. Says Pressman (2002: 417), ‘[t]he fact that in crucial scientific decisions matters of professional trust and consensus – a thickly constructed social process – can overshadow what can be derived solely from the laboratory printout is one of science’s dirty little secrets.’ There were actually no valid scientific ideas to legitimate the practice of psychosurgery: medical scientists were practicing and investigating within a particular paradigm, one that rapidly collapsed, but while operational relied heavily on trusted colleagues, authorities, and alliances of the broader scientific culture, led by a few distinguished figures attached to prestigious scientific academies such as Yale University (Pressman 2002: 416-417). Blinkered by the epistemological climate they worked within, clinicians existed in what Pressman (2002: 420) describes as ‘a model of “reciprocal legitimation” … [in which] parties thus agree to the fictions of the standard model wherever possible,’ backing each other up and justifying their methods and therapeutic practices whenever necessary. When psychiatry turned away from psychosurgery, embracing new drug therapies instead, this so-called psychopharmaceutical revolution in psychiatry signalled by the advent of chlorpromazine was more a continuation than a break with past practices, with many doctors calling the new medications a ‘chemical lobotomy’, and the peer-reviewed experimental drug trials dogged by accusations of a lack of scientific rigour (Pressman 2002: 422-423). The control over psychiatry now exercised by
massively wealthy psychopharmaceutical companies is a highly charged issue, one that we will return to in more depth later in this chapter.

Chlorpromazine, although extensively used, did not ‘cure’ any afflictions, but, rather, controlled psychotic symptoms well enough to inspire clinical confidence that hitherto intractable patients could be removed from the asylum (Samson 1995b: 65). In the twenty-first century, years after deinstitutionalisation has drained the asylums of most of their occupants, no-one argues that there are less people with mental disorders. Although asylum care was sometimes appalling and asylums have been excoriated by anti-psychiatry practitioners such as Ronald Laing (1990), sociologists like Erving Goffman (1961) and Thomas Scheff (1984), and popular writers like Ken Kesey (2002), the various policies of deinstitutionalisation – returning patients to ‘care in the community’ – are, says Edward Shorter (1997: 277), ‘one of the greatest social debacles of our time.’ Many vulnerable former patients drifted into homelessness or ended up in the criminal justice system. The anti-psychiatry movement may have proposed deinstitutionalisation, but it was the invention of antipsychotic drugs that really drove the process, along with the ideology of ‘community care’ that was taken up by many world governments as a way of reducing spending on expensive residential psychiatric care (Shorter 1997: 279-281). Arguments over the inhuman treatment of patients may have influenced public opinion, says Andrew Scull (1985), but the major rationale for deinstitutionalisation was the economic considerations of the state. I will return to both the anti-psychiatry movement and the psychopharmacology industry below, but as I have now looked at the ways that the tinkering trades managed the mental disorders of adult women and men, I will firstly turn to how the disorders of childhood have been diagnosed, treated, and understood.

**Child and Adolescent Mental Disorders**

Nowadays it is believed that behavioural and emotional problems are relatively common in childhood. As an example, one in ten children and adolescents in the United States are now diagnosed with a mental illness severe enough to cause impairment (Yiming and Fung 2008: 1). However, child and adolescent psychiatry and psychology have a surprisingly short history, only starting to take their present form about fifty years ago. The disciplines developed out of the mental hygiene movement of the early part of the twentieth century, that in turn was influenced by eugenic theory: notions of degeneracy and the social control of sexuality. Initially, psychiatrists were primarily concerned with so-called maladjustment and with advice on child-rearing and there was little attention paid to diagnosis of any psychological problems. However, there had been interest in the psychological development of children in the 1890s, as a supplement to the medico-hygienic discourses that dominated at that time. Much of this research was part of a wider concern with children’s welfare, and dovetailed with the educational reforms needed after the introduction of compulsory schooling and the banning of child labour. The twin fields of psychology and pedagogy carved out a niche of assessment and measurement of both individual pupils and the effectiveness of educational programmes (Jansz and van Drunen 2004: 55-60). Compulsory education revealed a new category of problematic children: those who did not fit within the regimented structure of teaching. Psychological tools and methods were also utilised in the management of juvenile delinquents, and the development of intelligence testing identified another area for social intervention: recognising and caring for the ‘feeble-minded’, as children with learning difficulties were then termed (Jansz and van Drunen 2004: 60-65). Childhood became accepted as a separate stage of life, and as education extended, ‘adolescence’ was introduced as a new period between childhood and adulthood.
As well as the development of educational psychology, after the First World War there was an enormous increase in social intervention in child-rearing practices. In the United States and Europe, medical opinion gradually replaced moral and religious strictures as the most influential advice on child-rearing, and psychological perspectives on infant development became increasingly popular by the 1920s. Scientific approaches to motherhood were emphasised, with maternal love regarded as sentimental and irrational (Jansz and van Drunen 2004: 67-68). This negative view of female emotionality was widespread. Mothers were instructed, by male experts, on how to objectively manage feeding schedules, toilet training, temper tantrums, and childhood fears. John Watson, writing in 1928, admonished women to:

Never hug and kiss [your children], never let them sit in your lap. If you must, kiss them once on the forehead when they say goodnight .... In a week’s time you will find how easy it is to be perfectly objective with your child and at the same time kind. You will be utterly ashamed of the mawkish, sentimental way you have been handling it (John Watson in Jansz and van Drunen 2004: 68).

Although there were other, more liberal approaches, advocating a more child-centred way of rearing children, the rigidity of ‘scientific motherhood’ was dominant until after the Second World War.

Psychoanalysis offered a differing approach towards children and young people. Freud’s theory of infantile and unconscious sexuality, as mentioned earlier, was and still is attacked by many critics, but his stages of organic infant development have been extremely influential and are now part of popular culture. The physical metaphors used in Freud’s examples, as in the oral stage, when the erotic satisfaction of suckling a nipple becomes displaced to thumb-sucking, kissing, eating, and smoking, is readily understood and used in commonplace conversations. The anal stage, with its emphasis on the repression of pleasure and the social control of toilet training, is also part of modern-day language (Craib 2001: 48-52; Freud 1991). Later stages, the phallic and the Ωedipal, are more problematic. Freud’s assertion that the pleasure of the sexual drive is inexorably directed toward heterosexual genitality as children become adult, and his unpleasant patriarchal attitudes on the inferiority of women have been widely critiqued (Craib 2001: 53-63). This need not concern us here: suffice it to say that these stages remain powerful ideas, with, for example, ‘penis envy’ – as shorthand for any perceived inferiority – still used as a staple of popular discourse.

Freud’s ideas concerning children came mostly from working with adults, but his daughter, Anna Freud, set up child therapy clinics in the 1940s. A major conflict over developmental theories of childhood arose between Anna Freud (1937) and Melanie Klein (1959), with Klein making aggression the central driving instinct, as opposed to sexuality. In London, Klein worked directly with children, some as young as two years old, and saw play as the primary mode of emotional communication (Craib 2001: 64-70). Klein questioned the normalising goals of Freudian child analysis, and her earliest clinical efforts were directed toward understanding how the child’s repressed desires could generate meaning, as revealed in symbolic play (Kristeva 2001: 40-43). Klein’s work influenced Wilfred Bion (N. Symington and J. Symington 1996), Donald Winnicott (1964), and all their followers. Therapists working within this field did not generally work with children who were intellectually disabled, as it was widely believed that client-centred therapy and other forms of psychotherapy were not suitable for ‘severely retarded’, handicapped, or ‘imbecile’ children (Sinason 2010: 53-57). From the 1930s to the present-day, however, a few psychoanalysts have disagreed with this stricture, and have shown an interest in treating intellectually disabled, psychotic, and autistic children, reporting dramatic changes during therapy: some of these children had been chronically sexually
abused. Some may have been disabled and mentally disordered before the effects of trauma, but some were clearly damaged by their experiences: ‘trauma does indeed create not just pictures reminiscent of handicap but real handicap’ (Sinason 2010: 55; emphases in original). In Britain, this therapeutic approach has since 1920 been based at the Tavistock Clinic in London, where a range of what are now termed psychodynamic methods, strongly influenced by psychoanalysis, have been developed, including work with psychotic and autistic children (Alvarez 1992; Rustin et al. 1997; Alvarez and Reid 1999).

Academic child and adolescent psychiatry hardly existed fifty years ago. Although psychoanalysts and psychologists first received his report with hostility, it was John Bowlby’s (1951) review of maternal deprivation for the World Health Organization that radically shook up the field. Bowlby’s work drew attention to the damage caused to children who were separated from their mothers while in institutional care, and was heresy to many psychoanalysts, as he showed that real life experiences, rather than internal conflicts, were the causal factors in childhood mental illness (Rutter and Stevenson 2008: 3). Bowlby’s (1969) attachment theory, in which a young child needs to develop affectional bonds with a primary caregiver if social and emotional development is to occur normally, is still a dominant force in child psychology.

Psychodynamic psychotherapy is an alternate stream that has flowed into the kind of humanistic person-centred approach that is still developing in theory and practice in the early twenty-first century, aimed at adults as well as at children. Carl Rogers (1951; 1961), one of the most important American psychodynamic therapists, published the first of his more than twenty books on client-centred therapy in 1942, arguing for the three core conditions of ‘empathy, congruence, and unconditional positive regard’ as the most effective way of helping a client within the therapeutic relationship (Sanders 2008: 6-9). But at the same time that this more sensitive approach was becoming established, it also became fashionable in other areas of the field to blame parents – especially mothers – for their children’s mental disorder: for example in the case of schizophrenia the ‘schizophrenogenic mother’ was culpable (R. Lidz and T. Lidz 1949: 332-345) and for autism the ‘refrigerator mother’ was at fault (Bettelheim 1967). In the 1940s, clinical thinking had little time for biological causes, although there was some limited research on epilepsy, and the earliest treatment of hyperactive children with amphetamine-derived stimulants was tried, along with some attempts at behavioural therapies (Rutter and Stevenson 2008: 3).

The systematic diagnosis and classification of childhood mental disorder did not begin to come into fashion until the 1950s after descriptions of adult psychopathology had been rationalised by the American Psychiatric Association (APA) in the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1951 (Rutter and Stevenson 2008: 3). Attempts had been previously made to establish a standardised nosology, but these were, by modern standards, filled with broad categories and nonspecific treatments (Kutchins and Kirk 1997: 38-39). Nowadays, the current DSM includes a section on ‘Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence’, but clearly states that this provision is for convenience only, as there is no ‘clear distinction between “childhood” and “adult” disorders’ (APA 2000: 39). Most individuals with childhood disorders do, however, present for clinical attention when young, although some adults are diagnosed retrospectively. Moreover, listings classified as adult disorders can have early onset during childhood and adolescence. The DSM-IV-TR includes mental retardation, learning disorders, communication disorders, and eating, tic and elimination disorders, but the classifications that here concern
me are the attention-deficit and disruptive behaviour disorders, and the pervasive developmental disorders, which include autism.

**Attention-Deficit and Disruptive Behaviour Disorders**

Impulsivity, poor concentration, and overactivity in children were first conceptualised as medical phenomena early in the twentieth century, at a time when, as we have seen, compulsory schooling was introduced in much of the Western world. These ‘problem children’, who had ‘defects of moral control’, and who were, incidentally, mostly boys, were initially regarded as suffering from minimal brain damage that caused behavioural problems and restlessness; indeed, hyperactivity by itself was considered enough evidence to diagnose brain damage. This notion of organic lesions in the brain causing attention-deficit and disruptive behaviour disorders persists to this day, despite the fact that no specific physical cause has been found (Mayes, Bagwell and Erkulwater 2009: 45-46; Timini 2002: 86-87).

In the mid-1960s ‘hyperkinetic reaction of childhood’ was included in the second edition of the DSM but altered to attention deficit disorder (ADD) by the time DSM-III was published in 1980. By 1987, when a text revision led to a new version of the handbook, the DSM-III-R, hyperactivity was given more emphasis with the new term attention-deficit / hyperactivity disorder (ADHD) (Timini 2002: 87). By the time DSM-IV-TR, the fourth, and current, version of the manual, appeared in 2000, inattention, hyperactivity, and impulsivity were listed as the essential features of the diagnosis (APA 2000: 85). Each time the DSM classifications were reconsidered, the prevalence of children found to be above the diagnostic threshold increased exponentially, so that now, it is argued, nearly all children, especially boys, could at some time in their lives meet the definitions and warrant a diagnosis of ADHD (Timini 2002: 88).

There are currently two major diagnostic criteria used to classify ADHD, one European and one American: the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10), published by the World Health Organisation (2007), and the *DSM-IV-TR*, published by the American Psychiatric Association (APA: 2000). Although the criteria are very similar, the definition of ADHD is somewhat wider in the *DSM-IV-TR*, and epidemiological studies show prevalence rates that vary from one to nineteen percent of the population, depending on the stringency of the diagnostic criteria applied (Carr 2003: 370-375). In the United States, one in every ten to fifteen school children (from seven to ten percent) is now diagnosed with ADHD (Mayes, Bagwell and Erkulwater 2009: 1). There is a preponderance of boys over girls, around four or more boys to one girl in ADHD symptomology, which is very similar to the gender distribution found in oppositional defiant disorder, conduct disorder, pervasive developmental disorder, and autism (Frith 2003: 65; Timini 2002: 88).

As the most commonly diagnosed mental disorder in childhood and adolescence, ADHD is controversial and, partly, this is because the diagnostic labels have shifted. Although inattentive, restless, and hyperactive children have been clinically identified since the beginning of the twentieth century, around twenty different names have now been applied to describe them, and aetiological explanations have varied dramatically: causes proposed range from a biological brain disorder, to damage and deficiency in a child’s central nervous system, to genetic mechanisms (Mayes, Bagwell and Erkulwater 2009: 44-45). Decades of research points to ADHD having valid neurological underpinnings, rather than, as is often claimed, it being a purely behavioural problem, but there is no blood test, laboratory test, or X-ray that can identify it: a clinical
diagnosis is made on the basis of a history of symptoms, behaviour-rating scales, observation, and from following the child’s developmental course (Mayes, Bagwell and Erkulwater 2009: 17). The condition is still poorly understood, and looks likely to remain so, although recent research has confirmed genetic markers for ADHD. More importantly, these same genetic variants resemble those identified in autism, epilepsy, mental retardation, and schizophrenia. These genetic variants, although heterogeneous, have a surprising number of overlaps (N. Williams et al. 2010: 1401-1408). How clinicians will interpret and understand this diversity of neuropsychiatric phenotypes in view of these overlapping genotypes remains to be seen, and how these findings will impact on clinical practice is speculative (Peter and Burbach 2010: 1367-1368).

Most contention, though, is over the ethics of millions of children being prescribed stimulant drugs that initially had no large-scale paediatric research (Mayes, Bagwell and Erkulwater 2009: 45). When research began, studies tended to be on short-term usage, and it is still unclear what sort of effect methylphenidate (Ritalin) has on the developing brain (Timini 2002: 103). Many researchers, it has since been revealed, were funded by the pharmaceutical industry, and clearly it is in drug companies’ interests to enhance product sales by highlighting studies with positive outcomes for trials of their medications (Timini 2002: 103). Peter Breggin (2001: 47-48) says that although ‘[n]o official statistics on prescription drug use are kept in the United States … probably at least 5-6 million school age children are taking stimulant drugs, while another million at least are taking other drugs as well.’ These medications are increasingly prescribed to pre-school toddlers, and they are all amphetamine-based, marketed under the brand names Ritalin, Adderall, and Concerta. Paediatric psychopharmaceuticals are also widely prescribed in the United Kingdom and Australasia. Indeed, the overall use of psychotropic drugs to treat mental disorders in all individuals, whether adult, adolescent, or child, has increased enormously over the last twenty years, and I will address this issue below. For now, I wish merely to note that presently, even though so many children and young people are on prescription for stimulant medication, some experts argue that close to twenty million Americans are actually candidates for the drug (Rasmussen 2008: 231-235).

Stimulant medications, unlike the newer antidepressants and antipsychotics, are based on amphetamine, a drug created in 1929 in an attempt to synthesise an allergy medicine. Amphetamines became widely used as antidepressants, as diet pills for weight loss, as performance enhancers in sport, and in the military to promote alertness (Rasmussen 2008: 1-6). ‘Speed’, as it is popularly called, has had a huge impact on society, culture and medicine, and by the 1960s there were around ten million regular users, legal and illegal, in the United States alone (Rasmussen 2008: 1-4). Since amphetamines enhanced mental performance in many adults, in the 1930s it was tested on children who we would now describe as having learning disabilities (formerly called mental retardation) in state homes and mental institutions in the United States, and the drug was found, paradoxically, to make some children calmer and more cooperative, although others became more agitated. The drug company responsible for this testing in the late 1930s, Smith, Kline and French, did not at the time market the drug to boost school performance in children, however, as Benzedrine (as they branded their product) had become widely used by university students, medical worries about addiction and misuse temporarily blocked the marketing of amphetamine as a mental performance enhancer (Rasmussen 2008: 30-31). The paediatric use of amphetamine did not catch on until the 1970s, when suddenly ‘hyperkinetic disorder of childhood’, the precursor diagnosis to ADHD, became much more commonly diagnosed.
Why was this the case? Despite being the most extensively researched paediatric mental disorder, the validity of ADHD as a distinct diagnostic category has not been established (Mayes, Bagwell and Erkulwater 2009: 1-5; Timini 2002: 88). Indeed, it now seems clear that ADHD is actually a particular phenotype of overlapping genotypes also linked to autism, epilepsy, mental retardation, and schizophrenia, a research finding that is yet to be clinically translated (N. Williams et al. 2010: 1401-1408). As a diagnosis, it is certainly not easy to separate ADHD from other disruptive, defiant, and aggressive disturbances of childhood, and impulsiveness, hyperactivity, and inattentiveness are anyway commonplace behaviours in children and not always medicalised (Mayes, Bagwell and Erkulwater 2009: 4; Timini 2002: 88). Allen Frances (in Ronson 2011: 256-257), the chair of the task force that prepared the fourth edition of the DSM, admitted in a recent interview that the DSM psychiatrists made some terrible mistakes in rapidly enlarging their diagnostic categories, especially in ADHD, Asperger’s disorder, and childhood bipolar disorder: “It’s very easy to set off a false epidemic in psychiatry,” he said.” Frances believes that the worst epidemic is in the currently huge surge in diagnosis of childhood bipolar disorder, where drug companies and advocacy groups have had an enormous influence in propagating the identification of this condition in children who are merely moody, irritable, and prone to temper tantrums.

As ADHD’s genetic underpinnings are deciphered they reveal a significantly complex picture, and many people persuasively argue that the way ADHD appears is socially constructed through an intricate web of interactions between unrealistic academic demands, over-worked teaching staff, and stressed parents suffering high divorce rates. The tendency of the currently dominant biological psychiatry to determine behavioural problems as a form of mental illness, as well as the fact that ADHD is a symptom category emphasised by drug companies seeking to expand their market share is another concern. Parents looking for bureaucratic assistance, insurance support and entry into special education for their child also drive the diagnosis (Hinton and Wolpert 1998: 315-317). Rick Mayes, Catherine Bagwell and Jennifer Erkulwater (2009: 11), in a comprehensive study of ADHD, believe that the diagnosis and treatment of all mental disorders are powerfully influenced by their environmental and cultural contexts: ‘ADHD and stimulants do not exist in a clinical vacuum.’ Indeed, all mental disorders and their treatment are ‘social, psychological, and cultural to the core,’ strongly affected by public opinion and current expectations of normal and abnormal, whether in childhood development or adult behaviour (Good 1997: 231). The fact that new research shows a clear a genetic link between patients with ADHD is not the issue: the sheer diversity of the way the disorder manifests is striking. This multiplicity of phenotypical expressions, whether ADHD, autism, epilepsy, mental retardation, or schizophrenia, only makes a stronger case for the force of the complicated tangle of social interactions in which we are all embedded. Once again, we are reminded of Hacking’s (2007: 23-26) writings on ‘making up people’, which I will return to further below.

Genetic research is now confirming what many have long argued: the classification system of the current biomedical model fixes diagnoses in separate boxes, but the issue is really much more complex. Comorbidity is common in psychiatric diagnoses, as well as the multiple prescription of psychopharmaceuticals, or polypharmacy (Ross 2000b: 14-15). However, if many disorders actually have overlapping genotypes, comorbidity is substantially reduced. As I noted earlier, the endlessly shifting signifiers that the current practices of psychodiagnostics rest upon – behavioural symptoms and verbal clues, not physiological or bodily signs – makes ætiology irrelevant (Pilgrim 2009: 7; Verhæghe 2008: 3-5).
These signifiers merely label the surface appearance of a disorder, which as we have seen is highly suggestive to social forces. Classification is then merely the label of whatever is diagnostically in fashion.

There is an interweaving of common threads between the disruptive behaviour disorders and the developmental disorders. Lisa Blakemore-Brown (2002: 15-20) uses a metaphor of a tapestry to describe the overlap between the two spectrum disorders of hyperactivity and autism, arguing that a deeper understanding of the complexity of human development is required to enable more appropriate interventions. Donna Williams (2006: 343-359), diagnosed with autism as an adult, argues that the disruptive / hyperactivity and developmental disorders are not single conditions, and calls them 'fruit salads'. Rather than classifying and treating them separately, a ‘multi-dimensional approach’ would work better, recognising that within these ‘fruit salads’ there are simply different types of personalities (irritable, avoidant, anxious, obsessive, or schizoid), or individuals with information-processing problems, learning difficulties, or physical clumsiness.

Research has shown convincingly not only that there is a high incidence of comorbidity in childhood populations diagnosed with ADHD and autism spectrum disorder but also that the disorders share genetic variants, and it is to the developmental disorders that I will now turn.

**Autism: A Spectrum of Disorders**

Autistic disorder and Asperger's disorder, in their current forms, are listed in the section of the *DSM-IV-TR* sub-headed ‘Pervasive Developmental Disorders.’ This division classifies impairments in social and communication skills, as well as stereotyped behaviours, and there are several other related disorders such as childhood disintegrative disorder and pervasive developmental disorder not otherwise specified (PDD-NOS). Both childhood disintegrative disorder, where the essential feature is a clear regression in former social, language, toileting and motor skills (APA 2000: 77-78), and PDD-NOS, which is like a sub-threshold version of autism (APA 2000: 84), have ‘severe and pervasive impairments’; and are described as ‘insidious’, of lifelong duration, and only marginal improvement is predicted (APA 2000: 77-78). The definitions of these disorders in *ICD-10* are essentially the same (WHO 2007).

*DSM-5* is due to be published in 2013, and the task force has recommended that most of these diagnostic categories should be rationalised, with autistic disorder, Asperger’s disorder, and the pervasive developmental disorders subsumed under a new spectrum of impairment to be termed autistic spectrum disorder (ASD), a category which is already in common use (APA 2010). This change is contested by some paediatricians and psychiatrists as well as by advocates for the neurodiversity movement, who claim Asperger’s is a marker of positive identity rather than of a deficiency (Lenne and Waldby 2011: 70-71). This controversy is an indicator of the biomedical uncertainty that surrounds ASD, which has widely variable symptoms that manifest differently in highly unpredictable combinations in every individual diagnosed with the disorder (Grinker 2007; Lenne and Waldby 2011: 71). Clinical presentation is therefore highly idiosyncratic, and diagnosis is messy; there are at least thirty diagnostic and treatment tools, but no gold-standard randomised controlled trial evidence for any of them, and paediatricians and psychiatrists are faced with complex problems in their clinical practice (Lenne and Waldby 2011: 73-74). There is, as I demonstrated earlier in my thesis, much tinkering and negotiation when dealing with ambiguous diagnoses, and many clinicians readily admit to relying on their ‘gut feelings’ rather than unreliable standardised diagnostic tools; several also highlight parental agency in the establishment of a diagnosis of ASD (Lenne and Waldby 2011: 75-80).
The core feature however that distinguishes the spectrum of autistic disorders is deviant social development, and even though some social skills are learned over time, even individuals with high-functioning forms of autism have conspicuous difficulties negotiating the social world. Cognitive abilities vary from severe mental retardation to unusual savant skills, but problems with speech are common, with strengths more likely in visual and non-verbal abilities (Volkmar and Pauls 2003: 1133-1141). Although a biological and genetic basis for all variants of autism is strongly claimed by many researchers, there is currently no biological marker or set of pathology tests to aid in diagnosis. The essential features of the diagnosis of autism have changed considerably since the first detailed case descriptions of the disorder were published in the 1940s, and I turn here in more detail to Hacking’s (2006: 23-26) views on ‘making up people’ – that is, how certain dominant understandings of human nature shape human beings, how people become classified and how the effects on people in turn change the classifications (the ‘looping effect’). Hacking (2007) argues that people classified, whether as potential suicides, prostitutes, the poor, or if diagnosed with multiple personality disorder, or with autism, are not definite classes of human beings, but, rather:

Moving targets because … investigations interact with the targets themselves, and change them. And since they are changed, they are not quite the same kind of people as before. The target has moved. That is the looping effect. Sometimes our sciences create kinds of people that in a certain sense did not exist before. That is making up people (Hacking 2007: 293).

Autism as a classification has evolved in the last hundred years, and continues to change; as mentioned above, when published in 2013, DSM-5 will likely change the diagnostic criteria yet again.

There is now said to be an autism epidemic, with diagnosis rates for all autistic spectrum disorders as high as 116.1 per 10,000 live births internationally, and boys affected around four to five times more frequently than girls (Ministries of Health and Education 2008: 30). In 2000, the American Psychiatric Association (2000: 73) reported prevalence rates of two to twenty cases per 10,000 individuals in the United States. Six years later this estimate had (at the very minimum) trebled, to 60 in every 10,000 live births, and by the end of the decade had topped 100 per 10,000 births. This increase is even more striking when you consider that even in the early 1990s autism was considered a rare disorder with around three diagnoses in 10,000 births, a prevalence rate virtually unchanged since the 1940s (Grinker 2007: 1). This is an enormous increase, especially in the diagnosis of intellectually higher-functioning types of autism such as Asperger’s disorder, where the gender difference is in the region of 15:1. In autism, the diagnosis of boys predominates much more at the higher intellectual ability levels (Frith 2003: 65-66).

The increase in the number of children diagnosed with autism spectrum disorders is probably linked to this broader definition, which now includes individuals who may in the past have been merely considered eccentric, as well as to the more accurate compilation of statistics (Grinker 2007: 4-5). As I mentioned above, Allen Frances (in Ronson 2011: 253) believes that when he headed the DSM task force, they inadvertently added to the ‘autism epidemic’ by making the category too wide. Indeed there is general agreement that once a diagnosis of autism became based on the observation of behaviour, rather than deeper considerations of aetiology, the social construction of an autism epidemic had fertile ground on which to grow (Eyal, Hart, Onculer, Oren and Rossi 2010: 19). Diagnosis may also be driven by parental demand: a label of autism gains parents access to funding and support services for their child (Berg 2009: 14). Controversy continues to rage over paediatric exposure to vaccines, especially the MMR triple vaccine for
measles, mumps and rubella, despite a striking lack of scientific evidence (Fitzpatrick 2009: xii-xiii). But nothing is simple. The pendulum swing from the mid-twentieth century blame of ‘refrigerator mothers’ to the recent emphasis on genetic determinism is beginning to shift yet again, with the new paradigm proposing a combination of genes and environmental triggers ‘that contribute to the constellation of autistic traits’ (Berg 2009: 16). Under this new paradigm, the broad symptomology of the autism ‘spectrum’ is probably best thought of as deriving from multiple pathways, making it a highly complex disorder. As Hacking (2009: 46) points out, adults and children with autism are extremely diverse, and a slogan current in service-user circles emphasises this: ‘If you know about one autistic person, you know about one autistic person.’

Majia Holmer Nadesan (2005) has made extensive use of Hacking’s work in her research on the way social forces shape the ‘truth’ about what it means to be autistic in the late twentieth century. Nadesan is particularly interested in the way high-functioning types of autism have emerged, and argues that autism, although it seems to have a biological component, illustrates what Hacking terms ‘niche’ disorders or ‘transient mental illness’ (Nadesan 2005: 24-26). Hacking’s (1998b) definition of a ‘transient mental illness’ comes from his examination of fugue, a strange epidemic of obsessive traveling that flourished in the late nineteenth century, a phenomenon that was documented for around twenty years and then faded away.

By ‘transient mental illness’ I mean an illness that appears at a time, in a place, and later fades away. It may spread from place to place and reappear from time to time. It may be selective for social class or gender, preferring poor women or rich men. I do not mean that it comes and goes in the patient, but that this type of madness exists only at certain times and places …. [and requires a metaphorical] ecological niche within which mental illnesses thrive (Hacking 1998b: 1).

I have already mentioned Hacking’s work in relation to hysteria, perhaps the most notorious example of a transient mental illness. Hacking (2007: 303), though, has more recently explored the way the concept of autism has evolved, concluding that in his opinion autism is not a ‘transient mental illness’ but, rather, ‘before 1950, maybe even before 1975, high-functioning autism was not a way to be a person.’

If, as is generally argued, autism has a genetic, neurological component, the deficit existed before the word ‘autism’ was invented, and children were labelled instead as ‘feeble-minded’ or ‘mentally retarded’ or other unpleasant epithets. Once it was possible to be diagnosed as autistic, some individuals, their families, and the clinicians who worked with them – who all lived with the awareness of this new ‘way to be a person’, and who developed social skills and insight into the condition – changed the concept of the disorder: what Hacking (2007: 301-304) terms a ‘looping effect’ took place, and the idea of the high-functioning mildly autistic person was created. High-functioning autism is, then, a way of ‘making up people’ that exists in the ecological niche of late twentieth and early twenty-first century culture. This niche, argues Hacking (2007: 305-306), was constructed both by the methodology of the human sciences (in their imperatives to ‘Count! Quantify! Create Norms! Correlate! Medicalise! Biologise! Geneticise! Normalise! Bureaucratise!’), as well as by another powerful motor of change, the ‘resistance by the known to the knowers … [and] the source of many looping effects’, service-user’s imperatives to ‘Reclaim Our Identity!’ This begs the question: where were all the high-functioning autistic people before this metaphorical ecological niche was constructed, before high-functioning autism was a way to be a person? Stories of autism are now blazoned on newspapers, magazines, movies, television shows, and incorporated into novels, and many people know someone diagnosed on the autism spectrum, but even ten years ago there was little popular information about the disorder. I suggest, following Hacking (2007; 2006; 1999), that the ‘looping effect’ is crucial for
understanding the autism epidemic: the enormous rise in the number of diagnoses is not entirely a naturally-occurring event, nor totally a socially constructed fiction, but is part of a spiral in a vortex of looping processes. Part of the looping spiral grew out of deinstitutionalisation, when children formerly labelled ‘feebleminded’ or ‘mentally retarded’ were no longer incarcerated in children’s homes; another spiral developed when parents and therapists who now cared for these atypical children began to organise into groups with their own expertise; yet another spiral on the loop came into existence as new therapies changed the appearance of autism by working on behaviour modification, social interaction, and sensory difficulties in children, and the autistic experience became shaped as neurodiversity – as a personal identity – rather than denigrated merely as ‘autistic aloneness’ (Eyol, Hart, Onculer, Oren and Rossi 2010: 23-24). All these events were reinforced by another looping effect: that as the profile of autism changed, the population became more heterogenous, extended to include not only severe cases but also higher functioning types, such as Asperger’s disorder.

Autism thus has become protean, a vast spectrum encompassing multiple forms and degrees of severity, a ‘free-floating signifier’ that could be many things at once, that could mean one thing and its opposite at one and the same time: profound mental retardation and near-genius abilities, hyper-sensitivity and hypo-sensitivity, aloofness and over-attachment, flat affect and combustible tantrums (Eyol, Hart, Onculer, Oren and Rossi 2010: 24-25).

The diagnosis has also become entangled with dominant Westernised cultural norms of masculinity – notions of what Simon Baron-Cohen (2003) labels the ‘extreme male brain’ – and this gendered construction of autistic traits is profoundly interesting in sociological terms. It will aid understanding to next outline a brief history of autism.

Eugen Bleuler introduced the term ‘autistic’, derived from the Greek word autos, meaning self, in the early twentieth century to describe what he regarded as one of the four underlying symptoms of schizophrenia: a tendency to withdraw from the external world into fantasy. Known as the ‘Four As’ of (impaired) Associations, Ambivalence, Autism and (inappropriate) Affect, Bleuler believed these four aspects to be fundamental to schizophrenia (Bentall 2003: 23-24). The pioneers of childhood autism, though, were Leo Kanner (in Baltimore) and Hans Asperger (in Vienna) who, in the 1940s, almost simultaneously delineated autism as a developmental problem resulting from a biological disorder. Both Kanner and Asperger saw children who seemed unable to relate to other people, shutting out the social world; who had an interest in objects rather than in people; who demonstrated a marked tendency to repetition in behaviour and speaking; an obsessive desire for sameness; and a sometimes unusual ability in rote memory. It was further observed that the children avoided eye contact, had peculiar speech inflections, and performed odd, stereotypic movements such as flapping hands and rhythmic tapping (Frith 2003: 5-8).

Both Kanner and Asperger drew on Bleuler’s term ‘autism’ to name the disorder, indicating the way the children seemed to exclude the outside world (Frith 2003: 5). Asperger, certain that autism was unrelated to schizophrenia, was convinced that it resulted from a complex interaction between environmental and biological factors, and, more than Kanner, he believed that autism existed on a continuum, from severe deficits to high intelligence (Grinker 2007: 56-57). Although recent research confirms a genotypical overlap between autism and schizophrenia (N. Williams et al. 2010: 1401-1408), studies on gene-environment interactions in mental illness are growing (Casi and Moffitt 2006: 583-590), and I will return to this issue later. Kanner’s work, which focused on children who were severely impaired, became more familiar to
mental health professionals, probably because he wrote in English. It was not until 1981 that Lorna Wing (1991: 93-121; 1981: 115-129), a British mother of a child with autism, popularised Asperger’s work and coined the name Asperger’s Syndrome to describe children with forms of behaviour that were less disabling than Kanner’s case descriptions (Grinker 2007: 60-61). The APA did not recognise Asperger’s disorder until the publication of DSM-IV in 1994, when Allen Frances was chair of the task force.

Childhood autism was categorised as ‘childhood schizophrenia’ in both DSM-I and DSM-II, and it was not until DSM-III was published in 1980 that autism was put in a new category of the ‘Pervasive Developmental Disorders’ (Nadesan 2005: 11). As mentioned above, clinical understandings of autism swung from that of psychoanalytic theory, which believed bad parenting caused autism, to the current domination of biological and genetic theories, where the problem is located inside the brain or genetic code of the person with autism. More nuanced accounts of an interplay between environmental effects and genetic susceptibility are emerging, but it is now agreed that all children with autism, however intelligent, suffer from three consistent impairments: impairment of play and imaginative activities, impairment of verbal and non-verbal communication, and impairment of social interaction with others (Attwood 2008; 2000; Baron-Cohen and Bolton 2002). As well as these difficulties, which persist into adulthood, children with autism also have sensory sensitivities, they develop obsessional interests in unusual topics, and, rarely, they may have savant abilities (Hill and Frith 2004: 1-19).

The ‘triad of impairment’, as it is often termed, focuses on central difficulties for all people with autism spectrum disorders (ASD) but there are other aspects. The ability to recognise the intentions, beliefs, desires, and thoughts of other people as a way of understanding and predicting social behaviour is a key part of being human, and recent research assumes that people with an ASD, whether mildly or profoundly disabled, have difficulties with empathy (Attwood 2008: 112). This idea, called ‘Theory of Mind’, has been widely publicised by Simon Baron-Cohen (1997), who argues that children with autism suffer from what he terms ‘mindblindness’: unlike ‘normal’ children, they cannot ‘read minds’, or, in less metaphorical language, they cannot predict behaviour from social cues. Despite no biological evidence, and of course the fact that other people, such as those suffering from psychotic and personality disorders, also lack empathy, Theory of Mind is usually presented as a unifying theory, a neurological deficit that produces the ‘core cognitive feature of autism spectrum conditions’ (Baron-Cohen 2001: 169). The notion of autistic ‘mindblindness’ and concomitant social impairment (as the core feature of ASD) now dominates the field of autism studies, in scholarly articles and in handbooks for parents, therapists, and teachers (Attwood 2008). However, the theory raises profoundly ethical issues. There is a danger that it constructs autistic people as less than human: if a person lacks the capacity for human relationships, they may be defined as biologically but not socially human. This effectively places autistic people outside the moral community (Barnbaum 2008), with uncomfortable echoes of the early twentieth-century’s eugenic theories and the Nazi doctrine of Lebensunwertes Leben (life unworthy of life) that underpinned the murder of hundreds of thousands of mentally ill and physically disabled people in the 1930s (Burleigh1995).

The Theory of Mind perspective establishes models of autism that fail to respect the feelings and opinions of people with autism, leaving their voices out of the scientific discourse. It is too simplistic to presuppose autism derives from a single core deficit within the brain, and autistic people prefer to illustrate their experiences as individual and diverse (Smukler 2005: 14-15). There is a vocal attempt in the autism rights

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movement to reclaim the identity of autistic people, and whether to say 'person with autism' or 'autistic person' is itself a political statement; of the two, the more politically correct is 'person first' language, based on the arguments of Kathie Snow (2009). However, Jim Sinclair (1999), dislikes this verbal hygiene, arguing that autism is not a negative characteristic, and is, rather, a valuable part of him, inseparable from how his brain works. No science is truly objective, and although autistic people may sometimes struggle to understand people who they call 'neurotypical', Theory of Mind research has been widely challenged by those who say that there are alternative explanations for autistic behaviour. As David Smukler (2005: 16) remarks, 'it is important to note that researchers write from a position of power based on dominant social norms, and their subjects are accorded little power, voice or respect.'

Indeed, Baron-Cohen (2003) has shifted his focus, becoming more interested in what he now terms a continuum of human behaviour, with 'empathising' at one end and 'systemising' at the other. However, as Smukler (2005: 19) observes, although Baron-Cohen now seems to be willing to move away from the deficit model toward one of difference, he still claims that autistic people represent the furthest point on his measured scale, in this case an example of what he calls the 'extreme male brain'. On Baron-Cohen's continuum, females are empathisers and males are systemisers, a difference he describes as biological rather than cultural. Autistic people, in Baron-Cohen's model, are hypothesised as mostly males with brains that are 'more male than normal', with a tendency toward systemising objects (Smukler 2005: 19). Baron-Cohen and his colleagues (Baron-Cohen, Auyeung, Ashwin and Knickmeyer 2009: 44) has tested foetal testosterone in autistic people, using fairly small samples, and claims a scientific link has been discovered between raised foetal testosterone and autistic traits, but when addressing criticisms of this model he admits that no robust correlation between its presence and the development of autism has actually been found.

The notion that there is something inherently masculine about autism does have a statistical foundation, with four to five more boys affected than girls (Ministries of Health and Education 2008: 30). The rate of diagnosis for Asperger's disorder, at the so-called 'higher' or less impaired end of the autistic spectrum can be as high as fifteen males to one female (Frith 2003: 65-66). Whatever neurological basis causes this discrepancy remains undiscovered, but accounts of autism always stress the maleness of the kinds of obsessions, interests, and concerns of autistic people, as if it is difficult to understand the condition in relation to the West's culturally normalised views of what girls and women are like (Murray 2008: 139-140). This is despite the fact that there are several high-profile autistic women writers who comprehensively describe their lives, for example Temple Grandin (1996), who has a doctorate in animal science, and the writer, poet and painter Donna Williams (2006; 2003; 1999a; 1999b).

However, mathematics, science, logic, intellectual genius (and lack of empathy) are paradigmatic expressions of masculinity in Westernised culture, so that an individual such as Daniel Tammet (2006), an autistic savant mathematician who wrote a best-selling book on his life, comes to represent, in the public sphere, what autism is in the twenty-first century; in much the same way that the film Rain Man (1988) did in the 1980s (Murray 2008: 140-141). A television documentary about Tammet broadcast in 2005, titled Brain

35 Django says that he does not care about it either way, as long as 'autistic' is not used as an insult. He does, though, prefer not to be labelled at all whenever possible; he’s just himself, he argues. I use both terms in my writing.
36 Currently Professor at Colorado State University, USA, Grandin is the author of many books and academic articles and is nowadays a celebrity advocate for autism.
37 Donna Williams began writing in 1990, after a suicide attempt. She wanted to burn the manuscript but her psychiatrist persuaded her not to give up, and found her a publisher.
Man, underscores this connection in the cultural sphere. Tammet has synaesthesia, which he says helps him to memorise his mathematical calculations, and phenomenal linguistic skills; and he is by all accounts a gentle and articulate person. His publishers, and the neuroscientists who discuss Tammet (2006: xi-xiv) in the opening pages of his book, all emphasise his savant abilities, but much of Tammet’s memoir is more concerned with his emotional relationships with his family, friends, and partner. Tammet (2006: 242) is not an un-empathic ‘hyper-masculine’ brain living alone: his ‘perfect moment’, described at the end of his book, is cooking dinner at home with his partner, Neil. As Stuart Murray (2008: 142) remarks, debates about male behaviour and status are currently undergoing sustained analysis in all types of cultural and social contexts, and autism, presented as a kind of hyper-real form of maleness, has become ‘a novel explanatory category’ in these debates.

The disproportionate medicalisation of behaviour in young boys raises even more questions when compared to the fact that by age twenty, the opposite gender bias shows in the prevalence of all other mental disorders – with twice as many women as men likely to get a psychiatric diagnoses, especially with anxiety and depressive disorders (Timini 2009: 135; 2005). One also has to question diagnostic accuracy in childhood; are boys over-diagnosed? Or is there less societal anxiety about young female behaviour, meaning that girls who could be diagnosed as on the autistic spectrum are just overlooked, more able to remain hidden due to powerful social conditioning that teaches females to be more compliant and well behaved? (Boyd 2009: 127-128). But, of course, many people with autism are female, and many autistic boys and men, as well as girls and women, do have significant emotional relationships with loved ones, and do not want to be isolated or alone, a myth that has remained one of the central tenets of autism. Autistic people do not benefit from being portrayed as ‘mindblind’, as having ‘extreme male brains’, as puzzles with a missing piece, as exotic and alien by cognitive scientists (Smukler 2005: 14-16), or like an ‘empty fortress’ as Bruno Bettelheim (1967) notoriously described autistic children in the 1960s. According to Bettelheim, autistic children suffered from emotional disconnection from ‘refrigerator mothers’, and he compared the world of autistic children to conditions in the Nazi concentration camps (Murray 2008: 173-175). While not as bleak as Bettelheim’s perspective, the Theory of Mind follows the ‘empty fortress’ template, and the writings of its proponents are very one-sided: after all, how many ‘neurotypical’ people can understand autistic people? (Bogdashina 2006: 12-13).

Autistic individuals describing their own experiences often point to the positive sides of their condition, seeing it not as a ‘triad of impairments’ but, rather, ‘fundamentally different ways of being.’ The negative aspects of their lives are, unsurprisingly, often ascribed to social and environmental factors, and this echoes the arguments of the disability rights movement (Bogdashina 2006: 78-81). Disability is here defined as any restriction on the ability of an individual to live in a way considered as normal human activity, whereas impairment relates to the malfunctioning of physiological or psychological processes: disability is caused by social and cultural restrictions, and impairment by the body or psyche of the individual. The disabled person is at a disadvantage, is handicapped, by living in a society where cultural norms marginalise him or her (Whyte and Ingstad 1995: 5-6). Autism, from this perspective, is not impairment, nor a mental disorder, but a disability, and indeed the autism rights movement, as well as a growing number of parents and professionals, challenge the notion that autism is a toxic disease that should be defeated or cured (Fitzpatrick 2009: xvi-xviii).
In 2010, President Obama nominated Ari Ne’eman to the National Council on Disability in the United States. Ne’eman will be the first autistic person to sit on the Council, and his view, as the founder of the Autistic Self-Advocacy Network, is that autism should be recognised as a form of neurodiversity that is part of personal identity. He very publicly clashed with the powerful autism organisation, Cure Autism Now, which insists that funding should be spent searching for a cure for autism, as Ne’eman argues that the millions of dollars involved would be better spent on helping improve the quality of life for autistic people (Harmon 2010: A16). Cure Autism Now, along with several other campaign groups, is a mix of parents, celebrities, and wealthy donors; the organisation is prominently anti-vaccine, and advocates so-called ‘biomedical’ approaches to autism that are based on unorthodox dietary regimes, hormonal treatments, and methods like chelation therapy. Some alternative medical theories propose that autism is caused by mercury or lead poisoning, and use intravenous chelation methods to cleanse the blood of heavy metals. These treatments are unregulated and highly dangerous (Fitzpatrick 2009: x-xvi and 5-6).

Other so-called cures that are behavioural rather than ‘biomedical’ can also be unsafe and harsh. Earlier in this chapter I mentioned intensive behavioural intervention treatments carried out on autistic children, based on Skinnerian theory. Ivan Lovaas’s Applied Behavioural Analysis (ABA), which is highly publicised in the autism treatment field, employs rigid punishments and aversive stimuli such as smacking – and even painful electric shocks delivered by what look like small cattle prods – to produce reinforcement or extinction of certain behaviours. The effects can be dramatically effective in some cases, but ABA is criticised by many: does a child trained to hug really want to hug, or even understand the concept? To a behaviourist, this question is unimportant (Schriebman 2005: 134-157; Aspies For Freedom). Temple Grandin, like many autistic people, finds the behaviourist approach to autism cruel, and compares Skinner’s denial of feelings and focus on conditioned reflexes to the brutal way that animals are managed in farms and in slaughterhouses (Grandin and Johnson 2005; Sacks 1995: 255). There are hundreds of treatment programmes available for autism: some are expensive quackery based on flimsy evidence, and some are neither humane nor safe. The campaigns to ‘defeat autism’ have over the years acquired a higher public profile, but there is still no scientific support for autism as an epidemic disease, a result of childhood inoculations such as the measles, mumps and rubella triple-vaccine (a persistent belief that has been comprehensively debunked), or of other suspect environmental factors. Indeed, the anti-vaccine movement has led to an increased risk of the reappearance of harmful infectious diseases as public confidence in vaccines has been undermined (Offit 2008). But worse is the negative effect on autistic people, portrayed as damaged, inhuman, alien, and somehow not a ‘real’ person (Fitzpatrick 2009: xv-xvi; Gerland 1997).

The multiple metaphors that continue to emanate from Bettelheim’s ‘empty fortress’ keep on proliferating: recently, the jigsaw puzzle has become an all-pervasive image in autism, referring metaphorically to the notion ‘that the “real” child is absent,’ that is, he or she is the ‘missing piece’ (Smukler 2005: 11; D. Williams 2006). Many autism societies use jigsaw puzzle pieces as their logo, or as graphics on their websites. Time magazine, in a cover story, described autism as ‘a catastrophe,’ and ended the article with this quote: ‘Put the pieces together one way, and you end up with a normal child. Put them together another way, and you end up with a child with autism’ (Nash and Bonesteel 2002: 57; Smukler 2005: 11). This is a terribly depersonalising tactic – to be defined by a lack – and many parents and groups like Cure Autism Now (CAN)

38 Grandin’s innovative engineering plans have revolutionised the design of cattle shutes in abattoirs, making them less frightening to the animals; she draws a parallel between society’s mistreatment of animals and the disabled.
describe autism in their publicity newsletters in overwhelmingly negative terms; as monstrous, as ‘[t]he shadow of the beast’, and even that ‘[a]utism … steals the soul from a child’ (CAN in Fitzpatrick 2009: 44).

Another persistent trope in writings on autism is that autistic people are in some way alien (Hacking 2009: 44). Clara Claiborne Park (1995), in her account of her autistic daughter’s life, echoes Bettelheim’s ‘empty fortress’ in her title The Siege, and Park even calls her first chapter ‘The Changeling’, suggesting that her ‘real’ child has been stolen. Working to release the ‘real’ child imprisoned within invisible walls is a common narrative trope in this kind of biography, as David Smukler (2005: 11) observes. One of CAN’s members intones: “Imagine that aliens were stealing one in every two hundred children …. That is what is happening in America today. It is called autism”’ (in Hacking 2009: 44). But many autistic people, to turn this perspective around, find ‘neurotypical’ (NT) people alien. Douglas Biklen (2005), who has interviewed severely disabled autistic people who were hitherto considered to be tragically isolated and unreachable, found that his subjects have rich and insightful perspectives on the social world in which they live, as well as deep affective bonds with their mothers and caregivers. Says Biklen (2005: 1-21): ‘people classified as autistic, even those who cannot speak, are thinking people with ideas about their lives and relationship to the world,’ and many, communicating through typing or unconventional methods like pointing at letters or with support from facilitators, have a keen sense that they are misrepresented by ‘neurotypical’ (NT) people. Temple Grandin, a self-described ‘autistic weirdo’ who as a professor of animal science and a spokesperson on autism has widely engaged with the NT world, once memorably described herself as ‘an anthropologist on Mars.’ The complexities of the emotional games and tricks NT people play, their motivations and intentions, are, she says, puzzling and confusing (Grandin in Sacks 1995: 248).

The world of NT people can be an intolerable place for autistic people as there are several sensory conditions that appear to be quite common in autism. Audio processing problems often mean that it is difficult to hear over intrusive background sounds; light sensitivity can make a printed page look distorted; sensitivity to touch can mean that only the softest cloth can be tolerated next to the skin. Synaesthesia means that senses get confused: words and numbers are experienced as colours, tastes as shapes, sounds as tactile sensations, sights as smells, or other permutations (Bogdashina 2003: 119-133). Some of these abilities are pleasurable, but some are profoundly disabling if the environment cannot be controlled. Not only is it often too noisy, too disorganised, and too emotionally confusing, but also the way that autistic people try to cope with this sensory overload is nearly always misinterpreted. Autistic people often feel that NT individuals invade their personal space, trying to ‘normalise’ them, touch them, and force eye contact (Lawson 2008: 84-85). As Hacking (2009: 51) remarks, the eyes as ‘windows of the soul’ has been for millennia a standard metaphor in the West, and NT people often believe that one of the main characteristics of autism is avoidance of eye contact. This is, however, not true. Instead, autistic people glance quickly at the eyes of others, rather than holding their gaze. This is not ‘odd’ behaviour, as Simon Baron-Cohen and Patrick Bolton (2002: 44) unsympathetically describe it, but is done, rather, because staring directly at the eyes is often experienced as overwhelming or painful. Autistic people describe eye contact as a sensory overload, as they feel so tormentingly self-aware that it makes them tense and nervous; the gaze feels ‘creepy’, as if it is a kind of long-distance touching; other peoples’ eyes do not stay still, and the effort to stay focused means that hearing becomes fragmented and impaired. It feels like an attack (Bogdashina 2003: 86-88; D. Williams 2003: 10-12).
The intense fear and anxiety felt by autistic people often goes unnoticed by others. Grandin (1996: 88-89) describes how her life, and those of many other autistic people, is constrained by attempts to control paralysing anxiety, panic attacks, and fear. Highly structured environments and familiar surroundings are beneficial, as chaotic events are minimised, and some of the fixed routines common to autism are attempts to manage the environment. For example, schools that provide structured work-spaces, as opposed to open-plan classrooms, are now known to be much more successful in accommodating autistic children (Grinker 2007: 189). The terror of a world where sudden, loud, unpredictable things happen is all-pervasive, and profoundly disabling. Donna Williams (2006: 271) mentions that, due to her extreme sensitivity, many things that NT children shrug off as they grow up she found traumatic; she felt she had to try to hide her disability, feeling alienated from people who judged her as ‘abnormal.’ Indeed, she says that as a child she felt she had about the same level of status as a pet. Like Donna Williams, Temple Grandin (in Grandin and Johnson 2005: 4-8) compares herself to the non-human world, and says her relationship with animals is what saved her from feeling like an outsider; she believes that like most autistic people, animals are visual creatures. Grandin argues that she experiences the world in the same way as an animal does:

I always find it kind of funny that normal people are always saying autistic children “live in their own little world.” When you work with animals for a while you start to realise you can say the same thing about normal people. There’s a great, big, beautiful world out there that a lot of normal folks are just barely taking in. It’s like dogs hearing a whole register of sound we can’t. Autistic people and animals are seeing a whole register of the visual world normal people can’t, or don’t (Grandin in Grandin and Johnson 2005: 24: emphasis in original).

Grandin (in Grandin and Johnson 2005: 189-194) argues that both animals and autistic people appear ‘wild’ sometimes because they are terrified of so many things, and the regulation of fear is connected to the role of the amygdala in the brain.

Following the proposal of an ‘amygdala theory of autism’ – where ‘social intelligence’ enables the interpretation of facial expressions – there has been considerable attention given to studying ‘autistic’ brains using advanced medical technologies such as functional magnetic resonance imaging (fMRI), magnetic resonance imaging (MRI), positron emission tomography (PET), and computerised axial tomography (CAT) (Baron-Cohen et al. 2000: 355-364). The amygdalae, small almond-shaped groups of nuclei located in the medial temporal lobes of the brain, play a primary role in the processing and memory of emotional reactions in humans and other animals (Markram et al. 2008: 901-912), and the consensus of opinion in the field now is that autistic people with communication and social impairments, such as the lack of an ability to interpret facial expressions, have increased cortical thickness in the amygdala and part of the temporal lobe, the fusiform gyrus (Schulz 2005: 125-141; Schumann et al. 2009: 942-949). Indeed it is now argued that an abnormal amygdala-fusiform system is ‘a core pathophysiological mechanism of autism’ (Dziobek et al. 2010: 397-405). However, this is not a straightforward correlation, as people with personality disorders also have difficulties in this area, tending to interpret neutral facial expressions in other individuals as threatening and frightening (Donegan et al. 2003: 1284-1293).

This brings me back to my contention that psychiatry privileges the inner world of the individual, a perspective that necessitates a concomitant denial of the outside world of the social. Research into post-traumatic stress disorder has long established that anxiety and fear-like responses and behaviours are connected to the role of the amygdala, which has a primary role in the formation and storage of memories
associated with powerful emotional events, particularly terror (van der Kolk 1996a: 214-241). If the ‘amygdala theory of autism’ is turned on its head its arguments can be interpreted differently. The lives of constant fear and anxiety reported by autistic people surely may have a detrimental effect on the structure and function of the amygdala-fusiform system: terror, rather than autism, then becomes the cause of the dysfunction in neurological development, which then becomes a symptom, not a cause (van der Kolk 1996c: 295-296).

Autistic children, like all young people with mental illnesses and disabilities, are over-represented in cases of maltreatment and neglect, whether in the family, school, or in care-homes (Goldson 1998: 663-667). All children are dependent on caregivers for their safety, care, nurturing, and education. Disabled children, due to their vulnerability, physical and mental impairments, and, often, their lack of communication skills, are even more dependent, and thus at higher risk of victimisation, whether physical battering, neglect, sexual abuse, psychological maltreatment, or murder (Goldson 1998: 664). Edward Goldson (1998: 665) argues that disability is a risk-factor for abuse, listing several reasons: our society does not accept differences, despite the rhetoric of inclusiveness; the child is regarded as the property of the parent or caretaker; violence is an accepted means of conflict resolution; disabled children carry a social stigma and are commonly regarded as less than human; there is a common belief that disabled children have no feelings; and caring for a disabled child is stressful: parents and caregivers have difficulties accessing financial support and adequate services, which causes frustration and anger.

Although the association between disability and child maltreatment has long been a controversial topic, it is now clear that children with developmental disabilities and mental impairments are definitely at increased risk of physical and sexual abuse, which is often not recognised or disclosed by health professionals (Kvam 2000: 1073-1084). Research shows that disabled children are 3.4 times more likely to be abused than their non-disabled peers; a recent study found that in 47% of cases the disability led to or contributed to the abuse, and in 37% of cases the abuse contributed to or resulted in a disability (Sullivan and Knutson 2000: 1257-1273). Autistic children have the same risks of physical and sexual abuse as other disabled children (Mandell et al. 2005: 1359-1372). It is difficult to unpick the complex links between impairment and abuse: already existing disabilities make children more vulnerable to exploitation and abuse worsens pre-existing conditions; however, there is no doubt that neglect, physical injury, sexual abuse and incest during childhood lead to increased risk of physical and psychological damage (Westcott and Jones 1999: 497-506). Furthermore, observes Valerie Sinason (2010: 116) the kinds of behaviours that lead to diagnoses of intellectual impairments or developmental disorders are sometimes screens overlaying the memory of sexual or physical abuse: a defence against the recollection of traumatic experiences.

Donna Williams, who was diagnosed with autism as an adult, was abused and neglected by her alcoholic and violent mother when she was a child. Williams (2006: 288-292) believes that the clinical focus on neurological damage as the cause of autism, and the emphasis on education, communication, the immune system and dietary issues in the treatment of autistic spectrum disorders blinds professionals to the possibility that the behavioural and emotional problems in autistic children are underpinned by hidden histories of trauma, neglect, or abuse. The problem with eye-contact, often regarded as a key marker of autism, is also common in abused children, as are dissociative and communication problems, as well as challenging and self-injurious conduct. Williams has been given many diagnostic labels, as her
hallucinations and dissociative experiences, her constant fear and panic, presented a confusing clinical picture. She says: ‘I guess I did not appear to be terribly normal. “Haunting” or “haunted” would have been better adjectives’ (D. Williams 1999b: 16). As I mentioned earlier, psychiatry has no genetic or biomedical model to explain the conceptual problem of this kind of extensive comorbidity, which is a common problem. Colin Ross (2000b: 27-46) proposes an alternative approach to account for this issue: dissociative experiences triggered by traumatic events, especially childhood sexual and physical abuse, should be taken seriously by psychiatry, which needs to move away from its excessively bio-reductionist focus.

Remembering that autism is a highly individual disorder, with many different manifestations, it is probable there are many pathways toward the behavioural and emotional problems labelled as autistic. Although, as we have seen, biological psychiatry and biodynamic psychoanalytic groups have widely divergent positions, and Anne Alvarez (1992: 184-187) argues that to understand autism we must comprehend how innate factors, such as biological and genetic damage, interact with the environment. Overlaps between genotypes of individuals with autism, schizophrenia, epilepsy, and ADHD show that phenotypes can be highly diverse (N. Williams et al. 2010: 1401-1408), and while collaborative research is a growing field, the mystery of gene-environment interactions is yet to be solved (Caspi and Moffit 2006: 583-590), although traumatic events are a known trigger of some states of mental disorder. Psychogenic theories, while appreciating that the strange behaviour of autistic children masks intense terror, do sometimes hold that autism ‘is the reaction to a delusory traumatic situation which seems to threaten life’ (Tustin 1992: 11), due perhaps to an extreme hypersensitivity to the outside world (Rustin 1997: 261-266).

However, there is also recognition that not all terror is delusional, and that uncontrollable traumatic events in the real world, rather than in fantasy, can trigger symptoms that fit the profile of autism, and Susan Reid (1999: 93-109) proposes a diagnosis of autistic post-traumatic developmental disorder for children who, at a young age, suffer sexual and physical abuse that results in autistic behaviours. Reid (1999: 99-100) interprets many autistic symptoms, such as not hearing, being unresponsive to pain, lack of eye-contact, and being in an apparently ‘frozen’ state as a form of dissociation. Long-term examinations of Romanian orphans, suffering sometimes extreme deprivation and abuse during infancy and later adopted into families in the United Kingdom, show that a substantial number show autistic-like traits, ranging from mild to severe, as a result of their early trauma (Rutter et al. 1999: 537-549). The tendency of traumatised, especially sexually abused, children to ‘disappear’, that is, to feel they are observing the things happening to them from a distance outside their own body (clinically termed dissociation), has long been noted by trauma researchers such as Bessel van der Kolk (1996b: 191-193) and Colin Ross (1997: 64-66). Indeed it is known that severe and prolonged stress activates the hypothalamic-pituitary-adrenal axis, with deleterious effects on the central nervous system that can produce permanent brain damage, memory deficits, and psychiatric disorders (O’Brien 1999: 199-201). This brings me back to the third thread of my thesis, the widespread psychiatric denial of the damage wrought by the sexual abuse of children, which will be explored in my next chapter. Reports of PTSD symptoms such as hypervigilance and hyperarousal in autistic children (Klauber 2001: 172) seem to support Reid’s (1999: 93-109) argument that, in some cases, autistic symptoms can be caused by trauma, and that current diagnostic categories do not adequately recognise this fact. Diagnoses, although they can be seen as just ways of describing kinds of behaviours and development, are a cornerstone of the psychiatric profession, and I will next turn to a brief examination of the modern diagnostic system.
The DSM
To recapitulate an earlier discussion, in medical diagnostics symptoms are subjective experiences reported by the patient, whereas signs are medical facts detected by the physician, characteristics that reveal to his or her clinical gaze the underlying cause of the disease. However, modern psychiatry, unlike medicine, still has unresolved problems with the ætiology of psychopathology, and although dominated by the empirical Kraepelian view that diseases of the nervous system or the brain, or genetic abnormalities, underpin all mental illness, there is still limited evidence that this is the case (Pilgrim 2009: 7). Psychodiagnoses deals with symptoms, not signs, with the diagnosis of mental illness focused on the patient's communications and behaviours (Rogers and Pilgrim 2005: 3), signifiers with endlessly slippery and culturally specific meanings (Verhæghe 2008: 3-5). Schizophrenic, affective, acute, and paranoid psychoses are termed 'functional' rather than 'organic', which means that none of these groups are clearly defined disease entities, and instead are defined solely by clinical syndromes that merge into one another, their diagnosis 'based upon symptoms of speech and action, not on bodily diagnostic signs' (Pilgrim 2009: 7). In the introduction to *DSM-IV-TR*, the most recent edition and text revision of the DSM, there is an acknowledgement that although the manual is a classification of mental disorders, ‘it must be admitted that no definition adequately specifies precise boundaries for the concept of “mental disorder” …. [which] lacks a consistent operational definition that covers all situations’ (APA 2000: xxx). The DSM is also silent on ætiological claims, emphasising only the behavioural descriptions of mental disorder (APA 2000: xxx).

Psychiatric diagnosis, although criticised since its origins, is in an ambiguous position. Some consider it pseudoscientific, a misleading medicalisation of everyday life that obfuscates the social causes of mental illness and human misery, arguing that it conceals the social control vested in the power of therapeutic authority (P. Miller 1986: 12-42; Pilgrim 2007: 536). Then again, the legitimacy of psychiatric diagnosis is accepted by many people outside the psy professions: many service-user groups and their relatives, as well as the mass media, policy organisations, and insurance companies find it helpful and reassuring to employ the concision of a diagnostic vocabulary to make sense of an otherwise confusing variation of symptoms and behaviours (Pilgrim 2007: 536). At the heart of every science is classification, and with no system for labelling and ordering experiences and objects, investigators would be unable to communicate and knowledge would not develop, but when the subject matter is human emotion or behaviour in general, and mental disorder in particular, the endeavour presents difficulties. Indeed, Herb Kutchins and Stuart Kirk (1997) argue that the DSM is not only a scientifically based reference work, but also a collection of popular mores and current phobias.

As we have seen, the question of what is ‘normal’ and what is ‘abnormal’ has long generated heat, and establishing the boundaries of proposed categories of psychopathological disorder has always been and still is contentious. When the professionalisation of psychiatry began, mental illnesses were serious conditions, overt psychoses managed in state institutions (Shorter 1997: 69-70) and the less dangerous neuroses were analysed outside the asylum (Shorter 1997: 156-157). Today, however, behaviours formerly regarded as eccentricities, moral failings, quirks of character, or merely questionable habits, are now commonly viewed as mental disorders (Kirk 2005: 7). Sadness can now be described as dysthymic disorder (APA 2000: 376-381); drinking or smoking excessively, or even drinking too much coffee, can be classified as a substance-related disorder (APA 2000: 191-295); an individual preoccupied with playing cards or betting on the horses can be diagnosed with pathological gambling, an impulse-control disorder (APA 2000: 671-674). As Kirk
(2005: 7) notes, the psychiatric authority enshrined in the DSM has colonised much of the cultural and social space formerly governed by counselors, educators, religious ministers, and indeed by friends and family. As a direct consequence of this process of medicalisation, the recommended treatment nowadays for all of these disorders is to take medication, often over a long term, from which of course pharmaceutical companies have grown exceedingly rich (Kirk 2005: 8). The pharmaceutical industry has an interest in driving and sustaining the establishment of particular diagnoses (Pilgrim 2007: 543), an issue that I will return to below.

For most mental health professionals nowadays the DSM is the standard diagnostic tool. It is now in its fourth revised edition, *DSM-IV-TR*, and the next edition, *DSM-5*, will be published in 2013 after a development period of around fourteen years, recommendations from over six hundred mental health professionals, and numerous field trials (APA 2010). As Kutchins and Kirk (1997: 37-38) point out, each revision of the DSM is more elaborate than the last, with increasing numbers of people appointed to task forces, as advisors, on governance committees, and in work groups involved in the process. Every decision is presented as guided by scientific advances that correct any mistakes and clarify any ambiguities that existed in previous editions. Psych professionals respond to contention over diagnoses by seeking greater consistency in psychiatry’s knowledge claims; this is seen in every revision of the DSM, but, as David Pilgrim (2007: 540) remarks: ‘the logical problem … is that consistency may improve reliability but it does not prove validity.’ Every revision is the result of a profoundly political struggle, with competing interest groups lobbying to get a condition or disability included or removed from classification. Furthermore, as Hacking (2007: 306) observes, as the style of thought of psychiatry changes, the next step in this process is the ‘looping effect’ as the people classified by these new descriptions challenge and interact with their classifications.

A famous example of the political manoeuvrings involved in DSM revisions is that of the gay activists who after nearly twenty years of protest forced the APA to remove homosexuality from the DSM, after persuasively demonstrating the social construction of homosexuality as deviance rather than mental disorder (Kutchins and Kirk 1997: 55-99). At around the same time, feminist groups fought the gender bias of APA clinicians and prevented the inclusion, in 1987, of a new diagnostic category named masochistic personality disorder, an offensive label that pathologised female experience (Kutchins and Kirk 1997: 126-175). Some lobby groups, though, wanted their problems to be included rather than excluded, and Vietnam veterans successfully petitioned for PTSD to be classified in *DSM-III* in 1980 after a campaign to gain recognition for their wartime suffering (Kutchins and Kirk 1997: 100-125). The various editions and revisions of the DSM became the key for access to medication, hospitalisation, or psychotherapy in the United States: a psychiatric diagnostic label allows mental health professionals to claim insurance reimbursement worth millions of dollars from private and government health insurance and disability programmes for their patients (Kutchins and Kirk 1997: 12). While medical insurance is not the issue in all countries, it is still vital to have a diagnostic label in order to be eligible for state assistance to most forms of psychotherapeutic treatment, medication, welfare benefits, and special education. To reiterate Ian Hacking’s (2007: 305-306) comment,

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39 Gay activists first attacked the APA in 1970; *DSM-II* (published in 1968) had listed a disorder termed Sexual Orientation Disturbance’ which was replaced in 1980, in the *DSM-III*, by a classification of ‘Ego-Dystonic Homosexuality.’ This was not discarded until publication of the *DSM-III-R* in 1987.
after medicalising, biologising, and geneticising humanity, the APA has successfully bureaucratised the field of mental disorder.

The classification system of the present manual, *DSM-IV-TR*, as a psychiatric nosology has been shaped by numerous factors: psychiatrists and their political, ideological, and moral considerations; their personal social origins; their desire for legitimacy and status; the geographical location of their practices; the characteristics of their patients; and the broader intellectual and social currents prevalent at any particular historical time (Grob 1991: 421). Often termed the ‘psychiatric bible’, the DSM is now the world’s most authoritative textbook on mental disorder: defining, classifying, and describing what the APA claims are abnormal behaviours, learning disabilities, and psychopathologies (Kutchins and Kirk 1997: x). *DSM-IV-TR* is embedded in all areas of psychiatric enterprise worldwide, and is used in the United States by almost all mental health clinicians and researchers, as well as in prisons, schools, law centres, insurance companies, and welfare agencies. Indeed, for its publishers, the APA, the continually revised DSM has become a massively profitable investment (Kendell 1991: 300; Kutchins and Kirk 1997: 247). To understand and critique its phenomenal influence, it is here necessary to briefly explore its history. The first edition, *DSM-I*, was published in 1951, and was superseded by *DSM-II* in 1968 (Kutchins and Kirk 1997: 24). Both of these texts ‘were administrative codebooks put out by a small, obscure committee’ and did not claim the status of scientific records (Kutchins and Kirk 1997: 247). Indeed, at the time, psychiatrists tended to view classification as an unimportant and peripheral aspect of their professional duties (Healy 2002: 302).

While psychoanalysis was the reigning paradigm many psy professionals were simply uninterested in the issue of diagnosis, instead focusing on the presumed intrapsychic cause of distress. Psychiatric illness had long been classified on the basis of symptoms, since causes were so vague, but these symptoms were interpreted very differently depending on which country the patient lived in, and indeed where the psychiatrist had trained. Schizophrenia, for example, was diagnosed many times more frequently in the United States than in Europe, and these international differences became embarrassing, revealing unreliability in clinical methods in a discipline vying for scientific status (Shorter 1997: 295-297). By the 1970s it was clear that psychiatric diagnosis in the United States and Britain was out of step, and as a group of American psychiatrists, led by Robert Spitzer, took over the task force to develop *DSM-III*, standardisation of diagnosis was a major concern (Shorter 1997: 297-301). Psychoanalysts had led the task forces for the earlier editions of the manual, but Spitzer’s collective were weighted towards biological psychiatry and psychopharmacology.

*DSM-III* revolutionised psychiatry in the United States (Kutchins and Kirk 1997: 5). The shift was recognised shortly after its publication in 1980: it transformed diagnosis from vaguely identified psychoanalytic explanations to meticulous symptom checklists, and in the process ‘legitimized and scaffolded the new psychiatry’s embrace of the disease model’ (Lewis 2009: 98). The magnitude of this change is difficult to capture now, when the notion of a ‘neurochemical self’ is a firmly established part of human identity in modern society and culture (N. Rose 2003a: 46-59). As Nikolas Rose (2003b: 407-437) argues, the psychiatric gaze became, literally, molecular, as the notion of what is abnormal moved from the entire physiognomy and psyche of a person to that of a hidden realm of synapses within the brain, where neurochemical imbalances can be manipulated by the application of the correct therapeutic drugs. Anomalies in the brain are now the origin of problems in affect, cognition, mood, or conduct: contemporary
psychiatry is inextricably bound up with neuroscience. The pharmaceutical companies loved the new DSM, says Robert Spitzer (in Ronson 2011: 253): ‘it was a gold rush for drug companies who suddenly had hundreds of new disorders they could invent medications for, millions of new patients they could treat.’

In 1980, psychiatry established this new biomedical self in the pages of DSM-III, which listed detailed instructions for making psychiatric evaluations that were, it was claimed, scientifically reliable. This extraordinary discourse reclassified human beings, placing those who were formerly neurotic or repressed or dreaming – with unconscious minds which could be psychoanalysed – into the same category as the psychotic: all were now mentally disordered, with faultily-biologised brains and damaged genetics, and could be treated by the new science of psychopharmacology (Hacking 2001: 141-167). The new psychiatry of DSM-III raised the stakes; previously psychiatry had only concerned itself with the seriously mentally ill in the asylums, but now it had colonised the semi-spiritual concerns of psychoanalysis, which formerly had very little to do with psychiatry (Healy 2002: 304-306). Previous editions of the DSM took a clinically-based biopsychosocial approach, influenced heavily by Meyerian legacies, but DSM-III, a Kraepelian manifesto for medicalisation, simultaneously dumped all ætiological claims; it unmoored the mentally disordered self from clinical signs and fastened it, instead, to categories of symptoms (Pilgrim 2007: 538). This new self was no longer the Freudian-constructed repository of memory and psychic trauma: now, the self was biomedical, neurochemical, the product of genetic inheritance, and understood by a psychodiagnostics interpreting signifiers carrying endlessly shifting meanings in interactions between the patient and other people (Verhæghe 2008: 3-5).

DSM-III’s colonisation of the spaces formerly defined as moral rather than mad – behaviours like excessive drinking, smoking and gambling, or sex addictions – and its collection of current phobias meant that many ordinary people, with frankly ordinary problems, became labelled as mentally disordered (Kirk 2005: 7). When Robert Spitzer (in Ronson 2011: 264-265) was asked about this phenomenon, in a 2011 interview, he said that he really did not know if this was the case: “I don’t like the idea of speculating how many of the DSM-III categories are describing normal behavior …. [b]ecause then I’d be speculating on how much of it is a mistake,’ he said. There was another long silence. ‘Some of it may be.’” However, back in the late 1980s and early 1990s, the DSM task forces were confident of their medicalising agenda, rapidly moving to prepare yet another edition of the textbook.

When DSM-IV was planned, only four months after DSM-III-R was published in 1987 (Kutchins and Kirk 1997: 47), the intention was to ensure that diagnostic criteria for psychiatric diagnoses were consistent internationally, and the APA established a task force to produce a classificatory system ‘based on a comprehensive and dispassionate review of the relevant literature, comparisons of alternative diagnostic criteria … and a series of opinion surveys, … reliability studies, and field trials’ (Kendell 1991: 297). Published in 1994, DSM-IV was designed to correspond with the nosology of the International Statistical Classification of Disease and Related Health Problems (ICD) published by the World Health Organisation (WHO). The ICD is regularly revised, most recently in 2007 (ICD-10), and is published in at least eight languages, aimed at cross-cultural use in around fifty-five different countries – unlike the DSM, which is targeted at the American and Westernised markets. The DSM differs from the ICD in some respects; for example, the focus on eating disorders and sexual problems in contemporary Western industrialised countries has no parallel in other cultures (Kendell 1991: 300). The WHO, with less money to spare than the
APA, tends to expand the document rather than thoroughly amend the text. The APA, however, quickly revised the DSM-IV, and published the DSM-IV-TR in 2000.

Despite these expert attempts to establish global consistency in psychiatric classification, patients are not always cooperative in having their symptoms correspond exactly to DSM-IV-TR diagnostic criteria. Even worse, many patients are not helped at all by drug treatments, despite all the allegedly robust evidence-based claims on the effectiveness of psychiatric medications. Simon Sobo (2009: 491) states that around half of people diagnosed with depression do not respond to medication, and if treated with a second medication, only a quarter of these non-responders will be helped; comparable outcomes are found with all mental disorders listed in the DSM. Argues Sobo:

Psychiatry has still not found its penicillin, a drug that will succeed 99% of the time in eliminating strep throat, because it kills the germ causing the illness. DSM IV diagnoses are operational definitions, the best attempt by committees of experts to group manifestations of psychopathology into “disorders.” This cataloging is not the same thing as understanding cause and effect. We have not yet discovered the etiology of any DSM IV diagnosis (Sobo 2009: 491).

Do the diagnoses in the DSM represent actual illnesses in the sense that medical conditions like streptococcal pharyngitis, polio, smallpox, or cancer exist? There are certainly fuzzy areas, as widening criteria in some diagnoses (as in spectrum disorders like autism) have resulted in a certain amount of bending the rules if clinicians are to fit awkward patients into ill-fitting categories (Sobo 2009: 491-492).

Biological psychiatry has, from its inception, been fixated on nosology, looking at behavioural disorders as if they are distinct, easily separable units with their own symptoms, outcomes, and treatment. Disputing this approach, Herman van Praag and his colleagues (van Praag et al. 1990: 501) argue that it would be better to use what they term ‘a functional approach to psychopathology,’ making the basic units of classification the psychological dysfunctions themselves (such as disturbances in information processing, memory, perception, and so on) instead of fixing these symptoms into syndromes or nosological entities. This would avoid the morass of comorbidly occurring syndromes, along with the accompanying polypharmacy: functional psychopharmacology would be oriented toward dysfunction rather than diagnosis (van Praag et al. 1990: 508). Psychiatric medications are often specifically linked to a particular diagnosis (for example, as methylphenidate is to ADHD), but are not always effective or useful to the patient, who is branded as non-compliant should she or he refuse to take them (Sobo 2009: 491). The point being, surely, that if psychiatrists focus solely on diagnosis it can blind them to more useful ways to help ameliorate the suffering of their patients (Sobo 2009: 493).

I have alluded several times to psychiatry’s shift during the 1970s from the psychoanalytic point of view, which regarded mental illness as psychogenic and largely a product of faulty child-rearing, towards the biological paradigm, where imbalances in brain chemistry and genes were regarded as causal (Shorter 1997: 239). This change was partly due to advances in genetics and neuroscience, whereby scientists were able to prove that nature, not only nurture, had a role in psychiatric illness, but it was also linked to the development of new drugs that could be used to treat mental disorders. The force behind the discovery of these new drugs was not clinicians or academics, but pharmaceutical companies. In the United States, Smith Kline and French, who marketed the first antipsychotic medication, chlorpromazine, formed a task force to enable drug trials in the huge state asylums in the 1950s. Chlorpromazine was never suggested as
a cure, but did calm many of the major psychotic symptoms in patients who were regarded as hopeless cases; furthermore it saved state legislators money, revolutionised psychiatry, and initiated the modern era of psychopharmacology (Shorter 1997: 240-255).

Pharmaceutical companies have a big stake in psychiatric diagnosis, providing significant funding for the APA's scientific journals and conventions, and garnering massive profits from the ever-expanding market for psychopharmaceuticals (Kutchins and Kirk 1997: 13). Pharmaceutical companies provide advice to the DSM task forces that develop new editions of the manual, and many fund psychiatric researchers and run academic symposia; scandalously, some companies are now known to have provided ghostwritten articles favourably reviewing their products for scientific journals, and to have prevented publication of the negative results of some clinical trials (Healy 2002: 309-312). David Healy (2002: 313-314) observes that, whereas once psychiatric forums had been the sites of intellectual debate, they had ‘by the 1990s been transformed into little more than trade fairs’ for the pharmaceutical industry. I will examine psychiatric medications further below as the new availability of specific drugs for serious mental illnesses was a powerful driver of the need for a system of reliable diagnosis.

Psychopharmacology

Drugs, relentlessly branded in the American ‘war on drugs’ as the weapon of a destructive subculture bent on undermining the Western way of life, are peddled with astonishing success by psychopharmaceutical corporations (Kirk 2005: 8). The aim of many illicit drug-takers is to jolt themselves away from conformity, to experience a form of human consciousness that is (in the case of the hallucinogens) radically different; (in the case of the narcotics) cocooned, dreamlike and sensual; (in the case of the amphetamines) speeded up and hyper-alert. On the contrary, the alleged purpose of drugs prescribed by the psychiatric profession is to return people spinning away from ‘reality’ back toward ‘normality’. We have seen how the psy industry works in the service of social control as well as the alleviation of distressing symptoms; along with insulin-shock coma, lobotomy, and electro-convulsive therapy (ECT), drugs are another way of altering the brains of people with mental disorders. David Healy (2002: 1-2) says that the discoveries of medications that ameliorate the conditions of delusions, mania, and nervous disorders are, arguably, among the greatest triumphs of modern medicine: the development of chlorpromazine (marketed as Thorazine and Largactil), the first of the antipsychotic drugs, led to the later discovery of risperidone (Risperdal) and the new generation of dopamine-blocking drugs; the first antidepressant, developed in the 1950s, imipramine, led to the barbiturates, such as Valium (diazepam), and then to the serotonin-enhancing drugs such as Prozac (fluoxetine); Benzedrine (amphetamine) developed in the 1920s led to Dexedrine (dexamphetamine), and to the children’s drug Ritalin (methylphenidate).

The success of psychopharmacology has reinforced the claims that all mental disorder stems from biological and genetic causes. However, the fact that psychotropic medications can produce changes in behaviour, emotion, and cognition in people with diagnosed mental disorders does not mean that the aetiology of their illnesses is entirely neurological and physical (Beck, Rector, Stolar and Grant 2009: 306). After all, every drug, illicit or prescribed – and there is also a huge illegal market in the sale of prescription drugs – has an effect on the person who ingests it. Psychological stressors such as traumatic events may produce symptoms or trigger imbalances in brain chemistry that can be diagnosed as, say, schizophrenia, but just because altering faulty neurotransmitter levels with medication can treat these symptoms, this does not
mean the problem originated in the sick brain of the sufferer. Some clinicians are now arguing that serious psychotic disorders are triggered by both psychological and biological factors, and can be treated by psychotherapy, especially cognitive behavioural therapy (CBT), as well as the judicious use of antipsychotic drugs (Beck, Rector, Stolar and Grant 2009: 306).

In the nineteenth century, ‘moral treatment’, which included attempts to understand delusional behaviour, achieved good results with psychotic patients. As psychiatry developed a more biological perspective, though, treatments moved toward somatic methods and eventually drugs. Following Freud, who only worked with neurotic patients and believed that psychotics could not be analysed, most clinicians did not see psychotherapy as a useful tool when working with individuals diagnosed with psychotic disorders. Despite dissenting voices such as those of Eugen Bleuler, Carl Jung, Sándor Ferenczi, Karl Abraham, and Melanie Klein, who all reported successful work with psychotic patients (A. Silver, Koehler and Karon 2004: 209-222), the treatment offered by psychiatric services became nearly exclusively that of psychopharmacology. Chlorpromazine, the first neuroleptic drug, was discovered accidentally, and although patients who take this or any other of the widely-used antipsychotic medications do experience fewer psychotic symptoms, there are also many disadvantages to the drugs (Bentall 2003: 499).

The most severe consequences of neuroleptics are the ‘extra-pyramidal’ side effects, where the patient experiences uncontrollable tremors; akathisia, a very disagreeable feeling of agitation; and tardive dyskinesia, where the tongue and jaw make uncontrollable spasmodic movements. Around half of the individuals taking the medication suffer sexual dysfunction and severe weight gain, and a fortunately rare reaction to the drugs, neuroleptic malignant syndrome, is fatal. Because of these many adverse reactions, antipsychotic medications can cause much harm, especially in high doses, and it has been found that many clinicians are overly zealous in their prescription of the drug to what is a very vulnerable and often silenced population. New drugs, the atypical neuroleptics, were first developed in the 1960s, and although these, fortunately, have fewer side effects than the earlier versions, they are nowhere near as effective as drug companies claim them to be. They are also extremely expensive, providing huge profits to their manufacturers (Bentall 2003: 499-503). Atypical antipsychotic drugs like risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole are now quite commonly prescribed for children who display aggressive and destructive behaviours. Although risperidone was approved in 2007 for prescription to children diagnosed with autism, schizophrenia, and bipolar disorder, there has been little paediatric testing on the long-term consequences of the metabolic changes, drastic weight gain, and heart problems associated with antipsychotic use (Olfson 2010: 1-4). It is, furthermore, disturbing to read that the children of poor and minority parents are four times more likely to be prescribed antipsychotic medication than the children of wealthy parents, and for behaviours much less extreme (D. Wilson 2009: A1; Olfson 2010: 1-4). Poor people tend not to have private health insurance, so cannot afford more expensive treatments like psychotherapy, and Medicaid, which covers health bills for the poor, spent US$7.9 billion on antipsychotic medication in 2007 (D. Wilson 2009: A1).

However, the neuroleptic drugs are prescribed much less than anti-depressant medication, one of which, Prozac (fluoxetine) was second in the list of top-selling drugs in the world by 1994 (the top seller was Zantac, an anti-ulcerant). Depression as a major psychiatric disorder has been known for centuries, but since the 1960s its diagnostic criteria have been unremittingly distended, and it is now the most commonly diagnosed
mental disorder. The huge success of Prozac led to the manufacture of other new antidepressants by competing drug companies. Although antidepressant medication had been available since the 1950s, these new psychoactive drugs, termed Selective Serotonin Reuptake Inhibitors (SSRIs), are designed to correct what is argued to be the biochemical imbalance common to all depressive disorders: an inadequate supply of the neurotransmitter serotonin (Shorter 1997: 321-324). There is no doubt that this new generation of psychoactive antidepressants has helped many people. However, the hegemonic role of the DSM in medicalising many hitherto fairly mild emotional problems that then require medicating with expensive substances provided by the very drug companies that provide hefty funding to the APA for its conventions and journals, and that sometimes even directly contribute to the DSM classification process, is surely cause for concern (Healy 2002; Kutchins and Kirk 1997).

The intertwining of capitalism and mental disorder in the form of what is sometimes called ‘Big Pharma’ has alarmed many, and it is obvious to any observer that that drug companies have a profound influence over the psychiatric field (Law 2006). In the United States, between 1990 and 2000, spending on antidepressant medication rose 800%, principally on the SSRIs: this represents US$10 billion out of a total US$23 billion of psychotropic drug sales in 2000. Over the same period, spending on the new ‘atypical’ neuroleptic drugs rose 600% to US$4 billion in 2001 (Mosher, Gosden and Beder 2004: 115-130). Pharmaceutical companies influence government decision-making processes by donating cash to political parties, use public relations companies to sway public opinion, manipulate medical opinion by paying for junkets for general practitioners, and give money to patient support groups, effectively ensuring their compliance. Small grassroots organisations of individuals with mental disorders and their families are understandably grateful for this support, and for the ‘education’ programmes that accompany it. Many groups repay their benefactors by establishing pressure groups that lobby for greater availability of the medication that they have been told will ameliorate their condition (Law 2006: 172-173). There are plenty of examples of drug companies harnessing this kind of support group as a way of pressuring governments to provide new drugs as preferred methods of treatment. A recent investigation of internet sites offering mental health-related advice found that over half of these sites do not acknowledge that they are funded by drug company money: these web pages, unsurprisingly, advocate treatment by the medications manufactured by their paymasters (Read 2008: 99-109). Sami Timini (2005: 21), a child psychiatrist critical of the power of ‘Big Pharma’, says that ‘both theory and practice in psychiatry has effectively become a commodity that can be and is being sold to the drug industry.’

As well as antipsychotic drugs and antidepressants, the medical use of amphetamine to treat children has also massively increased, a tendency I examined earlier in this chapter. In the United States, at least five percent of young people diagnosed with ADHD are treated with stimulant medication; furthermore, the drugs prescribed, Ritalin or Adderall, are amphetamines, chemically the same drug as Dexedrine and Benzedrine, or speed; unsurprisingly, plenty of Ritalin ends up on the black market. The consumption of these drugs has reached staggering levels, especially in the United States (Rasmussen 2008: 231-235), where, in the 1990s, they used 90% of the world’s stimulant medications, a figure that has now dipped slightly to 80%. In other countries, including Australia and New Zealand, usage is increasing (Breggin 2001: 47-48; Marwick 2003: 67). It is still unclear what effect methylphenidate has on the developing brain, but as many researchers are funded by the pharmaceutical industry (Timini 2002: 103), ethical concerns are eclipsed by the scale of the industry’s profits, worth over US$3 billion per year in the USA alone (Law 2006: 8; Mayes, Bagwell and
Therapeutic interventions such as psychotherapy are becoming increasingly uncommon, and medication is now the first line, sometimes the only, treatment offered to children with psychiatric diagnoses (Timini 2005b: 21).

As this review shows, there are many similarities between the hustling associated with illegal drugs and the marketing of psychiatric medications. Indeed, often they are the same substances but obtained by different measures. Big Pharma’s marketing tactics – the selling and prescribing of drugs to a highly vulnerable population of people suffering emotional pain and mental distress – should require as much vigilance as that poured into the so-called war on illegal drugs, but given the power of the industry this seems unlikely. Indeed, ‘Pharmageddon’, the epidemic of addiction to prescription pills such as alprazolam (Xanax), clonazepam (Klonopin), oxycodone (OxyContin) and hydrocodone (Vicodin) across the United States, has caused more accidental fatal overdoses than the combined total from heroin and crack cocaine use in the 1970s and 1980s (Adams 2011). The profitable association between capitalism and psychiatric power has been challenged by some mental health professionals who want to change the way psychiatry currently operates and, more significantly, by the mental health service-users movement. These ghosts formerly banished to the peripheries of society are breaching the zone assigned to them: no longer the Other haunting the margins of dominant institutions, they are challenging the therapeutic power of psychiatry and transforming its practices and philosophies.

Anti-psychiatry

Critiques of psychiatry have existed since its foundation, are inseparable from the history of psychiatry itself, and have come from both inside and outside the profession, driving a series of fundamental transformations of psychiatry’s theoretical, professional, institutional, and juridical existence (P. Miller 1986: 12). Peter Miller (1986: 13-21) outlines four different levels of critiques of psychiatry: critiques of its institutional practices focused on the asylum, supporting the development of ‘community care’ psychiatry; theoretical critiques directing attention to the theoretical categories used by psychiatry, sometimes questioning the very existence of mental illnesses; juridical critiques concerning the rights of service-users and their legal status; and technological critiques referring to different elements of therapeutic praxis. Contemporary understanding of psychiatry is often still mired in the notion that psychiatry is principally concerned with madness, the asylum, and medicalisation, but this is no longer psychiatry’s main concern. Nowadays it is focused more on the myriad less severe emotional and behavioural disturbances diagnosed in distressed individuals living within the community and family (P. Miller 1986: 14).

Psychiatry has been fundamentally reorganised in the last century, and its ‘social vocation’ is now deeply enmeshed in society. Its heterogeneous practices are sited in an enormous system of psychiatrisation that intersects capitalist social relations and the judicial apparatus, with treatments ranging from custodialism and compulsory medication in locked wards at one end of the therapeutic system to various gentler psychotherapies and counseling at the other (P. Miller 1986: 15). If we are now all ‘neurochemical selves’ (N. Rose 2003a), we also live in a state ruled by what Peter Miller and Nikolas Rose (1994: 33) term ‘therapeutic authority’: a web of psychiatric, psychological, and social interventions that attempt to resolve

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40 In the United States, most of these legal prescriptions are bought from so-called ‘pill mills’ located in southern Florida – poorly regulated, cash-only dispensaries where one doctor can earn over US$25,000 in one day, cash in hand. Thousands of people drive from all over the country to take part in this trade; they take the pills back to their home states and re-sell them, making huge profits.
issues such as child welfare, marital problems, social conflict, and criminal conduct in line with the demands of liberal governments and workforce productivity, as well as the cultural requirements of Western society, dominated by notions of personal fulfillment. These practices and policies of biopolitics and biopower intervene in the lives of individuals incapacitated by accidents, illnesses, disabilities, mental disorders, and other abnormalities; and connect them to insurance companies, medical treatment, diagnostic standardisation, state disability benefits, and educational assistance (Foucault 2003b: 242-244). Therapeutic authority, these related forms of knowledge and practice, are informed by the psy disciplines, functioning as forms of intervention that ‘transform relations of power between authorities and those whose lives they claim to understand and seek to improve’ (P. Miller and N. Rose 1994: 31).

Therapeutic authority, the expertise and praxis of the psy disciplines, is a category of what Foucault (1983b: 334) describes as ‘new form[s] of pastoral power’ ensuring the ‘salvation’ of people in worldly, rather than religious, terms. To recapitulate one of the theoretical underpinnings of this thesis, Foucault (1983b: 340) asserts that power does not directly act on others, rather ‘it acts upon their action: an action upon an action, on possible or actual future or present actions.’ According to Miller and Rose (1994: 35; emphases in original), following Foucault, therapeutic authority, operating as an ‘action on the action of others’ does not need techniques of domination, and only a comparatively small number of psy professionals are required to transform the way the majority of the general population understands its inner processes and interacts with others: as these experts use new techniques and abilities they construct the ways in which individuals can become self-regulating.

Therapeutic authority is mandated to operate in three arenas: firstly, an individual’s life difficulties and issues to do with personal distress are ‘addressed in terms of an inner world of psychological processes,’ problems that need expert intervention; secondly, these issues are described in new psychological or psychiatric terms, to render them contiguous with the discourse of the psy professions; and thirdly, the first two arenas combine, privileging therapeutic authority as the power to intervene in psychological realms in order to improve them (P. Miller and N. Rose 1994: 29-30). Various techniques are used in fields such as marriage guidance, child-rearing skills, and employment consultancy, and since these psy professionals are trained within institutional groups designed to transform their personalities, and are enrolled in therapeutic networks, they become part of a new form of expert authority, merging professional and personal development. The mastering of the self and the government of others becomes melded in the figure of the expert administrator of therapeutic authority (P. Miller and N. Rose 1994: 50-51).

Foucault (1983b: 329), when reflecting on his archaeologies and genealogies of psychiatry, medicine, and the human sciences, argued that the most effective way to explore the power dynamics of reason and science is to study forms of resistance, the counternarratives that emerge to struggle against an allegedly neutral discourse. These alternative points of view can be the subjugated knowledges of the marginalised, like the psychiatric service-user or survivor, or they can be insurrections against the dominant discourse of psychiatric thought, propounded by psy professionals critical of the status quo: all of these counternarratives illuminate the power relations inherent in psychiatry (Foucault 2003b: 7-9). However, while there has been a large amount of sociological analysis of psychiatric power, the resistance movements of ex-patients – the survivors of psychiatric regimes – whilst often acknowledged, have only recently been studied (N. Crossley 2004: 161). Before exploring this ‘revolt from below’, I will first examine the ‘revolt from above’ from within
the ranks of psychiatry itself – a revolt that critiqued the oppressive conventions of capitalist society that, it was argued, distorted and repressed human potential; and that challenged the hegemony of the psychiatric field and the medicalisation of emotional distress (N. Crossley 1998: 878). Other critics of psychiatry emerged from the discipline of sociology, concerned with the relationship between psyche and society, as well as issues of deviance and social control (Rogers and Pilgrim 2005: 11-18).

The zenith of the anti-psychiatry movement was in the 1960s and 1970s, when it emerged as a counter-theory to biological psychiatry. At that time, the anti-psychiatry label was not actually a widely used or accepted term, with the radical Marxist David Cooper (1967) one of the few critics of mainstream psychiatry to embrace it. Most anti-psychiatry of this period was not really anti-mental illness (this is a more contemporary understanding of the term), although there were some individuals who, like Thomas Szász (1972), argued that minds could only be ‘sick’ in a metaphorical sense (Double 2001: 29-31). To Szász (1961: 59-65), all mental illnesses are socially constructed, and the beneficiaries of this illusion are psy professionals and those constructed as ‘sane’; people who act in unintelligible ways or are distressed are suffering from social problems, not displaying medical symptoms.

The anti-psychiatry movement, during the 1960s and 1970s, can be better interpreted as a loose coalition of psychiatrists and sociologists who were anti-psychiatric power. During these decades labelling theory was influential in sociology, criminology, and psychological studies. Thomas Scheff (1984) questioned the disease model of psychiatric theory and regarded madness as a means of escape from the pressure of reality. He argued that most chronic mental illness is at least in part a social role, and that the societal reaction to the person exhibiting the ‘abnormal’ behaviour determines the entry into that role. Scheff (1999) continues to critique biological psychiatry, arguing that no clearly demonstrable linkage between neurotransmission and genetics has been found for any major mental disorder: these are only theories. Furthermore, he declares, even if the connection were made, most of the basic issues involving the social control of madness would remain.

Other anti-psychiatry approaches, such as those of Erving Goffman and Ronald Laing, offered different perspectives. Goffman’s (1961) analysis of life in ‘total institutions’ describes the way that the mental patient is constructed by interactions with the institution, physicians, and other inmates, rather than by the illness. To Goffman, the self is an aspect of social and cultural arrangements, rather than an isolated and self-contained individual. Goffman (1961) undertook fieldwork in the National Institute of Mental Health in Washington, using participant observation techniques. As in David Rosenhan’s (1973) study of normal people being admitted to asylums after claiming to hear voices (mentioned earlier in this chapter), Goffman (1961) found that other patients often recognised that he was a ‘pseudopatient’ although psychiatrists did not. Institutionalisation, Goffman decided, was a response by patients to the bureaucratic structures and processes of ‘mortification’ undergone in ‘total institutions’ such as mental hospitals, prisons, and army camps. Many of the features of institutions like asylums serve ritual functions, ensuring that both classes of inmates – guards as well as captives – know their social role and function. In an asylum, adjusting inmates to their role is more important than ‘curing’ them, so incarceration is really about social control, not therapeutics. Goffman also explored the idea of ‘service’, whereby an expert ‘server’ – in this case the psy professional – derives their authority from their special understanding of what the ‘served’ – the public – needs. To Goffman (1961: 323-386), and as later argued by Verhæghe (2008: 3-5), psychodiagnostics are
formed from a problematic focus on a patient’s symptoms, their communications and behaviour, and less so from their bodily states, or signs.

Ronald Laing’s work has often been misrepresented, and his later status as a cultural guru confused matters further. He developed his ideas at a time when political and public opinion was turning against the great Victorian asylums in Britain, a move that would eventually lead to their closure. Laing (1990) did not believe, as was later reported, that madness does not exist, but he challenged the core values of a psychiatric practice that focused exclusively on mental illness as a biological phenomenon, without consideration of the intellectual, social, and cultural dimensions of life. He also questioned the diagnostic process, claiming that psychiatry was based on false epistemological foundations – the problematic interpretation of symptoms (subjective experiences) as signs (medical facts) that I addressed earlier in this chapter (Bentall 2009: 70-71; Pilgrim 2009: 7; Rogers and Pilgrim 2005: 3; Verhæghe 2008: 3-5). Laing (1990) recognised the suffering of his patients and tried to understand what was going on inside the minds of people diagnosed as schizophrenic – a diagnosis that Laing regarded as theoretical, not a medical fact – and his practice, radically different and hugely controversial, tried to treat the distress of mental illness by listening to his patients (Bentall 2003: 116). Echoing Adolf Meyer’s ideas from the 1930s, Laing tried to revise diagnostic language to make it more relevant to his patients, and, influenced by existential philosophy, Laing took the expressed feelings of his patients as valid descriptions of lived experience rather than ignoring them as merely symptoms of an underlying disorder. Strange behaviour was understandable, not, as Jaspers had earlier argued, un-understandable. Laing defied the core values of a psychiatry that had no time for intellectual, political, or social causation of psychotic breakdown, and his anti-establishment and unorthodox views resonated with the spirit of the times (Bentall 2009: 70-71; 2003: 116).

Laing (1971) became involved with a series of experiments that set out to show that a kind of family therapy worked as well as, if not better than, drug treatment. He interviewed the families of schizophrenic patients and analysed the results, showing that a person could develop strange behaviour due to what was happening within the family: what became diagnosed as schizophrenia was a means of coping with an impossible situation, a strategy of coping with intolerable contradictions. Laing (1971: 23) declared that ‘not the individual, but the family is the unit of illness.’ In later writings, Laing (1967) warned that we are all so alienated that none of us can ever realise our authentic possibilities. Sane people are probably mad, and it is also possible that some of the mad are sane. The so-called illness, argued Laing (1967: 127-129), could be a creative and gifted state of consciousness – a complex response to intolerable situations: ‘Future generations will see that what we call ‘schizophrenia’ was one of the forms in which, often through quite ordinary people, the light began to break through the cracks in our all-too-closed minds.’ Although Laing has been vilified for his contention that schizophrenics are driven mad by their families (especially their mothers), his ideas have had a long-term impact on psychiatry. When Laing began his psychiatric practice, schizophrenic patients were treated in isolation and regarded as medically ill, and it was rare for clinicians to talk much to the family of patients let alone to the actual patient. Today, the role of the family is more important, if only because few patients spend much time in psychiatric wards, and care in the community requires involving the family.

Laing’s ideas were condemned by older members of the psychiatric profession, but were a powerful influence on younger practitioners. Many of Laing’s patients read his books The Politics of Experience
(1967) and The Divided Self (1990), and were impressed by his understanding of their estrangement; this fact disturbed many older psychiatrists as much as it inspired the younger (N. Crossley 1998: 879). Laing’s (1970) book Knots, written in the form of poetic dialogues and streams of consciousness described the patterns of ‘human bondage’ Laing saw enacted in the tangled relationships between children and parents, analysts and patients, and between lovers: parties to the oppression of the schizophrenic self. Knots sold 75,000 copies when first published in the United States, and was translated into a theatre production, a radio play, and a film (N. Crossley 1998: 879-880).

[T]here is something the matter with him
because he thinks
there must be something the matter with us
for trying to help him to see
that there must be something the matter with him
to think that there is something the matter with us
for trying to help him to see that
we are helping him
to see that
we are not persecuting him
by helping him
to see we are not persecuting him
by helping him
to see that
he is refusing to see
that there is something the matter with him
for not seeing there is something the matter
with him.41

Laing’s books became among the most widely-read of their era, embraced by a liberal-arts reading public who were persuaded of the accuracy of his interpretation of the meaning of psychotic experience, and this wave of influence ran from Laing and his colleagues out to the arts, the media, and educational and political fields, becoming a social movement that went well beyond the psychiatric field (N. Crossley 1998: 880).

As much as Laing’s work may have gained public acceptance, the anti-psychiatry he, Goffman and Szász spearheaded provoked aggrieved reactions from psy professionals. Anti-psychiatry’s critiques, it was argued, were politically inspired, and derived from sociology, a discipline envious of the scientific status of psychiatry. The fact that Laing and Szász, among others, were psychiatrists was conveniently overlooked (Pilgrim 2007: 538). However, these critiques undoubtedly encouraged psychiatry to reinforce professional diagnostic principles and thus were a factor in the new editions and revisions of the DSM in 1968, 1980, 1987, and 1994; the DSM being, as we have seen, a series of texts that are as much political manifesto as scientific discourse (Kutchins and Kirk 1997; Pilgrim 2007: 538). Critical discourse also brought the asylum system to public awareness, and when the political imperatives for community care were outlined in Britain in 1961, grim words were used to describe the old Victorian asylums, with deinstitutionalisation said to usher in

a new age of understanding and tolerance for the severely mentally ill (P. Thomas, Romme and Hamelijnck 1996: 401-402).

**Deinstitutionalisation**

I have already alluded several times to deinstitutionalisation, and the forces behind this process have been much debated (Geller 2000: 41-67; Turner 2004: 1-4). The second half of the twentieth century saw asylum populations fall steadily in Britain and the United States, with many other industrialised countries following suit. Some of the reasons behind this process were undoubtedly economic; large psychiatric hospitals were hugely expensive to run, and a system of community care where patients only returned to psychiatric wards when in crisis was assured to be much cheaper (Geller 2000: 51; Scull 1985). Public awareness of the routine violence and cruelty inflicted on some patients by some caregivers, as well as the shocking conditions in the large asylums, was also an important influence. Concern over these issues was increased as various forms of popular culture drew on tales of social misfits forcibly treated by psychosurgery, electroconvulsive therapy (ECT), and medication while incarcerated by oppressive psychiatric regimes, and former patients wrote narratives protesting psychiatric abuse, agitating for the reform of public asylums (Andame and Hornstein 2006: 147; Bentall 2009: 43-44). All of these accounts, as well as Laing’s hugely influential texts, eliciting shock and indignation from their audience, encouraged a climate of reform.

The most common argument for the establishment of community care and the closure of the asylums, though, is the development of new psychopharmacological products, beginning with the discovery and psychiatric testing of chlorpromazine in the early 1950s (Bentall 2009: 44; Healy 2002: 4; Turner 2004: 2). These advances in psychopharmacology were investigated earlier in the chapter, and their efficacy and safety, as we have seen, is highly contested. However, the decline in asylum numbers in the late 1950s through the 1960s does correlate with the development of chlorpromazine and other neuroleptic drugs. Other factors, like the growth of community mental health teams and outpatient clinics all contributed to deinstitutionalisation, and many former patients have been settled in the community with appropriate care and housing, and with few problems in relapse rates (Turner 2004: 2). However, this is not the case for a number of unfortunate ex-patients who could not find a place in society. As Peter Barham (1992) shows, deinstitutionalisation resulted in the dehumanisation and pauperisation of many seriously mentally ill individuals, particularly non-compliant young men with schizophrenia. Some are cycled in and out of hospital in a ‘revolving door’ system of care: they drift from treatment orders to hostels and, often, to living on the street or eventually ending up in prison (R. Gauld 2001; Turner 2004: 3). These failed cases have provoked much public concern over the dangerousness of the mentally ill, despite no evidence that there is an increase in homicide rates perpetrated by them. As a consequence, though, the number of places in secure mental health units is increasing, as are the numbers of mentally disordered people in prison, in a kind of reinstitutionalisation (Turner 2004: 3).

Paul Verhæghe (2008: 10) suggests that ideal categories of normality have changed, and criminality and psychopathology have become interwoven; for example, the new psychopathological diagnosis of antisocial personality disorder is deviant therefore punishable, whereas some criminal behaviour has become more acceptable as it is more explicable. Nowadays the incarceration rate of mentally disordered individuals into the prison population has risen by almost 600% in the United States: the criminal justice system, rather than the psychiatric asylum, is by 2010 the primary source of social control of the mentally ill (United States
Department of Justice statistics in M. Thompson 2010: 2-3). Deinstitutionalisation has been a tragedy for a considerable number of psychiatric survivors, as with few financial resources the community cannot offer care at all. Some former patients cannot cope with life outside the asylum: so-called ‘care in the community’ has for them meant nothing more than a geographical shift in the locus of control, from the asylum to the prison. Laing, who advocated community care, would be shocked to see the plight of many of today’s mentally ill, now homeless and sleeping rough in doorways, parks, and under bridges – or incarcerated in prison cells – in all countries where deinstitutionalisation became state policy. Indeed, Robert Desjarlais (1997) estimates that at least twenty-five percent of America’s homeless people are severely mentally ill.

Despite the rhetoric, the institutionalisation of the mentally ill did not end when the asylums closed their doors. Psychiatric services, although paying lip service to rehabilitative models of care, actually maintain people in the role of chronic patients (Breggin 1994). The massive numbers of community-based clients on maintenance doses of neuroleptic drugs facilitated deinstitutionalisation, but they are not moving toward recovery, they are, rather, trapped in the ‘static-passive-hopeless situation’ of the sick role (Coleman 2000: 1). Ron Coleman, once diagnosed as schizophrenic and now an advocate for voice-hearers, states:

I think that the idea that institutionalisation ended when we closed hospitals is a nonsense, because what it fails to recognise is that institution was not the hospital; institution is institutional psychiatry, and more importantly it’s institutional biological psychiatry – where we create an individual who becomes addicted and dependant on a drug, that does more damage to him often than good (Coleman 2000: 2).

However, and despite the appalling daily realities of many deinstitutionalised people, some ex-patients have benefited from the changes, largely because individuals like Coleman speak up for their collective rights to live in the community, form survivor social movement organisations, and have become instrumental in training hospital staff to provide meaningful interventions for the mental health service-users in their care (Bassman 2000: 93-102; M. Crossley and N. Crossley 2001: 1477-1489).

Critical Psychiatry

New ways of thinking about mental health opened up around the end of the twentieth century, as the prejudices of the system were challenged by groups of mental health service-users and their caregivers, as well as some mental health professionals who wanted to change the way psychiatry operates. The concerns of critical psychiatry illustrate Hacking’s (2007: 285-318; 2006: 23-26) concept of the ‘looping effect’, for as Ian Parker (2007: 1; emphasis in original) suggests, people do not behave in the way that psychological modelling predicts, and their awareness of the process in turn ‘changes that process.’ It also turns the gaze away from service-users on to psychiatry itself. What is emerging in the twenty-first century, then, is a ‘post-psychiatry’ movement, that advocates a collaborative relationship between mental health service-users and the professional psychiatric sector, and that wants to steer academic and clinical psychiatry away from its narrow focus on biological and psychopharmaceutical approaches (Bracken and Thomas 2005: 1-2). Post-psychiatry implies something existing ‘after’ psychiatry, and it has philosophical links to Foucault (2006a: xxviii), who claims that there is no common language between psychiatry and the mentally disordered: it is ‘a monologue by reason about madness.’ Post-psychiatry wants to establish a dialogue.

Patrick Bracken and Philip Thomas (2005: 11-13) acknowledge the links between the anti-psychiatry movement of the 1960s and 1970s and the new post-psychiatry evidenced by organisations such as the
recently established Critical Psychiatry Network based in Bradford, in Britain: a group which attempts to limit the influence of the psychopharmaceutical industry and to weaken the coercive power of psychiatry over service-users. The psychiatric profession has always been split between care and healing on one hand, and coercion and social control on the other, with the emphasis much more on control than care. Psychiatric care is justly accused of being highly discriminatory towards minority ethnic groups, and the profession and practice of psychiatry only marginally addresses issues of race and culture. The experiences of people from minority ethnic groups in psychiatric care are ‘largely negative and aversive,’ claims Sashi Sashidharan (2001: 244-245), as they tend to be judged ‘as deviant from … White norms.’ In trying to challenge power differentials, post-psychiatry is particularly concerned to give a voice to survivors of the psychiatric system, the service-users themselves.

Critical psychiatry is sceptical of the reductionist claims of neuroscience to explain emotional distress by problems located solely in the brain, and about the claims of the pharmaceutical industry to be a first-line treatment for these ‘broken brains’ (P. Thomas Undated). Duncan Double (2002: 900-904) maintains that the Critical Psychiatry Network aims to open channels of communication between psychiatry and anti-psychiatry, dismantling the biomedical model that believes drug treatment is a panacea for all the problems encountered in emotional distress, and constructing a new framework for mental health practice. Double (2002: 900-904) states that the three elements of critical psychiatry are: it challenges the dominance of neuroscience in psychiatry but does not exclude it; it introduces a strong ethical perspective on psychiatric knowledge and practice; and it politicises mental health issues.

The response to critical psychiatry from mainstream psychiatry has been mostly pragmatic, indeed, many counter-arguments assert that there is no time for what they dismiss as critical psychiatry’s idle theorising, as the profession is too under-resourced to change; some claim that the biopsychosocial model adopted by some practitioners has, anyway, already mended the division between biological and social models of psychiatry (B. Cohen 2008: 27-28). Indeed, many argue that psychiatry already has a more eclectic and biopsychosocial approach than that of the hardline biomedical model, but Colin Samson (in B. Cohen 2008: 28) observes that while psychiatrists may speak ‘the rhetoric of eclecticism … the fundamental orthodoxy of the biomedical viewpoint remains firmly intact.’ Therapeutic innovations utilised at some institutions, for example, are not widely practiced elsewhere, and in Samson’s opinion:

Ever since the co-option, then disappearance, of moral treatment in the 19th century, British psychiatry has been predominantly biological in its aetiological theories, medical in its professional organization and political allegiances, and yet ‘eclectic’ in its self-perception. That is, while biological medicine has provided the main source of knowledge for theory and practice, members of the profession have represented their enterprise as one engaging in wider domains within the social sciences. Although social theories of mental ill health have been forwarded, these have been present only on the margins of the profession (Samson 1995a: 248).

Although not breached, the dominance of the biomedical model in psychiatry has, however, been fractured in all developed countries by alternative approaches to mental disorder, psychoanalysis, humanistic psychology, the New Age movement, spiritualism, and the empowerment of psychiatric service-users and survivors (B. Cohen 2008: 30; Samson 1995a: 265-266).

Studies revealing the role of stress, economic strain, and long-term adversity in psychopathology are becoming more influential in psychology and neuroscience, in part due to some well-regarded longitudinal
empirical research projects that examine the correlation between violent victimization and mental disorder (Caspi and Moffitt 2006: 583-590; E. Silver et al. 2005: 2015-2021). Although many of these publications are connected with investigations into post-traumatic stress disorder and will be explored in more detail in my next chapter, there is now strong evidence that other types of distress such as major depression, substance abuse, and antisocial personality disorder are also triggered by environmental adversity (Pearlin et al. 2005: 205-219) and by what Bruce Dohrenwend (2000: 1-19) calls ‘uncontrollable negative changes [that] take place following a major negative event.’ This, of course, is a more academic way of saying ‘bad things happen and can drive you crazy,’ which is the way many people suffering from emotional and mental distress understand the cause of their ‘symptoms’ (Read and Haslam 2004: 133). Critical psychiatry, a philosophy that recognises that the meaning of distress is culturally contingent, realises that engaging with the belief systems and values of sufferers is of paramount importance, and many people diagnosed as mentally ill are engaged in forms of ‘talking back’ to psychiatry (L. Morrison 2005: ix).

The Psychiatric Consumer / Survivor / Ex-Patient Movement

In the field of contention surrounding mental health services and psychiatry, much has been written about issues of power and control, as we have seen, but rather less about resistance to this power and control. Roy Porter (1999b) describes the resistance of several historically well-known ‘mad persons’ to their treatments and diagnoses, but it is only recently that individuals have joined together in groups, organisations, or networks specifically to challenge psychiatric power and effect changes in the therapeutic approaches to those suffering from mental and emotional distress. The voices of psychiatric survivors have profoundly influenced the way society now regards mental illness, for although stigma and prejudice still exist, there is more awareness that life is complicated, with all of us living in a state of complex personhood amidst the vast network of society: an attentiveness to the fact that ‘even those called “Other” are never never that’ (Gordon 2007: 4-7). As Avery Gordon (2007: 4-7) contends, people may sometimes be trapped by the symptoms of their misfortunes, yet they can also transform themselves: society’s ghosts can emerge from the marginalised zones they were previously forced to inhabit. A central plank of current mental health policy is now termed ‘recovery’, increasingly discussed as an indication of progress in social inclusion and improvements in service quality (Pilgrim 2008: 295). This concept was largely driven by service-user contestations, but is still hampered by intolerance, stigma and institutional discrimination – including the prejudices of psychiatrists – against those with mental health problems. David Pilgrim remarks that:

Despite the new discourse of listening to users’ views, a tension remains because of privately held and so undisclosed professional assumptions about patient irrationality. This implies that private pessimism about user-involvement might co-exist with optimistic public rhetoric in professional mental health work (Pilgrim 2008: 298-299).

If mental health services could take on the concept of recovery in more authentic ways it would undoubtedly be hugely beneficial to service-users, but rather than being transformative it is often merely tokenism.

The psychiatric consumer / survivor / ex-patient movement, a mixed group of individuals that I will refer to from now on as service-users or as psychiatric survivors, represents a ‘revolt from below’ – ‘an insurrection of subjugated knowledges’, as Foucault (1980: 81; emphases in original) pronounces – that challenges the power of biomedical and psychopharmacological models of psychiatry. This movement has a wide diversity of concerns: some radical and aiming to destroy the coercive power of psychiatry, and some working to
reform the mental health system, providing more client-friendly approaches and services. There is no official leadership or hierarchy, with, rather, a coalition of advocacy groups working towards self-determination, choice, freedom of information, and human rights (L. Morrison 2005: 57-58). Nick Crossley (2006b: 552) argues that the various protests and movements are best understood as ‘fields of contention’ where resistance to psychiatric practices and agencies is orchestrated by distinct groups that interact with each other, forming ‘a relatively autonomous configuration’ that mostly exchanges resources and cooperates, but that nevertheless can sometimes hold polarising and conflicting stances. These fractured groups, says Nick Crossley (2006b: 552; 2004: 161-180), do not adopt the unified form of traditional movements, but are a way of making alliances between different struggles, enabling activists to achieve effective results within an oppositional habitus that Crossley terms ‘social movement organizations’ (SMOs).

There are two major themes in the history of the service-user SMOs: one is to end psychiatric oppression, and this struggle includes advocacy for human rights and self-determination, challenging the expertise of clinicians, and providing a choice of alternative treatments (L. Morrison 2005: 60-61). The other major theme is to end what Foucault (2006a: xxviii) describes as ‘a rupture in a dialogue’ between reason and madness. The goals here are to gain access to the information held by the psychiatric profession and to provide a forum for service users to speak (L. Morrison 2005: 59). The narratives of psychiatric survivors describing experiences, often of forced incarceration and abusive treatment, can be characterised as an emergence of subjugated knowledges – those defined by Foucault (2003b: 8) as historical truths that have been repressed or buried, belonging to the marginalised, the delinquent, the criminal, the psychiatric patient, and those that simply fall outside the dominant discourse as they are judged naïve, inferior, or unscientific.

The service-user SMOs developed throughout the 1960s and 1970s, with collaboration between dissenting psychiatric workers and ex-psychiatric patients. There were then, as we have seen, concerns over the meaning of madness, over social control, the effects of psychiatric drugs, and practices such as ECT and lobotomy. Foucault’s writings on disciplinary knowledge, his major text focused on madness (2006a), as well as many other essays and interviews, gave critical force to the importance of marginalised voices and counternarratives, and his public lectures on psychiatric power provided intellectual contributions to the service-user movement, a struggle that Foucault (2006b: 353) saw as a necessary form of resistance to achieve the ‘depsychiatrization’ and ‘demedicalization of madness.’ Says Foucault (2006b: 341-346); reforms of psychiatric practice and thought revolve around issues of power relations and violence, with the doctor’s power and its effect on the patient the key issue. In all anti-psychiatry, ‘[m]ore precisely … what was at stake was how the doctor’s power was involved in the truth of what he said and, conversely, how this truth could be fabricated and compromised by his power.’

The psychiatric ‘field of contention’ emerged from the social world of mental health services, profoundly influenced and inspired by the ideas of Laing and his sympathisers. These anti-psychiatry projects, at their most popular from 1964-1974, coincided with new campaigns for civil rights for psychiatric patients in Britain and the United States, and challenged the assumptions surrounding psychiatric regimes of diagnosis, categorisation, and treatment. Anti-psychiatry was by no means the sole cause of the rise of SMOs formed in opposition to mainstream biomedical psychiatry, as the issue was much more complex, but its authoritative critique provided a focal point with wide popular support. As Nick Crossley (2006b: 555-557) points out, ‘[t]he “rules of the game” were changing and those who failed to adapt risked irrelevance.’

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There are several other important factors, one of which is deinstitutionalisation, which has allowed psychiatric survivors to freely pursue associations with like-minded others, providing peer support, and actively challenging the medical model (N. Crossley 2006b: 560; Hornstein 2009a: xx). Neoliberalism, since the 1980s the prevailing ideological political model in developed countries, has made sweeping public sector reforms in line with market-oriented economic theories, including reducing expenditure throughout substantial health sector restructuring (R. Gauld 2001: 79-110). Although it has caused much harm in health-care management, neoliberal policies prioritising the ‘consumer’ and in introducing a consumption model of health care, along with deinstitutionalisation, have serendipitously created opportunities for service-user groups to collaborate and demand a voice, enabling some survivors to develop alternative forms of expertise in working with unusual experiences such as obsessions, delusions, and ‘hearing voices’ (N. Crossley 2006b: 560; Hornstein 2009a: xix-xx and 165), as I will further discuss in relation to the Hearing Voices Network. Another point is that as the diagnostic system broadened since the 1980s to include less serious forms of mental disorder, more and more middle-class patients began to be drawn into the mental health field. These service-users tended to be more articulate than the earlier patient populations in the asylums, who were largely drawn from lower-class backgrounds and diagnosed with psychotic disorders (N. Crossley 2006b: 560). This is not to suggest, however, that psychiatric survivors diagnosed with psychoses are passive; indeed many people labelled schizophrenic or bipolar regard themselves as active social agents (Hornstein 2009a: xx), and some, like the writer Ron Coleman, have achieved world renown for their advocacy in the psychiatric field (Coleman and Smith 2002).

Testimonies

Psychiatric patients have long authored memoirs of their experiences, often written secretly when incarcerated. However, service-users’ strong sense of injustice could not, until recently, be published without assistance from more powerful figures. Now, though, this form of testimony has become a crucial part of the psychiatric survivor movement. The survivor movement uses many tactics to resist the power of psychiatry, and one of these is to construct ways of ‘not being mentally ill,’ as Ron Coleman (in N. Crossley 2004: 161) asserts: ‘[f]ourteen years ago I was diagnosed as schizophrenic; five years ago that was changed to chronic schizophrenic; three years ago I gave that up and went back to being Ron Coleman.’ Psychiatric survivors have established their own knowledge base in opposition to the truth claims of psychiatry: instead of statistical evidence, scientific classification, and professional expertise, survivor knowledge privileges the experience of the individual, his or her life-course trauma, and personal testimony (Cresswell 2005: 1668).

Individuals diagnosed with serious mental disorders are often described as ‘person[s] of unsound mind’, and have historically been marginalised and denied the capacity for rational thought by the psy professions, so speaking out becomes a form of self-advocacy, claiming the political right to articulate personal narratives (M. Crossley and N. Crossley 2001: 1669). These survivor autobiographies are often harrowing accounts of childhood trauma, sexual abuse, brutality and destitution, and of the further mistreatment and personal anguish experienced when under the control of various psychiatric regimes. A famous example is Speaking Our Minds (Read and Reynolds 1996) a collection of over fifty survivor narratives that sets down a confrontational challenge to the professional therapeutic authority that dominates the psychiatric field (M.

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42 The health sector reforms in Aotearoa / New Zealand were one of the most radical restructurings in the world.
Mark Cresswell (2005) states that these claims to truth can be ‘subsumed … under the rubric of “confession”,’ using the term in the Foucauldian sense of:

> [A] ritual of discourse in which the speaking subject is also the subject of the statement; it is also a ritual that unfolds within a power relationship … a ritual in which the expression alone … produces intrinsic modifications in the person who articulates it (Foucault in Cresswell 2005: 1670).

However, argues Cresswell (2005: 1671-1672), these confessions are also testimonies, in the juridical sense, as survivors are witnesses to their own experiences of oppression. Survivor testimony is not merely a story of past events, but a ‘performative discourse’ with a political function, attempting to transform the state of affairs witnessed by the narrator. These testimonies are counternarratives, using a subversively different framework to describe the power of the psychiatric viewpoint in radically different terms (Hornstein 2009a: 163-164).

### The Hearing Voices Network

One way of diminishing the power of psychiatry is to remove barriers between so-called psychotic individuals and people defined as ‘normal’. As we have seen, auditory hallucinations are a first-rank symptom of schizophrenia, but it is now known that ‘hearing voices’ is quite a widespread occurrence in the general population, with around three million people in the United Kingdom reporting this experience (A. Morrison 2004: 299). Discovering that hearing voices are a common experience can be liberating information for someone who thinks that they must be mad, and Marius Romme, whose research into this phenomenon led to these findings (Romme and Escher 1989: 209-216), helped to establish self-help groups for voice hearers, including a Dutch organization called Resonance, the international Internet group INTERVOICE, and the Hearing Voices Network. Voice-hearing has a history of over two thousand years in the West, with Pythagoras, Socrates, and St. Augustine recorded as notable exemplars: the experience has only been pathologised since the mid-nineteenth century (Leudar and P. Thomas 2000: 1-2).

Psychiatric research and clinical work has for a long time marginalised the kind of awareness that people with a diagnosis of schizophrenia have about their own experience. Indeed, alleging that the mentally ill lack insight into their own inner processes is part of their diagnosis as mentally disordered. In the Hearing Voices Network, INTERVOICE, and other sites run by psychiatric survivors, this subjugated knowledge at last has a place to speak: the service-user hauntungs of social life can be heard. There are many alternative ways of working with voices that do not involve psychopharmaceuticals or trying to modify people’s so-called delusions. ‘It may actually not be normal to be normal, rather it may be normal to be different and to have different beliefs about the world,’ asserts Rufus May (2009: 6), who recounts how:

> [I]n the hearing voices self help movement many people have shown that accepting their voices as real rather than imaginary has been helpful in their recovery journeys. For example, for many people their voices are spiritual entities …. [I]t is now being recognized as culturally oppressive and colonial (May 2009: 6).

This standpoint equates service user organisations with other liberation movements, such as civil rights, gay rights, women’s rights, and anti-colonial and anti-racism groups, a link promulgated by service-user advocacy groups such as MindFreedom International and Mad Pride since 1988.
There are now many published narratives of the experiences of psychiatric survivors, as well as oral histories, online blogs, and outsider artworks produced outside the mainstream of modern Western art (Rhodes 2004). Peer support groups exist all over the world, giving current and former psychiatric patients forums to help one another recover and work together to try to unravel the mysteries of mental disorder (Hornstein 2009b: 6). In the stories told by survivors there are no debates about neurochemical imbalances, anatomical defects or faulty genetics; instead cultural and racial prejudice, parental neglect, sexual abuse, poverty, and experiences of marginalisation and violence are considered as the major causes of mental and emotional distress. Survivors relate horrific accounts of mistreatment and brutality both inside and outside psychiatric care facilities, but also proffer tales of support, resilience, and recovery. There is mounting evidence that people who have psychotic symptoms such as auditory, verbal, and sensory hallucinations are likely to have had traumatic experiences such as physical, emotional, and, especially, sexual abuse in childhood (Bebbington et al. 2004: 220-226; Read 1997: 448-456; Read, Goodman, Morrison, Ross and Aderhold 2004: 223-252; Read, Perry, Moskowitz and Connolly 2001: 319-345). As in Freud’s day, research in this field is racked by controversy, although some large-scale studies convincingly posit a causal relationship between ‘victimization experiences’, especially childhood sexual abuse, and the later development of adult psychosis (Bebbington et al. 2004: 220-226). The psychological damage caused by childhood trauma will be examined in my next chapter; for now, suffice it to say that many adult psychiatric service users, when given voice, report histories of childhood neglect and sexual abuse.

**Progress?**

Far from a history where medical knowledge triumphantly advances, and diagnosis and treatment become more enlightened and effective, an examination of psychiatry’s past reveals continual challenges between powerful discourses and influential individuals. These discourses are embedded in hierarchies where certain belief systems become dominant and are then, in turn, challenged by other belief systems. The history of the mental health business is most emphatically not a history of genuine scientific progress, and as the dominance of the psychiatric field is fractured by many competing voices, and with survivors and service-users continuing to act as facilitators for change, one can only hope that meaningful help and empathic understanding, as well as medication, will increasingly be offered to individuals suffering from mental and emotional distress.

The psy disciplines swing between two opposing visions. One view emphasises the anatomy and chemistry of the brain, with adherents regarding mental illness as the product of biological or genetic problems in the cerebral cortex, nowadays best treated by medication and, sometimes, psychotherapy. The other view holds that repressed unconscious forces trigger psychic distress, best alleviated by psychoanalysis or psychodynamic therapies. Both of these perspectives have a troubled relationship with reality: problems within the individual, due to faulty biology or genetics, or conflicts within the psyche cause mental illness. As the testimonies of psychiatric survivors show, the psy disciplines have long had difficulty with the notion that violence and overwhelming terror – events that occur outside the individual – can profoundly alter a person’s biology and psychology, and a third point of view, now sometimes termed the trauma paradigm, will be explored in my next chapter (van der Kolk, Weisæth, and van der Hart 1996: 47).
It’s when you hear the shot,
and while you’re lying flat on your
face you’re spattered with gravel.

Ricochet –
it’s when a year later
you recognize the scar on the stone
where your life went on again.43
‘The scar on the stone.’44

Trauma intrudes explosively into our lives and reverberates unpredictably into our future; this is the subject of the third part of my history of the present. Successively surfacing and submerging, haunting the psy professions, the history of trauma resists a linear narrative, and although there are certainly continuities in the history of psychological trauma, Ruth Leys (2000: 8) asserts that a genealogical approach better suits the topic. As Leys notes, Michel Foucault (in Leys and Goldman 2010: 657) remarks that genealogy ‘operates on a field of entangled and confused parchments that have been scratched over and recopied many times’, a method close to the palimpsest that is the history of trauma. I will, therefore, focus on a series of crucial episodes in the study of trauma over the last century, shifting between time and place, following episodes of forgetting and remembering as psychiatric knowledge was neglected and later revived. The chapter sub-headings are quotes, chosen simply for their resonance with the subject matter that follows. Some are drawn from researchers in the field; others are from survivors; a number of them are from poems and literary writings. These headings differentiate this section from the two previous history chapters, linking it thematically to my autoethnography.

The poem that is this chapter’s epigraph, written by Fahrudin Zilkić who fought in the Balkan Wars during the 1990s, describes a traumatic event: the ricochet of the wounding gunshot lives on as a hidden scar on the psyche of the survivor. The word trauma denotes a physical wound but the meaning extends to include a psychic or emotional wound, where a terrifying experience, not only a physical wound, causes abnormal mental stress. This transference of meaning occurred around the end of the nineteenth century, coming to psychoanalysis from the medical sciences. Indeed at this time the culture of modernity, with its mechanical developments such as the railway, and, particularly, the technologies of war, was understood by many contemporaries as an environment that inculcated the experience of traumatic fright in the modern individual, a phenomenon first noted by Sigmund Freud, Walter Benjamin, Charles Baudelaire, and Georg Simmel – all social commentators and critics of the shocks and fractures of the Modern Era (Pusca 2007; Simmel 1903: 47-60). Indeed Benjamin conceives of modernity itself as a break in consciousness, a truly alien experience in which the coherence of subjective experience is disrupted and displaced (Newmark 1995: 236). This notion of trauma as a rupture, or breach, in the protective shield of consciousness persists in psychological writings, with Freud, especially, figuring individual conscious as besieged and disordered by alien psychic forces. The term ‘trauma’ in its clinical psychological sense is central to the work of Jean-Martin Charcot, Pierre Janet and Sigmund Freud in their investigations into the traumatic origins of hysteria, and arguably to the psy professions themselves, as after the First World War, when techniques to treat shell-shock and repressed traumatic experiences proved successful, psychological explanations of mental disorder gained legitimacy and the field of psychiatric jurisdiction dramatically expanded (Pilgrim and Treacher 1992: 8-10).

The study of traumatic stress, however, is not merely a matter of clinical objectivity, but also requires an awareness of the sociopolitical contexts in which trauma is embedded, as the acceptance of the concept is continually challenged by various political and social dynamics as well as scientific considerations. I examined some of the controversies over the causes of hysteria and shell-shock in my last chapter; the strange symptoms displayed by victims of nineteenth century industrial and railway accidents also provoked intense disputes that will be touched on in this chapter. Issues of memory and forgetting have always been

fundamental to the study of trauma, with individuals often suffering from haunting recollections of their experiences: memories that are frequently disbelieved by others. The fierce controversy over so-called ‘false memory syndrome’ during the latter part of the twentieth century will be addressed later in this chapter. Traumatic memories seem to be dissociated and stored in a manner inaccessible to ordinary awareness, expressed in unusual and incomprehensible ways and often relived in vivid sensory experiences. These adaptations and reenactments can be shameful for victims and a matter of grave concern for society, raising issues both of legal responsibility and the requirements for care of the vulnerable, as a wide range of self-destructive and outwardly violent behaviours can manifest.

It is mostly through the effects of war on combatants that traumatic psychological injuries have become clinically acknowledged: the acceptance of post-traumatic stress disorder (PTSD) as a formal diagnosis in 1980 was recognition of the effects of trauma in veterans of the Vietnam War, and once the category was enshrined in the psychiatric ‘bible’, the Diagnostic and Statistical Manual of Mental Disorders (DSM), it became extended, after political agitation from feminist groups, to include survivors of rape and childhood abuse and maltreatment (van der Kolk, Weisæth, and van der Hart 1996: 47-74). Indeed, this clinical and professional acknowledgement of PTSD is widely argued as a paradigm shift that has allowed conditions once thought of as separate, such as stress-related response, rape-trauma syndrome, shell-shock, or ‘acute environmental reaction’ to be considered as reflecting the same kind of pathological process. By the mid-1980s feminist groups argued that survivors of traumatic events, with their specific and painful kinds of suffering, had been mostly ignored and that ‘people deserve to be believed when they speak of traumatic experiences and their painful sequelae’ (Kudler 2000: 2-3; emphases in original). Although I looked at shell-shock in the First World War in my previous chapter, the psychological trauma experienced by combatants in modern wars will be addressed in more detail below.

Artists and writers have always drawn on life’s tragedies, knowing that exposure to overwhelming terror can lead to frightening memories and dreams. From around 2500 BC, when the epic poems of Gilgamesh were created, physical trauma and its concomitant emotional anguish has been a central theme of Western literature (Friedman and Marsella 1996: 11-12; Mitchell 2004). The first word of Homer’s (1988: 77) Iliad is ‘rage’ and as Simone Weil (1983: 3) says, presenting her vision of the story as an image of the modern world: this force, the true subject of the book, shows us that human beings are still worshippers and casualties of the will to violence. Although one can argue, as Bessel van der Kolk and Alexander McFarlane (1996: 3) declare, that ‘experiencing trauma is an essential part of being human; history is written in blood,’ it was not, however, until the end of the twentieth century that large-scale scientific studies examined the effects of trauma on the bodies and minds of survivors.

Psychiatric interest in the concept of psychic trauma has waxed and waned over the last hundred years, and researchers of PTSD tend to write a chronological history running from the Iliad through nineteenth century industrial accidents and ‘railway spine,’ hysteria, and shell-shock, until the war-related trauma of Vietnam veterans fixed PTSD into the classificatory system of DSM-III in 1980. PTSD describes real phenomena, as confirmed by empirical research into people’s experiences and lives, but the disorder is an historical and cultural product, not a timeless diagnosis. As Allan Young (1995: 5-6) states, as diagnostic constructs, PTSD and traumatic memory have been made real to describe the real occurrences that effect clinicians, researchers, and sufferers, ‘glued together by the practices, technologies, and narratives with which it is
diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources.’ PTSD, Young (1995: 7) argues, ‘is a disease of time’ that through intrusive images, thoughts, and compulsions, allows the past to relive itself in the present; this indeed is the disorder’s classificatory space in the DSM: traumatic aetiological event ➔ symptom. However, PTSD can also have a delayed onset, with the trauma survivor fixing retrospectively upon his or her ‘aetiological memory / event’ – time can, therefore, also run in the opposite direction, from present to past. People can become trapped in the torments of the past, or split between the ordinary memory of everyday life and the deep memory of buried horrors: time, as a linear measurement, becomes meaningless.

The key issue is violence. Whether suffered in warfare, rape, or the physical and psychological battering experienced in domestic abuse or childhood maltreatment, atrocity leaves a psychic scar. Following a traumatic incident, an apparently normal personality can, it is argued, switch to an emotional ‘alter’, a hidden personality (there can be multiple hidden personalities) that seems to act as a reservoir for traumatic reactions and experiences; the trauma can thus be ‘forgotten’ in one ego state, while in another, it is remembered and perhaps fixed at the developmental age at which the event occurred (van der Kolk, van der Hart and Marmar 1996: 317-318). This process is termed dissociation, a concept Pierre Janet investigated over a century ago (van der Hart and Horst 1989: 1). The view that these bizarre alter personalities could be awoken and traumatic memories recovered under hypnosis was at first enthusiastically embraced by nineteenth century physicians, but psychiatry seems to mirror the amnesia suffered by traumatised victims, as the profession switches between fascination with trauma and disbelief of its relevance to diagnosis (van der Kolk, Weisæth, and van der Hart 1996: 47). Janet’s theories of post-traumatic dissociative states have been reconsidered by trauma researchers since the 1980s and will be explored in this chapter.

There are however problems with an uncritical application of Western models of the mind to other cultural frameworks. The DSM includes a section on cross-cultural perspectives on dissociative states that can be an accepted part of religious experience in many societies, as in spirit possession and trance states, and sometimes intentionally sought in yogic meditation (APA 2000: 519; Bourguignon 1976), but whether trance and spirit possession is a cultural expression of what Western psychiatry has pathologised as dissociative disorders, with similar core symptoms, is a vexed question. Some argue that multiple personality disorder and dissociative identity disorder are social constructions derived from earlier historical notions of possession (Cardeña 1992: 294); however, possession states have long been associated with the symptoms of the functional psychoses, such as hallucinations and delusions, and the spontaneous trances experienced in different societies may be culturally structured reactions to psychological trauma and environmental stress (Bentall 2000: 85-120; Castillo 2003: 9-21; Ross 1997). Western interventions in violent conflict and natural disasters in the developing world have sometimes involved uncritical applications of therapy, and the effectiveness of biomedical psychiatry and psychology in other cultural settings is much debated. While this issue is outside the scope of this thesis it is important to note that PTSD has been criticised as a Western culture-bound syndrome, and some argue that the individualised and internalised approach of the Western psy professions can be inappropriate and ineffective outside of its own milieu, a fact that destabilises the international validity of psychiatric categories (Fernando 2010: 94-96; Friedman and Marsella 1996: 12; Kleinman 1991). The diagnosis of PTSD originated in the United States, and very often writers in the trauma field retain a very selective, American approach to history, repeatedly referring to Vietnam experiences – buttressed by Holocaust studies – while ignoring a more global experience of suffering and warfare.
The diagnostic categorisation of PTSD in 1980 is significant, as it acknowledges that a real event can trigger a mental disorder, but this breach in the brain disease model of modern psychiatry has not yet opened into a full-scale admission of social causation.

The concept of trauma has, in the last decade, attained prominence in the humanities as well as in the psy disciplines. The literary critic Cathy Caruth (1995 and 1996), for example, draws on the neuroscientific work of Bessel van der Kolk, and has written widely on the topic of trauma. The Holocaust, the Nazi genocide of European Jews during the Second World War, or, as it has been called in Israel since 1951, the Shoah, is a ‘limit event’, a catastrophe of such overwhelming violence and significance that its effects rupture the normative foundations of moral and political community (Friedländer 1996a: 3). The Shoah exemplifies the contemporary vision of traumatic history, and, as Dominick LaCapra (2001: x-xi) asserts, its occurrence challenges the most fundamental principals of Enlightenment understandings. To LaCapra, a theory of trauma should be at the centre of any critical apprehension of twentieth-century history, and trauma theory, informed by deconstruction, post-structuralism, and psychoanalysis, is widely employed by literary and cultural critics. Cultural theory’s use of trauma is mostly outside the remit of this thesis, although I will refer to the work of Dori Laub, Shoshana Felman, and Elie Wiesel (Felman and Laub 1992) who examine the function of literary testimony in reporting survivors’ experiences during the Shoah. Testimonies of survivors are often fragmented and inconsistent, and Holocaust deniers, arguing that Jewish genocide never really happened, seized on the instability of traumatic memory. Memory researchers who argue that recovered repressed memories of rape and incest must be false have used a similar logic (Walker 2003: 107).

Memory is one of the constant reference points of contemporary intellectual and political debates and it has become a key term in our culture’s engagement with the past. Over the last decades there has been fierce controversy in what are sometimes termed the ‘memory wars’, dominated by scepticism about memories of childhood sexual abuse, and whether autobiographical memory is reliable or too readily manipulated to be trustworthy. This mistrust of women’s and children’s memories of abuse is now so familiar that the terms ‘recovered memory’ and ‘false recovered memory’ are often used with no real explanation of the background to these cultural and scientific debates (Campbell 2003; Davis 2005: 219-243; Shanks 1997). In the 1980s, when feminist activism around sexual abuse forced the issue into the pubic domain, the numbers of child abuse reports rose, and child protection agencies were expanded to investigate these cases. In a short space of time, the hitherto rare syndrome of multiple personality disorder (MPD) was diagnosed in tens of thousands of patients, mostly adult women (Davis 2005: 222-223; Hacking 1995: 65). MPD is now listed as dissociative identity disorder (DID) in the DSM, and we have already seen its origins in the nineteenth century, with double personality, somnambulism, hypnosis, and hysteria. Although the diagnosis of DID is often sensationalised and has been the subject of many sceptical attacks, I believe that dissociation is a common feature of many post-traumatic states diagnosed as mental disorders (Ross 1997). My exploration of memory will be woven in various skeins throughout the following sections, and be examined in more depth towards the end of this chapter.

The two previous chapters of this thesis examine the way that the psy professions privilege the inner world of the individual whilst dismissing the impact of the social world and those violently traumatic events occurring

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45 Ross argues that dissociation is not one of the core symptoms of PTSD, as dissociation is also linked with so many other pathologies. PTSD is strongly comorbid with anxiety disorders, affective disorders, and substance abuse, as well as with dissociative disorder.
outside the individual that have a profoundly destabilising effect on the psyches of survivors. This chapter explores this phenomenon. My focus here is the sexual abuse of children, but trauma research is built on foundations that were established during the nineteenth century, continuing through the world wars of the twentieth century and the testimonies of Holocaust survivors. I will of necessity look at these events only briefly. I will also examine the sequelæ of childhood trauma and sexual abuse in adult survivors, as despite the Freudian emphasis in psychotherapeutics on the after-effects of childhood terrors on adult competency, children themselves have had, until recently, a relatively low status within sociological research (Rogers and Pilgrim 2005: 105); even less attention is paid to children with disabilities, especially those who suffer maltreatment and abuse (Fisher 2009: 326-327; Westcott and Jones 1999: 497-506). Psychiatrists often feel they cannot address the problem of sexual abuse, regarding it as a social problem, an issue not located in the inner world or brain of the patient. Many psy examinations of child sexual abuse ignore the social context, focusing instead on stress / resilience and changes in the brain due to traumatic experiences. In a sociological thesis, I have more freedom to insist that ‘bad things happen and can drive you crazy’ (Read and Haslam 2004: 133).

During my journey through the psychiatric establishment with Django, trauma was the ‘missing piece’ of his diagnosis; his hidden scar was as unrecognised as his trauma history. As seen in my autoethnographic chapter, Django emerged from his psychiatric assessment with several diagnoses, an extensive comorbidity that Colin Ross claims arises due to ‘deficiencies in the dominant biomedical model of mental illness.’ Despite paying lip-service to biopsychosocial models of mental disorder, says Ross, psychiatry ignores trauma, especially sexual abuse, as a factor or cause of the person’s problems, finding it irrelevant to treatment plans (Ross 2000b: 13). Indeed, John Read and his colleagues (Lothian and Read 2002: 98-103; Read and Fraser 1998: 355-359) assert that despite the now robust establishment of causal relationships between child abuse and psychological disorders, it is rare for patients to be asked about a history of abuse or maltreatment. Notwithstanding this professional reticence over addressing what may be embarrassing or uncomfortable questions, research shows that two thirds of adult individuals contacting mental health services say, when asked, that they have suffered from traumatic abuse at some point in their lives.

If adult abuse survivors are silenced, then how much more hidden are the trauma histories of children? In the previous chapter we saw how men like Charcot, Freud, and Breuer, who helped to establish the dominant model of psychiatry and mental illness that we know today, were misogynists who used coercive methods against the ‘mad’ women in their care, whilst refusing to acknowledge the reality of the childhood sexual abuse that was the major cause of these women’s symptoms (Herman 1998: 10; Masson 1998). I would like to include what these patients said in their own words, but these voices have mostly been lost; incorporated into the case histories of their male therapists, silenced under theoretical explanations of their suffering. Before investigating the traumatic psychological impact of war, we will briefly return to the nineteenth century to explore Freud’s ‘seduction theory’, a discovery that he swiftly repudiated after initially claiming it to be ‘a solution to a … thousand-year-old problem, a “source of the Nile!”’ (Freud in Masson 1998: 9).
'The unsaid, lost, in the body, in between the bodies.'\(^{46}\)

The study of psychology centres on 'how the psyche need[s] to defend itself from its own inner forces in order to maintain a kind of inner stability,' says George Makari (2009: 85), but what those hidden forces of unconscious desire or repressed memory actually are is speculative, a fact earlier acknowledged by Freud. As is well known, Freud turned to the study of sexuality to provide the key to the puzzle. In 1896 in Vienna, Freud first publicly aired his theory that the origin of neurosis was located in experiences of sexual trauma in childhood. Presenting a paper called 'The Ætiology of Hysteria,' Freud described how his patients had been harmed: cruel and violent sexual acts perpetrated by powerful adults on children too weak, too young, and too frightened to fight against their abusers caused profound psychic damage, even though these events had, for a time, been forgotten. Memories of this sexual trauma remained buried in the child's psyche for years, only erupting years later with the emergence of mature sexuality, when it caused the pathogenic symptoms of hysteria. Hysteria, claimed Freud in his revolutionary new theory, was caused by sexual abuse in childhood, most commonly perpetrated by the father (Masson 1998: 3-5; Makari 2009: 90-91). Charcot, Janet, Breuer and Freud had long acknowledged that memories of past traumatic experiences, even when long-forgotten, had intense effects, with Breuer and Freud (1893: 11; emphases in original) famously stating: 'hysterics suffer for the most part from reminiscences.' But how did Freud come to speak out on the much more contentious issue of child sexual abuse within the family?

The existence of child maltreatment in all societies throughout history, whether through infanticide, abandonment, cruel physical punishments, child prostitution, or harsh working practices, is beyond doubt (Corby 2008: 7-20). However, during the nineteenth century, a time of great social upheaval and change, especially for the poor, new concerns about regulating family life and new forms of state intervention arose, some of which were described in my last chapter. By the 1880s in Britain, various philanthropic societies were formed to protect children from societal neglect, cruelty and abuse, and by the early twentieth century, the National Society for the Prevention of Cruelty to Children (NSPCC) was even tackling child abuse within the family (Corby 2008: 22-26). When Freud was constructing his theory in the 1880s and 1890s, forensic statistics were being collated in Germany and France that revealed horrifying figures documenting sex crimes against children: as many as seventy percent of reported rapes were of children under twelve years old (Makari 2009: 90). In the nineteenth century, however, incest tended to be hidden, as George Behlmer (in Corby 2008: 27) said at the time, silenced as “an evil which is altogether too unmentionable”. Most research in this field was totally ignored by the medical and legal professions, but Ambroise Tardieu, the dean of forensic medicine in France, published a large-scale study on child battering and rape that attempted to reveal the true extent of the problem; a year after his death in 1880, his colleagues disavowed his work, accusing children of lying about sexual attacks (Summit 1988: 45-46). Freud read widely from Tardieu's writings, as well as attending autopsies of some of the child victims. These deaths were usually recorded as accidents, as medical practitioners, as well as society, preferred to deny the reality of such cruelty (Masson 1998: 15-19).

Freud, listening to his women patients in 1895 and 1896, heard violent stories of sexual abuse inflicted within the family, terrible secrets kept since childhood. Other psychiatrists had dismissed these accounts as lies or fantasies, but Freud initially believed that these memories were true (Masson 1998: xvi). Freud's patients

were not poor or destitute, like the thousands of women Charcot had, from 1862 until the 1890s, observed in the Salpêtrière (Didi-Huberman 2003: 17): Freud’s clients were, on the contrary, from families of the wealthy Viennese bourgeoisie. Charcot, although believing that the symptoms of hysteria originated in long-buried memories of trauma, never wavered in his conviction that traumatic neurosis could only emerge in individuals damaged by the taint of degenerative heredity (Makari 2009: 20). But, thought Freud, if a father had secretly molested his daughters, the effect would seem superficially the same – what Freud termed ‘pseudo-heredity’ – as this familial descent into further neuroses could be interpreted as a degenerative bloodline, even though it was, in reality, the result of incest and violence (Makari 2009: 98). Writing to Wilhelm Fleiss in 1896, Freud (in Makari 2009: 98) wrote: “It seems to me more and more that the essential point of hysteria is that it results from perversion on the part of the seducer, and more and more that heredity is seduction by the father.” By ‘seduction’ Freud meant serious episodes of sexual assault, and his unfortunate choice of word diminishes the violence of the act whilst implying some consensual activity on the part of the child (Masson 1998: 3-5). Freud never put a name to his theory of traumatic memory: the misleading label of ‘seduction theory’ was bestowed in 1950, eleven years after Freud’s death, by Ernst Kris and Ernest Jones, propagating the claim that psychoanalysis and its Œdipus complex originated in 1896 (Triplet 2004: 651-652). But, says Jeffrey Masson (1998: 3-5), there is no doubt that when he first described his belief in widespread infant sexual abuse, assault, and trauma, Freud intended ‘seduction’ to mean ‘an act of cruelty and violence which wounds the child in every aspect of her … being.’ Indeed, Freud’s (in Triplet 2004: 660) unmistakable claim in his early writings was that hysterical symptoms were caused by ‘“stimulation of the genitals, coitus-like acts”’ that could be classified as ‘“grave sexual injuries”’ during early childhood.

Freud’s 1896 lecture was met with an icy reception from the elite Viennese medical community in his audience. Richard von Krafft-Ebing (in Masson 1998: 9), professor of psychiatry at The University of Vienna, commented that Freud’s theory sounded “like a scientific fairy tale.” Freud’s other colleagues were equally damning. In listening to his patients remembering the shame and trauma of their childhood sexual abuse, Freud had believed that he had discovered the truth behind the florid symptoms of hysteria, but the social and professional isolation he endured after presenting his paper persuaded him to repudiate his views (Masson 1998: 9-11). Perhaps Freud, who did not deny the reality of child abuse, just could not face the scale of the problem. In a letter to his friend Wilhelm Fleiss, explaining his abandonment of the ‘seduction theory’, Freud (in Gay 1995: 112) considered his own father as a perpetrator: ‘in every case the father, not excluding my own, had to be blamed as a pervert … such a widespread extent of perversity towards children is, after all, not very probable.’ Freud’s close colleague, Sándor Ferenczi (1932: 291-303; emphases in original), continued to insist that sexual assaults on young children were commonplace, calling it ‘the terrorism of suffering’, and his courage cost him his career and his friendship with Freud (Masson 1998: 145-188). Freud’s denial of his belief in childhood sexual assault and traumatic memory powerfully endorsed the incredulity that attended all child sexual abuse accusations, then and for at least a century afterwards (Summit 1988: 47). Indeed the label ‘seduction theory’, a rhetorical strategy employed by Freud’s heirs, represents an historical distortion that has misdirected all subsequent investigators (Triplet 2004: 664-665). Until he became interested in the nature of traumatic memory in cases of shell-shock in the First World War twenty years later, Freud ignored the causal relationship between actually occurring terrifying events and the

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47 In Freud’s writings he makes it clear that girls are usually the victims, but he does not exclude boys from experiences of rape, with what Freud thought of as life-threatening consequences for the survivors.
resulting psychopathology, focusing instead on subjective experience and intrapsychic reality: ‘Real-life trauma was ignored in favour of fantasy’ (van der Kolk, Weisaeth and van der Hart 1996: 54-55).

There is still widespread societal denial of the reality and extent of child sexual abuse, a problem that Roland Summit (1988: 51) describes as ‘a massive blind spot.’ Surely, if child sexual abuse were so prevalent, if so many apparently upstanding pillars of society were child rapists, then parents, doctors, psychiatrists, the justice system, would all find out: but no, it is easier just to argue that ‘[y]ou can’t trust kids’ (Summit 1988: 51). With continuing revelations of child sexual abuse perpetrated by priests in the Roman Catholic Church, and the conspiracy of silence and cover-ups from as high as the Vatican, society is beginning to acknowledge that the practice of child rape is appallingly commonplace (Chu 2003: 1-9; Doyle, Sipe and Wall 2006; G. Robertson 2010). Bessel van der Kolk and Alexander McFarlane (1996: 3-4) point out that the psychiatric profession has, for at least the last hundred years, gone through phases of fascination with trauma, followed by periods of disbelief about the relevance of sufferers’ stories. This mystification mirrors the bewilderment of victims whose lives are destroyed by traumatic experiences, who themselves stumble through intrusions, incredulity and confusion. To protect themselves from the memory of incomprehensible and overwhelming events such as sexual abuse by a parent or caregiver, children commonly dissociate from the experience. Clinicians and scholars, says Ruth Blizard (2003: 1), are vulnerable to the same defences, likely to grasp at other explanations for patients’ reports of trauma, rationalizing their memories as fantasy.

When survivors do tell their stories it is often in a fragmented, emotional, and contradictory way, which serves both their desire to maintain secrecy and to tell the truth, whilst undermining their credibility. As Arthur Frank (1997: 97-114) asserts, these ‘chaos stories’ are threatening, full of horror, seemingly impossible to heal, and the listener is overwhelmed. Says Judith Herman (1998: 1) ‘the central dialectic of psychological trauma’ is a struggle between the will to deny atrocity and the will to proclaim its experience. It is perhaps unsurprising that it is difficult for individuals who have never experienced trauma to empathise with survivors of traumatic events, given this simultaneous revelation and concealment, as well as the dreadfulness of the narrative. Joanne Hall (1999: 89) believes that living through trauma means existing in a liminal zone that she defines as: ‘Liminality: Having experiences not shared by others: severe trauma, stigmatization and illness is conducive to fostering abilities to empathize with others but carries the risk of alienation, altered perceptions and psychological strain.’

Every culture has a zone where it excludes individuals denied personhood, says Avery Gordon (2007: 4-7), and these ghostly figures are either viewed as victims or, if they overcome their disadvantages, as heroic, but this simplistic portrayal denies their multifaceted and at times ambiguous subjectivity. All people really exist in a state of complex personhood amidst the vast network of society, with life full of twists and turns, forgetting and remembering. These subjugated knowledges belonging to marginalised sections of the population such as the mentally ill are, as Foucault (2003b: 8-9) asserts, commonly dismissed as naïve, inferior, or unscientific, and disowned or repressed by the dominant discourse. This liminal zone where traumatic memories torment survivors attracted researchers other than Freud, but before turning to this topic I first need to fill in some background on the development of the concept of traumatic neurosis.
'A state of collapse from fright and from fright only.'\textsuperscript{48}

A swift expansion of, and innovation in, science and industry in the West characterised the nineteenth century: incalculable new energies that were from the beginning linked with pathologies of the mind and body (Rabinbach 1992). As Wolfgang Schivelbusch (1986) shows, human adaptation to the transformations of modernity was very much a learned behaviour, and nineteenth century reactions to ‘the first dramatic avatar of technological change, the railroad,’ reveal ways in which human perceptions of time, distance, speed and risk were altered by railway travel. Indeed, as Lars Weisæth (2002: 443) points out, the origins of industrialised human consciousness shows that ‘[p]sychiatry owes a lot to British Rail.’ The search for the origin of the new shock-related injuries associated with railway accidents represents the first controversy between those holding that the complaints must have a physical cause, such as minute brain or spinal haemorrhages, and those who believed that terror and fright alone could profoundly damage the human nervous system.

The railway was regarded as the most spectacular symbol of modernity. It created a new system of travel and communication that demolished the traditional temporal and spatial boundaries of existence, giving rise to new fears of injury and accident; an experience characterised by nineteenth century writings as an ‘annihilation of space and time’ (Schivelbusch 1986: 33-44). However, as Schivelbusch (1986: 131) says: ‘the more civilized the schedule and efficient the technology, the more catastrophic its destruction when it collapses. There is an exact ratio between the level of technology with which nature is controlled, and the degree of severity of its accidents.’ Pre-industrial accidents were regarded as natural, caused by ‘outside’ forces, such as thunderstorms and floods. Post-industrial accidents, involving new technological devices such as steam locomotives, were regarded differently: it was the machine’s own power and speed, it’s ‘inside forces’, that obliterated it, as well as anything or anyone else involved in the collision. Mechanised progress entailed the containment of dangerous forces and the railway accident revealed a calamitous failure of human command over modern machinery (Harrington 1994: 15).

There were other effects as well as the physical destruction of the locomotive and its passengers. The unprecedented violence and shock of railway accidents caused terrible bodily injuries, but many accident victims who suffered minor or no wounds developed mysterious psychic and physical problems, frequently total disability and sometimes even died. Systems of financial compensation for the victims of accidents were developing in Europe, especially in regard to industrial and railway accidents; prior to the nineteenth century, there was practically no law of negligence. After railway companies became legally liable for the safety and health of their passengers (in 1864 in England, and in 1871 in Germany), symptoms unrelated to visible physical injuries became the subject of legal and medical disputes (Harrington 1994: 134-135). Between the 1840s and 1870s there were an escalating number of accidents and fatalities on Britain’s railways, and an anxious public increasingly believed that not only were these dangers occurring more frequently but that the safety of passengers was a matter of indifference to the railway companies (Harrington 2001: 33).

The entire chapter of the medico-legal history of the nervous disorders that followed railway accidents need not be addressed here. What is relevant to my purpose is that debates over the destructive force of railroad

disasters have important consequences in the emergence of twentieth-century conceptions of traumatic disorders. Nineteenth century medical models could not understand this type of injury: how could cause be so disconnected to effect? At first, it was regarded as solely an organic disorder, despite contemporary medico-legal disagreements over what kinds of organic processes were at fault (Harrington 2003: 209-223). The injury was believed to be pathological, originating in undetectable physical damage to and deterioration of the spinal cord, caused by mechanical shock. This medical notion was bolstered by the fact that only physical injuries legally qualified as just cause for financial compensation (Schivelbusch 1986: 135). In 1866 in England, the surgeon John Erichsen developed the concept of ‘concussion of the spine’ and popularised the term ‘railway spine’, believing that molecular changes in the structure of the spine and nervous system, especially an inflammation of the bone marrow, led to neurosis. Nine years later, however, Erichsen acknowledged that psychological factors such as terror greatly intensified the damage to the nervous system (Harrington 1994: 18; Trillat 1995: 437). Erichsen explicitly warned that these symptoms were not to be mistaken with those of hysteria, which he maintained only arose in women (van der Kolk, Weisæth and van der Hart 1996: 48). By 1885, Herbert Page, a railway company surgeon, took an even more explicit position against organic explanations for railway spine, asserting that there were few facts to support any structural injury, rather, a ‘general nervous shock’ caused by a high level of fright inflicted by the railway accident, accounted for the phenomenon (Harrington 1994: 18-19). Thus, ‘railway spine’ became ‘railway brain’ and gradually a new psychopathological viewpoint emerged (Weisæth 2002: 444), with contemporaries believing that ‘the railway could dissolve the human nervous system in an instant, a cataclysmic split second of fright’ (George Drinka in Harrington 1994: 19).

The most prominent cause of the illness was now held to be the psychic experience of shock, although this hypothesis was still highly contentious. Page declared that the mysterious injuries following railway accidents were produced ‘from fright and from fright only,’ and by the early 1890s ‘railway spine’ had been replaced by the concept of the ‘traumatic neuroses,’ a term proposed by Hermann Oppenheim in Germany, who had found analogous cases with symptoms of hysteria (Schivelbusch 1986: 135-145; Trillat 1995: 438). Page and Oppenheim, however, were not entirely in agreement: Oppenheim was an organicist, like Erichsen, who believed that the neuroses were produced by undetectable damage in the central nervous system, whereas Page believed that the mental state of individuals suffering from railway brain was similar to that of hysteria patients whilst under hypnosis, in other words, it was like somnambulism, or magnetic sleep (van der Kolk, Weisæth and van der Hart 1996: 48). In France at the Salpêtrière, Charcot was simultaneously exploring the connection between trauma and hysteria, and his choc nerveux was defined as a somatic brain event that could induce a hypnoid auto-suggestive state (van der Kolk, Weisæth and van der Hart 1996: 48; Weisæth 2002: 444). Freud and Janet, who both worked with Charcot, continued to decipher the nature of the traumatic neuroses and related dissociative states, and etiological explanations moved further toward psychological factors and away from purely somatic accounts of phenomena.

‘What shall we call our “self”? Where does it begin? where does it end?’

In my previous chapter I briefly touched on the nineteenth century’s fascination with the phenomena of double consciousness, somnambulism, and alternating personalities, noting that these new terms describing a part of the mind dissociated from conscious control made it possible to envisage that human beings had an

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unconscious existence (Hacking 1995: 153-155). To recapitulate what was stated earlier, the notion of the sovereign consciousness of the self, a vision set out by classical philosophy and taken for granted in everyday existence, was profoundly disturbed by the time of the nineteenth century. However, as Jerrold Seigal (2005: 3) states, ‘[f]ew ideas are both as weighty and as slippery as the self’ and the concept is subject to continual redefinition. The modern Western viewpoint defines the self as rational, autonomous, and unified, privileges its inwardness and establishes a binary opposition between ‘inside-outside’ that seems self-evident (Taylor 2001: 111). This artifact of Western thought is challenged by anthropological studies that suggest human nature, in its ideas, values and emotions, is never independent of its cultural matrix (Geertz 1993: 49-50).

Western thought has another less dominant current of thought running through it, which argues that the ‘self’ does not have a stable essence at its heart but is, rather, made up from constantly changing yet interrelated elements. I touched on the Gothic literary themes of vampirism and possession in an earlier chapter, and the novelist Henry James (2003: 253) also drew on this tradition, depicting the ‘self’ as permeable, and in his novels, his characters influence each other, their ‘selves’ in constant interaction and exchange. As I pointed out before, identity is unstable, we have, rather, a mind constituted by a flux of successive perceptions: as David Hume (1985: 299-301) describes it, the ‘bundle of the self’. Nietzsche also contends that the self is created by the incorporation of active experiences (Schacht 1995: 104-107), as does Foucault (1994: 187), who states that it is the practices that human beings engage in and the relation we have with ourselves that shape our understandings of our existence (Dreyfus and Rabinow 1998: 112-115). These ideas have been built on by Nikolas Rose (1998: 24; 1997: 226-227), who argues that the psy disciplines have made us into ‘assembled selves’ with our supposedly ‘private’ interiority actually constructed by links to ‘public’ practices, techniques, languages, and artifacts. As we have seen, this notion is further endorsed by Hacking (2006: 23-26; 2004: 279), who asserts that new classifications of human nature create new ways for people to exist; ‘making up people’ also has a ‘looping effect’ as classifying changes people, but the classifications are redrawn by the individuals changed by this labelling. The Soviet neuropsychologist Alexander Luria defined what he termed the ‘extended mind’ in the 1930s, but Western cognitive neuroscience is only now beginning to affirm that the ‘self’ may be an illusion formed from not only the interaction between areas of the individual brain, but also a product of social and biological forces as our brains interact with each other and our wider society. Individual consciousness is not a closed system, and is as much emotional as intellectual (Homskaya 2001: 84-86; Zeman 2002: 291). New research on the role of emotion in social life notes that ‘[a]ffect arises in the midst of in-between-ness: in the capacities to act and be acted upon,’ and studies show that these invisible, visceral forces, that run alongside and underneath conscious knowing, reveal a much more complex social self than that of the unified, autonomous self (Seigworth and Gregg 2010: 1; emphases in original).

‘Traumas “produce their disintegrative effects in proportion to their intensity, duration, and repetition.”’

Thinking about human beings as ‘assembled’ selves, as Rose (1997: 226-227) suggests, or as a bundle of fluctuating perceptions, as Hume (1985: 299-301) argues, makes the notion of dissociation easier to understand. As we saw in previous chapters, there was a great deal of work focused on questions of double

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consciousness, multiple personality, and dissociation during the late nineteenth and early twentieth centuries. William James, the influential American philosopher – and Henry James’ elder brother – who published his *Principles of Psychology* in 1890, undertook a serious study of multiple personality, arguing that a normal individual consisted of a plurality of selves, parallel rational conscious streams that could become deranged, resulting in pathological alters (Ellenberger 1970: 762-763). James went so far as to argue that an appreciation of multiple personalities was the key to building a proper model of the mind (Manning and Manning 2007: 839). Other leading figures, such as Freud, Charcot, Hippolyte Berheim, Ambroise Liébeault, Alfred Binet, and Morton Prince, wrote case studies of multiple personality and fugue states, experimented with automatic writing and hypnosis, and expounded theoretical treatises. James and Prince, especially, conceptualised dissociation as a normative process that only becomes pathological under certain circumstances (Putnam 1989b: 416). However, the first clinician to systematically explore and treat the traumatic memories underlying psychopathological dissociative behaviour was Pierre Janet (Putnam 1989b: 413-414; Ross 1997: 23-24).

Dissociative states were linked with hysteria and hypnosis. As described in a previous chapter, hypnosis was used to both relieve and induce attacks of hysteria, with Charcot asserting that the two states were essentially identical (Crabtree 1993a: 166-167). British, American, and French physicians experimented with hypnotic trance and somnambulism, fascinated by the way their hypnotized subjects switched to an alternative consciousness (Hacking 1995: 153-155). In contrast to Charcot, with his theatrical public demonstrations of hysteria, Janet interviewed his patients in private, building up over five thousand extensive case histories (Putnam 1989b: 414). Whilst working with hysterical patients Janet insisted that in response to trauma the personality of some individuals divides into a number of psychic structures. These entities have their own traits, coexisting simultaneously at a subconscious level but able to take over consciousness during hypnosis, automatic writing, or during a crisis. Janet argued that these dissociated elements could be traced back to past traumatic experiences, a view initially shared by Freud and Breuer but repudiated once Freud introduced the concept of the unconscious (Middleton, Dorahy and Moskowitz 2008: 11; van der Hart and Horst 1989: 409-410). Janet devised the term ‘subconscious’ as a clinical concept (Ellenberger 1970: 800), although Freud condemned the notion, arguing that it is impossible to locate: is it a kind of subterranean second consciousness, or something underlying consciousness? (Thwaites 2007: 45).

To Freud (in Thwaites 2007: 45), the only trustworthy antithesis was between conscious and unconscious, a division that could provide for ‘the existence of psychical acts which lack consciousness,’ although as we saw in a previous chapter, Freud’s topographical model of the unconscious is very much a philosophical and metaphorical construct. To solve the problem of how to describe the workings of the psyche, images were borrowed from all sorts of other cultural ideas; thermodynamics, physics, electromagnetism, fluid mechanics, neuroscience, evolutionary biology, and cellular biology – powerful frameworks that Freud, among others, was aware of plundering. Indeed, it is perhaps impossible for consciousness to explain itself in its own terms: ‘its very object is the subject: what it studies is what is doing the studying, and the gaze is always on its own gazing’ (Thwaites 2007: 48; emphases in original).

Janet rejected Freud’s symbolic dream interpretations and intrapsychic sexual theories as mere metaphysics (Ellenberger 1970: 344). Janet’s model was ‘based on lateral splitting of the psyche, whereas Freud used the now more familiar depth model with vertical division’ (P. Brown, Macmillan, Meares and van der Hart
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Freud regarded one of the main causes of psychopathology to be the repression of painful childhood experiences, and, while still adhering to his seduction theory, believed that this negative ‘psychic energy’ became dammed up. Blocking this energy was exhausting, and if the patient could recall the repressed memory under hypnosis the energy could be discharged by the expression of emotions linked with the repressed incident; this anger, disgust, desperation, or fear provided catharsis or abreaction and then the symptoms would spontaneously vanish (Miltonburg and Singer 1997: 609-610). Although Freud later abandoned the notion of blocked psychic energy as the core of psychopathology, and shifted his focus from actual experiences to fantasies, psychoanalysis continues to stress the therapeutic importance of expressing emotions. It is important to note here, though, that there was ‘a shift from dissociation to repression, from trauma to drive, from hypnosis to free association’ in Freud’s theories, and the concept of hysteria went through a split in meaning when Freud moved from dissociation to repression (O’Neil 2009: 309).

Janet’s position, unlike Freud’s more speculative theories, was based on the precise observation and rigorous documentation of his many patients, and his studies on hysteria, hypnosis, and somnambulism were published in 1889 in his major work, L’automatisme psychologique (Dell 2009: 715). Janet argued that consciousness and identity are not unified, instead noting that an individual can be directed by two or more personalities that can take control at different times (van der Hart and Horst 1989: 402). The more horrific the trauma, the greater the fragmentation of the personality, asserted Janet (in van der Hart and Witzum 2008: 259): ‘[Traumas] “produce their disintegrative effects in proportion to their intensity, duration, and repetition.”’ Janet, like Freud, names some of his patients in his psychological observations, women such as Bertha, Lucy, Celestine, Léonie, Maria, and Justine. However, despite being well known for the respectful way he treated his patients (Ellenberger 1970: 351-352), they play a passive role in the case histories, their dialogues paraphrased and actions described, as when Janet (1901: 23) mentions: ‘Bertha now cries out when we pinch her and feels it quite perfectly.’ Janet extended his research into the neuroses, continuing to assert that traumatic experiences could trigger the creation of second selves and dissociative splits, but unlike Freud, who forcefully rejected degenerative heredity, Janet never entirely rejected degeneration theory, although he substantially modified its arguments toward dispositional and environmental factors, and this provided a plausible biological underpinning for his claims and his further insistence that the clarification of traumatic origins could bring about cathartic cures (Ellenberger 1970: 344 and 369; Makari 2009: 50).

Janet argued that the fragmentation of consciousness seen in hysterics and traumatised individuals was a failed integration of emotions, cognitions, and behaviours, and this malfunction could derive from a constitutional vulnerability, or be caused by exhaustion, illness, or, most likely, the violent emotions intrinsic to traumatic experiences (Dorahy and van der Hart 2006: 32).

Janet considered the ‘hysteric’ personality to be the original personality state, and the ‘normal’ personality the dissociated state. Morton Prince, on the other hand, took the opposite view: the ‘hysteric’ state was the dissociated secondary state, characterised by psychological and somatic symptoms. Prince argued that these secondary personalities could split into multiple fragments, with control of the dominant presenting face alternating, both with each other and with the ‘normal’ personality: a prescient anticipation of current dissociation theory (van der Hart and Dorahy 2009: 11). Prince’s famous case study of multiple personality, published in 1905, reads, as Leys (2000: 41-42) says, like a fairy tale, with the therapist struggling to hypnotically suppress his patient’s many alters, especially the rebellious, flirtatious and attractive ‘Sally’, to enable ‘the real Miss Beauchamp’ to regain control and thus attain the conventional female role of in life, to
marry and ‘live “happily ever afterward”’ (Prince in Leys 2000: 41-42). As Roy Porter (1999b: 35) points out, Prince, unsurprisingly, decided that the ‘real’ Miss Beauchamp was ‘the compliant one.’ As we saw in Freud’s failed treatment of ‘Dora’ (Ida Bauer), to a male therapist, a female patient resisting and rejecting patriarchal explanations for so-called deviant behaviour was always in error, and to Freud, as to Prince and many other therapists, when a patient denies an interpretation, the unconscious is always secretly in agreement: no always means yes (Porter 1999b: 115).

In agreement with Janet, Prince believed that fragmentation of the personality is caused by an external traumatic event that splits the psyche, and Prince’s treatment involved the use of hypnosis to enable the patient to remember and integrate the forgotten trauma, although restoring Miss Beauchamp to normality meant destroying the more dangerous ‘Sally’ in what Prince described as a ritual exorcism (Leys 2000: 74-75). In Prince’s (in Leys 2000: 75) case history, exactly what terrifying event triggered Miss Beauchamp’s “psychical catastrophe” remains unclear, whether adult sexual conflicts, the sudden death of her infant brother, or childhood sexual abuse perpetrated by her father. Prince believed that trauma leaves an ineradicable imprint on the brain that can be remembered and emotionally re-experienced in hypnotic trance, but the issue of confabulation haunts any recollection of traumatic memory when, as in Prince’s therapy, role-playing and dramatic reconstructions are part of the process (Leys 2000: 78). This issue is at the heart of what Ian Hacking (1994: 32) calls ‘memoro-politics’, which, as he describes, consists of ‘a power struggle built around knowledge, or claims to knowledge’ over the truth of recovered memories of childhood sexual abuse; this controversy will be examined near the end of this chapter.

To Janet, as with Prince, the somnambulism, hallucinations, amnesia, and hysterical disturbances enacted by his patients could all be traced to actual traumatic experiences, and cure involved the recapturing of lost memories from a psychological system hidden from the control of consciousness (Ellenberger 1970: 371). Janet’s cure, though, was different to that employed by Freud, whose repression model holds that remembering eliminates hysterical symptoms: in Janet’s dissociation model the memory has to be integrated using a narrative actively constructed by the patient and the therapist, permitting the subject to then deal with the trauma (P. Brown and van der Hart 1998: 1027-1043). Janet’s approach, argues Hacking (1995: 195-197), was more pragmatic than Freud’s, with Janet willing on occasion to erase his patients’ memories if this was more useful than integration. Although it has been intimated, most notably by Hacking (1995; 1998b), that Janet eventually repudiated his confidence in dissociation theory, the evidence for this position is disputed (Dorahy and van der Hart 2006: 29-31; van der Hart 1996: 80-84). The danger is that researchers using the incorrect notion that Janet recanted his belief in multiple personality and dissociative theory are nowadays once again attempting to undermine the existence of dissociative disorders (Dorahy and van der Hart 2006: 31). This point is crucial, as the history of trauma is a history of forgetting: although Janet’s work profoundly influenced his contemporaries, Freud’s ‘metaphysics’ eventually crowded out all competing theories and Janet’s work slipped into oblivion. It was not until the 1980s when research into the origins of post-traumatic stress disorder explored the phenomenon of dissociation that Janet’s writings on trauma and memory were resurrected (van der Kolk, Weisæth and van der Hart 1996: 52-53).
‘Confusion of tongues.’

Just as the terms hysteria and dissociation underwent splits in meaning, the organisation of psychoanalysis was similarly fractured. Janet was not the only clinician whose work fell into disfavour and disrepute. Freud’s relationships with his associates were notoriously conflicted and entangled, despite his publicly avowed tolerance of diverse opinions (Makari 2009: 266). The Vienna Psychoanalytic Society was riven with disputes between Freud and his colleagues, and many eventually left to go their own way (Thwaites 2007: 116). Some, like Alfred Adler and Carl Gustav Jung, went on to form their own influential schools of psychotherapy and psychological theory, but some formerly loyal followers were entirely eclipsed. Sándor Ferenczi, one of Freud’s chosen disciples and for over twenty years one of his closest analytic friends, was coldly dismissed; his work was suppressed and never translated into English, and his reputation destroyed over allegations of mental instability. Why this occurred was unreliably reported until Masson (1998: xiv and 145-188) showed that Ferenczi had diverged from the Freudian gospel, continuing to believe in his patients’ accounts of cruel sexual violence in their childhood, having verified their truth with other family members.

Ferenczi’s (1932: 291-303) beliefs culminated in a paper titled ‘Confusion of Tongues Between Adults and the Child’ that he read before the International Psychoanalytic Congress in 1932. As Masson (1998: 148-149) shows, Freud’s ideas propounded in his seduction theory in 1896 were here reiterated and developed, with Ferenczi speaking for the abused child with compassion and eloquence, explaining that the child’s need for tenderness is all too frequently exploited by the adult’s drive toward sexual gratification, which the child is too helpless to refuse. Ferenczi (1932: 294-295) accused his fellow-analysts of not listening to their patients and the analytic relationship as toxic, ‘with its reserve and coldness, professional hypocrisy and the dislike of the patient it masks’ – a state of affairs that the client intuited and felt inhibited by. How could traumatised patients speak of their past terrors without trust in their analyst? Ferenczi berated the analysts in his audience, expounding how psychoanalysis could have developed if Freud had not rejected his seduction theory (Masson 1998: 150).

In his analytic practice Ferenczi had broken with established techniques, working in what he termed ‘mutual analysis’, communicating with, touching, and even kissing his patients instead of remaining the remote unspeaking figure recommended by Freud. Freud knew of Ferenczi’s experiments, and had warned him that physical contact could become dangerously sexual, a tendency to which Ferenczi had allegedly succumbed much earlier in his career (Masson 1998: 160). Ferenczi, though, argued that his methods were intended as a kind of ‘maternal indulgence’ in a sympathetic and honest environment, designed to relax the patient into a trance state, similar to hypnosis. For Ferenczi, the aim of this treatment was to abreact the trauma so that the patient’s neurotic inclinations could be converted into a conscious memory of the dissociated event, re-experienced in ‘almost hallucinatory intensity’ (Leys 2000: 120-121). Ferenczi’s ‘mutual analysis’ was clearly a risky undertaking and he kept a diary detailing the problems he encountered, but the intimate therapeutic relationship enabled his patients to talk about real events of childhood trauma (Masson 1998: 161). In his paper, ‘Confusion of Tongues,’ Ferenczi states that:

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Above all, my ... assumption, that trauma, specifically sexual trauma, cannot be stressed enough as a pathogenic agent, was confirmed anew. Even children of respected, high-minded puritanical families fall victim to real rape much more frequently than one had dared to suspect. Either the parents themselves seek substitution for their lack of [sexual] satisfaction in this pathological manner, or else trusted persons such as relatives (uncles, aunts, grandparents), tutors, servants, abuse the ignorance and innocence of children. The obvious objection that we are dealing with sexual fantasies of the child himself, that is, with hysterical lies, unfortunately is weakened by the multitude of confessions of this kind, on the part of patients in analysis, to assaults on children .... Actual rape of girls barely beyond infancy, similar sexual acts of grown women with boys, even sexual acts of a homosexual character by force are commonplace (Ferenczi 1932: 296-297).

According to Ferenczi (1932: 300-301), the parent or caregiver, denying the harmful effects of sexual abuse, often projects their wickedness onto the child, becoming violent, and as a defence the child dissociates, becoming depressed or even psychotic. Furthermore, ‘there can be no shock, no fright, without traces of a personality split’ and these fragments can become completely atomised. Another consequence, argues Ferenczi, is the development of sexually precocity (Masson 1998: 148-149). He also points to a concept that did not receive attention in the context of child abuse and domestic violence for another fifty years: ‘identification with the aggressor’ (van der Kolk, Weisaeth and van der Hart 1996: 56). The child is bound to the aggressor in ‘the terrorism of suffering’ experienced through familial interpersonal violence, which is so overwhelming in its power that the child surrenders entirely to the perpetrator’s will. In a traumatic trance, the victim psychically internalises the perpetrator and the assault is no longer seen as an external reality, the child becoming totally identified with the aggressor (Ferenczi 1932: 298-302; emphases in original).

Ferenczi died in 1933, the year after he presented his famous paper, and his death allowed Freud and other psychoanalysts to suppress his theories as well as accuse him of suffering from mental disturbance in his last years. As discussed earlier, Freud’s attempts in 1896 to reveal the truth that the aetiology of psychopathology originated in the widespread sexual abuse of children was met with scepticism and disgust, leading him to swiftly repudiate his seduction theory. When Ferenczi, thirty years later, spoke publicly of the same issue of sexual violence within the family, it was Freud who crushed the idea. The truth of the pervasive nature of child sexual abuse has continually met with hostility. In 1981, Jeffery Masson (1998: 192), after an extensive re-examination of Freud’s letters and archives, published his book The Assault on Truth in which he argued that the seduction theory deserved significant reassessment, and Masson says he ‘met with irrational antagonism and ostracism.’ Masson believes that it is not the evidence that is faulty, but its revelation: ‘this recurring hostility … has its source in an emotionally charged aversion to the truth of the theory itself.’ As Judith Herman (1998: 33) observes, ‘[p]sychological trauma is an affliction of the powerless,’ where the victim is engulfed by fear and helplessness, and the chaotic stories told by survivors torn between secrecy and truth are contradictory, emotional, and fragmented, often undermining their own credibility (Frank 1997: 97-114).

As Janet and Ferenczi showed, traumatised individuals dissociate their memories of overwhelming terror, which are preserved in an abnormal state split apart from ordinary consciousness. This notion of the traumatic fragmentation of the self is often regarded as bizarre, provoking disbelief from others, including psy professionals. To reiterate: the history of trauma is a history of forgetting, but although Ferenczi’s disclosure of the damage wrought by childhood sexual violence was suppressed, his ideas were picked up Abram Kardiner, an American psychoanalyst investigating war neuroses (Leys 2000: 143). As Blizard (2003: 1) says, psy professionals are as likely as child victims to dissociate reports of trauma, rationalising reality into theories of fantasy. Perhaps it is less threatening for clinicians to address the effects of trauma when the
victims are adult men engaged in combat, rather than infants and children raped by their families and caregivers, for it was in the bloodbath of mechanised modern warfare that the study of traumatic neurosis was developed.

‘Shook Over Hell.’52

The American Civil War is arguably the first modern and industrialised war, in which new technology such as ironclad warships, locomotives, rifled muskets, Gatling guns and heavy artiller y was employed. The total death toll was devastating: over 600,000 soldiers died in 1861-1865, at a time when the total population of the United States was thirty-five million souls (Dean 1999: 46-51 and 180).53 It has been argued that cases of psychological trauma in the American Civil War can be deduced from reading anecdotal sources such as soldiers’ letters home, journals, and diaries. Other evidence for combat trauma is more indirect, with some scholars interpreting soldiers’ anomalous or unusual behaviour as dissociation. This approach identifies trauma-related disorders as timeless psychopathologies and regards historical cases as providing legitimacy for present-day psychiatric classifications. John Talbott (1996: 41) asserts that, ‘[t]he human response to stress did not change between the Civil War and the Vietnam War, but understanding and interpreting the response were transformed.’ Talbott notes that in the 1860s there was as yet no recognition that ‘wounds to the mind’ could be inflicted by the terrors of war and the shattering sound of heavy artillery. The military proto-psychiatrists, it must be stressed, served the military elite and the state, not the damaged soldiers, who were often stigmatised as lacking moral fibre (E. Jones and Wessely 2005: xvi-xvii). Peculiar behaviour in soldiers led either to a court martial and execution for cowardice, or resulted in committal to an asylum for the insane; the psychosomatic effects of the horrors of combat did not achieve a reluctant recognition until the First World War (Lerner and Micale 2001: 11; Talbott 1996).

No over-arching classification system for the diagnosis of mental disorders existed in the mid-nineteenth century. As Eric Dean (1999: 92-93) shows, the diaries and letters of Civil War soldiers reveal a bitter alienation from those who did not understand the combatants’ suffering as they were torn from loved ones and plunged into the horrors and hardships of war. There is ample evidence that many soldiers felt emotionally overwhelmed, depressed and anxious due to their terrifying battlefield experiences, and they employed a colourful nomenclature to describe their physical and mental states, such as ‘the blues’; ‘rattled’, meaning mental exhaustion brought on by combat; and ‘badly blown’, generally referring to fatigue caused by disease or physical exertion. Other phrases included downhearted, disheartened, lonesome, demoralised, played out, melancholy, worn out and nervous. More official diagnostic categories such as ‘sunstroke’, ‘irritable heart’, ‘soldier’s heart’, ‘nostalgia’ and ‘insanity’ were employed when it was necessary to determine whether a man should be excused from military service (Dean 1999: 115-116).

‘Soldier’s heart’, sometimes called ‘irritable heart’ or ‘trotting heart’, was believed to be a severe cardiac disease that mysteriously betrayed no physical pathology. This disorder, which exhibited symptoms of dizziness, vertigo, insomnia, and heart palpitations, was actually an indication of severe anxiety and stress. Hyperventilation often occurred when soldiers were fearful and anxious, and this was a factor in many cases of soldier’s heart (Dean 1999: 130-131). ‘Disordered action of the heart’ was also observed in British troops


53 Around 1.71% of the American population died in the Civil War. In comparison, over a period of ten years in the Vietnam War 58,000 American soldiers died at a time when the total population of the United States was over 200 million people.
fighting in the Crimean War (1854-1856), along with dizziness, headache, diarrhoea, limb pain and sweating. Although it is difficult to know whether soldiers were suffering from a combat-related disorder or some variety of depression, it is clear that during the Victorian period, in both the Crimean and American Civil Wars, the stress of combat was conveyed by means of bodily symptoms, with neither patients nor doctors ready to think in a vocabulary of psychological terms (E. Jones and Wessely 2005: 4-5).

Combat trauma in the American Civil War was therefore labelled as many different diagnostic entities by various subjective medical opinions, these entities being the somatic symptoms of what in later years would be interpreted as pathological psychological states induced by terror and shock. This is not to argue that the late-twentieth century classification of post-traumatic stress disorder (PTSD) was present, and this notion is problematic to apply retroactively to a different temporal and cultural milieu; indeed, Allan Young (1995) argues that PTSD is culturally conditioned, based on modern concepts of memory such as the unconscious mind that did not exist in earlier societies.

‘There are strange hells within the minds war made.’

The large-scale psychological breakdown of soldiers in battle was evident in the First World War when early military psychiatry engaged with shell-shocked men. This phenomenon was investigated in the previous chapter from the perspective of military psychiatry, that is, from ‘above’, but there are many writings from ‘below’, from the soldiers who suffered from the terrible effects of war trauma, and from front-line surgeons who struggled to repair their damaged bodies and minds. As Peter Barham (2004: 153-154) notes, to genuinely help shell-shocked men the traditional standards of objective reality adhered to by clinicians, judging whether a man was near an exploding shell or poison gas, shot, buried, or otherwise physically harmed, needed to be set aside: ‘the reality that counted here was the subjectivity of the suffering individual, which was not bound by the topography of the external world or by the divide between war and peacetime lives.’

As some doctors recognised, one did not need to be a coward or ‘inferior’ to suffer shell-shock: stressful environments and violent events could cause psychoneurosis in most individuals, whether in civilian or military contexts. This new emotional landscape could not merely be reduced to dreams and intrapsychic conflict: ‘[m]emories and emotions intruded into the organization of space and time, with the result that it was radically disrupted’ (Barham 2004: 153-154). Millais Culpin, a surgeon treating the broken soldiers of Passchendael and the Somme, soon became aware that bodily complaints such as a twisted torso, face, or hands, inability to walk, mutism, and apparent deformities of the foot, were mostly psychically driven rather than the result of a diseased body. Moreover, the sufferer was unaware of the mental processes that created these abnormalities, and powerless to stop them unless assisted in becoming actively involved in his own cure by a compassionate therapist (Barham 2004: 155-157). Culpin believed that arguments over shell-shock essentially repeated earlier arguments over the cause of railway spine; when Page had asserted that damage was caused by fright alone, not bodily injury, this explanation had been acrimoniously disputed (Barham 2004: 158; Harrington 1994: 18-19).

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There was a revival of interest in the Great War during the 1970s, and although the experiences of shell-shocked combatants were mostly unrecoverable or buried in military archives, the writings of war poets like Wilfred Owen, Isaac Rosenberg, and Siegfried Sassoon were widely read (Fussell 2000: 340). The kind of patriotic verse popular prior to the First World War had faded, and a darker, more complex view prevailed, with the discontent and malaise of the post-war world coloured by literary descriptions of trauma (Leese 2002: 166-167). Sassoon (in Babington 1997: epigraph), incarcerated in Craiglockhart Military Hospital, had written this poem, entitled 'Survivors,' during his stay in 1917:

No doubt they'll soon get well; the shock and strain
Have caused their stammering, disconnected talk.
Of course they're 'longing to go out again,' –
These boys with old, scared faces, learning to walk.
They'll soon forget their haunted nights; their cowed
Subjection to the ghosts of friends who died, –
Their dreams that drip with murder; and they'll be proud
Of glorious war that shatter'd all their pride …
Men who went out to battle, grim and glad;
Children, with eyes that hate you, broken and mad.

Sassoon, although not officially diagnosed with a war neurosis, was tormented by nightmares, and observed his stricken fellow officers as they continually recollected the horrors of the Western Front (Babington 1997: 108-112), in “that underworld of dreams haunted by submerged memories of warfare and its intolerable shocks” (Sassoon in Talbott 1997: 448). He befriended Wilfred Owen, who returned to the front and was killed, machine-gunned during the last days of the war (Fussell 2000: 290-291). Wilfred Owen (1994: 118-119) describes the hellish torments of shell-shocked soldiers in his poem 'Mental Cases':

These are men whose minds the Dead have ravished.
Memory fingers in their hair of murders,
Multitudinous murders they once witnessed.
Wading sloughs of flesh these helpless wander,
Treading blood from lungs that had loved laughter.
Always they must see these things and hear them,
Batter of guns and shatter of flying muscles,
Carnage incomparable, and human squander
Rucked too thick for these men's extrication.

Therefore still their eyeballs shrink tormented
Back into their brains, because on their sense
Sunlight seems a blood-smear; night comes blood-black;
Dawn breaks open like a wound that bleeds afresh.

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55 Sassoon was hospitalized after the intervention of politically influential friends: the British military authorities wanted to court-martial him due to his pacifist denunciations that the Great War was being deliberately prolonged as a war of aggression and conquest, and labelling him as shell-shocked stigmatised him and made his protests ineffective.
As Wilfred Owen shows, many combat survivors are troubled by their memories of violence and atrocity. Sassoon recovered and led a long and productive life, never forgetting those less fortunate than himself:

Shell shock. How many a brief bombardment had its long-delayed after-effect in the minds of these survivors, many of whom had looked at their companions and laughed while inferno did its best to destroy them. Not then was their evil hour; but now, now, in the sweating suffocation of nightmare, in paralysis of limbs, in the stammering of dislocated speech. Worst of all, in the disintegration of those qualities through which they had been so gallant and selfless and uncomplaining – this, in the finer types of men, was the unspeakable tragedy of shell-shock … In the name of civilization these soldiers had been martyred, and it remained for civilization to prove that their martyrdom wasn't a dirty swindle (Sassoon in Herman 1998: 23).

Although the poetry of some of the officer class entered the literary canon, Judith Herman (1998: 23) observes that this was a cultural rather than a medical awareness; indeed psychiatric attention to psychological trauma diminished only a few years after the First World War ended. However, in Britain, by 1937 there were around 35,000 ex-servicemen with mental disabilities still collecting war disability pensions, with as many as thirty percent of these men labelled psychotic. Most of these men were working-class, ordinary soldiers whose histories were silenced, a forgotten population Peter Barham (2004: 4-7) describes as 'a cultural mass grave … [with] no signs of commemoration.'

Sassoon and Owen both spent time in Craiglockhart Military Hospital, under the care of W. H. R. Rivers. As described in my previous chapter, Rivers used psychotherapeutic techniques such as dream analysis and abreaction (Leese 2002: 82-83; Shephard 2003: 105-106), but, wrote Sassoon, these sunny daylight discussions in a comfortable room could not banish the demons altogether:

[B]y night each man was back in his doomed sector of a horror-stricken Front Line, where the panic and stampede of some ghastly experience was reenacted among the livid faces of the dead. No doctor could save him then, when he became the lonely victim of his dream disasters and delusions (Sassoon in A. Young 1995: 43).

Rivers had studied with Kraepelin and also knew Freud's work, which he disagreed with over the centrality of sexuality in psychic life. Rivers argued that traumatic disorders are only understandable by taking the human instinct for self-preservation into account, and by weighing up the psychic conflicts that arise in the horrors of warfare between the fear of death and the sense of camaraderie with other soldiers (Talbott 1997: 446). After the war, Freud (1920: 50-51) modified his own beliefs, admitting that sudden traumatic shock could damage the psyche, speculating that the repetitive frightening dreams suffered by shell-shocked combatants was evidence for a 'death drive': sexuality and aggression became part of Freud's new dual-drive theory (Mitchell and Black 1995: 18-19).

Soldiers in the trenches of the Great War endured some of the most intense conditions of warfare ever known, particularly the constant bombardment from heavy artillery explosives. The acute shell-shock suffered by combatants was eventually classified into three forms of combat neurosis: hysteria, which included somatic symptoms such as an inability to feel pain, deafness, blindness, mutism, paralyses, and muscle contraction; neurasthenia, which consisted of depression, compulsions, obsessions, and anxiety; and transient psychosis, with unstable and wide-ranging psychotic and affective symptoms, similar to bipolar disorder. Combatants also suffered alterations of consciousness, often accompanied by post-traumatic amnesia, although memories could often be recovered (van der Hart, Brown and Graafland 1999: 38). In attempting to manage the war neuroses during the Great War, sympathetic clinicians turned to hypnosis,
especially the method of hypnotic catharsis used by Breuer, Freud, Janet and Prince. Freud as stated, had abandoned this technique in favour of free association, but his famous expression, 'hysterics suffer ... mainly from reminiscences,' (Breuer and Freud 1893: 11) that is, repressed traumatic memories, became the foundation for a new form of hypnotic therapy aiming to bring back the victim’s memory through the trancelike repetition and abreaction of the original devastating event (Leys 2000: 84-85).

By the 1920s, there were two sides to the debate on how memory could be recovered: one held that the emotional intensity of the re-lived event was crucial to the efficacy of the treatment, the other that although affective recall was important, any cure depended on the way the mind consciously reintegrated the repressed traumatic memory (Leys 2000: 85-86). This disagreement, argues Ruth Leys (2000: 86-87), underlines professional and public unease over trance states and the suggestibility of hypnotised individuals, and furthermore deserves consideration over the patient’s role: a hypnotised subject can be passively under the sway of an authoritative hypnotist, whereas a subject engaged in a more cognitive approach is more actively collaborative with the therapist. However, all forms of psychotherapy are based on power that can control and manipulate, with the therapist in the superior position in the ritual of therapeutic hierarchy and the patient inferior. As Dorothy Rowe (1997: 13; emphasis in original) points out, a psychiatric clinician’s ‘truths have a higher truth value than the patient’s truths. The psychotherapist interprets the patient’s truths and tells him what they really mean.’ The debates over suggestibility and the reliability of traumatic memory re-emerged in the 1970s and 1980s, and will be addressed further below.

However, despite the tinkering with hypnotic therapy during the Great War, between the First and Second World Wars the understanding of psychic trauma remained dominated by psychoanalysis and its theories of unconscious intrapsychic conflicts, and psychiatric disorder was unlikely to be ascribed to real events that had detrimental effects on sufferers. In Britain, some young psychologists like Donald Winnicott (1984; 1964), who later became one of the leading figures in developmental psychiatry, did retain the insight that ordinary people are vulnerable and emotional beings that can be affected by intolerable events, and in the United States Abram Kardiner applied Ferenczi’s ideas on dissociation, Freud’s theory of repetition compulsion, and Rivers’ work with shell-shocked soldiers to his own theories on the traumatic neuroses of war (Leys 2000: 138-152; van der Kolk, Weisaeth and van der Hart 1996: 56-58).

‘How easy it is to make a ghost.’

Abram Kardiner is now recognised as one of the great pioneers in the field of psychological trauma, his work routinely cited as a milestone in the development of the nosology of post-traumatic stress disorder. Like Janet and Ferenczi, he meticulously documented the unusual and complex symptoms displayed by his patients (van der Kolk, Weisaeth and van der Hart 1996: 57; A. Young 1995: 89). Kardiner, who had survived a childhood of neglect, poverty, domestic violence, and his mother’s early death, profoundly empathised with trauma victims (Herman 1998: 23-24). After the end of the First World War psychiatric interest in the traumatic neuroses had waned, and Kardiner’s monograph, The Traumatic Neuroses of War, was published in 1941, just before the United States entered the Second World War (A. Young 1995: 90). Like Rivers, Kardiner (1941: 193-205) considered Freud’s emphasis on childhood sexual fantasy to be irrelevant to the understanding of combat trauma, which he defined as a ‘physioneurosis’ making it clear that

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he regarded traumatic neurosis as more than an intrapsychic disorder. Kardiner's assertion that the reaction to traumatic stress needs to be understood as a 'psychobiological phenomenon' echoes the late-nineteenth century opinions of Janet, 'looping back,' as psychiatric thought so often does, to an earlier point of view (Herman 1998: 24; Talbott 1997: 449). As Allan Young (1995: 89) describes, Kardiner began with Freud's contention that sudden traumatic events breach the barrier (the 'stimulus shield') that protects the human brain against external stimuli. Freud regarded the symptomatic reaction – paralyses, mutism, obsessions, amnesia, depression, psychotic episodes, and so on – that follows this fright as defensive, a way of preserving the ego. Kardiner, however, believed that the symptoms were adaptive, as an individual attempts to control or eliminate the distressing alterations in their external and internal environments caused by the trauma (van der Kolk, Weisæth and van der Hart 1996: 57-58).

Attempting to explain the recurrent nightmares that are part of the symptom profile of the traumatic neuroses, Freud had emphasised the significance of the repetition compulsion as a defensive manoeuvre by the ego to retain control, but Kardiner claimed instead that the traumatic experience actually substantially altered the ego, shattering its unity and forcing it to continually struggle for mastery over its environment. Nightmares were where the sufferer inevitably encounters his or her indelible traumatic experience (A. Young 1995: 90). Kardiner describes many of his patients' dreams (most commonly of their own death), nightmares still repeated many years after the battlefield trauma. The dream images remain the same, crystallised “like the picture of a normal piece of action slowed down by the motion-picture camera” (Kardiner in A. Young 1995: 91; emphases in original; van der Kolk 1996c: 279-302; van der Kolk and McFarlane 1996: 9-10). I will return to Kardiner's striking cinematic metaphor later, as it has become one of the most vivid illustrations of the terrible power of traumatic memory.

It is often asserted that military psychiatry performed a significant role in the Second World War, both in reducing the number of psychological casualties and in caring efficiently for those that did occur. While it is indisputable that between 1939 and 1945 there were many more psychiatrists in the armed forces than in the First World War, that these clinicians were trained in psychoanalysis and social psychology, and that they were widely deployed, their treatment methods may not, however, have been as effective as maintained (E. Jones and Wessely 2005: 67-68; Shephard 2003: 205-227). By 1940, after the catastrophe of Dunkirk, the British army was faced with a crisis as large numbers of troops with functional somatic and psychological disorders were hospitalised (E. Jones and Wessely 2005: 70). Early treatment was mostly analytic and abreactive, and recovery was poor. Experimental treatments using sodium amytal, a barbiturate sometimes termed a 'truth serum' for its ability to circumvent inhibitions in psychiatric patients, seemed to proclaim a new era in shell-shock treatment and it was enthusiastically taken up by some clinicians, who claimed that its use would avoid extended treatments and reduce the vast expense of war pensions. Much of this kind of treatment was narrowly physiological and behavioural with little attention given to the mind or to psychotherapy, and many psychiatrists disputed the efficacy of the new drugs (Shephard 2003: 207-210).

Debates within military psychiatry continued, as the profession struggled to prove its worth to a high command that not only still refused to accept the inevitability of psychological trauma in war, but also the utility of psychiatric units as a way of returning soldiers to battle. The lessons of the First World War had been largely forgotten (van der Kolk, Weisæth and van der Hart 1996: 58). At the end of 1942, the Allied invasion of North Africa severely tested the ability of front-line psychiatric treatment to manage the torrent of
British and American casualties that flooded in from the battlefield (Shephard 2003: 211). Some of these men were treated by American psychiatrists Roy Grinker and John Spiegel, who were actively trying to apply Kardiner’s work on the traumatic neuroses in the field of combat, and these clinicians were able to confirm many of Kardiner’s observations. Grinker and Spiegel found that the best protection against psychological collapse in the field was strong morale and emotional attachments between soldiers in small fighting units (Herman 1998: 25). Trying to cure men who nevertheless had broken down, they rediscovered Janet’s techniques, using hypnosis as well as ‘narcosynthesis’ to induce altered states of consciousness, enabling the recovery and abreaction of forgotten memories of trauma (van der Kolk, Weisæth and van der Hart 1996: 59). Grinker and Spiegel wrote a widely-read handbook on their therapeutic methods, which involved a highly theatrical form of psychotherapy as well as the administration of sodium amytal, but its front-line use was a total failure. An unexpected side-effect of their techniques was that the emotions released in traumatised soldiers interacting with sympathetic therapists totally broke down military discipline, meaning that few men treated with their methods were capable of returning to battle (Shephard 2003: 214-215).

Grinker and Spiegel warned that simple catharsis may get soldiers back to the front lines faster, but would not help the men recover. The military high command paid little attention, however, to the human cost of war, with as many as 80% of traumatised American soldiers returned to active duty after only a week of minimal treatment (Herman 1998: 25-26). Grinker and Spiegel (in van der Kolk, Weisæth and van der Hart 1996: 59) advised that traumatic memories leave permanent psychic traces, ‘not like the writing on a slate that can be erased, leaving the slate like it was before. Combat leaves a lasting impression on men’s minds, changing them as radically as any crucial experience through which they live.

Once the war was over official interest in war neuroses swiftly diminished. The Veterans Administration published a follow-up study of traumatised soldiers in 1955, but there was, says Allan Young (1995: 92-93), no attempt to match symptoms with diagnostic categories, and with no way to compare the study with Grinker and Spiegel’s earlier descriptions, the result was chaotic. This confusion of symptoms and categories astonished Kardiner (in A. Young 1995: 93), who in 1959 wrote ‘it is hard to find a province of psychiatry in which there is less discipline than in this one. There is practically no continuity to be found anywhere, and the literature can only be characterized as anarchic.’ The permanent effects of combat trauma were once again mostly forgotten by psychiatry and the military, and it was not until soldiers themselves agitated for research into the psychological effects of warfare after the Vietnam War that organised, large-scale investigations were set in motion (Herman 1998: 26).

‘Was it possible that they were there and not haunted? No, not possible, not a chance, I know I wasn’t the only one.’

As many have pointed out, the Vietnam War played a crucial role in changing ideas about combat and psychological trauma. A political campaign by Vietnam veterans, needing treatment and other benefits to help with their psychiatric disabilities, was successful in introducing a new diagnosis of post-traumatic stress disorder (PTSD) into DSM-III in 1980. The nineteenth century studies of traumatic memory and the concomitant fascination with repression, dissociation, and the notion that what human beings forget moulds

58 A description of this struggle is beyond the scope of this thesis, but see Herman 1998; Jones and Wessely 2005: 163-165; Kutchins and Kirk 1997: 100-125.
our personality, our character, our modern soul (Hacking 1995: 209), is best known nowadays in connection to PTSD. The diagnosis, as Allan Young (1995) shows in his analysis of the disorder, is another manifestation of ‘making up people’ (Hacking 2006). The diagnostic constructs of PTSD and traumatic memory have been *made* real to describe the real occurrences that effect clinicians, researchers, and sufferers, and are ‘glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources’ (A. Young 1995: 5-6). According to Hacking (2004: 279), new classifications create new ways for people to exist, and the people who are altered by being so classified also change in ways that cause systems of classification to be modified in turn. As we have previously seen, Hacking terms this the ‘looping effect’ of classifying human beings: ‘Classifying changes people, but the changed people cause classifications themselves to be redrawn.’

It is still frequently asserted that post-traumatic stress disorder is a timeless diagnosis, with the long human history of warfare and violence cited as evidence of similar suffering throughout the ages (Andreason 2010: 67-71). There is certainly no doubt that people have always been tormented by memories of frightening and horrible events and haunted by loss, remorse, and sadness. However, Allan Young (1995: 3) demonstrates that the kind of traumatic memory described in the diagnosis of PTSD is a new kind of memory, linked to modern constructs of dissociation and repression that were unthought of in earlier eras. Hacking (1995: 6) makes a similar argument in his deconstruction of multiple personality disorder and the nineteenth century sciences of memory, and he goes on to state that the relationship ‘between people who are known about, the knowledge about them, and the knowers’ is dynamic: ‘[n]ew meanings change the past … it is reorganized … filled with new actions, new intentions, new events that caused us to be as we are … not only making up people but making up ourselves by reworking our memories.’

To argue that the categories of PTSD and traumatic memory are composed through types of scientific reasoning, practices, technologies, and historically specific ways of seeing is not to deny the very real suffering, pain, and loss endured by people diagnosed with PTSD. Allan Young (1995: 10) clarifies: ‘suffering is real; PTSD is real’ but the facts of the diagnostic construction are not timeless, but are, rather, embedded in the technological, cognitive, and social conditions whereby clinicians and researchers establish meaning and truth. Indeed, far from being timeless, Young (1995: 7) goes on to argue that PTSD ‘is a disease of time’: that the disorder’s intrusive images, thoughts, and compulsions allow the past to relive itself in the present. This is, indeed, the disorder’s classificatory space in the DSM: traumatic ætiological event ➔ symptom. However, time can also run in the opposite direction, from present to past, with the trauma survivor fixing retrospectively upon his or her ‘ætiological memory / event’. When PTSD has a delayed onset, the symptoms can emerge before the traumatic event is remembered: ætiological event ⇐ symptom.

Traumatic memory, argues Michael Hampe (2007: 91-93), is involuntary: the person cannot deliberately forget — flashbacks, dreams, and associations with present-day perceptions that lead back to the original event, are all uncontrollable. When memory cannot be integrated, time suffers a miss-step: past, present and future lose their linearity. Trying to explain the latency of some cases of PTSD, Hampe (2007: 93; emphases in original) says that when something happens to a person, this needs to be assimilated into the person’s life history: '[f]orgetting and remembering seem to be in part dependent upon the extent to which
events that are newly encountered can be superimposed upon the background of old experiences and their organizational patterns.’ Newly-encountered traumatic experiences make psychic impressions that are too massive to be transformed into memory, as Hampe (2007: 94) explains: ‘some very deep impressions require enormous reconstruction of the narrative of a life history, and will not be integrated until this is possible.’ This suggests that the traumatic event leads to a rupture in a person’s biography – their ‘historical reality’ as a person – which, if accepted, would result in the person becoming someone other (Holzhey-Kunz in Hampe 2007: 91-92). However it is understood – and I will return to this issue at the end of this chapter – coherent personal identity is challenged by suffering violent and terrifying experiences. Indeed, says Hampe (2007: 95; emphases in original): ‘Traumatic memory can be understood as a calling-into-question of the unity of the person that is constituted by a connection between memories.’

Violence is a reality of human life, but is mostly considered as an undesirable form of human behaviour, its eruption an unfortunate event that people will try to avoid. Military training, of course, inverts this belief, teaching men to kill, indeed to regard killing as pleasurable (Bourke 2000b: 23). Even so (and as we have already seen), many combatants, even when trained to kill, find that the murderous demands placed on them by the military are insupportable. A violent event is a real occurrence, turning ‘anybody who is subjected to it into a thing’ (Weil 1983: 3; emphasis in original). Psychiatry (as we have also, repeatedly, seen) finds reality problematic: PTSD is the only diagnosis in the current edition of the DSM to recognise that an environmental or social cause can trigger a mental disorder (Read and Sanders 2010: 84). As such, it represents a shift in the clinical conceptualization of traumatic syndromes (Kudler 2000: 2), as well as an acknowledgement from psychiatric power, after years of obsessive focus on intrapsychic conflict and brain disease: that ‘bad things happen and can drive you crazy’ (Read and Haslam 2004: 133). It is, so far, the only breach in the currently dominant biogenetic model of psychiatry, but, as this chapter will repeatedly note, this crack is besieged by all manner of dissenters attempting to widen this fissure.

Many argue that post-combat disorders, whether labelled as ‘disordered action of the heart’, shell-shock, PTSD, or Gulf War Syndrome, would be better classified as ‘medically unexplained syndromes’ (Barsky and Borus 1999: 910-921; Bass, Peveler and House 2001: 11-14; E. Jones and Wessely 2005: 191). All are characterised by a range of functional somatic symptoms, such as fatigue, headaches, sleep problems, joint pain, muscle aches; difficulties with memory, concentration, and attention; gastrointestinal symptoms; depression, anxiety, palpitations, irritability, dizziness, breathlessness, dry mouth, and sore throat (Barsky 1988: 414-418; Barsky and Borus 1999: 910). Although there are claims for a simple biomedical cause there has been no such discovery, argue Edgar Jones and Simon Wessely (2005: 191), and psychiatric classifications have difficulty in interpreting the symptoms. PTSD is now the major disease entity binding together these syndromes, which as transculturally applied has been extensively criticised as a sociopolitical and medical response to the specific problems of a particular group at a precise point in time (Mezey and Robbins 2001: 561-563; A. Young 1995). The globalisation of Western cultural trends has meant that psychological therapies and the concomitant medicalisation of distress have reached into developing nations racked by violent conflict and natural disasters. Derek Summerfield (1999: 1449) argues that Western knowledge is privileged, with its ‘experts’ given the power to define problems from afar, but ‘[f]or most survivors, post-traumatic stress is a pseudocondition, a reframing of the understandable suffering of war as a technical problem to which short-term technical solutions like counselling are applicable.’ Notwithstanding these criticisms, the recognition of PTSD as a valid construct breached psychiatry’s focus on the inner world,
as the key issue in trauma is the impact of outside reality onto the psyche, albeit through the subjective assessment of helplessness and threat by victims themselves (van der Kolk and McFarlane 1996: 6).

Throughout the duration of the Vietnam War, 1961-1975, there was a spectacularly low rate of diagnosed psychiatric casualties, reportedly ten times lower than the Second World War. Military psychiatrists claimed that their tactics and treatments, based on traditional methods of ‘proximity, immediacy, and expectancy’ – the so-called PIE system of frontline treatment – and forward psychiatry, were a resounding success (E. Jones and Wessely 2005: 128). However, this view altered dramatically once the veterans came home. Opinions over the reasons for this transformation remain divided, and range from arguments over the effects of defeat, as the war was lost, the deleterious effects on morale of the one-year rotation policy (E. Jones and Wessely 2005: 129-130), and the way the home community rejected returning veterans as a result of antiwar sentiment (Herman 1998: 70). A further factor is the way psychological breakdown was classified by the prevailing psychodynamic point of view. In the Vietnam War, the required tour of duty for a combatant in the United States armed forces was one year, a requisite based on statistical data collected during the Second World War. This information suggested that after twelve months of combat, psychological breakdowns in soldiers rapidly increased, and this official evaluation meant that soldiers who broke down were commonly regarded as malingering or suffering from an already existing personality disorder: combat neurosis and shell-shock did not exist in the diagnostic manuals used at the time (Shay 2003: 203-204), which were not yet standardised in the now-familiar DSM psychiatric nosology (A. Young 1995: 94). Michael Herr, who spent a year following enlisted men – ‘grunts’ – around various theatres of the war, including some of the worst battle sites, published one of the first accounts of soldiers’ experiences in Vietnam at a time when most veterans were silent on their wartime suffering. Herr describes the official stance on psychological trauma:

In this war they called it ‘acute environmental reaction’, but Vietnam has spawned a jargon of such delicate locutions that it’s often impossible to know even remotely the thing being described. Most Americans would rather be told that their son is undergoing acute environmental reaction than to hear that he is suffering from shell shock, because they could no more cope with the fact of shell shock than they could with the reality of what had happened to this boy during his five months in Khe Sanh (Herr 1979: 78).

DSM-I, published in 1952, had included a disorder named ‘gross stress reaction’ that was described as a temporary state caused by acute environmental stress, but when DSM-II was published in 1968 gross stress reaction was dropped from the manual. Traumatised Vietnam veterans, therefore, were assessed using a diagnostic system that had no official diagnosis for categorising their mental disturbances, and their problems were subsumed under the psychoanalytically influenced term ‘adjustment reaction to adult life (W. Scott 2003: 32-34).’

Some mental health professionals disagreed with the diagnostic re-shuffling, finding the old listing of gross stress reaction both useful and diagnostically valid. John Talbott (in W. Scott 2003: 34), a psychiatrist who served in Vietnam, describes a veteran with severe trauma, including sleep disturbances, startle reaction, and flashbacks, but the man had nevertheless been denied benefits because he did not have a combat-related disorder according to the DSM-II classificatory scheme. There were many such cases; with American psychiatrists trying to evaluate traumatised veterans using an official taxonomy that avowed no such thing as war neurosis existed (W. Scott 2003: 34-35). This bizarre situation was successfully challenged, after turmoil within the American Psychiatric Association, when, as we saw in the previous chapter, the publication of DSM-III in 1980 heralded a paradigm shift in psychiatric thought. As pointed out
earlier, not only are the various editions and revisions of the DSM a system for processing insurance claims and record-keeping, they are also ‘an official map of mental illness and disorder in society’ (W. Scott 2003: 27). Psychoanalysis was junked in favour of a return to Kraepelin’s biological model of mental disorder, and PTSD, now deemed a valid and reliable diagnosis and therefore a social reality, entered the canon.

Combat veterans, not only of Vietnam but also from more recent theatres of war like Iraq and Afghanistan, have described the effects of war and combat on their sanity, and emphasise that trauma narratives uncover a bewildering and messy reality. Post-traumatic stress disorder needs to be understood in a different way to other disabilities where there is a clear impairment, as ‘the site of injury for PTSD is experience itself’ (Paulson and Krippner 2007: xvi-xvii). A veteran’s subjective memory of an event, a traumatic fragment that intrudes into the psyche like shrapnel, may differ markedly from the official version of the same event witnessed by others or captured by camera or film. The experience of an agreed reality is ruptured, with the sufferer’s inner world and the social milieu surrounding him or her profoundly out of step, making interaction difficult, and truth claims impossible (Paulson and Krippner 2007: xviii-xix). Killing a man is not the only way to make him into a ghost: these veterans were transformed from fighting men into ghostly figures by their victimhood, becoming marginalised by their suffering (Gordon 2007: 6-7). Trauma survivors’ accounts of their own experiences are subjugated knowledges: even after its inclusion in DSM-III and subsequent editions, the legitimacy of the classification of PTSD is still questioned, not merely from critics on the fringes of professional respectability in the psychiatric world, but by influential sceptics publishing articles in leading medical journals (Brewin 2003: 2). Passionate and sometimes vicious debates have raged at both public and professional level over traumatic memory, its difference from ordinary memory, and whether it is true, false, or – echoing earlier accusations of mesmerism and hypnotism – maliciously implanted by therapists (Brewin 2003: 2-3 and 128-151; Masson 1998: 319-327; Mollon 2000). I will return to the ‘memory wars’ later, when I address the fraught topic of child sexual abuse. However, as Arthur Frank (1997: 97-114) points out, reality-threatening ‘chaos stories’ telling of horror and suffering, spilling from a traumatic past into the present, and told in a non-linear, fragmented manner, are difficult for listeners to believe.

Post-traumatic stress disorder is a disease of time whereby the past keeps jolting into the present (A. Young 1995: 7) in a baffling ‘loss of synchronicity with the immediate world’ (Paulson and Krippner 2007: xvii). Legions of Vietnam combatants returned to civilian life shattered by their war experiences, indeed Herr (1979: 53; emphases in original) says everyone told him that ‘going crazy’ was standard behaviour on a tour of duty, so much so that nobody noticed, and all you could hope was that no-one crossed the line into ‘the kind of crazy that made men empty clips into strangers or fix grenades on latrine doors. That was really crazy.’ Like the marines and soldiers, Herr (1979: 61) had horrifyingly realistic dreams that troubled him for years after he left Vietnam: ‘[o]ne night, like a piece of shrapnel that takes years to work its way out, I dreamed and saw a field that was crowded with dead.’ This multitude of corpses haunted him back in the United States, where in a recurring nightmare the ‘living room was full of dead Marines …. it wasn’t just some holding dread left by the dream, I knew they were there, so that after I’d turned on the light by my bed and smoked a cigarette I lay there for a moment thinking that I’d have to go out soon and cover them’ (Herr 1979: 195-196).
‘History ... is a nightmare from which I am trying to awake.’  

That traumatic experience is continually repeated in terrifying nightmares is not a recent observation. Dreaming is a universal human experience, but the perceived significance of dreams and the conceptual framework by which they are interpreted changes over time. Dreams can be interpreted as prophetic, as the ‘royal road’ to the unconscious, as wish-fulfillment, as a way of removing ‘neural garbage’ from the brain, or as rehearsals for learning behaviours and motor skills, and it is clear that neurological disorders can also alter dreaming (Sacks 1996: 212-216). *The Interpretation of Dreams* was the central book of Freud’s career, and although he took dreams seriously, Freud regarded their content as symbolic representations of mental conflict: the unconscious purpose of dreams is the fulfillment of wishes (R. Robertson 1999: vii-xxxvii). Despite this assertion, Freud did recognise that memories of real trauma could emerge in dreams, and later in his career, in the case of war neuroses, he stated that repetitive combat nightmares could be understood as re-enactments of experiences of terror and fear (Barrett 1996: 2). It is now known that dreams featuring the traumatic event are experienced for days or weeks by nearly all traumatised individuals, however some go on to suffer from these nightmares repetitively for many years (Hartmann 1996: 100-101).

Post-traumatic nightmares are now one of the diagnostic criteria of PTSD, with some suggesting that disturbed dreaming is the core symptom (Ross, Ball, Sullivan and Carroff 1989: 697-707), and these nightmares are very different from ordinary dreams. They are probably best understood as ‘a memory intrusion into dreams as well as into waking life’ (Hartmann 1996: 100). Research on former soldiers has found that veterans with no actual combat experience commonly have life-long nightmares, similar to the kind of bad dreams where one is chased by monsters, threatened, or wounded, indeed the same kind of ordinary nightmares that many non-traumatised children and adults also endure. Individuals with severe combat experience, however, sometimes have a different kind of nightmare: the traumatic event is eternally repeated as though burned into the memory, with one significant difference in that the dreamer often sees himself in the scene. This seems to arise as a form of ‘survivor guilt’, as the most traumatic event of all is one where the soldier’s close friend is killed right by him (Hartmann 1996: 101-102). Soldiers who experience traumatic events in combat but do not go on to develop PTSD tend to be over twenty-one, and have no close friends. Soldiers who do develop PTSD are typically very young, around seventeen, have very close attachments to other men in their fighting unit, and they often attempt to wall off their memories without trying to integrate them, thus perhaps causing these encapsulated events to suddenly erupt during sleeping or dissociative waking states, when they are called flashbacks (Hartmann 1996: 110-111; van der Kolk, Blitz, Burr, Sherry and Hartmann 1984: 187-190).

The ways people describe their recollections of traumatic events have changed over time, revealing the weight of culture in shaping the nature of memory and experience (E. Jones and Wessely 2005: 174). Kardiner’s description of dreams as pictured by a movie camera led into the concept of the flashback, describing intrusive waking images or sensory experiences and named after a dramatic cinematic technique that cuts from the present to a past scene, and now part of the symptomology of PTSD (APA 2000: 468). These dissociative episodes are nowadays regarded as a core characteristic of traumatic memory, and the term denotes the literal reproduction of past scenes, as if the victim’s flashback has eerily rewound the film of

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life, or jump cut to an earlier edit (Leys 2000: 241). Metaphor, as we saw earlier, is a key component of scientific explanation, and as society changes so do the analogies used to understand the occult innards of mind and body (Leary 1990: 1-78; Soyland 1994). While some argue that veterans of the American Civil War describe flashbacks (Dean 1999), the quality of these emotional reminiscences is actually quite different to that of current usage. Edgar Jones and Simon Wessely (2005: 174) suggest that the technologies of cinema and video have manipulated the way we understand how our memories are organised ‘by providing new templates for expressing distress.’ As Leys (2000: 241) points out, the term flashback was first coined to describe the altered states of awareness experienced by hallucinatory drug users in the 1960s and 1970s, and this usage is still included in DSM-IV-TR as ‘Hallucinogen Persisting Perception Disorder (Flashbacks)’ (APA 2000: 253-254). Flashback officially became part of psychiatric discourse in 1980, when it was listed in DSM-III as one of the observable symptoms of PTSD (A. Young 1995: 107).

This phenomenon is sometimes termed ‘flashbulb memory’ in another metaphorical attempt to describe the uncanny reality of these intrusions, like a photograph fixed by bright illumination. Studies show that emotion plays a powerful role in the formation of these persistently vivid memories, and that the memory does not seem to be narrative or verbal, but, rather, an image (Brewin 2003: 89-93). There are many puzzling contradictions in memory research, which we will return to later in this chapter. Suffice it to say for now that there seem to be two opposing processes, as although some people find that traumatic events become fixed in the mind, with exceptionally vivid fragments of bodily sensations, smells, sounds, and images, others suffer amnesia for details of the traumatic event, with blank periods and confusion common. Furthermore, it is possible for an individual to experience forgetting and hyper-clear recall for aspects of the same event, and although it seems that emotional intensity interferes with memory processes, theories on how this process works remain speculative as well as fiercely contested (Terr 1994; van der Kolk 1996c: 279-302; van der Kolk and Fisler 1995: 505-525).

Prior to the acceptance of PTSD as a diagnostic category, studies of concentration camp survivors from the Second World War documented their psychiatric and general somatic morbidity as well as their increased mortality. ‘Concentration camp syndrome’ included many of the symptoms currently listed under PTSD, emphasising the damaging effect of extreme stress on subsequent health (van der Kolk, Weisæth and van der Hart 1996: 58-60). Although the camps were liberated in 1945, it was not until several decades later that it became clear that many survivors continued to suffer from the horrors they experienced, with memory and sleep disturbances, depression, and anxiety the main problems. Most of what is presently understood about the long-term effects of trauma derives from studies on Holocaust survivors (Aarts and op den Velde 1997: 360).

‘Memory peels off like tatters, tatters of burned skin.’60

At the end of the Second World War, many Jewish Holocaust survivors fled Europe for Palestine, where the new state of Israel was being founded. These refugees were offered a new identity as Israelis: a spiritual rebirth as pioneers of a Jewish homeland. Annual state rituals of mourning and commemoration provided some therapeutic support for survivors’ feelings of grief, fear, and anger, but for around twenty years after the war ended most of their terrible traumatic experiences and massive emotional burdens were simply

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ignored and unacknowledged. Their physical and social needs were amply provided for, but survivors' emotional needs, as many Israeli psychiatrists and psychologists now admit, were met with 'an all-encompassing conspiracy of silence' (Solomon 1995: 215-217).

After the war ended there was a widespread hesitation to explore the Shoah in all scholarly discourse and this silence around its ongoing tragedies was not breached until the 1980s and 1990s when historians began publishing the textual excavations that have now resulted in a vast literature on the social significance of Nazi extermination policies. Raul Hilberg, an early researcher in the field, argues that this silence was largely due to the fact that so many people would be compromised by a thorough investigation of what had happened (Hilberg 1988: 17-26; McIntosh 2002: 164). Hilberg observes that for decades after the war:

There was a widespread taboo between the occurrence of the catastrophe and the current wave of interest. Nor was this hiatus an accident. In Germany the perpetrators – and there were many – did not want to hear what they had done. In the whole Western world the bystanders – and there were many more – did not want to be told what they had not done. For several decades both groups were to a large extent protected from exposure … [and] the early researchers who insisted on concerning themselves with the Holocaust were engaged in a revolt against silence, and their writing, to the extent that it emerged in print, was perceived as an implied, if not explicit, set of accusations directed at Nazis, the Jewish Councils, the United States Department of State, the Pope, indeed anyone who was suspected to have been aware at the time of the Final Solution that a whole people was threatened with annihilation. Even now the Holocaust stands as an abyss in history (Hilberg in McIntosh 2002: 164).

There have been many post-war scholarly debates over how to represent the Shoah and whether it is actually possible to describe its horrors. It has been argued that for those who were not there, the extremity of the Shoah, as a limit event, is incomprehensible and unspeakable, and therefore impossible to represent in literary and visual culture, historical discourse, and in testimonial narratives. All representations of the Shoah, whether literary, cinematic, artistic, or historical, are judged to either correspond or not to this traumatic rupture (LaCapra 2001: x-xi): ‘an Entity, an Event, or a Place … an epicenter which is often imagined as a black hole, (re-)entered only at peril to the communicability of the act and the sanity of the actor’ (Ezrahi 1995: 121). The unique nature of the Shoah, it is believed, requires a special kind of representation, ethical constraints that restrict and silence some forms of discourse and aesthetics, and yet it is agreed that for its memory to survive, the Shoah must become historically embedded (Kellner 1994: 127).

The discussions over how to debate issues in relation to the Holocaust are beyond the scope of this thesis, but the challenge of representing the unspeakable has cast a long and enduring shadow. As James Young (1997: 47) states, ‘[f]or all of us there is a twilight zone between history and memory, between the past as a generalized record which is open to relatively dispassionate inspection and the past as part of, or background to, one’s own life.’ When survivors finally speak of their experiences, it is about the emotional impact the events they witnessed had on them, not an exact list of evidence: people get details wrong. This sometimes leads to their memories being discredited, but when something unimaginable occurs eyewitness reports are incomplete and fragmented, narratives from a twilight zone of extreme psychic trauma, riven with silences and forgetting (Laub 1992: 58-62). Furthermore, in the decades following the Second World War, most people did not want to hear about the horrors of the Shoah, with some refusing to believe that such

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61 Hilberg’s (2002) magnum opus, the first clear description of Nazism’s machinery of destruction, The Destruction of the European Jews, was rejected for publication for six years, finally going to press in 1961. It is now widely regarded as a seminal study of the Final Solution.

62 There is a large literature on this issue, of which I select several texts: Bernard-Donals and Glejzer 2001; Friedländer 1996b; Lang 2000; Rothberg 2000.
dreadful events had actually occurred. Attitudes toward Holocaust victims were contradictory as well as uncomprehending: those who were killed in the genocide were commonly blamed for their passivity, and those who survived sometimes accused of selfishness, contemptible because their lives may have been bought by immoral acts. Survivors mostly kept silent, alienated by widespread social reactions of avoidance, repression, indifference, and denial (Solomon 1995: 217-218).

In Israel, the emotional distress of survivors was obvious to many mental health professionals as well as to non-professionals, but the copious evidence of symptoms reported by survivors – which included depression, anxiety, nightmares, anhedonia, nightmares, concentration difficulties, memory intrusions – as well as the alarming numbers of suicides – went largely unheeded by Israeli psychiatrists. The dominant Freudian orthodoxy made matters worse, as adult traumatic experiences were considered unimportant, and it was not until 1961, when the trial of Adolf Eichmann forced an intense national reliving of the events of the Holocaust, that Israeli attitudes towards survivors changed, becoming more sympathetic (Solomon 1995: 221-223). By 1967 it was recognised that concentration camp syndrome could have a delayed onset, the symptoms remaining latent or in remission until triggered by the vulnerabilities of the survivors as they aged, or in many cases began to confront and mourn their past trauma and losses (Aarts and op den Velde 1996: 224-227).

Many adult survivors of the Shoah who settled in Israel after the Second World War went on to successfully cope with their families, jobs, and society. However, these individuals, especially survivors of the extermination camps, still suffer from the effects of their persecution, with high rates of anxiety, fatigue, depression, nightmares, anhedonia, and memory intrusions of Holocaust events (Robinson et al. 1990: 311-315). Some people in this survivor cohort seem to be selectively resilient, coping with their psychic scars by emotionally shutting down, but studies undertaken fifty years after the end of the Second World War show that sleep disturbances are common (Collins, Burazeri, Gofin and Kark 2004: 403-411). Notwithstanding this outward appearance of coping, studies of survivors who were children during the Shoah suggest that the psychological consequences of their experiences, which include separation from their parents, abandonment, starvation, and extreme violence, are a lifelong burden that worsens with age (Amir and Lev-Wiesel 2003: 295-299). A recent research project investigating child survivors of the Shoah discovered that there was a strong association between the degree of persecution suffered in childhood and the development of late-onset schizophrenic psychosis, preceded by chronic PTSD, and, commonly, anxiety disorders and depressive episodes (Reulbach et al. 2007: 315-319).

Some survivors, though, went straight from the concentration camp to Israel’s psychiatric hospitals, where they remained; others were admitted as they aged, diagnosed with late-onset schizophrenia and severe depressive disorders. It is only recently that the plight of these patients, around two-thirds of Israel's total asylum population, has been publicised (Read and Masson 2004: 40; Rees 2005: 16). Henry Szor (in Rees 2002: 40), a psychiatrist at Israel’s largest mental health facility, says: ‘It’s the last chapter in the Holocaust … [t]he conspiracy of silence is being broken.’ Shosh Shlam, the daughter of a survivor, filmed a documentary in 2001 about Shaar Menashe Hospital, a new hostel for Holocaust survivors, some of whom had been previously hospitalised in mental institutions for up to fifty years. Shlam had originally intended her film, Last Journey into Silence, to be a series of stories about the Holocaust, but found that the women she wanted to interview had lost the power of speech:
Several young Israeli psychiatrists successfully campaigned to have their patients treated for ‘long-term post-traumatic psychosis’ instead of for schizophrenia. Previously, these patients had been considered hopeless cases, treated with antipsychotic medications like haloperidol and chlorpromazine and often kept in solitary confinement, which profoundly worsened their condition. Many of these survivors gradually responded to various ‘socialising therapies’ such as animal therapy, forming relationships with pets; and ‘testimony therapy’, where they were helped to talk, with the doctors listening for the first time as the inmates recounted their stories of horror and trauma (Rees 2002: 40-41; Shlam, Pozorski and Schweitzer 2006: 1).

These survivors are imprisoned in their memory, in traumatic time. Within their own psyches, the Shoah never ended, a problem that once again raises the question of the relationship between time and traumatic events (Shlam, Pozorski and Schweitzer 2006: 4). Some survivors, sixty years after the war ended, still struggle with intrusive memories of the horrors they experience, while others have distanced themselves from their recollections by a process now termed dissociative amnesia (van der Hart and Brom 2000: 233). Primo Levi (in van der Hart and Brom 2000: 233-234), who wrote to witness his experiences of the concentration camp in order to safeguard the loss of the collective memory of Jewish suffering in the Shoah, noted that survivors fall into two groups, ‘those who repress their past en bloc and those whose memory of the offence persists, as though carved in stone, prevailing over all previous or subsequent experiences …. I have not forgotten a single thing.’

There have been many emotionally-charged disagreements over the issue of amnesia for traumatic experiences in Holocaust survivors, in a similar way that heated debates have ensued over trauma-induced amnesia in cases of child sexual abuse and the reality or falsity of recovered memories of rape and incest, a controversy I will return to later in this chapter. Janet remarked in the nineteenth century that it is possible to entirely lose a lifetime of remembrances, and the phenomenon of complete dissociative amnesia as a result of massive traumatisation, although under-reported in Holocaust survivors, has been observed in recent studies (van der Hart and Brom 2000: 233-248). Alexithymia, when a person is powerless to speak of their suffering – unable to identify or describe their emotions – also seems to be related to amnesia and PTSD, as in the silent Holocaust survivors filmed by Shosh Shlam (Shlam, Pozorski and Schweitzer 2006: 1-6).

As the history of the Shoah reveals, there is no ‘liberation’ after the traumatic experience is over. The historic trauma of the Second World War is not an incident cocooned in the past; essentially, it is a history that is still present and evolving in the fields of today’s arts, cultures, and politics (Felman and Laub 1992: xiv). The Shoah is an event at the limits of human experience: before this ‘industrially organized … attempt totally to exterminate an entire human group within twentieth-century Western society’ nobody considered it as even possible (Friedländer 1996a: 3). As such, argues Dominick LaCapra (2001: x-xi), the Holocaust exemplifies the contemporary vision of traumatic history, and a theory of trauma should be at the centre of any critical apprehension of twentieth-century history. This is not to say that the qualities of one dimension of trauma can be transferred regardless to another, as the Shoah represents losses of unique magnitude (LaCapra 1999: 725). However, theoretical and methodological innovations derived from work around the
experiences of Holocaust survivors have permeated many academic and cultural studies, especially in film and literary criticism, where trauma theory has become very fashionable (Radstone 2007: 9-10). Although an examination of this wider application of trauma theory need not concern us here some of these literary writings on traumatic memory and the testimony of survivors are useful.

It has been proposed that the literary or discursive mode of our times is a new form, that of testimony. Says Shoshana Felman (1992: 5-9), the most familiar function of literary testimony is to record and report the facts of historical events, with the narrator as witness. However, when the narrator bears witness to the survival of trauma, testimony is not merely a medium of historical transmission, but becomes an active agent, part of a clinical intervention in a healing process. ‘Trauma theory emphasizes the dialogic nature of testimony,’ asserts Susannah Radstone (2007: 13 and 24), an implicit process that gives weight to the role of the listener and intersubjectivity, as well as an emphasis on brain function, memory, and the pathologies of dissociation. Freud (1920: 56-58) recognised that his patients’ compulsion to repeat in the present experiences that should be remembered as belonging in the past included harrowing events and intensely painful emotions that could never be pleasurable or gratifying. To Freud, the trauma victim returning, in dreams or in therapeutic transference, to the site of loss and shock, was locked in a repetition compulsion in an effort to gain, in a controlled symbolic context, psychic mastery over a past that refuses to go away. Psychoanalysis is a dialogue that acknowledges ‘an interchangeability between doctor and patient’: both doctor and patient witness the testimony of the unconscious, recognizing ‘that one does not have to possess or own the truth, in order to effectively bear witness to it’ (Felman 1992: 15; emphases in original).

Cathy Caruth (1996: 4), in her work on trauma, examines Freud’s speculation that the human brain is biologically shielded from traumatic occurrences such as the shocks of war, which would otherwise overwhelm the human psyche. Caruth underscores Freud’s conjecture that the violent event ‘is experienced too soon, too unexpectedly, to be fully known and is therefore not available to consciousness until it imposes itself again, repeatedly, in the nightmares and repetitive actions of the survivor.’ Trauma, argues Caruth (1996: 4-5), is not merely pathological, and is more than a ‘wounded psyche’: because the horrifying event was never assimilated as it occurred, it haunts the survivor, and cannot be described in a straightforward manner. Rather, ‘the complex ways that knowing and not knowing are entangled in the language of trauma’ require a ‘literary … language that both defies, and claims, understanding.’

Many cultural critics, as Ruth Leys (in Leys and Goldman 2010: 665-666) points out, are attracted to trauma theory, and often have a tendency to regard trauma as solely a physiological process involving the body, rejecting cognitive approaches and instead embracing fashionable notions such as embodiment and affect while naively borrowing from neuroscience. There are many reasons, says Leys (in Leys and Goldman 2010: 665-668), that people are drawn to noncognitive models of trauma, and these include the reaction against psychoanalysis after the APA abandoned it as an organising principle in favour of the organic models of the DSM-III; the current academic fascination with the body and emotion in subjectivity; the attendant interest throughout the humanities, albeit ill-understood, in neuroscience; the belief that affects are solely a bodily system, separate to intention or cognition, occurring unconsciously and therefore outside conscious control; and the recent interest in emotion in non-human animals. The codification of PTSD in the DSM-III and the disorder’s further elaboration in subsequent editions of the manual has been critical to all of these developments (Radstone 2007: 11). However, the insistence on the dichotomy between cognition and affect
is artificial, just as the notion that a traumatic event occurs entirely externally to the victim is false: there is interplay between inner and outer worlds, and between thought and emotion.

Narratives of trauma do not tell of an escape from death, but, rather, are testimonies of living alongside death: a ‘double telling’ oscillating between the agonising nature of an event and the equally intolerable nature of its survival (Langer 1991: 6-7). ‘Testimony is a form of remembering,’ states Laurence Langer (1991: 2-3), but it is an impossible task for Holocaust survivors, witnesses of inhuman horror, to coalesce these memories with their lives beyond the camps. In her memoir, Auschwitz survivor Charlotte Delbo (1995: 255) says that in the death camps, everything human was stripped away, even remembrances of life before the camp: ‘[m]emory peels off like tatters, tatters of burned skin.’ After this psychic destruction, a survivor has to attempt, with enormous difficulty, to reclaim all that was lost: childhood memories, intellect, knowledge, sensitivity, as well as the ability to imagine, laugh, and dream. Delbo (1990: 2) says she is often asked how she managed to extricate herself from her memory of Auschwitz once she returned to a life outside the camp, and invents a dialogue with an imaginary interlocutor:

Delbo (1995: 261) describes feeling as though she is not alive, but ‘imprisoned in memory and repetitions,’ her ‘underlying memory sensations … intact’ (Delbo 1990: 3), and her mind and body still indissolubly tied to the trauma in present-day existence, with continuity and chronology invalidated, an experience she describes as a ‘doubling’ of the self (Langer 1991: 4-5). Delbo (1990: 3) declares that it was so improbable to survive Auschwitz that she feels she was never there: she is ‘a twofold being’ split between the ‘deep-lying memory’ of her Auschwitz double and the ‘ordinary memory’ of her survivor self. The tough skin that enfolds her memories of Auschwitz gives way in dreams, where she feels her whole body become ‘a mass of suffering’ with death imminent (Delbo 1990: 3), although this is not a metaphorical nightmare, but a memory of what really happened (Langer 1991: 8). This memory intrusion into dreams is one of the hallmarks of PTSD (Hartmann 1996: 100; Ross, Ball, Sullivan and Carroff 1989: 697-707).

This ‘twofold being’ that Delbo speaks of nullifies notions of time and continuity. When she talks about Auschwitz, Delbo (1990: 3-4) speaks from her ordinary ‘intellectual memory’, detached from her ‘deep-lying memory’ where emotionally-charged recollections, physical impressions, and bodily sensations are preserved. In oral testimony of traumatic events, ordinary memory, with its normalised accounts of horror, mediates atrocity; but when a witness shifts to deep memory, it excavates corrosive episodes that burrow under the surface of the narrative (Langer 1991: 9). This is, once again, Frank’s ‘chaos stories’:

What cannot be evaded in stories told by Holocaust witnesses is the hole in the narrative that cannot be filled in … [t]he story traces the edges of a wound that can only be told around. Words suggests its rawness, but that wound is so much of the body, its insults, agonies, and losses, that words necessarily fail … those who are truly living the chaos cannot tell in words … chaos stories are not narratives [they are] an anti-narrative of time without sequence … these stories cannot literally be told but can only be lived (Frank 1997: 98; emphases in original).
Testimonies of survivors are, therefore, often fragmented and inconsistent: these stories are difficult to hear, not only because of the terrifying events recounted, but because these stories are told ‘on the edges of a wound [and] on the edges of speech .... in the silences that speech cannot penetrate or illuminate’ (Frank 1997: 101). Chaos stories are embodied, told by a self that to survive has continually dissociated from the pain of a suffering body (Frank 1997: 103). Elaine Scarry (1985: 3-23), describing the extremity of torture, argues that ‘physical pain has no voice.’ There are culturally stipulated responses to pain, but language itself is shattered into screams and cries: ‘what is quite literally at stake in the body in pain is the making and unmaking of the world.’ Chaos stories are told at the end of this process (Frank 1997: 103), and whether the experiences were endured in the Shoah or in traumatic events such as torture, rape and incest, the instability of these memories makes it easy for others to deny their reality and truthfulness (Walker 2003: 107).

'I don't think I know a single woman who does not live with some fear of being raped.'

Rape and sexual assaults against women and children are pervasive worldwide. In the 1970s, the women’s movement based in the United States created a centre for research on rape, where women for the first time became investigators rather than merely objects of knowledge. These feminist researchers reframed rape as a crime of violence and power rather than as merely a sexual act, and women began to talk publicly about their experiences of sexual and domestic violence (Herman 1998: 30; Hesford 1999: 192-221). Rape, asserted Susan Brownmiller (1976), was a weapon used by men to subjugate women. The unspeakable was finally being voiced, and the terrible secrets of sexual abuse that Freud had rejected as fantasy in 1897 were confirmed as real. A famous survey led by Diana Russell (1984a; 1984b) showed that one in four adult women had experienced rape, with one in three sexually assaulted in childhood. It has also become clear that sexual aggression perpetrated against boys is far more common than previously realised, and boys and men have only recently begun to speak on this formerly taboo subject (Dorais 2002). Adult women who are raped are over twice as likely to have a history of child sexual abuse than women who have not been raped; for men, this is even more dramatic, with adult men who are raped five times more likely to have a history of child sexual abuse than men who have no experience of sexual assault (Elliot, Mok and Briere 2004: 210). Victimisation can become a lifetime burden, as several studies have found (Neumann, Houskamp, Pollock and Briere 1996: 6-16).

Rape, especially as a weapon of terror in war, has a long and brutal history. Following the conflict in the Balkans and the genocide in Rwanda the international community was finally galvanised into addressing the issue in the context of war crimes and torture, with rape recognised as a crime against humanity in 2001 (Bourke 2007: 384-385). Joanna Bourke (2007: 386) argues that throughout the twentieth century violence has been increasingly sexualised and is nowadays so commonplace in warfare that soldiers enthusiastically photograph their participation in sexual assaults. In the Democratic Republic of the Congo, where the prevalence of rape is the worst in the world, it is described as ‘almost a cultural phenomenon’ after decades of civil war (McCrummen 2007), and in South Africa, which has the highest incidence of child and baby rape in the world, a woman has a greater chance of being raped than of learning to read (Dempster 2002). The International Criminal Court is currently investigating evidence that Colonel Muammar Gaddafi ordered the rape of hundreds of women as a weapon against rebel forces. Witnesses have confirmed that the Libyan

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63 Susan Estrich, rape survivor, in Judith Lewis Herman. 1998. Trauma and Recovery: From Domestic Abuse to Political Terror. London: Pandora, p. 73.
government has purchased large amounts of Viagra-like drugs to enhance the sexual performance of pro-Gaddafi soldiers, enabling them to rape multiple women (BBC News: Africa 2011).

It is notoriously difficult to classify sexual abuse, and societal and legal definitions are changeable; the fact that around seventy five percent of women do not report complaints of sexual violence to the police adds to the problem of accurate statistics (Bourke 2007: 15-16). There are many reasons for this silence: victims fear they will not be believed; some fear reprisals, especially if the perpetrator is a father, partner, or brother; the process of pursuing a criminal case is slow and often embarrassing; and there is still a profound stigma over sexual victimisation. In the United Kingdom, less than five per cent of reported cases of rape result in the perpetrator’s conviction (Bourke 2007: 16). What is rape? As Bourke (2007: 15-16) says, it is not easy to establish a universally-agreed classification, but in this thesis we will agree that if the act is non-consensual, coerced, or unwanted by the victim it is rape; if the injured party is a child or mentally impaired and cannot designate themselves as a victim it is also rape. Rape between husband and wife was only recently criminalised, and it is worth noting that before the 1970s incest was generally regarded as a moral issue, not as child sexual abuse (Bourke 2007: 9; Sgroi 1975: 18-21). Ian Hacking (1991: 253-288) discusses this development in terms of ‘making up people’: the same vile things have been done to children throughout history, but only since the mid-1970s have definitions of abuse and our values and moral codes been revised: ‘child abuse’ is now a standard locution that we take for granted.

Rape and sexual assault on adults has a devastating impact, frequently triggering psychological effects similar to those experienced by combat veterans. Rape is commonly experienced as a life-threatening event with fear of mutilation and death, and victims complain of nightmares, insomnia, startle responses, and dissociative symptoms (Herman 1998: 31). There have been many writings by rape survivors documenting their struggles with trauma, memory, and recovery, in what Susan Brison (2002) calls ‘the undoing and remaking of a self in the aftermath of violence.’ Brison (2002: x), who was diagnosed with PTSD after surviving a murderous sexual assault, struggled to recover from her ordeal and recognised that ‘trauma not only haunts the conscious and unconscious mind, but also remains in the body, in each of the senses, ready to resurface whenever something triggers a reliving of the traumatic event.’ When a child is sexually abused the pathological effects are even more severe, provoking behaviours sometimes labelled as chronic mental illness: psychotic breaks, dissociative experiences, hallucinations, multiple personality, borderline personality disorder, depression and suicidality (Corwin 2002: 1-25).

Repeated trauma, as is often the case in child sexual abuse within the home, forces an adaptation to living in an abusive, dangerous, terrifying and unpredictable environment, resulting in a child developing altered states of consciousness that can be both destructive and creative, with an extraordinary array of psychological and somatic symptoms (Herman 1998: 96-97). In earlier sections of this thesis we have seen how these phenomena have long fascinated researchers investigating double consciousness, splitting, and hysteria: strange occurrences that some cultures and religions still define as spirit possession and trance (Bourguignon 1976; Klass 2003).
In the coming section I will explore the topic of childhood maltreatment and neglect, especially sexual abuse, and its overwhelming impact on child development. But as my autoethnography describes, I am myself a survivor of rape and domestic violence, and I am all too familiar with the way trauma unravels the self; my son Django, who as a young child suffered prolonged childhood sexual abuse, was profoundly damaged by his experiences: I cannot pretend to be a dispassionate observer of the controversies that continue to rage throughout this contentious field. Until now, in my history of the present, I have remained hidden behind the text, my researcher’s bias revealed only by the stories I have chosen to tell or turn away from, and the theories I have privileged or critiqued. Now, however, I need to step in through ‘the other door’, as Avery Gordon (2007: 197; emphases in original) says, occasionally interrupting the flow of academic discourse with personal interjections, noting where my studies have reached a “crossroads where ghostly signals flash” (Benjamin in Gordon 2007: 204) – where some historical or sociological illumination has intersected with my own experience, and has seized me ‘by the throat’ (Gordon 2007: 204). I am involved and implicated in this research project – here is where I speak into the text, whispering into the reader’s ear.

‘Certain violations of the social compact are too terrible to utter aloud: this is the meaning of the word unspeakable.’

Meticulous studies on the destructive effects of sexual abuse on children first emerged in the early 1980s, corroborating many of the assertions made by survivors, clinicians and feminists over the last hundred and fifty years (Olafson, Corwin and Summit 1993: 7). Child maltreatment has, of course, existed in all societies and cultures throughout human history, but modern notions of the problem only began with research on ‘battered-child syndrome’ in 1962 (Kempe et al. 1962: 17-24), and our current concept of child abuse, as Hacking (1991: 253-288) shows, dates from the mid-1970s (Corby 2008: 7-20). Scientific and clinical questions over the consequences of sexual abuse on child development are sometimes lost in the heat of arguments over the number of children who are molested and the reality of trauma-related pathologies. Clearly paedophiles, rapists, child and spousal abusers, and people who run child prostitution rings have a vested interest in downplaying the scale of the problem, but powerful social institutions such as insurance companies, seeking to avoid insurance claims, also benefit from denying the reality of the impact of child sexual abuse and trauma (McFarlane and van der Kolk 1996: 38-39). The widespread scale of the systematic rape and molestation of children by paedophile priests in the Roman Catholic Church and the subsequent cover-ups and conspiracy of silence led by the Vatican to shield these perpetrators from criminal charges of child rape has been described as a crime against humanity.65 Victims of clerical abuse, states Geoffrey Robertson (2010: 3), characterise their experience as ‘soul destroying’, a consequence of being groomed by men vested with spiritual power.

The extensive collective denial of the reality and extent of child sexual abuse is described by Roland Summit (1988: 51) as ‘a massive blind spot.’ Society has for a long time trivialised or overlooked the scale of the problem and even though there have been dramatic revelations in recent years its reality is still shrouded in myth and belittled by the scepticism of adults backed up by authoritative social organisations (Berliner 1991:

64 Judith Lewis Herman. 1998. Trauma and Recovery: From Domestic Abuse to Political Terror. London: Pandora, p. 1; emphasis in original.
65 G. Robertson (2010: vii) points out that financial settlements in court cases brought by victims so far exceed US$1.6 billion in the United States alone.
According to John Briere (1992: 94), there are powerful cultural aspects of the problem of child abuse: social forces allow the victimisation of those with lesser social power, for example, surveys show that there is a high number of men in so-called ‘normal’ walks of life who admit to paedophilic tendencies, and the sexualisation of children is no doubt in part a social phenomenon. There are, in addition, socially transmitted attitudes and beliefs that deny or minimise the harm of child abuse, with surveys revealing that a significant number of men believe that children would enjoy sex with an adult if they were allowed to try it, and that children are sometimes deliberately seductive. Furthermore, says Briere (1992: 94-95), ‘there are often negative social reactions to the abuse survivor’s subsequent behaviour, based on his or her deviation from social norms regarding appropriate conduct.’ This includes victim-blaming by clinicians and others who question the credibility of survivor’s reports, or see claims of molestation as attention-gaining behaviour. Psychiatrists tend to dismiss abuse as either fantasy or memory distortions, or are trained to think that the subsequent negative sequelae of abuse are congruent with faulty brain functions rather than caused by trauma.

As we saw in the previous two chapters, there are various economic and ideological forces that have worked against the acceptance of an environmental aetiology for mental disorder. Instead, a reductionist biological explanation has been encouraged, hindering the examination of societal ills such as childhood sexual abuse, dangerous families, and poverty as causal factors in mental illness (Bentall 2006a: 12). The clash between the anti-psychiatry movement and the more established forces of biological psychiatry is widely regarded as being won by the latter power base in the 1970s, reinforcing its status as a branch of medicine and turning away the critiques of nonconformists like Laing (1971), Scheff (1984) and Szász (1972), who derided mental illness as a myth (Bentall 2006a: 12; Cooper 1967). Laing (1971: 23) notoriously claimed that ‘not the individual, but the family is the unit of illness,’ and many families found this rightfully offensive, but the current simplistic ideology of biological psychiatry has exonerated the family, making psycho-social dynamics taboo and aetologically irrelevant (Aderhold and Gottwalz 2004: 338). The publication of *DSM-III* in 1980 was affirmation of the ascendancy of psychiatry’s return to its origins in Kraepelin’s theories and its dismissal of Freudian psychoanalytical models of the mind, and as Bentall (2006a: 12) points out, the dominance of the biological model has been reinforced by the financial might of psychopharmaceutical companies (Healy 2002; Kutchins and Kirk 1997; Shorter 1997: 240-255). This interweaving of capitalism and mental disorder, sometimes termed ‘Big Pharma’, has buttressed the construction of a biomedical and neurochemical self, an illusion that floats free of social and environmental suffering (Bentall 2003: 499-503; Law 2006; Mosher, Gosden and Beder 2004: 115-130; N. Rose 2003a: 46-59; N. Rose 1999; Timini 2005: 21).

The psychiatric profession, as we have seen, has oscillated between giving credence to the detrimental effects of trauma and total doubt over survivor’s accounts (van der Kolk and McFarlane 1996: 3-4), and in my personal experience the scales are still heavily weighed towards disbelief. It is very difficult to discern the true incidence of childhood sexual abuse: most reports of victimisation are retrospective, and survivors struggle to tell their painful histories, having to cope with further stigmatisation as their unspeakable experiences commonly provoke incredulity in listeners. Child victims of sexual abuse commonly experience rejection, blame, and disbelief when they attempt to tell an adult about their molestation. Roland Summit

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66 The individuals surveyed were all male university undergraduate students who had not been incarcerated or clinically treated for their attraction to children: 7% said they would have sex with a child if they thought they could get away with it. These men also used pornography and endorsed sexual aggression against women.
(1983: 178) emphasises that ‘[i]f a respectable, reasonable adult is accused of perverse, assaultive behavior by an uncertain, emotionally distraught child, most adults who hear the accusation will fault the child.’ Chaos stories, as Arthur Frank (1997: 97-98) asserts, are messy and incoherent, provoking so much anxiety that they are hard to hear and harder to believe, and the delays in disclosure and frequent recantations common in children’s testimony make it very difficult to prosecute child sexual abuse cases: few are vindicated by criminal proceedings (Staller and Vandervort 2010: 2-3).

Child sexual abuse is usually a crime with no physical evidence and no witness except for the perpetrator and the victim and adult’s reactions to disclosure, especially if the perpetrator is a friend or family member, are often to accuse the survivor of lying or fantasy (McGregor 2008: 25; Summit 1983: 178). Adults protect themselves with the mythology that young people make baseless accusations out of vindictiveness or as a kind of adolescent ‘dangerous game’, but in fact most allegations are valid and most young people who are sexually abused are less than eight years old when an adult first initiates them into sex (Summit 1983: 178). Parents and caretakers usually look to psychiatrists and other mental health professionals to confirm abuse, but as we have seen, many so-called experts are blind to the reality of trauma. Adults who cannot empathise with the victim do often not see children’s responses to sexual assault by a trusted caretaker as appropriate, but a young child is small and vulnerable and abuse only occurs when the child is alone with the offender. The abuse is a secret and the child is inevitably intimidated, helpless and afraid – he or she rarely fights back or seeks help, and other adults, if the child eventually tells, often judge the child for failing to protest, cry out, or otherwise behave rationally (Summit 1983: 179-183).

In my own experience, as recounted in my autoethnography, I did not know that Reynard was molesting Django while he lived in our home. During an argument, I suddenly became aware of the person underneath his carefully constructed mask and immediately recognised him as a sexual predator. This glimpse resonated with my personal history of surviving seven years of sexual violence and without delay I made Reynard move out and he had absolutely no further contact with Django, who was then nearly five years old. At that stage I did not suspect that Reynard had assaulted Django. Django’s behaviour – aggression, bed-wetting, smearing faeces on walls, having constant abdominal pains, and spitting and growling instead of speaking – were problems that led child psychologists to diagnose him with a developmental disorder, most likely severe attention-deficit / hyperactivity disorder. No health or education professional suggested his behaviour could have resulted from abuse, and Django did not disclose anything to me or to anyone else until much later on. After I began to think that Django’s behaviour could have been caused by Reynard sexually molesting him, I spoke of my concerns to Django’s psychologists, and, later, psychiatrists, but no one would even consider the idea, indeed they thought I was hysterically imagining the whole horrible thing.

Django began showing his therapist and I drawings in which fierce beasts terrorised small animals, and I could recognise that he was often dissociating, as I was familiar with the state myself. Django told me that he heard voices telling him he was bad and stupid; it took over a year for him to tell me through drawing and whispering that the scariest voice was Reynard threatening him and telling him not to speak. Frank (1997: 97-98) asserts, are messy and incoherent, provoking so much anxiety that they are hard to hear and harder to believe, and the delays in disclosure and frequent recantations common in children’s testimony make it very difficult to prosecute child sexual abuse cases: few are vindicated by criminal proceedings (Staller and Vandervort 2010: 2-3).
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98-102) illustrates this process clearly when he describes how in trying to tell a chaos story, the teller is wounded and cannot reflect enough on the narrative to be able to put it into words. It is, claims Frank:

[A]n anti-narrative of time without sequence .... Hearing is ... difficult because the chaos narrative is probably the most embodied form of story. If chaos stories are told on the edge of a wound, they are also told on the edges of speech. Ultimately, chaos is told in the silences that speech cannot penetrate or illuminate. The chaos narrative is always beyond speech, and thus it is what is always lacking in speech. Chaos is what can never be told; it is the hole in the telling (Frank 1997: 98-102; emphases in original).

As Frank (1997: 102-104) asserts, it is dangerous for a terrorised individual to be connected with their body, which has been corrupted by maltreatment. Dissociating from their body, the person also dissociates from the pain of the traumatic event, trying to slip away from remembering and telling of the hurts that unmade their world (Scarry 1985). Body, mind and brain are inextricably linked and trauma seems to have an effect on people in many levels of biological functioning. Abused children commonly have significant problems in language development in addition to difficulties in verbal recall of traumatic events that nonetheless retain a powerful and frightening charge emotionally, as well as physically, as in chronic pain (Scaer 2001: 74-75; van der Kolk 1996a: 214-241).

Sexual molestation within the family is rarely a one-time occurrence. If not immediately brought to light a pattern forms with the perpetrator continuing to abuse the child until the secret is revealed or contact is ended. In Django’s case it began from around age two and ended when he was four and a half years old. A child who, like Django, lives in the same house as the perpetrator, is essentially trapped and learns to live with and accommodate to the sexual demands of someone who is regarded as a caring parental figure (Summit 1983: 184). Traumatic events such as this kind of sexual betrayal by a loved caretaker can result in amnesia for abuse, which Jennifer Freyd (1997: 3-4) claims can result in the hidden knowledge emerging in other ways such as somatic symptoms, phobias, poor self-image, and disruptive behaviours. Indeed Freyd (1997) regards betrayal as the core issue of child abuse trauma: when a person we depend on for survival violates us in some way a conflict arises between external reality and a vital system of attachment. The betrayal needs to be forgotten, so the traumatic events are blocked from memory and awareness. Summit (1983: 184) says the child has to believe he or she is bad and deserving of the abuse to enable the perpetrator to remain, delusionally, as a ‘good parent’, for to admit that the parent is dangerous is to confront annihilation, and this performance fragments or splits consciousness. The child needs to be able to trust the abuser who as a parent or caretaker has power over him or her, and the ability to split or dissociate is a way of avoiding pain and continuing to live in the household (Freyd 1997: 11-14). We have already encountered the phenomenon of dissociation, which in the context of sexual abuse is described by Lenore Terr (1994: 85) as ‘a sidewise slippage’ that steps aside from thoughts, feelings and connectedness, switching off the ‘psychological apparatus that fully perceives, registers, and stores memories’ (Terr 1994: 70).

Most sexual abuse is never revealed while it is occurring. Disclosure usually comes about through conflict in the family, accidental discovery or sometimes through child protection professionals who notice something untoward in the victim’s health or behaviour (Summit 1983: 186). This is what happened in my case, where conflict with Reynard revealed something hidden, although it took some time for Django to communicate any further information about his terror. In many cases, maintains Summit (1983: 188), after years of putting up with the abuse, the child may make a delayed accusation, which is often received by his or her family with total disbelief as well as humiliation and punishment, especially if, as is common, the child or adolescent is
rebellious and angry. Unless there is immediate support and intervention the child will often retract their claim, as after years of secrecy and guilt he or she cannot bear to be responsible for the kind of chaos that results in a family after sexual abuse allegations are made. It is no wonder that childhood sexual abuse is significantly under-reported, hidden from adults and psychiatric and health-care professionals; and it is surely unsurprising that children are much more likely to disclose sexual abuse to a friend of their own age rather than to an adult (Priebe and Svedin 2008: 1095). Statistics have often become a battleground, diverting attention from the real issues; the recognition that sexual abuse is widespread, the necessity of helping survivors, and working out how to prevent further abuse occurring. I will nevertheless outline some of the most well-known reports into the prevalence of sexual abuse, mostly gained from asking adults about their childhood experiences.

There have been several landmark studies, one of the earliest being Diana Russell’s (1983: 133-146) survey of 930 women in San Francisco. Russell and her team found that 28% of women under the age of fourteen and 38% before the age of eighteen had been subjected to unwanted sexual contact, ranging from fondling to intercourse: only 2% of intrafamilial rapes and 6% of extrafamilial rapes were reported to the police (Russell 1983; 1984a; 1984b). David Finkelhor and his colleagues (Finkelhor 1984; Finkelhor and Hotaling 1984: 23-33), trying to evaluate the prevalence of sexual abuse from retrospective reports, estimate that 38% of girls and 9% of boys are sexually victimised although John Briere (1992: 4) cites studies that indicate that the rate for the sexual abuse of boys may reach 20% in some populations. The problem of child abuse initially received more attention in the United States than in other countries. Some observers assumed that it was an American problem, especially in light of the high rates of crime and violence in the United States. As Finkelhor (1994b: 409-417) points out, however, epidemiological research has shown that just as childhood sexual abuse was widespread in North America before it gained attention in the late 1970s it was similarly masked elsewhere in the world. Surveys conducted in nineteen countries, including Canada and the United States, found wide-ranging rates of child sexual abuse of between 7% and 36% for women and between 3% and 29% for men.

A study comparing international epidemiological rates of child sexual abuse in 2009 with David Finkelhor’s study undertaken in 1994 found that prevalence rates had remained fairly stable over time, and did not vary greatly in different countries (Pereda, Guijera, Forns and Gómez-Benito 2009: 331-342). Although some data showed high rates of up to 53% for women and 60% for men, male sexual victimisation was relatively neglected until recently and there are still less males than females who seek professional help for abuse-related problems so the differential between rates for women and men is, logically, suspect. The number of boys molested by priests in the Catholic Church and Catholic-run boys institutions is believed to total more than 100,000 worldwide over the last thirty years, but the figure keeps rising as more men break their silence (G. Robertson 2010: 228). Michel Dorais (2002) believes that around one in six men suffer sexual abuse during childhood and adolescence. Even measuring incidences of sexual abuse by a family member or caretaker at a conservative level of 5% leads to high prevalence rates, and the United States Department of Justice currently estimates that every year 250,000 children are sexually abused in the United States (Finkelhor 1984; Finkelhor and Hotaling 1984: 22-33; McFarlane and van der Kolk 1996: 38).

In Aotearoa / New Zealand, John Angus (2009: 8-10), the Children’s Commissioner, estimates that there are around 1,000 new cases of child sexual assaults every year, but as most abuse is significantly under-
reported this is an underestimate. There have been several recent studies in New Zealand that have included questions on sexual abuse. The Youth '07 report (Clark et al. 2009) and its earlier questionnaire, Youth 2000 (Fleming et al. 2007), surveyed almost 10,000 secondary school students on a wide range of issues, and found that 19.9 – 26% of girls and 5.4 – 14% of boys complained of unwanted sexual contact, which was also associated with mental health issues, substance abuse, and health problems. A different community study of 2,855 women found that prevalence rates for child sexual abuse were around 28%, with victims twice as likely as non-victims to experience further violence from partners and others later in life (Fanslow, Robinson, Crengle and Perese 2007: 935-945; Fergusson, Horwood and Lynskey 1997: 789-803). This ‘abuse-related learned powerlessness,’ as John Briere (1992: 26) terms it, has been noted in many other studies worldwide (Barnes, Noll, Putnam and Trickett 2009: 412-420). The Christchurch Health and Development Study (Fergusson, Horwood and Woodward 2000: 529-544), in existence for over thirty years, and which follows a group of 1,265 children born in the region in mid-1977, has found that 18% of the children in their sample experienced sexual abuse before the age of sixteen, that is, 25% – 30% of the girls and 6% of the boys in their cohort. The leaders of this study state that it is difficult to substantially determine exact numbers as some respondents reported abuse in one assessment but failed to mention it in another: abuse at an early age is susceptible to memory loss and there is, as noted earlier, a considerable amount of under-reporting of sexual abuse (Chesney 2006: 10). Even when it is certain that sexual abuse in childhood has occurred, due to hospital emergency room records, when questioned many years later survivors may prefer not to disclose this traumatic episode (Finkelhor 1994a: 42).

As can be seen, the statistics on child sexual abuse are highly variable and the reports of survivors are unstable, inconsistent, and subject to memory failures as well as an understandable unwillingness to look back on past humiliations and suffering. Despite continual societal scepticism over growing numbers of individuals reporting histories of sexual assault, the numbers of all prevalence assessments are, I repeat, underestimates, and there is no evidence that fabrication or confabulation, which occurs only rarely, is a threat to the validity of surveys of victimisation; indeed the withholding of information is a much larger problem (Finkelhor 1994a: 42-43). Most researchers do agree on several points, however, one of which is that these estimates of abuse prevalence are likely to seriously underrate the true extent of the problem. Another is that children exposed to sexual abuse have greater sexual vulnerability during adolescence and later in life, so go on to suffer further victimisation. Yet another, and there is increasing concurrence on this issue, is that there is a robust relationship between childhood abuse and the development of complex psychiatric and emotional difficulties.

Complaints of child abuse and neglect to Child, Youth and Family (CYF) care and protection services have risen enormously in the last few years, with 31,781 notifications in the year ending June 2003, with 7,361 children confirmed as neglected or abused; 53,097 notifications were received in 2005, and by 2007 numbers exceeded 73,000. The Children’s Commissioner cites a figure of 110,000 notifications in the year up to June 2009. Some of these notifications are repeat offending for the same children. Notifications are of course not the same as substantiated abuse, and the number of cases that CYF determines require care and protection was between 40,000-50,000 in 2009; between 12,000-14,000 children are confirmed to have been actually abused or neglected every year, and police estimate that they see around 65,000 children during domestic violence complaints. Emotional abuse, such as witnessing violence between adults, and parental neglect are the most common problems, with physical abuse third and sexual abuse fourth. These statistics are for children under the age of 15, but research on children under 5 years old shows them to be even more vulnerable: in 2006 CYF received notifications for 6,699 children under 2 years of age and a male caregiver non-biologically related to the victim was the most common perpetrator of violent assaults against young children. Many of these young children suffer repeated abuse. Young children with disabilities are more likely than other children to experience neglect and abuse: there is a high proportion of children with developmental delays referred to CYF, but it is unclear whether their disability makes them more vulnerable, or if their problems are caused by the effects of the abuse. Ministry of Social Development (MSD) figures cited by Chesney 2006: 10; other statistics are from Duncanson, Smith and Davies 2009: 5-11.
Repeated victimisation is a result of several factors that are partly environmental and partly as a result of personality changes that occur as a result of childhood sexual abuse, especially if it is long-term. The first pathway is living in a dangerous community; the second is being part of a dangerous family; and the third that this family life is a chaotic environment with multiple problems. Fourthly, a child who has experienced sexual abuse is likely to develop emotional problems that increase risky behaviour, and such a person commonly provokes antagonism in others by conduct deemed antisocial or disruptive, lacking emotional self-control, or, alternatively, behaving unusually submissively, as well as having little interpersonal skills in self-protection (Finkelhor, Ormrod, Turner and Holt 2009: 316-329). There is increasing interest in the relationship between childhood trauma and the risk of developing severe mental disorder in adulthood, and it is to this area of research that I now turn.

‘As my eyes meet those of the dragon it realizes that I am going to kill it and, for the first time in my life, it is scared.’

After surviving adult rape it is common to feel fearful, anxious and depressed. Many individuals also report guilt, shame, fatigue, and feelings of worthlessness, sleep and eating disturbances, irritability, decreased libido, and suicidal ideation. If there is a prior history of child sexual abuse it is now known that as well as these emotional disturbances there is also a strong likelihood of developing much more serious psychological sequelae such as major depressive disorder (Cheasty, Clare and Collins 2002: 79-84). As mentioned in my previous chapter, children with disabilities and developmental disorders, including autistic children, are at increased risk of sexual and physical abuse, which is often not disclosed and goes unrecognised by health professionals (Goldson 1998: 663-667; Kvam 2000: 1073-1084; Sullivan and Knutson 2000: 1257-1273; Mandell et al. 2005: 1359-1372; Sinason 2010: 214). It is sometimes hard to see if these children have difficult temperaments to start with or if traumatic victimisation causes some or all of their symptoms (Finkelhor, Ormrod, Turner and Holt 2009: 325; Reid 1999: 93-109; Ross 1997: 64-66; Rustin 1997: 261-266; Tustin 1992: 11; van der Kolk 1996b: 64-66), as already-existing impairments make children more vulnerable and abuse worsens pre-existing conditions (Westcott and Jones 1999: 497-506). Furthermore, says Valerie Sinason (2010: 6), people working with the intellectually disabled often simply do not want to see that sexual abuse and apparent mental impairment coexist, or that disability or apparent learning difficulties can be emotional in origin, and not due to brain damage. And sometimes, says Sinason (2010: 116), ‘trauma evokes handicap as a defence against the memory of physical or sexual abuse’ – the appearance of disability is a screen to hide behind.

We have already seen that an increasing amount of careful longitudinal studies reveal complex interactions between genes and environmental stress (Caspi and Moffitt 2006: 583-590; Dohrenwend 2000: 1-19; Read, Goodman, Morrison, Ross and Aderhold 2004: 223-252). The original stress-vulnerability model proposed by Joseph Zubin and Bonnie Spring (1977: 103-126) suggested that rather than people having a genetic predisposition to serious mental illnesses such as schizophrenia, this susceptibility can be acquired by experiencing traumatic events. Since then, these psychosocial factors have usually been demoted to the status of mere triggers that exacerbate genetic sensitivity but the pendulum is swinging back to demonstrate that childhood maltreatment is a major cause in the development of adult psychosis (Bentall 2006a: 7; Gold 2008: 1-5; Lardinois, Lataster, Mengelers, van Os and Myin-Germeys 2011: 28-35; Lysaker, Outcalt and

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It is difficult to know when and if any neurological dysfunction predates trauma, but an upbringing of unrelenting exposure to serious abuse undoubtedly shapes neural and psychic development; indeed, vulnerability may be a post-traumatic phenomenon, rather than an antecedent (Stein 2007: 90-91). Children who survive prolonged exposure to sexual assault, violence, fear and anxiety fall behind in their social, cognitive and emotional growth as well as having poorer than average physical health (Fairbank, Putnam and Harris 2010: 239-240; Howe 2005: 199-214). Despite this research now being well substantiated, these issues are still often overlooked by psy professionals and medical doctors, who commonly fail to note the impact of trauma on children in their care (Fairbank, Putnam and Harris 2010: 240-241). A lot of clinicians simply do not ask questions about previous histories of child sexual abuse or other maltreatment (Lothian and Read 2002: 98-103; Read and Fraser 1998: 355-359; Read, Hammersley and Rudegeair 2007: 101-110) and as a consequence many children are misdiagnosed for trauma-related problems and receive inappropriate or no treatment (Burns et al. 2004: 960-970).

The mental, emotional and behavioural problems of children subjected to sexual abuse and other maltreatment are wide-ranging, not only varying between individuals but also manifesting differently within the same child on any given day. There is no unique psychiatric diagnostic syndrome that describes the sequelæ of child sexual abuse, and although the category of post-traumatic stress disorder (PTSD) is sometimes utilised the diagnosis is not always applicable, as it does not apply to all victims, fails to account for all of the symptoms, and does not always explain the source of the trauma (Finkelhor 1987: 348-366; Rowan and Foy 1993: 3-20). While a diagnosis of PTSD does have benefits for advocacy purposes, clarifying that traumatic abuse rather than 'characterological deficiencies' are at fault (Rowan and Foy 1993: 18), PTSD is a protean diagnosis appearing to mimic every personality disorder in the DSM. There are, however, three categories of symptoms that do not come under its purview: the affective, dissociative, and somatic sequelæ of prolonged traumatic abuse (Herman 1992:377-391).

Although the concept of a spectrum of post-traumatic disorders has been mooted for nearly thirty years, with David Finkelhor (1987: 354) developing an alternative to PTSD that he calls the ‘traumagenic dynamics model of child sexual abuse’ and Judith Herman (1992: 377-379) suggesting the category of ‘complex PTSD’, comorbid psychiatric illnesses are the most common diagnoses for abused children. These can be a pick-and-mix from obsessive-compulsive disorder, phobic disorder, attention-deficit / hyperactivity disorder, oppositional defiant disorder, panic disorder, conduct disorder, affective disorder, adjustment disorder, attachment disorder, borderline personality disorder, dissociative disorder, eating disorders, post-traumatic stress disorder (PTSD), psychosis, and autistic spectrum disorder (Rustin 1997: 261-266; Terr 1995: 301; Willows 2009: 89-102; Williams 1999). Indeed, 75% of individuals diagnosed with PTSD receive one or more comorbid lifetime diagnoses, and around half report a lifetime history of major depression (Stover, Berkowitz, Marans and Kaufman 2007: 705). Up to 98% of abused children who meet the diagnostic criteria for dissociative disorder experience hallucinations, frequently hearing the perpetrator’s voice, although these hallucinations are not typically associated with other psychotic symptoms that could lead to a diagnosis of schizophrenia. These children tend to display aggressive, impulsive, and self-injurious behaviour, as well as having nightmares and frequent trance-like states (Stover, Berkowitz, Marans and Kaufman 2007: 705-706).
There are of course many ways in which child sexual abuse can detrimentally affect adult life once the child grows older, such as alcohol and substance abuse, suicide ideation and the diagnosis of serious and stigmatizing adult psychiatric disorders such as schizophrenia and bipolar disorder with psychosis. A storm of dissension continues to coalesce around the claim made by John Read and his co-researchers (Read, van Os, Morrison and Ross 2005: 330-350) that in adults some symptoms deemed characteristic of schizophrenia and psychosis, particularly command hallucinations, are strongly related to a history of sexual and physical child abuse, a contention strengthened by other studies (Bebbington et al. 2004: 220-226; Cutajar et al. 2010: 813-822; Lardinois et al. 2011: 28-35; Lysaker, Outcalt and Ringer 2010: 1143-1151; Read 1997: 448-456; Read and Argyle 1999: 1467-1472; Read, Goodman, Morrison, Ross and Aderhold 2004: 223-252; Rosenberg et al. 2007: 245-253; Úçok and Bikmaz 2007: 371-377; Whitfield, Dube, Felitti and Anda 2005: 797-810). These researchers continue to argue that the more brutal and long-lasting the originating childhood trauma, the stronger the association with extensive comorbidity and severe psychopathology, asserting that some hallucinations seem not to be delusional at all but are, more accurately, memories of traumatic events, flashback intrusions of the type that are usually associated with PTSD rather than schizophrenia (Hovens et al. 2010: 66-74; Read, Perry, Moskowitz and Connolly 2001: 319-345; Read, van Os, Morrison and Ross 2005: 341). There is also growing evidence of links between childhood trauma and the psychotic subtype of major depression, with many of these individuals also diagnosed with comorbid PTSD (Gaudiano and Zimmerman 2010: 462-470).

Although I am focusing on victimhood in this section it is also important to note that early abuse and neglect also leads to juvenile and adult criminal violence, which, states Abby Stein (2007: 3), ‘is a transgenerational phenomenon.’ There seems to be a high prevalence of depersonalisation, derealisation, dissociation, and amnesia in the commission of violent crimes (Moskowitz and Evans 2009: 197-207). However, despite the centrality of serious childhood abuse and, commonly, the subsequent development of defensive dissociation in violent criminals – and Stein (2007: 119) says this was the case in nearly all of the perpetrators of American homicide cases she reviewed – mostly this is overlooked in the criminal justice system, with very few accused arguing child abuse as a mitigating factor or diagnosed with a dissociative disorder. As we have seen throughout this thesis, ‘bad things happen and can drive you crazy’ (Read and Haslam 2004: 133) a fact that the service-user / psychiatric survivor movement has made abundantly clear.

The service-user movement, whose struggle to make their marginalised voices heard is an apt example of what Michel Foucault (2006b: 353) describes as ‘the insurrection of subjugated knowledge,’ has published many narratives relating childhood neglect and sexual abuse, violence, and cultural and racial prejudice (Bassett and Stickley 2010; Read and Reynolds 1996; Romme et al. 2009). In the previous chapter I mentioned INTERVOICE, Resonance, and the Hearing Voices Network, advocacy groups for voice-hearers who, as auditory hallucinations are a first-rank symptom, are often diagnosed with schizophrenia. These voices have been construed differently in the past, in other cultures, and by a range of theories: as supernatural or divine messages, sub-vocalisations, or traumatic re-experiencing, but philosophical debates over the distinctions between inner and outer that underpin psychiatric ‘reality testing’ need not concern us here (Leudar and P. Thomas 2000: 172-175). Hearing voices is a matter of language, whether one voice or several are heard simultaneously, and voice-hearers themselves report the phenomenon in various ways, from ‘a silent nerve language,’ to whispering, talking, or shouting (Leudar and P. Thomas 2000: 175-176). Some people experience these voices negatively, as evil forces that criticise and drive them to harm
themselves or others. This is not, however, the only response, as some people find the voices help them, providing information, encouragement, and guidance (Beavan and Read 2010: 201-205). Hearing voices is quite a common occurrence in the general population and it is usually when people are troubled by negative and destructive voices that they turn to psychiatric help (A. Morrison 2004: 299; Romme and Escher 2006: 162-191; Romme and Escher 1989: 209-216); furthermore, the responses of friends and family members profoundly influence voice-hearers in the way they understand their experiences (Leudar and P. Thomas 2000: 129-131). An occasional voice-hearer myself, I have only ever had positive experiences, but I think that my acceptance of my own voices enabled me to help Django when he was trying to cope with hearing Reynard’s voice threatening and belittling him. Many advocacy groups argue that accepting the voices as real rather than as evidence of psychopathy helps people to recover – the voices are often believed to be spiritual entities (von Peter 2008: 391-414), and as Rufus May (2009: 6) remarks, ‘insist[ing] on medicalizing this experience is now being recognized as culturally oppressive and colonial.’

Promoting the occurrence of hearing voices as a meaningful experience means that what the voices have to say becomes significant. However, ‘[t]he content of auditory hallucinations has historically been of little interest to researchers and clinicians in psychiatry’ (Beavan and Read 2010: 201). Much of the content of the ‘schizophrenic symptoms’ of adult psychiatric patients who were sexually assaulted in childhood is clearly related to their experiences of abuse, both symbolically representing traumatic experience and containing flashback elements (Read and Argyle 1999: 1467-1472). Hearing the perpetrator’s voice is only one of the forms that hallucinations can take, with the voice commanding suicide, or threat, or humiliations; some individuals hear screaming, and some believe that aliens or demons are trying to get inside their body. Olfactory hallucinations, such as the smell of sperm, are also reported (Read, Agar, Argyle and Aderhold 2003: 1-22; Read and Argyle 1999: 1467-1472; Read, Goodman, Morrison, Ross and Aderhold 2004: 235-236). Clinicians who attend to the voices heard by their clients say that most people are eager to discuss their experiences and welcome the chance to become active participants in the recovery process (Geekie 2004: 147-160). Rather than remaining marginalised, service-users are, in growing numbers of cases, becoming acknowledged as ‘experts on their own experiences’ (British Psychological Society, in Geekie 2004: 159).

Confronting and understanding these voices is usually an overwhelming experience that brings up traumatic memories that the voice hearer would prefer to keep buried, and this process requires a safe therapeutic relationship. The voices are ‘embodied’: felt and heard physically in the body with the mind in another space, an experience that some describe as ‘more real than reality’ (Karlsson 2008: 365-373). Neuroscience and cognitive science, despite claims that they have moved beyond the ontological dualism, the division of mind from the body that is the heritage of Cartesianism, still ‘uphold the epistemological separation of inner mind from outer world’ (P. Thomas, Bracken and Leudar 2004: 14). An understanding of embodiment and the totality of human experience, using the clinical tools provided by the ontological ‘being-in-the-world’ phenomenologies of Martin Heidegger (1996) and Maurice Merleau-Ponty (2003), can provide a way of thinking of the mind and the world as part of the same system (P. Thomas, Bracken and Leudar 2004: 16).

The brain is not actually a computer or a machine, despite the current ubiquity of this analogy. People who hear voices cannot capture their meaning by the narrow frameworks provided by psychological or
neurological explanations alone, and it is necessary to explore the embodied and situated features of the voices to understand them (P. Thomas, Bracken and Leudar 2004: 22). Identifying voices merely as evidence of degeneration, mental disorder, and the corrosion of personality is increasingly regarded as an unethical practice, and it is important that clinicians avoid offering merely ‘value-laden advice and opinions’ and instead allow the voice-hearer to lead the way toward illuminating meaning (Martin 2000: 135-141). Voice-hearer networks like INTERVOICE and others are establishing safe places for people to deal with their frightening memories. Ron Coleman (in Romme et al. 2009: 7) asserts that recovery from a dysfunctional psychiatric illness means ‘living your own life, not the life of your voices;’ when reading the stories of psychiatric survivors it is clear that the reality of the voices needs to be accepted in order for the voice-hearer to work through the experience and recover control of their life.

The feeling of powerlessness that voice-hearers have when their voices dominate, criticise, and threaten them has a direct correlation with their experiences of powerlessness during the period when they were emotionally neglected, and physically and sexually abused. Working with the voices, and discovering that the voices are expressing emotions that erupted during a past traumatic situation, enables a recovery process where the individual becomes more independent of the voices and, as a result, more in control (Romme et al. 2009: 8-9). ‘Killing the dragon’ as one survivor describes his management of his illness, is a life-long battle (Amsel 2010: 58-74). This is not a ‘cure’, in the medical sense, but it means that the person can work through their traumatic background and deal with the massive emotional burden that they have carried ever since. There are overwhelming emotions related to experiences of trauma: ‘[v]oices are the stories of threatening emotions; emotions of the person twisted by terrible experiences, hopelessness, feelings of guilt, aggression and anxiety’ (Amsel 2010: 9). Rather than being merely un-understandable hallucinations, what voices have to say can provide vital clues to resolving buried issues of unresolved trauma (Beavan and Read 2010: 201-205; Knight 2009; Read, Fink, Rudegeair, Felitti and Whitfield 2008: 235-254). As stated earlier, around 98% of abused children who meet the diagnostic criteria for dissociative disorder hear voices, frequently that of the perpetrator, as did Django, although these hallucinations are not typically associated with other psychotic symptoms (Stover, Berkowitz, Marans and Kaufman 2007: 705-706). These children, like Django, tend to display aggressive, impulsive, and self-injurious behaviour, as well as having nightmares and frequent trance-like states, and many survivors of childhood sexual abuse report dissociative experiences.

‘The field of psychiatry is composed of dissociated subsystems that do not communicate or cooperate with each other.’

We saw in a previous chapter that schizophrenia is not a unitary disorder but, rather, a collection of disjunctive categories linked together by clinical appearance and an allegedly shared underlying causation (Read 2004a: 43-56). Eugen Bleuler (in Schäfer, Aderhold, Freyberger and Spitzer 2008: 151; emphasis in original) in 1911, was aware of this problem when he initiated the term, and was careful to emphasise this by referring to a ‘group of schizophrenias.’ Although the concept of ‘schizophrenia spectrum disorder’ has been mooted since the 1970s (Bentall 2003: 104-106), research increasingly supports the case for a new psychiatric model, a trauma-related dissociative subtype of schizophrenia that Bleuler had noted (Bentall 2003 19-25; Ross 2008: 21-34), although the notion is currently ignored by psychiatry (Ross 2008: 32; Ross 2004a: xi-xiv; Şar and Öztürk 2008:165-175; Şar et al. 2010: 33-40; Schäfer et al. 2006: 135-138). If

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recognised, this will permit clinicians to acknowledge the role of trauma in the ætiology of psychosis, just as it has in PTSD (Bentall 2004: 195-208; Bracken and P. Thomas 1999: 1-4; Ross 2004a: xi-xiv). This is, however, likely to be a laborious and acrimonious process, mirroring the fractures in a dissociated psyche; as Ross (2008: 29) remarks: ‘The field of psychiatry is composed of dissociated subsystems that do not communicate or cooperate with each other.’ One of these subsystems, says Ross (2008: 29), is known as ‘biological psychiatry,’ a powerful collection of experts, academic journals, conferences, grant agencies, diagnostic categories, and treatment methods, which is largely funded by the massive profits of the pharmaceutical industry. The other is vastly less influential, consisting mostly of psychotherapists and lower-status researchers with much less social and economic capital: this, says Ross, ‘is the dissociative disorders field.’

As Ross (2008: 29) also notes, investigations in the dissociative disorders field tend to be under-funded. The pharmaceutical industry is not interested in the dissociative disorders, for they are not profitable: there is no specific medication for dissociative identity disorder. Off-label drugs designed for other illnesses are prescribed, such as antipsychotics, antidepressants, mood stabilisers and anxiolytics. To integrate dissociation into mainstream studies of schizophrenia these fields – biological psychiatry and the dissociative disorders field – will have to change, so it is perhaps not surprising that the DSM-5 sub-work groups in post-traumatic and dissociative disorders are not currently planning the inclusion of a trauma-related subtype of schizophrenia for publication in 2013; although the APA is considering the addition of two new trauma-related categories, developmental trauma disorder and disorders of extreme stress not otherwise specified (DESNOS) (Phillips 2009; Pine 2009).

Some kinds of alterations in consciousness, such as absorption in an activity, imaginative involvement, daydreaming, or a temporary detachment from emotional or physical pain, are regarded as normal human behaviour (Putman 2009: 81-82). This commonplace and temporary kind of dissociation is distinguished from pathological kinds, such as depersonalisation, amnesia, and identity diffusion, as in DID (Dalenberg and Paulson 2009: 146-147; van der Hart, Nijenhuis and Steele 2005: 413-423). This is usually represented as a continuum running from normal to pathological dissociation, although there is a lack of consensus on this concept, with many leaders in the dissociative disorders field asserting that alterations in consciousness, including depersonalisation and derealisation, should be differentiated from trauma-related dissociations. Some researchers also note that trauma-related complex post-traumatic stress disorder and bipolar disorder have dissociative underpinnings (Steele, Dorahy, van der Hart and Nijenhuis 2009: 162-165). Structural dissociation, described as having a psychobiological organization, is closely linked with experiences that are repudiated and discredited by mainstream psychiatry because many of its bizarre and painful symptoms are hidden; and ‘seldom present[ed] as clear-cut “dissociative identities”’ (Steele, Dorahy, van der Hart and Nijenhuis 2009: 164). Ross (1997: 119) asserts that: ‘DID patients rarely come for treatment with obvious or overt multiplicity … which could present with the signs and symptoms of almost any other medical illness …. DID is the great imitator in psychiatry, and it … is directly linked to sexuality.’ Conceptualising the phenomenon of alternate identity in medical terms is profoundly problematic, and although DID is increasingly diagnosed, it remains a controversial psychiatric category (McAllister 2000: 25-33).

The power of therapeutic authority, as we have seen throughout this thesis, operates through ‘action on the action of others,’ by an expert intervention that deals with personal distress in terms of an inner world of
psychological process and chemical imbalances in the brain (Miller and Rose 1994: 29-33). In the case of the dissociative disorders, which are clearly bound by cultural and historical imperatives, it is tricky to differentiate between non-pathological and pathological types of manifestations (Cardeña, van Duijl, Weiner and Terhune 2009: 171-181), and in Western culture individuals who dissociate or suffer psychotic breaks do not generally have the opportunity to transform their experiences into the kind of social capital that can lead toward the development of shamanic or mediumistic skills, although there are exceptions in modern neo-pagan movements (Green 2001: 209-225). Indeed Paul Johnson (2003: 334-354) draws parallels between ishāmkamu or ‘soul loss’ in Ecuador and the way neo-shamanism in the modern West uses the after-effects of psychological trauma as a therapeutic tool. In Western industrialised states, though, a person with DID or suffering from traumatic psychosis is usually just stigmatised as crazy, existing in a liminal zone on the margins of civilised society (Hall 1999: 89). The kind of ‘complex personhood’ involved in living as an individual who is not an individual at all, but, rather, a collection of alternate identities is, as Avery Gordon (2007: 7-8) puts it, a ‘ghostly matter’: multiple personalities haunt the psy disciplines, ‘highlight[ing] the limitations of many of our prevalent modes of inquiry and the assumptions they make about the social world, the people that inhabit this world, and what is required to study them.’ Gordon continues:

If haunting describes how that which appears to be not there is often a seething presence, acting on and often meddling with taken-for-granted realities, the ghost is just the sign, or the empirical evidence if you like, that tells you a haunting is taking place. The ghost is … a social figure, and investigating it can lead to that dense site where history and subjectivity make social life. The ghost or the apparition is one form by which something lost, or barely visible, or seemingly not there to our supposedly well-trained eyes, makes itself known or apparent to us, in its own way, of course. The way of the ghost is haunting, and haunting is a very particular way of knowing what has happened or is happening. Being haunted draws us affectively, sometimes against our will and always a bit magically, into the structure of feeling of a reality we come to experience, not as cold knowledge, but as a transformative recognition (Gordon 2007: 8).

If the human sciences and the psy disciplines have few tools for grasping and understanding enchantment in a disenchanted world, service-user / survivor perspectives, spiritually informed approaches, and non-Western cultural appreciations have no such limitations.

‘For he said unto him, Come out of the man, thou unclean spirit. And he asked him, What is thy name? And he answered, saying, My name is Legion: for we are many.’

In an earlier chapter I described how mental disturbances have been explained by three frameworks: firstly, a supernatural intrusion paradigm, as in demon possession; secondly, from the sixteenth century onwards in the Western world, an organic paradigm, where madness lies in the physical body and brain; and, thirdly, the alternate-consciousness paradigm, derived from the nineteenth century research into magnetic sleep and somnambulism which led to the realization that humans are divided selves, with part of the mind dissociated from conscious control (Crabtree 1993a: 86-88). Ellenberger (1970: 53) and Hacking (1995: 149-155) argue that this new way of thinking permitted a new way of theorising mental states, leading to the development of ideas about the unconscious mind as well as to what later became labelled as multiple personality disorder (MPD) and dissociative identity disorder (DID), although these disorders are still occasionally thought of in the terms of the older supernatural intrusion paradigm of demonic possession: indeed they are still sometimes treated by rites of religious exorcism, with both positive and negative outcomes (Begelman 1993:

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The idea that hysterical disturbances, somnambulism, hallucinations, and amnesia are occurrences that can all be traced back to actual traumatic experiences may have become more acceptable in the last thirty or so years, but dissociative behaviours such as these are still regarded with suspicion by mainstream psychiatry. Although Pierre Janet’s work has been rediscovered and is widely publicised in the dissociative disorders field, Freud’s fixation on intrapsychic conflict and biological psychiatry’s reification of an organic and genetic nosology still essentially marginalises the concept of dissociation (P. Brown, Macmillan, Meares and van der Hart 1996: 480). With its association with old forms of knowledge like exorcism, its links to the paranormal, as well as its connection to the ongoing clinical scepticism over ‘multiple personality,’ dissociation is still widely perceived as unscientific and therefore not ‘real’ (Ross 1997: 34-37). MPD and DID are, some argue, simply medicalised Western social constructions drawn from earlier historical notions of possession (Cardeña 1992: 294), and the spontaneous trances and other altered states of consciousness so ubiquitously enacted in non-Western societies may also be culturally approved reactions to psychological trauma, grief, and environmental stress (Bentall 2000: 85-120; Castillo 2003: 9-21; Klass 2003: 122-123; Kleinman 1991: 136; Nuckolls 1991: 63-77; Ross 1997; van Duijl et al. 2010: 380-400; van Ommeren et al. 2001: 1259-1267). Western psy constructions and treatments of mental disorder, with their focus on the individual and his or her inner world, can be inappropriate and ineffective outside their own cultural milieu (Fernando 2010: 94-96; Friedman and Marsella 1996: 12; Kleinman 1991; von Peter 2008: 391-414). The American Psychiatric Association (2000: 519), aware of these criticisms, includes a section in the DSM on cross-cultural dissociative states that can be accepted as non-pathological if part of religious experiences, as in spirit possession, trance states, and some forms of mind sought in yogic meditation, but this concession questions the validity of international psychiatric categories (Friedman and Marsella 1996: 12).

In the triumphalist myths of progress told by medical history, psychiatry is said to have emerged victorious in its conflict with demonology, ever since nineteenth century mad-doctors and alienists attempted to pathologise religious experience by mocking supernatural phenomena (Hayward 2004: 37-38). These critiques are now often understood more as aggressive professionalisation strategies, with medicine positioning itself as a modern, active agent opposed to demonology’s outdated practices. However, the reality is a more complex and open-ended process. Neurological, psychiatric, and epidemiological knowledge have become incorporated into spiritual practices as a way of making sense of the supernatural, and some clinicians, without rejecting medical models, still cleave to religious explanatory frameworks: the doctrine of demon possession has never disappeared Hayward 2004: 37-49). Contemporary biomedicine owes a debt to religious practice, with notions of order and hierarchy and magical terms still permeating medical and psychiatric language (Hayward 2004: 58).

Tracing the cultural evolution from demon possession to dissociative identity disorder in the Western world, Traugott Oesterreich (in Ross 1997: 13) argues that ‘there is a continuum from normality through obsessive

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71 Carl Jung, who was perhaps the first modern psychologist to believe that the human psyche is by nature religious, explored the paranormal. Beginning when he was 38, from 1913 to 1930 he had his famous ‘confrontation with the unconscious,’ seeing visions and hearing voices, recording his insights in a series of notebooks. This famous ‘Red Book’ was recently published; see Jung 2009: viii-ix. Jung, once Freud’s disciple, is nowadays most often claimed as a prophet or a mystic, a kind of New Age guru, and is commonly seen as a figure of ridicule in the psychiatric profession. See Tacey 2001.
states to possession, and that possession is a hypnotic phenomenon.’ Ross (1997: 13-14), following Oesterreioch, says that many of the features of demon possession, like DID, are exaggerations and embellishments of ‘normal psychology,’ and the diagnostic criteria for both states are more or less the same. Early Christian cases described possession by Beelzebub or other imps, and treatment was expulsion using theological exorcism. By the nineteenth century it was common for more psychologically informed theories to tell of a spirit taking control of the psyche (Ross 1997: 16-19). By the end of the nineteenth century, as we have seen, the person, usually female, had become a patient, often diagnosed with hysteria and double consciousness, and the unwanted alter (or, as the condition moved from double to multiple consciousness, alters) either expelled or integrated by hypnotic methods similar to those used by Morton Prince – a practice reminiscent of a ritual exorcism (Leys 2000: 74-75; van der Hart and Dorahy 2009: 11). Freud, although initially bringing dissociation into his conception of hypnoid hysteria later abandoned the concept in favour of repressed instinctual wishes (van der Kolk, Weisæth and van der Hart 1996: 53-54), whilst doing all he could to destroy Janet’s reputation (Hacking 1995: 44 and 150-151), but with its emphasis on dreams and the priest-like powers of the analyst, Freud’s free association was also elaborately ritualistic. Hacking (1995: 48-49) notes, furthermore, that multiple personality disorder has long been associated with spiritualism and reincarnation.

Some argue that the ontological status of dissociation or possession is irrelevant to diagnosis and treatment. If the client prefers to work with their subjective experience of possession, rather than medicalising their spirit or demon alters, or if a previous clinical approach based on DID has proved ineffective, then successful therapeutic relationships can be established despite scepticism on the clinician’s part (Crabtree 1993b: 257-258). Ross (in Bull, Ellason and Ross 1998: 188) says he has spoken with Satan and his demons many times, always judging them to be his clients’ psychological constructs, but asserts that there is no good reason to reject any therapeutic technique just because it does not conform to the prevailing expert opinion on the matter (Begelman 1993: 208; Dobkin de Rios 2002: 1576-1578). However, argues Ross (1997: 22), it is important for both religious and clinical reasons not to collapse DID into a kind of demonic possession fit only for exorcism: dissociative states are better regarded as ‘part of the whole person,’ and should be incorporated, not banished. There is not space here to thoroughly explore the wide variety of mystical occurrences linked to DID; I merely wish to point out that experiences usually described as extrasensory; such as psychic abilities, telekinesis, déjà vu, pre-cognitive dreaming, contact or channeling with ghosts or spirits, clairvoyance, knowledge of past lives, ‘flash-bulb’ memories, synæsthesia, ‘out-of-body’ experiences, and near-death experiences, are all known to occur in individuals who have suffered life-threatening trauma, especially in childhood, and that these same individuals then, unsurprisingly, tend to hold strong beliefs in the paranormal (Audain 1999: 35-49; A. Brown 2004: 28-29; Green 2001: 209-225; Lawrence et al. 1995: 209-215; Reiner 2004: 313-336; Ross and Joshi 1992: 357-361). I have experienced all of these states myself, and so has Django, and although there has been much scholarly emphasis on extreme cases of dissociation, such as DID, there is ample evidence that many survivors of sexual abuse commonly experience many of these phenomena and are often able to learn to manage or enjoy these experiences without needing the intervention of the psy professions.
The ability to dissociate is often described by trauma survivors and people who work with them as a coping mechanism. Survivors report that severe trauma and abuse suffered over a sustained period of time when they were very young triggered automatic dissociative states that allowed them to disconnect from feelings, thoughts, perceptions and memories of violence, rapes, and maltreatment, permitting them to carry on with their normal everyday life as if the abuse had not occurred. This is a practice Lenore Terr (1994: 85) describes as a 'sidewise slippage,' rather than the kind of burial of memory undergone in repression, an ability here outlined by Harvey Schwartz:

> Our innate, malleable survival capacities adjust creatively to environmental impingements or prolonged periods of stress and deprivation by segregating, sequestering, reduplicating, distracting, and / or sacrificing parts to protect the whole, such that when physical or psychological survival is threatened, breakdowns occur. Disunity is almost always favored over unity (Schwartz 2000: 8).

A relationship between dissociation and childhood trauma has been established by many reputable studies: in one early survey 97% of one hundred people diagnosed with multiple personality disorder (MPD) reported significant childhood abuse, mostly sexual (Putman, Guroff, Silberman, Barban and Post 1986: 285-293), and further research confirms sexual abuse, typically incestuous and with extensive violence, as the most common trauma history in DID patients (Ross 2000b: 25; Ross 1997: 119-122; Ross, Norton and Wozney 1989: 413-418). However, the kind of language used by researchers and clinicians is limited by conventional clinical and empirical models of the psychiatric concept of 'dissociation', which as a psychiatric concept 'has increasingly become a measure of structural pathology located in one’s identity; the basis of which is assumed to be memory’ (Hall and Powell 2000: 184-204). This approach is very different to the subjective experiences of abuse survivors and the way they talk about remembering their childhood abuse.

Survivors sometimes say that they cannot find the language to talk about their dissociative experiences. They need to explain what happened and find meaning in the events, but, frustratingly, they lack a vocabulary to decode their knowledge to an outsider: ‘There are no words. I try, but no one ever seems to get it, except sometimes another survivor’ (in Hall and Powell 2000: 194). We have heard these incoherent and messy chaos stories before, as when Arthur Frank describes the wounded storyteller trying to tell:

> [A]n anti-narrative of time without sequence .... Hearing is ... difficult because the chaos narrative is probably the most embodied form of story. If chaos stories are told on the edge of a wound, they are also told on the edges of speech. Ultimately, chaos is told in the silences that speech cannot penetrate or illuminate. The chaos narrative is always beyond speech, and thus it is what is always lacking in speech. Chaos is what can never be told; it is the hole in the telling (Frank 1997: 98-102; emphases in original).

Disconnecting from their body, the person also separates from the pain of the traumatic event, dancing the ‘sidewise slippage’ (Terr 1994: 85) away from remembering and telling of hurts that unmade their world (Frank 1997: 102-104; Scarry 1985: 3-23). Survivors of traumatic childhood abuse, like the shell-shocked soldiers of the First World War with their ‘strange hells within the minds war made’ (Gurney in Ricketts 2010: 184), and in common with the way that Charlotte Delbo (1990: 3) describes her Holocaust experiences, are trapped within the torments of their past, split between the ‘deep memory’ of trauma and the ‘ordinary

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memory’ of everyday life. As Shosh Shlam (in Shlam, Pozorski and Schweitzer 2006: 2-3) says, ‘they were unable to tell their story. Silence was the story.’

When survivors do try to answer questions about their experiences, few use clinical expressions like dissociation and rarely employ terms such as fragmentation. Most commonly, say Joanne Hall and Jill Powell (2000: 197) trauma survivors talk about pain, whether physical, psychic, spiritual or emotional, sometimes trying to go into more detail:

It’s this abyss, inside of me. And I am on the edge of it. Falling in is dangerous because that is when I feel like I want to die.

I feel like I have a black hole inside that is just pure emptiness, that can never be filled up. Not with drugs, nothing works.

Pressure, things coming up that are disgusting, and I know about them, but they keep coming up.

I wanted my female organs out. I had cramps. I have had problems ‘down there’ all my life. So I found a surgeon who would do it. Finally it is better.

Most survivors have incomplete memories of their maltreatment, and when entering therapy for other problems, some individuals are unaware of some or all of their history of sexual or physical abuse (Briere 1992: 35-36 and 100). As Ross (1997: 119) emphasises, people with dissociative identity disorder rarely ask for help with problems with dissociation, and can ‘present with the signs and symptoms of almost any other medical illness …. DID is the great imitator in psychiatry.’

As noted earlier, trauma survivors, especially children, commonly suffer from a variety of problems, presenting to clinicians with a wide range of emotional and somatic symptoms that do not easily fit into existing psychiatric diagnostic approaches. Individuals diagnosed with DID nearly always have a long prior history of involvement with mental health and medical systems. Extensive engagement with welfare, criminal and legal systems is also common, as is self-destructive behaviour, substance abuse, and suicide attempts (Ross 1997: 122-125). DID patients may not remember trying to harm themselves, as an alter personality may have been responsible for the behaviour (Ross 1997: 125). Similarly to victims of violence, perpetrators guilty of the most brutal and sadistic crimes are also very often dissociative, feeling like someone else inside them committed the offence, often professing amnesia of the actual events even when they confess their guilt (Stein 2007: 2). It is important to understand that traumatic maltreatment in early life creates violent offenders, as well as victims: children have no control over who their parents are, or what these caregivers do to them.

The wide-ranging somatic and emotional symptoms presented by dissociative individuals, sometimes complicated by self-destructive behaviour, deviance and / or criminality, results in extensively comorbid diagnoses, as well as concomitant poly-psychopharmacological treatments, which Ross (2000b: 27-36) defines as the central conceptual problem in the current practice of psychiatry. Indeed, says Ross (2000b: 69-89), ‘[t]he polydiagnostic patient with extensive comorbidity is the major recipient of inpatient psychiatric treatment.’ There is no scientific schema that presently explains this patient, as the dominant model, as we have seen, defines distinct genetic biomedical brain diseases in the kind of manual best represented by the DSM (Ross 2000b: 27-36). Ross (2000b: 69-89) argues for a functional approach to traumatic psychopathology; what Ross terms the ‘trauma model.’ Instead of fixing symptoms into syndromes of
nosological entities the basic units of classification should be the problems, whether disturbances in information processing, memory, perception, or other complaints. This approach would avoid the morass of comorbidly-occurring syndromes, along with the accompanying polypharmacy: functional psychopharmacology would be oriented toward dysfunction rather than diagnosis (Bentall 2006b: 220-233; van Praag et al. 1990: 501-510).

The limitations of post-traumatic stress disorder (PTSD) have been widely challenged: as the sole diagnostic category available for trauma-related conditions, PTSD is not always adequate to describe the profound complications of the various symptoms associated with surviving a prolonged exposure to maltreatment and violence (Finkelhor 1987: 354; Herman 1992: 377-399; Rustin 1997: 261-266; Terr 1995: 301). Chronic interpersonal trauma exposure, especially during early life, affects victims holistically: body, mind and spirit (Emerson and Hopper 2011: 15). Individuals exist in a state of ‘complex personhood’, as Avery Gordon (2007: 4-7) describes it, living amidst the vast networks of society; the twists and turns of fortune, the spells of forgetting and remembering, the contradictions between understanding and misunderstanding as their own and society’s problems become entangled. PTSD is not a flexible enough diagnostic tool to incorporate the complexities of experience that trauma survivors endure: sensory and auditory hallucinations (especially the voice of the perpetrator), self-injurious behaviour, aggression, impulsivity, and trance-like states, as well as feelings of worthlessness, shame, and self-blame (Stover, Berkowitz, Marans and Kaufman 2007: 705). Young children experience multifaceted consequences to complex trauma, extending through adolescence and into adult life, placing them at risk for cumulative harms, whether emotional, psychiatric, or medical; drug and alcohol addiction is common, in addition to legal, vocational, and family problems; there is also an increased risk of further victimisation (Cook et al. 2005: 390-398).

Survivors – even when they cannot remember all of the traumatic events that they have endured – often believe that they are responsible for the violence and abuse inflicted upon them, and this negative self-appraisal is frequently generalised to most of their other life-experiences, friendships, intimate relationships, actions, and decisions (Emerson and Hopper 2011: 15). The brain is far from a collection of computing devices that records events in an objective world, and the minds of severely traumatised people, says Abby Stein (2007: 4), ‘may undergo a kind of defensive cauterization, so that highly charged somatosensory data remain diffuse and inaccessible for higher levels of neural processing.’ The flood of images and feelings experienced in a traumatic encounter is interpreted by the brain and the central nervous system as danger and terror, and the cascade of hormonal and neurochemical changes triggered by fear can be long-lasting, resulting in permanent deformations of neuroanatomical structures.

‘Affect does not so much reflect or think: it acts.’

Emotions do not operate by conscious choice, and, says Bessel van der Kolk (2006: 280), brain structures in the limbic system – the amygdala and the hippocampus among them – determine the emotional significance of an event, as well as the physical response. Traumatised adults and children struggle to manage their overwhelming emotions, and often fail to recognise what they are feeling – a phenomenon termed alexithymia – and then, consequently, respond inappropriately to their own and other’s needs. In the face of
threat, real or imagined, they collapse, or lash out. Emotional memories persist, even if autobiographical memory of an event is forgotten (van der Kolk 2006: 281-282), a phenomenon that Freud (1966: 298) noted in 1895, speculating that memory could be represented at the synaptic level as ‘a permanent alteration following an event.’ Bessel van der Kolk observes:

The fact that reminders of the past automatically activate certain neurobiological responses explains why trauma survivors are vulnerable to react with irrational – sub cortically initiated – responses that are irrelevant, and even harmful, in the present. Traumatized individuals may blow up in response to minor provocations; freeze when frustrated, or become helpless in the face of trivial challenges. Without a historical context to understand the somatic and behavioral residues from the past, their emotions appear out of place and their actions bizarre … When people are reminded of a personal trauma they activate brain regions that support intense emotions, while decreasing activity of brain structures involved in the inhibition of emotions and the translation of experience into communicable language (van der Kolk 2006: 277-288).

The amygdalæ, which are part of the limbic system in the brain, have a primary role in the formation and storage of memories associated with powerful emotional events, especially terror and fear (van der Kolk 1996a: 214-241; van der Kolk 1996c: 295-296). Neurobiological models of trauma, as in van der Kolk’s work, are often criticised for suggesting that altered activity in the medial temporal lobes of the brain, at the time when traumatic memories are encoded, contribute to the establishment and maintenance of PTSD. However, new research supports these neurobiological theories that post reduced hippocampal and amygdala activity under conditions of high stress and arousal (Hayes et al. 2011: 660-669). A key symptom in PTSD, as we have seen, is the intrusive recollection of trauma, often re-experienced in highly-emotive, sensory-laden flashbacks. Autobiographical memory is the main psychological process implicated, and it is now certain that stress hormones (adrenaline, noradrenaline, and cortisol / corticosterone) impairs memory recall, damaging the amygdala and the hippocampus, two medial temporal lobe structures (Buss et al. 2004: 1093-1096; Cousijn et al. 2010: 9867-9872; Moradi et al. 2008: 645-653; Tollenaar et al. 2008: 542-541; van Stegeren 2008: 532-541; Wolf 2008: 513-531). In my previous chapter (when describing various theories on the causes of autism) I mentioned the ‘amygdala theory of autism’, whereby some researchers argue that an abnormal amygdala-fusiform system is a ‘core pathophysiological mechanism of autism’ (Baron Cohen et al. 2000: 355-364; Dziobek et al. 2010: 397-405). Abnormalities and damage in the hippocampus and related limbic system structures in the brain, it is further theorised, result in memory damage in people with autism (Ben Shalom 2003: 4-5). As I argued earlier, abnormalities in the limbic systems of people with autism could as easily represent a symptom rather than a cause of autism, and amygdala hyper-reactivity is found in people with many different psychiatric diagnoses that may be implicated in traumatic origins (Donegan et al. 2003: 1284-1293; Grandin 2005: 189-194).

To engage in psychotherapy, the rational, executive part of the brain needs to become connected, but this can be of limited use in addressing emotional arousal, or in regulating physiological stimulation (van der Kolk 2006: 281-285). Indeed, verbally describing traumatic experiences – if they are accessible to language – can activate implicit memories and trauma-related bodily sensations, evoking emotional flooding, helplessness, shame, fear, and rage, thus making trauma survivors (and their therapists) feel unsafe (Emerson and Hopper 2011: 17). Many trauma treatments today involve integrative intervention strategies and alternative therapies that move beyond the traditional talking methods, instead working directly on the body: dance, music, theatre, yoga, bodywork – Alexander Technique, Feldenkrais method, Rolfing, Hellerwork, and other holistic structural integration techniques of movement, deep tissue manipulation, and
massage – (Emerson and Hopper 2011: 17-18; Rothschild 2000; van der Kolk 2006: 282), breath training to enable calming (Briere and Scott 2006: 99-100), and sensorimotor psychotherapy – a method that mixes bodywork with cognitive and emotional processing – (Ogden and Minton 2000: 149-173; Ogden, Minton, Paine and Siegal 2006). I can attest to the usefulness and value of many of these practices, for both myself and for Django.

The terror and helplessness of trauma, and the associated cascade of stress hormones, induces changes in brain function as well as in other bodily systems, such as muscles, blood pressure, and digestion. Psychological trauma is powerfully interrelated with the body, as I have shown throughout this thesis, with the conversion of mental and emotional shock into physical forms – as we saw in hysteria, railway spine, and shell-shock, to mention only three examples – and these unusual symptoms can persist even when the person has forgotten the originating trauma (Rothschild 2000; Scaer 2001). As Toni Morrison (1990: 305) says, emotional memory is remembered in the skin, in the nerves, and in the body; once formed, traces of the conditioned fear response are ineradicable: indeed, emotional memory may be everlasting (Damasio 2000; LeDoux 1998; van der Kolk 1996a: 232).

Memory and forgetting, these life-long palimpsests whereby old ways are overwritten, only to remain, spectrally, under or alongside the surface of life, suffuse this thesis, which is at its heart a memory work. The nature of traumatic memory has preoccupied the psy professions for over a century, with Pierre Janet (1925: 145 and 661) proposing that when people experience ‘vehement emotions’ their minds may become incapable of integrating memories of the experience into personal awareness, instead splitting them off (dissociating them) from conscious control (van der Hart and Witzum 2008: 259). At around the same time, Josef Breuer and Sigmund Freud (1893: 11; emphases in original) made their famous pronouncement, ‘hysterics suffer for the most part from reminiscences,’ that is, survivors of traumatic experiences remain haunted by these events long after they are forgotten by the conscious mind. Every subsequent study of traumatic memories has essentially corroborated these initial observations: traumatic memories persist primarily as somatic, behavioural and implicit memories, and only secondarily as disorganised, fragmentated and incomplete narratives (van der Kolk, Hopper and Osterman 2001: 24), and this notion that ‘that what has been forgotten is what forms our character, our personality, our soul’ has been one of the theoretical underpinnings of the Modern Era (Hacking 1995: 209 and 180-181; emphasis added).

The mind can be thought of as many deep layers hidden from conscious thought, as Freud (2002a: 7-10) speculated when he considered the buried memories of repression, or, as Janet believed, it can be understood as a collection of lateral splits in consciousness, which could result in the dissociation of memories (P. Brown, Macmillian, Meares and van der Hart 1996: 480). Most types of psychotherapy nowadays – and hypnotherapy, similarly to nineteenth-century practices, is still part of contemporary techniques, which have a multiplicity of approaches – involve an exploration of the patient’s past, remembering and integrating things lost to consciousness (Clarkson 2003: 193-194). However, when memories of abuse are recalled, especially childhood sexual abuse, a series of legal and ethical questions arise, resting on whether these memories are true and, if true, whether they are accurate.
‘Memory print, voices and faces, stories like filament through a piece of time, so attached to the experience that nothing moved and nothing went away.’

Memory makes us who we are, and is one of the most intimate parts of ourselves. Memory is a storehouse of information; it is the thing that holds these memory traces, or experiences; and it is the mental process of learning, storing, or retrieving information (Radvansky 2006: 1). In trying to understand memory, different human cultures have used various metaphors over the centuries, and as society changed, so did the analogies used to illuminate the invisible workings of the mind (Leary 1990: 1-78). Each era has its dominant motifs, and memory was for thousands of years thought of as an art – a facility that could be trained, using mnemonic techniques that used imaginary places (buildings, theatres, wax writing-tablets), images, and symbols to locate mental images and thus recall them (Yates 1974: 1-26). By the seventeenth century, as scientific methods developed, the art of memory had changed from a way of memorising the world into a way of discovering new knowledge (Yates 1974: 368-369). It was not until the latter part of the nineteenth century that a whole new discourse of memory came into being: when clinical attention focused on pathological memory in cases of psychological trauma. Trauma, says Ian Hacking (1995: 4-5), became regarded as ‘a spiritual lesion, a wound to the soul,’ and memory became a science as a way of secularising the psyche, or soul.

To study human memory – to look at this practice aslant – is a way of trying to scientifically examine what have for centuries been regarded as the hinterlands of the soul. Speaking of the soul here is not suggesting something transcendental, but certainly invokes values such as self-understanding, reflective choice, character, honesty, freedom, and responsibility. ‘Love, passion, envy, tedium, regret, and quiet contentment are the stuff of the soul,’ says Hacking (1995: 6). People make themselves up by reworking memories, which are highly dynamic and unstable records: everytime you remember an event, you are actually remembering the last time you remembered it – a memory of a memory. The past is therefore reinterpreted, repopulated, reorganised, filled with new events, new intentions, new actions, that cause us to be who we now are (S. Rose 2003: 380). Hacking asserts that:

I do not think of the soul as unitary, as an essence, as one single thing, or even as a thing at all. It does not denote an unchanging core of personal identity. One person, one soul, may have many facets and speak with many tongues. To think of the soul is not to imply that there is one essence, one spiritual point, from which all voices issue. In my way of thinking the soul is a more modest concept than that. It stands for the strange mix of aspects of a person that may be, at some time, imagined as inner – a thought not contradicted by Wittgenstein’s dictum, that the body is the best picture of the soul (Hacking 1995: 6).

Hacking (1995: 5) argues that the new scientific battles over memory are displaced from the old spiritual battles over the soul and its defects. Sins like rape, incest, the sexual abuse of children, bearing false witness against mothers and fathers, and the destruction of the family are now fought over in a secular arena, ‘on the terrain of memory.’

Metaphorical frameworks direct the gaze. Nowadays, metaphors for memory are scientific, with the brain and memory increasingly seeming to be more like the technologies used to describe it. We now understand ourselves as individuals with memories ‘stored’ in our brains, ‘wired’ together like a computer; this cognitivist model regards the brain as akin to computer hardware, with mental activity, the mind, as software (Bracken 2003: 34; Draaisma 2001: 230-231; Leary 1990: 12; Turkle 2011: ix-x). As we engage in more face-to-face
interactions with computer screens, our minds seem more like programmes, and free will more illusory (Turkle 2011: x-xi). But our brains are not data processing machines – they cannot find and replace or cut and paste information, no matter how seductive these analogies seem to us. Indeed, the main question for memory research is over retrieval, as ‘to remember is much more than simply to extract a file from a computer store’; recollection suggests a bringing together, an assembling, a connecting, and indeed it is an active process, not some passive data encryption or hard-drive de-fragmentation (S. Rose 2003: 377-378).

Autobiographical memories are the kinds of memories that form our identities, making us unique individuals that can reflect on our life events and get to know other people by telling each other our life stories (Radvansky 2006: 239). Memory is not merely a recall of facts, and it is not just a personal act: it is relational and political; we are all formed in a network of personal relationships (Campbell 2003: 17-18). To reiterate: memories are dynamic and unstable records, that are really a memory of a memory – when recalling an event, it is really the last time you remembered this event that is being called to mind. The past is therefore reinterpreted, repopulated, and continually reorganised (S. Rose 2003: 380). We are, as Nikolas Rose (1997: 224-248) says: ‘assembled selves.’ I am not here concerned with the many characteristics of memory, such as relationships between episodic and semantic memories, and will here simply assume that autobiographical memories are constructive and integrative, spanning multiple life events – a kind of mental time travel – as well as including specific information about the world, like the concepts and skills that a person has acquired (Radvansky 2006: 239). I am here, though, only interested in one aspect of autobiographical memory: the perplexities that attend the encoding of what are termed ‘traumatic memories’, which are derived during conditions of extreme trauma.

The essence of the controversies over trauma and memory are two questions that have inspired multiple debates in psychiatry, psychology, neuroscience and the law, as well as generating arguments between professionals and laypeople alike: can individuals who have been traumatised by childhood sexual abuse forget their trauma, and, if so, can they later recover accurate memories of these horrible events? The answer to both questions is yes – albeit an affirmation tempered by the malleability of autobiographical memory. As Hacking (1995: 5) says, these battles over memory weave old spiritual concerns with new scientific knowledge: there is a profoundly religious – and, of course, political – aspect to debates over incest, child sexual abuse, and the sanctity of family relationships, especially in terms of the patriarchal orthodoxy of fathers as heads of households (S. Scott 2001: 17-18). Indeed Hacking (1994: 31-32) speaks in terms of ‘a politics of memory .... a power struggle built around knowledge, or claims to knowledge.’ Mistrust of women’s and children’s memories of abuse is now so familiar that the terms ‘recovered memory’ and ‘false recovered memory’ are often used with no real explanation of the background to these cultural and scientific debates (Davis 2005: 219-243).

Feminist activism in the 1970s and 1980s forced the issue of child sexual abuse onto the social agenda, following horrifying revelations over rates of physical abuse, or battering. The long-term consequences of sexual abuse – emotional, behavioural, and serious psychiatric problems – were extensively explored earlier in this chapter. As previously recounted, most child sexual abuse is discovered retrospectively, when adults (mostly women, but, increasingly, men) eventually disclose their secret histories of trauma. It was realised

76 I am not here interested in the more mundane aspects of recollection, like procedural or implicit memory – the ways we know how to ride a bike or play the piano.
that these survivors had been mostly ignored until they, finally, broke their silence, and there was a widespread belief, in feminist circles, that they deserved to be believed when they spoke out about their pain and suffering (Kudler 2000: 2-3). As mentioned before, Judith Herman and other feminist scholars working in the field of sexual and domestic violence made a case for a ‘commonality’ between the different kinds of violence suffered by women and men, arguing for the recognition of a shared cause:

[B]etween rape survivors and combat veterans, between battered women and political prisoners, between the survivors of vast concentration camps created by tyrants who rule nations and the survivors of small, hidden concentration camps created by tyrants who rule their homes (Herman 1998: 2-3).

The trauma suffered during combat and the trauma endured in sexual assault shared a further commonality: both experiences often involved prolonged and repeated events of overwhelming terror and danger, and could result in symptoms such as nightmares, persistent flashbulb memories, and other extreme psychiatric and somatic problems. Both combat veterans and survivors of sexual assault could, therefore, be diagnosed with the new psychiatric classification of post-traumatic stress disorder (Herman 1998: 86-87).

Child sexual abuse, enforced within the family by threats, violence, and fear of death, resulted in even worse pathologies than traumatic events endured by adults: dissociation, multiple personalities, and amnesia. As we have seen, multiple personality disorder (MPD) had slipped from clinical attention early in the twentieth century: Freud’s model of the unconscious mind had trumped Janet’s dissociation model, and the traumatic origins of MPD had been firmly repudiated (Ross 1997: 33). During a short space of time, throughout the 1970s, there was a resurgence of interest in MPD, which was diagnosed in tens of thousands of patients, mostly adult women, and nearly all in the United States (Davis 2005: 222-223; Hacking 1995: 65). As MPD was, at first, so geographically defined, it was initially thought of as a culture-bound phenomenon, but later research found MPD to have a world-wide distribution (Coons, Bowman, Kluft and Milstein 1991: 124-128). After a campaign to establish it as a legitimate diagnosis MPD appeared in the DSM-III in 1980, and has since been re-categorised as dissociative identity disorder (DID) (Putnam 1989a: 351; Ross 1997: 44-54). Although now classified in the DSM, Ross (1997: 44-54) argues that DID is not a biomedical disease entity, but, rather, a psychiatric entity, caused by social, environmental, and developmental interactions. The return of MPD and DID was directly connected to the women’s movement and its political agitation over child sexual abuse and incest, as well as to the increased understanding of the role of trauma in psychiatric disorders brought about by Vietnam veterans’ campaigns to include PTSD in the DSM – the ‘commonality of violence’ spoken of by Judith Herman (1998: 2-3). As reported earlier, a relationship between dissociation and childhood trauma – especially prolonged experience of incestuous sexual assaults – has been established by many reputable studies. MPD, DID, and alternating personality have already been examined in this thesis, and I mention the subject again only to establish a background for the fiercely political debates over the question of how trauma affects memory.

Over the last decades there has been intense controversy, often played out in the popular media in the United States and other English-speaking countries, over recovered memories of childhood sexual abuse,

77 The trope of the concentration camps persists throughout the ‘false memory’ debates, with researchers who argue that recovered repressed memories of rape and incest must be false using a similar logic to that employed by Holocaust deniers, that the Jewish genocide never happened because the traumatic memories of survivors are too fragmented and unstable to be true (Walker 2003: 107).

78 Putnam et al. (1986: 285-293) found that 97 out of 100 people diagnosed with MPD reported significant childhood sexual abuse; see also Ross 2000b: 25; Ross, Norton and Wozney, 1989: 119-122.
and whether autobiographical memory is reliable or too readily manipulated to be trustworthy (L. Brown 2000: 195-209; Campbell 2003: 1; Davis 2005: 219-243). This thesis is suffused with examples of traumatic disruptions to autobiographical memory: as Michael Hampe (2007: 95) says, ‘[t]raumatic memory can be understood as a calling-into-question of the unity of the person that is constituted by a connection between memories.’ Memories of trauma are embodied, as in Arthur Frank’s (1997: 98; emphasis in original) ‘chaos stories’ that are not narratives but, rather, ‘trace the edges of a wound that can only be told around …. an anti-narrative of time without sequence …. these stories cannot literally be told but can only be lived.’ Survivors of extreme trauma like the Holocaust can be imprisoned in the hell of their memories, totally silenced, losing their power of speech (Shlam, Pozorski and Schweitzer 2006: 2-3); or, as Charlotte Delbo (1995: 261; 1990: 2-4) describes, live like ‘a twofold being’ split between the ‘deep memory’ of Auschwitz and the ‘ordinary memory’ of everyday life. Trauma distorts time: the past jolts into the present in flashbacks and in dreams, with the event repeating and intruding into the psyche. These flashes of recall – images, sounds, smells, bodily sensations – are not like the autobiographical remembering of remembering described above (S. Rose 2003: 380), as they do not seem to be integrated or over-written: they are a rupture in a person’s biography (Hampe 2007: 91-92).

As I pointed out earlier, although some people find that traumatic events become fixed in the mind, others suffer amnesia for details of the traumatic event, with blank periods and confusion. Some individuals experience both forgetting and hyper-clear recall for aspects of the same event, and some develop ‘screen memories’ – trivial memories that hide traumatic memories. Although it seems incontrovertible that emotional intensity interferes with memory processes, theories on how this process works remain speculative as well as fiercely contested (S. Rose 2003: 380-381; Terr 1994: 223; van der Hart and Brom 2000: 233-234; van der Kolk 1996c: 279-302; van der Kolk and Fisler 1995: 505-525). Christine Courtois (1997: 206-229) argues that few survivors of childhood sexual assault have total amnesia, with most retaining some knowledge that they were raped even though their memories are fragmented and lack detail. Survivors sometimes report that more painful memories intrude into conscious awareness, but are rapidly suppressed, with only a more generalised knowledge of the period of abuse remaining. If repression is a burial of memory, says Lenore Terr (1994: 85), dissociation is ‘a sidewise slippage’ – a phenomenon particularly common in people who were sexually abused in childhood (Briere and Conte 1993: 21-31; Elliot and Briere 1995: 629-647). Children cannot form clearly narrative memories until they are able to construct meaningful phrases, at around three and a half years old, so memory for early trauma, especially if it consisted of repeated assaults, is often lost or fragmented (Terr 1994:51 and 224-226).

Trauma that occurs in familial or other close interpersonal relationships is particularly likely to result in psychic disorders, because of the betrayal involved in this violation of trust (Freyd 1997). To Jennifer Freyd (1994: 307), a child’s absolute dependency on adult care means that the child has to suppress or dissociate memories of sexual abuse and betrayal until she or he is older and no longer reliant on these same caregivers. Traumatic amnesia is therefore an adaptive response, as it ‘enables the child to maintain an attachment with a figure vital to survival, development, and thriving.’ This is a phenomenon noted earlier by Roland Summit (1983: 184-188): to preserve caregiver relationships, the child not only has to accommodate the unwanted sexual demands but has to continually re-invent the perpetrator as a ‘good’ parent: this performance splits the child’s consciousness, as splitting avoids pain. Summit says this knowledge is not always forgotten – it can be suppressed and split off; Freyd (2002: 140-141), though, insists that in betrayal
trauma ‘knowledge of abuse [is frequently] isolated from the victim’s conscious awareness’ and completely blocked (see also V. Edwards et al. 2001: 247-263; Hopper and van der Kolk 2001: 33-37; van der Kolk, Hopper and Osterman 2001: 9-31), although this knowledge can erupt unconsciously as somatic symptoms and disruptive behaviour (Freyd 1997: 3-4). Further work has reaffirmed this thesis: cognitive processes of memory and dissociative tendencies are interconnected, and knowledge of trauma can be effectively lost (Freyd and DePrince 1999 449-452). Forgetting these terrible events that were ‘forbidden to consciousness’ is therefore common in very young children who have been sexually abused, and the resurfacing of these long-lost memories in adult life has been widely reported, as well as corroborated. Summit (1992: 21-25) asserts that it is time for society to stop being so sceptical of dissociation: if people finally unearth these unspeakable memories of childhood sexual assault they should not immediately be faced with adversarial opposition to the phenomenon of delayed memory.

‘It is not your memories which haunt you / .... It is what you have forgotten, what you must forget. / What you must go on forgetting all your life.’

After more than a century of experimental and clinical research there is no longer any scientific doubt over the fact that memory recovery is a genuine phenomenon (Erdelyi 2010: 623-633). Individuals who have suffered profoundly damaging traumatic experiences, including that of childhood sexual abuse, can forget their trauma, and some of these same people can also later recall these dissociated experiences. However, not only do individuals suppress disturbing events, but so does society (Olafson, Corwin and Summit 1993: 7-24; Summit 1988: 39-60). In the 1970s the feminist movement opened the space for women to speak about intimate forms of brutality, both inside and outside the home: sexual assault (both adult and childhood), incest, date rape, domestic violence and sexual harassment (Herman 1998: 30-32).

By the 1980s many women (and some men) who had never before realised that they had been sexually abused as children began reporting memories of these traumatic experiences. These forgotten events were usually recalled with the assistance of psychotherapists, who often used hypnotherapy and guided imagery techniques; this occurred mostly in the United States, and to a lesser extent in Europe and elsewhere (Haaken and Reavey 2010: 1-5). These individuals re-defined themselves as survivors, not victims, of sexual abuse, and the term recovered memory was used deliberately to denote the fact that these survivors were taking back what was was stolen from them: reclaiming their memory, as well as trying to heal (Hall and Kondora 2005: 1340). Incestuous abuse and child molestation had been silenced for centuries, and when these women gave voice to these previously suppressed cruelties there was a widespread belief, in feminist circles, that they deserved to be believed (Kudler 2000: 2-3). Indeed, this formation of a survivor community, especially in the United States, remoulded victims into an active political force rather than them, as in earlier generations of abused women, remaining as individuals who behaved in a submissive or ‘hysterical’ manner (Hult 2005: 128).

In 1984 Jeffrey Masson published The Assault on Truth, in which he offered a provocative re-reading of Freud’s early work, claiming that Freud had deliberately suppressed the reality of incest and childhood sexual abuse when revising his psychoanalytic theories to a fantasy-based model of neurosis (Malcolm 1997). Freud became the ‘bad father’ who disguised the reality of patriarchal rape, and was vilified in many

feminist writings (Frosh 1997: 175-227). Within this climate of liberation from the oppression of centuries of misogyny and patriarchy, many incest survivors, after recovering abuse memories in therapy, broke off all contact with their families, and in some cases made criminal charges against their parents; there were several high-profile trials in the 1980s, involving women suing their parents and counter-claims from parents suing their daughters’ therapists (Sturken 1998: 103).

As increasing numbers of young women identified as survivors of childhood sexual abuse, the issue of recovered memory saturated the media. In front of rapt live audiences on television talk shows – and to great applause – celebrities and ordinary people confessed to their sufferings, revealing secret family histories of incest; and tabloid newspapers and gossip magazines printed lurid tales of hidden domestic terrors, which became increasingly embroidered with apocalyptic stories of satanism and ritual sexual abuse (S. Scott 2001: 34; Sturken 1998: 103). The topic was the theme of television dramas, movies, novels, and cartoon strips – these dark tales of incestuous families, denial, and victimhood became, says Marita Sturken, ‘a cultural phenomenon’ (Sturken 1998: 103). Diagnoses of MPD surged, as old, formerly discredited ideas like Freud’s ‘seduction theory’ and Pierre Janet’s work on dissociation were re-discovered, and as new research proved a relationship between dissociation and childhood sexual abuse, especially incest (Putnam et al. 1986: 285-293; Ross 1997: 64-66).

The proselytising of many self-appointed MPD experts fired up a social movement that organised workshops, wrote self-help books and memoirs, and made uncritical links with spiritualist groups, past-life gurus, hypnotists, and healers who claimed that alter personalities were spiritual helpers from the ‘inner self.’ As Ian Hacking (1995: 39-49) shows, ‘[i]n no other field of mental illness do fact, fiction and fear play so relentlessly to each other.’ Child sexual abuse was the driving force in the initial recognition of MPD, but fantastic stories of about criminal alter, gender-switching, and ‘inner child’ mystics opened the field to charges of charlatanism and fraud. This sensationalism distracted attention away from the actual cause of dissociation and MPD – that real events of brutal violence could cause serious mental pathologies in survivors – and seriously undermined belief in the truth of the many disclosures of sexual abuse and incest.

Gender power relations and contemporary uncertainties about sexuality and family relationships were all exposed in the controversies that followed, and although these public performances were ‘in many ways, an American story of the American family’ (Sturken 1998: 103), the panic also swept through the United Kingdom, Europe, Australia, and New Zealand (S. Scott 2001: 34). What was under attack was patriarchal family structures, defined by radical feminists as bastions of women’s and children’s sexual and economic servitude, ruled over by domineering, authoritarian fathers (Herman 1981; S. Scott 2001: 16-23). As men also began revealing forgotten childhood traumas, tales of sexual abuse perpetrated by priests, social workers, sports coaches, doctors, and medical orderlies emerged. As it became evident that paedophiles had set up organised networks of abuse in social structures like churches, child protection agencies, and children’s homes, these institutions, once above suspicion, also came under attack (S. Scott 2001: 28-29; G. Robertson 2010: 16).80 The recovered memory debates were political battles.

80 Exposés of clerical sexual abuse began in the mid-1990s, and burst into public scrutiny in 2002 in the United States with revelations that the Catholic Archbishop of Boston, Massachusetts, had covered up sexual misconduct by priests in his archdiocese.
A backlash against feminism, coupled with a carefully orchestrated campaign of scepticism against the recovered memory movement, gradually developed, reaching its peak in the late 1980s and early 1990s (Myers 1994). David Hechler (1988) says that the popular support that feminists had won over the issue of child sexual abuse, as well as political support that reinforced the child advocacy movement, meant that no-one was exempt from suspicion of incest, even ‘pillars of the community’ like religious leaders. Hechler believes that as powerful figures came under attack, ‘cries of “witch hunt” began to echo’ and it was increasingly argued that the pendulum had swung too far in the favour of accusers. One issue that fueled this counterattack were accusations of incest (some true, some fabricated) made by women against their ex-husbands during acrimonious divorce and child custody actions (Hechler 1988; Vacchs 1989: 1-3).

The backlash was strengthened by class issues, as well as by gender politics, when men (and some women) from elite backgrounds found themselves accused of sexual crimes against children (Olafson 2011: 10). Child sexual abuse had been thought of as a problem only in families with low socio-economic status, but once accusations were levelled at ‘decent’ middle-to-upper-class families, friction began to emerge into the public sphere (Hult 2005: 133-136). These wealthier families, who had privileged access to government officials, religious leaders, policy makers, the law, and academia and to the media, attacked the credibility of adult survivors and alleged child victims. Using flawed research and legal manoeuvres, they also questioned the credibility of the competence of child advocacy centres and law enforcement agencies, raising concerns that to this day compromise the effectiveness of investigations into child sexual abuse (Hult 2005: 10-11). The mass media, which initially had supported cases of recovered memory, began to criticise the practice, and feminism and the recovered memory movement were accused of breaking up families, and of inculcating what was regarded as a cult of victimhood among young women (S. Scott 2001: 37). The phenomenon of revelations of child sexual abuse, followed by powerful backlashes that conceal and suppress knowledge of the scale of the problem, has been a constant pattern – what Judith Herman (1998: 7-8) calls a history of ‘episodic amnesia’ – throughout the Modern Era (Hall and Kondera 2005: 1341; Olafson, Corwin and Summit 1993: 7-24; Summit 1988: 39-60; van der Kolk, Weisæth and van der Hart 1996: 47-74).

In 1992 the False Memory Syndrome Foundation (FMSF) was formed in the United States, established by Pamela and Peter Freyd, the parents of Jennifer Freyd (now Professor of Psychology at The University of Oregon). Jennifer Freyd (1997: 197-199) had, as an adult, recovered memories of persistent childhood sexual abuse by her father, although she never brought criminal charges or discussed her private life in public until her mother published an anonymous article attacking both Jennifer’s professional work and her private life. After Jennifer Freyd presented her academic work on betrayal trauma, her parents (who are both academics), along with Ralph Underwager (formerly a Lutheran pastor) and others, formed the FMSF. The foundation members of FMSF, Underwager, Elizabeth Loftus, and Richard Ofshe – all on the Advisory Board – had previously worked in criminal cases as defence experts for parents accused of child sexual abuse; Loftus and Ofshe are high-profile academics. Ralph Underwager resigned from the FMSF in 1991 after the publication of an interview in Paidika, a Dutch journal that promotes the normalisation of paedophilia (Dallam 2001: 9-36). In the interview, conducted with Underwager and his wife, Hollida Wakefield (also a member of the FMSF Advisory Board), Underwager was quoted as saying: ‘paedophiles need to become more positive and make the claim that paedophilia is an acceptable expression of God’s will for love and unity among human beings.’ He went on to make further remarks supportive of paedophilia, saying that it
could be a positive, loving, and nurturing relationship for a child; it was a much worse experience for a child (according to Underwager) to have their family torn apart by these kinds of revelations (Geraci 1993: 2-12).

The FMSF is not a scientific organisation, despite its claims, and its early activities were all focussed on influencing the legal system and the media: its actions have always been geared toward defending parents and blaming psychotherapists for creating false memories of sexual abuse (Dallam 2001: 12). According to Joseph Davis (2005: 228), paraphrasing a FMSF newsletter, the ‘victims’ are the person (usually a woman) making the claims of abuse and her parents (the people the woman originally accused of abuse); the therapist is re-cast as the ‘offender’, a witch-like figure who fosters ‘an inappropriate personal dependency ... [within] a “cult-like” clinical environment.’ The FMSF regards the recovered memory movement as a feminist plot used for anti-family, especially anti-father, purposes (Davis 2005: 232). As Ian Hacking (1995: 5) says, the memory wars are really not scientific at all – they are battles over what was formerly cast as religious territory: the sins of the soul, like bearing false witness against parents (especially fathers), and the destruction of the family. The FMSF have, however, framed their debates as a crusade between what they present as their own empirical science and the kind of ‘therapeutic romanticism’ they claim is embraced by trauma therapists.

The FMSF casts its accusations in empirical and scientific language, attempting by this rhetorical device to make therapists seem like quacks, delegitimising their status as healers (Davis 2005: 232). ‘False memory syndrome’ (FMS), though, is not a clinical entity, emerging rather from FMSF accounts of false accusations of abuse: indeed FMS’s main feature is that an individual becomes involved in therapy with a psychotherapist who believes in recovered memory, and who uses techniques such as hypnosis, guided imagery, dream analysis, sodium amytal, regression work and relaxation to elicit false memories of sexual abuse (Dallam 2001: 13-14). FMS has never been validated as a diagnostic construct, so is not listed in the DSM, which refused to include the ‘syndrome’ in its fourth edition or in the following text revision in 2000; furthermore, many behavioural scientists object to the name, arguing that FMS is not a syndrome, nor is it a robust psychological term (Dallam 2001: 15-16). Although it does not list recovered memory in its categories, the DSM does, however, recognise that memory problems – both failings and intrusions – are a common feature of post-traumatic conditions (Dallam 2001: 17). The notion of false memory has, though, become a commonplace in the media, and pressure from the FMSF has had an undeniable effect on psychotherapists, both on professional discourse and practice (Davis 2005: 229). Expensive malpractice suits against therapists have been enacted world-wide, and clinicians working with traumatised clients with a history of child sexual abuse now have to be very careful to avoid this medico-legal minefield (Ross 2000b: 349).

A great deal of therapeutic practice is based on re-working memory, and clinical listening, especially in psychodynamic therapy, is attentive to subtexts, recurring motifs, and emotions attached to childhood memories: these are heard as stories about the self (Haaken and Reavey 2010: 5). As therapy proceeds, it is common for clients to recall long-forgotten incidents, and occasionally memories of abuse – whether psychological, emotional, physical, or sexual – can be unexpectedly and shockingly remembered (Conway 1997a: 1). However, some techniques, particularly hypnotherapy and other similar rituals, can produce false beliefs in suggestible people: a phenomenon known from at least the eighteenth century and the mesmerism craze. Hypnosis has always been known to be able to manipulate the minds of vulnerable patients, creating
bizarre behaviours and confabulation (Trillat 1995: 437), and autobiographical memories, as we have seen, are anyway malleable, changeable, and unreliable (Hacking 1995: 6; S. Rose 2003: 380). Research suggests that recovered memories are no more and no less reliable and accurate than a normally functioning autobiographical memory, and longitudinal studies have confirmed that individuals with abuse histories (events that are legally documented and corroborated) have recovered accurate memories after years of forgetting (Dallam 2001: 17). Memories of long-forgotten childhood trauma can be triggered by events experienced in adulthood, not only in therapy – highly emotional and painful experiences often act as reminders: adult rape, domestic violence, interpersonal crises, or giving birth (Hall and Kondera 2005: 1344-1345; Herman 1998: 114).

The FMSF continues, however, to wield a powerful influence over the field. The organisation has successfully shifted the focus away from survivor testimonials toward investigations of the malleability of memory, using fears over suggestibility as their major strategy. As Sue Campbell (2003: 19) points out, the writings of the FMSF advisory board members Elizabeth Loftus and Richard Ofshe, which offer ‘descriptions of memory as suggestible, malleable and false come to characterise the woman who makes a claim about abuse in her past [and the] representation of women as highly suggestible in turn affects how we think about memory.’ This is a replay of the old tropes of women as weak and illogical, or, if they accuse their abusers, as vengeful harpies (Courtois 1997: 211): indeed, the FMSF has described the recovered memory movement as ‘an “hysterical epidemic” of false memory claims’ (Davis 2005: 230). As Judith Herman (1998: 1-4) notes, when men were found to suffer from amnesia or delayed recall of memories of combat atrocities, this issue was less controversial: once similar problems were documented in children and women in domestic settings, where the violence of intimate partners and incestuous parents was enacted, this at first seemed unbearable; once these victims began to seek justice, threatening powerful individuals and social structures like the patriarchal family, the issue rapidly became heavily politicised.

The FMSF relies primarily on Elizabeth Loftus’ work on memory. Loftus and her colleagues (Loftus, Miller and Burns 1978: 19-31) conducted laboratory experiments in which subjects watched a film or saw slides of a road accident (or a similar occurrence) and were then provided with a verbal description that included an erroneous statement about the event. Loftus (1993: 518-537; 1979a; 1979b: 312-320) argues that this misinformation became integrated into the memory of the original event, thus creating false memories. This work has been tremendously influential, but also controversial. Michael McCloskey and Maria Zaragoza (1985: 16) have challenged Loftus’ assertions, instead arguing that the effects of misinformation can be explained by biases created in the experimental procedure, and that Loftus’ integration claim is ‘so vague and ambiguous as to be virtually meaningless.’ It hardly needs to be pointed out that laboratory conditions cannot replicate the helplessness, horror, terror, or fear of death or mutilation that characterise traumatic events in the real world. Survivors of real-life traumas, though, do seem to remember accurate details of their experiences, even when they have incomplete recall of what happened to them (L. Brown 2000: 203; Elliot and Briere 1995: 629-647).

It is nevertheless clear that some research subjects do modify their memories if the person suggesting the misinformation is authoritative and powerful; however not only therapists should be suspected of these manipulations, as it is equally possible for ‘authority figures to induce false reports of not having been abused’ (Dallam 2001: 19-20; emphasis in original). Indeed, Richard Kluft (in Dallam 2001: 20) observes
that these experiments surely show ‘that “a family determined to mess up a child’s sense of reality has a good chance of succeeding.”’ Assumptions that false memory only pertains to those who allege that they are victims of abuse miss another vital point: the possibility that offenders may also have false memories is rarely mentioned. Men or women who commit sex crimes, whether inflicted on adults or children, are not known for their honesty (Courtois 1997: 211), and as Abby Stein (2007: 20) describes, violent offenders commonly dissociate and forget what they have done to their victims: “[p]erpetration is psychically exiled.’ But only a few offenders have their crimes luridly inscribed on the collective consciousness; most child sexual assaults happen in the shadows, in the home, in secret acts known only to their victims, their friends, and their families.

‘Go, go, go, said the bird: human kind / Cannot bear very much reality.’

The sexual molestation of children and the long-term psychological damage that it causes is a phenomenon that is still overlooked and belittled not only by the psy professions but by most of society. Occasionally there is a spectacular revelation of the scale of the problem, the suffering of survivors, and the depravity of the perpetrators. Then, typically, a backlash swiftly sweeps away much of the knowledge gained, and sceptics denounce the believers, scoring their insights as false, or as treacherous, or as confabulated as a fairy-tale (Summit 1988: 39-41). Indeed, as we have seen, the entire history of psychological trauma – whether the damage is wrought on men in combat or women and children by sexual assault and incest – is marked by these ‘cycles of discovery and suppression’ (Herman 1998: 3-4; Olafson, Corwin and Summit 1993: 7). I ask my readers to attend to the fact, often forgotten, that bad things actually do happen and really can drive you crazy (Read and Haslam 2004: 133).

As well as the already established diagnosis of PTSD, evidence on the aetiological relationship between adverse childhood events and psychosis continues to grow (Read, Bentall and Fosse 2009: 299-310) and links between trauma and the later development of major depression, alcohol and substance abuse and suicide ideation are becoming clearer (Gaudiano and Zimmerman 2010: 462-470). I have shown that children with disabilities and developmental disorders, including autistic children, are at increased risk of physical and sexual abuse, often undisclosed and undiagnosed. It is difficult to know if these children had difficulties to start with or if certain of their symptoms are caused by some form of traumatic victimisation (Finkelhor, Ormrod, Turner and Holt 2009: 325; Reid 1999: 93-109; Ross 1997: 64-66; Rustin 1997: 261-266; Tustin 1992: 11; van der Kolk 1996b: 64-66). The concept of a spectrum of post-traumatic disorders has been suggested for over thirty years (Finkelhor 1987: 354; Herman 1992: 377-379) but survivors of childhood trauma, especially those exhibiting dissociative symptoms, are still diagnosed with a list of comorbid disorders and treated with the accompanying polypharmaceutical arsenal (Ross 2000b). As Colin Ross (2008: 29-32) notes, the pharmaceutical industry, and thus most psychiatry, is not interested in the dissociative disorders, for they are not profitable. With the exception of PTSD, mental health services and research are still dominated by a reductionist focus on biological phenomena. Despite claims that psychiatry nowadays has a more nuanced view, the much-heralded biopsychosocial perspective, on the ground this is more often still experienced as a ‘bio-bio-bio-model’ (Read, Bentall and Fosse 2009: 299). The social context, where the brains and genes of individuals actually live, is still given minimal consideration.

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The kind of complex behaviours that Django enacted, his hallucinations, amnesia, dissociation, aggressive outbursts, and other emotional disturbances caused by his experiences of childhood sexual abuse, are, with diagnostic sleight of hand, transformed into tidy categories of illness located within his own defective neurochemistry. Survivors of trauma are thus still commonly faced with a culture that denies the reality of their suffering, even though there is more awareness of the problem now than there was a century ago. Furthermore, many people working with the disabled or mentally disordered often simply do not want to see that sexual abuse and mental impairment coexist, or that disability can be emotional in origin, and not due to brain damage. Although I can do no more than suggest the truth of this in an empirical work that explores only my own and my son’s stories, Valerie Sinason’s (2010: 116) insights ring true to me: the appearance of disability can be a defence, a screen to hide behind against the memory of sexual abuse. Roland Summit (1988: 58) says that we need, as a society, to pay closer attention to what children say and do to try to draw attention to their ‘hidden pain.’ We also need to listen to the trauma stories of adults who were abused as children, as well as adults traumatised and abused as adults. An alteration in perception and ‘a shift in caring might strengthen women, sensitize men, and actually eliminate substantial amounts of heartbreak, alienation, mental disorder, and mayhem.’ As a memory work and an historical genealogy – a witnessing of trauma – this thesis endorses this request.

There is nothing heavier than compassion. Not even one’s own pain weighs so heavy as the pain one feels with someone, for someone, a pain intensified by the imagination and prolonged by a hundred echoes.\textsuperscript{32}

‘He who fights with monsters should look to it that he himself does not become a monster. And when you gaze long into an abyss, the abyss also gazes into you.’

I have claimed that this thesis is about haunting. It is a story about one child, Django, haunting his social world, increasingly pushed into an exclusion zone by his bizarre behaviour and unrecognised history of childhood sexual abuse. This tale is told in my autoethnography. This thesis is also an exploration of a larger social picture: of the Otherworld where many other people are banished as a result of their mental disorders – disorders often also caused by past experiences of traumatic events. To illuminate this state of affairs, a situation that is often forgotten or ignored by the psy professions, I have written a history of the present that explores both the development of psychiatry and the battles fought by trauma survivors, revealing shadowy connections that are ordinarily overlooked and concealed: the links between subjects and social structures, biographies and history. Psychiatry’s gaze, as I have repeatedly pointed out, is still nearly always focused on the inner world – the broken brain, now, rather than intrapsychic conflict – of the individual as the site where mental disorder originates. As a counternarrative, my thesis is designed to question this stance and to insist that terrible things really do happen and really can drive people mad.

This has been a harrowing journey for me; in part due to the isolating nature of doctoral research, but principally because my investigations have repeatedly shown me things that I did not want to see. I knew, of course, that these stories of cruelty and suffering existed, and were true, before I began my studies, but gazing into the abyss – as Nietzsche says – can make the monsters come to life in one’s own head, as well as out there in the world. These stories of pain have sometimes overwhelmed me. Chaos stories, as Arthur Frank (1997: 97-102) observes, are threatening to hear. Telling this story, which is my own and Django’s, as well as recounting the chaotic stories of others, has wounded me. I have, through this entire process of research and writing, been torn between what Judith Herman (1998: 1) describes as ‘[t]he conflict between the will to deny horrible events and the will to proclaim them aloud [that] is the central dialectic of psychological trauma.’

I can, therefore, understand the desire to look away from atrocity, to banish it from consciousness. Some things, I agree, are so terrible that it is a natural human response to bury these events, to leave them unspoken. ‘Go, go, go, said the bird: human kind / Cannot bear very much reality’ says T. S. Eliot (1944: 13-20), and I think he is right. Only, the ghosts do not remain silent, and the echoes and murmurations of forgotten, lost things remain there, hidden behind the walls built by dominant ways of looking at the world. Avery Gordon’s writings have spoken directly to my desire to trace these ghosts: the shape of their presence defined only by their absence in the historical record and psychiatric discourse. I began my thesis several years before I read Gordon’s work, but her exploration of the connections between history, horror, and haunting has profoundly affected me. ‘To study social life one must confront the ghostly aspects of it,’ she writes, insisting that this kind of research calls for a sociological perspective that enters ‘through the other door’ (Gordon 2007: 4-7 and 65-66 and 197; emphases in original).

‘It’s not that the ghosts don’t exist.’

These stories need to be told: it is an issue of social justice. Avery Gordon (2007: 64-65) observes that ‘entire societies become haunted by terrible deeds that are systematically occurring and are simultaneously denied by every public organ of governance and communication’ and oppression in the past needs to be spoken for, as well as injustice in the present. Entering through a different door, I have used interdisciplinary methods, mixing the personal – my autoethnography – with an extensive history of the present, in order to illuminate my account of what Roland Summit (1988: 39) calls the ‘[h]idden victims [and] hidden pain’ of the sexual abuse of children. To do this I realised that I needed to uncover psychiatry’s other ghosts: earlier practices that are now discredited and abandoned by mainstream medical treatment, like mesmerism, hypnosis, and psychosurgery, but also the power struggles between different factions of the psy professions. The current institution of biologically-based professional psychiatry did not, after all, develop from a series of progressively more enlightened scientific discoveries, but rests on a much more contingent array of techniques of dominance and suppression.

In writing this history, I do not argue that Django’s suffering, my own suffering, the suffering of countless others, should be rewritten in medical terms. I have shown that the psy professions have always had a highly problematic relationship to real traumatic events and to the very real and destructive psychological suffering caused by these occurrences, but to pathologise trauma is not the ultimate answer to this dilemma. As I found, suffering needs to be medicalised in order to gain access to state funding, to education, to treatment, indeed to the kind of social personhood that is permitted in our culture. Even a person labelled with a stigmatising mental disorder is at least a category of a person, able to draw benefits and demand some kind of ethical treatment. But this is surely wrong: it turns pain into currency, exchanging a passive role of victimhood into a further passive role, of post-traumatic stress disorder, or dissociative identity disorder, or schizophrenia, or autism spectrum disorder, or one of the many other disorders proliferating in psychiatric diagnostic categories. This is a process criticised by Arthur Kleinman (1997: 175-176), as he describes the techniques of violence used to suppress political resistance: trauma silences through suffering, but ‘to receive even modest public assistance it may be necessary to undergo a transformation from one who has lived through ... terror, to stereotyped victim, to standardized sufferer of a textbook sickness.’

The psychiatric survivor / service-user movement is defying the power of psychiatry to label individuals as ‘mentally ill’ instead working to build their own kind of identity. Psychiatric survivor Ron Coleman (in N. Crossley 2004: 161) says he does not want to labelled, he wants to be himself: ‘[f]ourteen years ago I was diagnosed as schizophrenic; five years ago that was changed to chronic schizophrenic; three years ago I gave that up and went back to being Ron Coleman.’ Psychiatric survivors are establishing their own knowledge base in opposition to the truth claims of psychiatry: instead of statistical evidence, scientific classification, and professional expertise, survivor knowledge privileges the experience of the individual, his or her life-course trauma, and personal testimony (Cresswell 2005: 1668). After all, why call the devastating effects of traumatic events a disease? As I have shown throughout this thesis, men in active service in combat situations, women enduring rape and domestic violence, and children victimised by incest and sexual abuse all experience intense fear, terror and helplessness, and all can develop profoundly disabling
and painful symptoms of emotional and psychic distress. However, the locus of this suffering is not within the individual mind: it is a social problem.

The DSM can try to manage suffering by categorising it as a mental disorder, and physicians can try to mitigate the pain by prescribing medication developed and marketed by pharmaceutical companies, but this is just bureaucratising violence and misery. This social construction of personhood is what Michel Foucault (1992: 6-7) describes as ‘the games of truth and error through which being is historically constituted as experience; that is, as something that can and must be thought.’ This process has been recognised throughout this thesis: the notion that it is a person’s inner world or broken brain that causes mental disorder exists within a certain kind of reality that permits the way of ‘making up people’ that dominates the current episteme of the Modern Era, affecting the way that nearly all of us see and speak (Deleuze 1999: 47-48; Foucault 1994: 238-309; Hacking 2006: 23-26). It does not have to be this way. Even Foucault (2006b: 341-346; 1980: 81) – a notoriously pessimistic theorist – acknowledged that resistance is possible, regarding the challenges of the psychiatric survivor / service-user movement as a good example of ‘an insurrection of subjugated knowledges’ working against psychiatric power, and towards what he described as the ‘depsychiatrization’ of society and a concomitant ‘demedicalization of madness.’

Psychiatricising and medicalising trauma is a further violation of survivors: the person is treated as other, as a patient or as a mental health service-user, as having an inner pathology that can be fixed. This kind of suffering, as we have seen, is in reality interpersonal in its cause. We should – indeed it is surely essential that we must – all respond to psychological trauma as a form of social suffering, but as Kleinman (1997: 189) points out, our technologies, our policy frameworks, and the professional discourses we use to diagnose, treat, and evaluate trauma are all such powerful political and cultural forces that it is difficult to change the way they operate. A psychiatric diagnosis can open the door to resources, as I describe in my autoethnography, but Django’s labelling as a mad kid, a ‘mental health service-user’ is also stigmatising. I have been very careful to protect him while he is still a child, but as he has reached adolescence and grows into adulthood the world may not be kind to him. Django’s pain has burdened me, although it is a weight I have willingly carried. ‘There is nothing heavier than compassion’, writes Milan Kundera (1987: 31), but an ethic of compassion surely requires that we look at the wider social, cultural and economic systems of oppression and violence that pathologise suffering while refusing to look beyond it to systems of structural violence that deny the widespread reality of childhood sexual abuse and the damage that it causes.

‘Complex personhood means that even those called “Other” are never never that.’

The questions I set at the beginning of my thesis have no simple solutions. My history of the present describes how people deemed mentally disordered, or mad, have been managed, categorised, and diagnosed by the psy professions for the last two hundred years. I think it is clear that this process of care and control has been wildly variable and full of contestation, lurching from what was at the time believed to be one good idea to the next innovation. Some diagnoses and treatments now seem bizarre, such as somnambulism and hysteria, along with dermagraphism and hypnotic treatments. Degeneracy theory and the physical assaults of insulin shock coma and psychosurgery are horrifying. But as I have shown, these ideas and practices did not occur at the periphery of professional praxis, but at its centre; indeed the

originator of the practice of leucotomy, António Egas Moniz, was awarded the Nobel Prize in 1949. Well-intentioned and trusted psychiatrists performed these dangerous treatments despite having no scientifically valid proof to legitimate their actions, as they were blinkered by the epistemological climate they worked within. The so-called psychopharmaceutical revolution currently in vogue is similarly dogged by accusations of a lack of scientific rigour. As we have seen, patients, psychiatric survivors, and service-users are usually powerless in the face of this medical recklessness. Tracing these historical, social, cultural, philosophical and economical practices, legitimations and beliefs does not reveal a steady progression of scientific knowledge nor does it reveal a blossoming of ethical and compassionate therapeutic methods. When we turn to the past, ‘the storm of progress’ is not a reassuring sight (Benjamin 1999: 249).

How this can be resolved and remedied calls for a different way of doing psychological healing, moving away from generalising categories and towards compassion. As we have seen, psychosocial treatments for mental disorder have been largely relegated to an inferior role by psychopharmacological interventions. There are, however, many academics and psy professionals who do not work within the practices of biological psychiatry, eschewing drugs unless absolutely necessary, and instead using psychotherapy and cognitive behaviour therapy. There are, as well, many programmes and projects run by psychiatric survivors / service-users. The hegemonic grasp of the dominant biogenetic model of mental illness disregards the psychosocial factors that cause serious emotional and behavioural problems, so it is usually assumed that nothing can be done to prevent the continual – indeed ever-growing – incidence of mental disorder. Psychological trauma is appallingly common in our society. To prevent mental illness, as George Albee (1996: 1130-1133; 1985: 213-219) has argued for decades, there need to be social programmes for decreasing stress and preventing the sexual exploitation of children, while at the same time enhancing self-esteem, coping skills and building better support networks for children and their caregivers. Power needs to be redistributed, social justice needs to be increased, and sexism, racism, exploitation and colonialism must be rejected (Albee and Gullotta 1997). ‘It is,’ says Albee (1996: 1131), ‘as simple and as difficult as that!’ As Emma Davies and Jim Burdett (2004: 279-280) observe: ‘lives experienced as worth living need a social context of vibrant interconnectedness and interdependence.’ Thought about in this way, it is not so much that something needs to be abolished, more that we need to build a society that allows women, men, and children to thrive. Mental health flourishes in loving families, caring relationships, friendship, economic equity, and enfranchisement in the local and wider community.
'This is my secret, this is the chord most perfectly strung.'

We sit at the table by the window. The sun was up several hours but there was no sign of it. A low haze of sullen rainclouds, sudden squalls of wind straight off the sea. Somewhere out there behind the rainstreaked windows are pōhutukawa, a line of silver dollar gums, and cabbage trees. Birds hiding in the branches. The wind did not abate; the wires behind the house sing. We are drinking tea; hands warm on the green cups.

I say: ‘You just turned sixteen – can you remember much from ten years ago?’

‘Hmmm, not really,’ says Django, ‘not much at all ... I can remember the Hospital, because of the ambulance every morning – it was pretty exciting, and you gave me a Walkman so I could um listen to tapes. It was such a long drive every morning. I had Roald Dahl stories, didn’t I?’

‘That’s right ... it’s funny, isn’t it? Everyone has iPods now, and before that Lula had a Discman with CDs, but back then you had a Walkman with cassette tapes, so that was even earlier – ten years is a really long time ago,’ I say. ‘Do you remember any of the psychiatrists?’

Django pauses, looks a bit worried, ‘No. But I can remember the Somali girl at the Hospital – was she Somali? – Amina was her name, I think. I liked her.’

‘Yeah, I remember her as well. Can you think of anything else?’

‘No.’ He looks over at me, he’s drawing something on a scrap of paper left on the table.

‘Tell me what you do remember from back then,’ I say, ‘anything at all that pops into your head. Do you remember Reynard at all?’

‘Well,’ says Django, ‘all I remember about him is that he had red hair and he was always going to the bottle shop. He liked to drink, aye Mum. I don’t know why.’ Django stops for a few minutes, folding the piece of paper into an origami fox. ‘I remember starting at the School, though.’ He pauses again, standing the fox on the table, and then flicking it over with his middle finger. ‘I think it’s because I felt I belonged there. I can’t really remember the earlier schools – I know I went to them, but I can’t picture being there at all.’

We sit for a while, drinking the green tea. I am watching him.

Django breaks the silence: ‘I remember going to see Wade, and playing with sand, and drawing pictures. And Maya, the homeopath – she had, what did you call them?’ He looks at me, teasing: ‘Fairy drinks, fairy pills?’

‘Yeah, I wouldn’t get away with calling them that now, would I?’ I laugh as well. ‘Seriously, though, what – or who – do you think has helped you most over these years, since you went to the Hospital, and then to the School? All those therapists, shrinks, and teachers you saw.’

Django stretches a bit, looks out the window. The rain gets heavier; big drops, and is that hail? He sighs. ‘I can vaguely remember going to all sorts of things – swimming lessons? some kind of social skills thing? Art classes, definitely, and piano lessons. Didn’t I learn how to play the X-Files theme tune? I liked the swimming and the art; I love the art. I really liked Hedda and Perdita when they were my teachers.’

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'They spent heaps of time with you, helping you with all sorts of different art techniques at school. It's a shame they left, but they must have been with you for, oh, about seven years, I think.'

'Yeah, they were both great. And I'm glad that we're still friends with Perdita – that night-time bush-walk we went on with her was great, in the Waitakeres, you know – those cave weta were, like, amazing.'

'Do you think that relationships with people – like Wade, Hedda, and Perdita – were the most helpful thing for you?' I ask. 'Or the treatments – the medications?'

'Definitely the people,' says Django. He frowns. 'I don't like taking the pills. I think they might have helped a bit sometimes, but I don't want to take any more again – I know the Prozac helped for a while, and I guess the aripip – what are they? Ar-ip-ra-zae. Yes, that's it. I know taking that stopped the voices in my head. I can't say I liked Selby much [the child psychiatrist] as he was always so kind of weird, trying to make me like him. The yoga is better – meditation and yoga are really good.'

'You've got very interested in Eastern philosophy and Buddhism now, haven't you?' I say. 'And I can see that the yoga and meditation are really good for you. They may help you to stop the meds, after a while. You like swimming, too – I think that you've always found it relaxing to do things with your body: when you were younger you liked running, as well, and trampoline, and swings – letting off steam. And we've always liked walking in the bush or by the sea.'

'That's true.' Django sits quietly for a while, staring at the rain stippling the dark glass. 'Really, Mum, it's you, and Nan, and Paura, Fionn and Lula, that have been the best. It's family, isn't it? We all look after each other, we love each other. The dogs, too, Tulip, and now Booker. Silly old thing, aren't you Booker.'

Pokes Booker with his foot; Booker, lying apparently comatose, wags his tail like a furry metronome. Django stands up, puts a CD on the stereo – his brother Fionn's band.

'I like listening to Fionn singing,' he says.

Lula's photographs line the walls, images she caught in Smith's Bush, desolate factories in south Auckland, and eerie twilight landscapes from Texas, California, and Virginia. Django's wearing a greenstone that Paora carved for him. The scent of Nan's baking drifts upstairs. We're all around him.

'That's a nice thing to say, sweetie. I'm sure it's true. I really love you, and you've helped me a lot, too. Truly, really, I just can't imagine life without you.'

Django sits back in his chair, smiling.

Thunder rumbles. We count to nine before lightning glimmers. No rainbows. A day when the air is particularly thick, with winter still in the corners.

'Are you bored with this conversation now?' I say.

Django laughs, 'Can we go into town next Sunday? I want to go to my yoga class, and I know you're writing later so we can't go today.'
'Yes, I’ll have finished writing the thesis this week.’ I sigh, and make a terrible face, like Edvard Munch’s ‘The Scream.’

Django grabs the remote, and switches on the TV: ‘Watch Monty Python with me ... I can walk like the Ministry of Silly Walks, y’know.’

We both laugh.

One is afraid of
the self that is afraid of
the self that is afraid of
the self that is afraid
One may perhaps speak of reflections 87

‘One may perhaps speak of reflections.’88

Reflecting on exclusion zones, and banishment, we need to ask what it means for people to be pushed to the margins of society. If one is pushed outside the social, one dies a kind of social death, losing human status, becoming abject, abhuman. This liminal condition leaves people at the mercy of the vast indifference of policies that seek to contain them and eliminate them from society. Family may oftentimes cause the injuries of psychological trauma, but it can also ameliorate the damage done by terrible events. Throughout this thesis, I have demonstrated that trauma and adversity can cause the development of mental health problems, but the opposite is also true: interpersonal relationships can heal suffering and mental illness. If, as Judith Herman (1998: 53; emphasis in original) says, a ‘traumatic event ... destroys the belief that one can be oneself in relation to others,’ and since the self fundamentally exists in relation to others, the self and meaningful relationships with others can be rebuilt. I stated this belief at the beginning of my autoethnography: re-making the self in the aftermath of trauma needs an audience, an understanding listener, and a witness: it is a moral duty ‘to listen to the voices of those who suffer’ (Frank 1997: 25). This story is not, however, a restitution narrative: there is no destination, no solution. The chaos stories that underpinned my autoethnography have quietened now, except in my memory, and what is left is the journey – this is a quest narrative, accepting disability and trying to make use of it: trying to gain some enlightenment from the experience of pain and suffering. As Zygmunt Bauman (2005: 1096-1097) insists, when writing as a sociologist, there is no ‘morally neutral way’ of practicing sociology: understanding the human condition, making it intelligible, and disclosing the reality of human suffering may not resolve the misery, but it brings light to the possibility of transformation.

अहिंसा

89 Django chose this Sanskrit word to end the thesis. Ahimsa means ‘do no harm’, the avoidance of violence.
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