

# Madpeople's Coping Mechanisms

## Abstracts of Presentations (in order of presentation)

### "You think too much, that's your problem"

Anne O'Donnell

*that I could not go on living. I came to theory desperate, wanting to comprehend—to grasp what was happening around and within me. Most importantly, I wanted to make the hurt go away. I saw in theory then a location for healing." bell hooks (hooks 1991)*

Since my teens, I have been told that if I didn't think so much, I would be fine. But I wasn't fine. I was hurting as bell hooks describes her own experience, and I wanted to understand why. It's been a long journey from reading psychology textbooks in the local library to being a Mad Studies lecturer and PhD candidate. But now I am here, I can look back on a life of "thinking too much" and I see that trying to make sense of myself and of the world I live in was not the problem. It was and still is the means through which I keep continue to live. In short "thinking too much" has been and continues to be my main "coping mechanism" or as hooks puts it "a location for healing"

In this talk, I will explore my experiences of distress and of thinking too much in relation to epistemic injustice. I will also explore my experiences of the intellectual work in survivor activism and how critical pedagogy (Freire 1970, 1993, hooks 1991, hooks 1994) and Mad Studies (LeFrançois, Menzies et al. 2013) have also been part of my "coping mechanisms" of thinking too much.

I will consider concepts such as intellectualisation as a defence from psychoanalysis, and rumination and overthinking from cognitive behavioural therapy. These concepts have been used against me "thinking too much" by many mental health workers. However, some workers who have validated this have been invaluable to me.

I will conclude by sharing my thoughts about how my experiences of "thinking too much" *may* be useful to other Madpersons and how we might collectively develop spaces both within and outwith mental health services that can support "thinking too much".

### References

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- hooks, b. (1994). *Teaching to Transgress: Education as the Practice of Freedom*. Routledge
- LeFrançois, B. A., R. Menzies and G. Reaume, Eds. (2013). *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto, Canadian Scholars Press Inc.

## **A fluent mind and a box: Fitting the cycles of life and creativity into a rigid work society?**

**Ida Hallgren**

The rigidity of modern work society suppresses valuable human traits such as creativity, sensitivity and the natural tendency to respond to moral concerns. Social norms that favor work society devalue traits unfavorable to predictable and standardized productionism, such as spontaneity, complexity and a rich variety of emotional expressions. Individuals at odds with predictable productionism are often described as oversensitive, overthinking, unattentive, highly sensitive, emotionally unstable or too emotional. In contrast to norms associated with modernity, industrialism and standardized conformity to static demands, post-modern work society puts demands on individual flexibility. In the post-modern era, individualized expressions of emotional uniqueness can be channeled through individualized life projects and identity transformation through consumption, where “the individual” is perceived of as at odds with “society”, but the norms of work society are left intact.

Work society is focused on calculated utility and predicted outcome. Using examples from situated personal experiences of exposure to the slaughtering of animals during an upbringing on a dairy farm and of an inability to adjust to the 365 days per year work norms of farm life as well as to any 9 to 5 year-round work life, due to “seasonal affective disorder”, I will discuss the interplay between static norms of industrialized work society and individual emotional responses. I will suggest that rather than condescending or diagnosing individual humans at odds with standardized productionism, in order to “treat” individuals by shaping their emotional patterns and values to fit work society, diagnostic vocabulary can better be used to describe social structures. Work society can be described as insensitive, indifferent, emotionally flat, unethical, manipulative and psychopathic, and social practices that uphold work society can be described as relying on defense mechanisms such as denial, suppression, rationalization, splitting and avoidance. Diagnosing social structures and practices rather than individuals can validate reasonable emotional responsivity, reduce the stigma of “mental illness” and liberate emotional powers than can be used in the service of social change.

In order to restore the foundational aspects of human emotional life, to leave room for the fluency of natural life cycles and to allow for the development of vibrant politically engaged communities, focus should shift from attempts to provide individuals with tools to operate within the boxes of work society to a focus on emancipation from destructive social norms. The boxes of work norms must be broken. Such emancipatory work can include the scrutiny of character ideals, which are reproduced by social practices. In my dissertation I point to two influential but unbeneficial character ideals, the ideals of unselfishness and selfishness, and point to a preferable character ideal, the ideal of selflessness. The ideals of unselfishness and selfishness both stay true to the norms of work society, albeit with different intended beneficiaries of utility (as working for “the other” or working for “the self”), while selflessness is less concerned with outcome and favors fluency, creativity and embodied emotional responsivity based on hypoegoic compassion.

## **The politics of my experience: from madness to international mad activism**

**Matthew Jackman**

Matthew explores what it means to be Mad, the Genesis of Madness, and how Madness is utilized in their international activism, academia and worldview. What does it mean to be Mad identifying and come to teaching Mad Studies in a world that exists in a plurality of truths and multiverses? Matthew's presentation walks through the grief, loss, trauma and oppression constructing Mad responses leading to post traumatic growth and Madness as a gift, superpower and strength in dismantling how the system has viewed them as mentally ill, a diseases, and a person in need of cognitive and social control through devianly behaviours outside the capitalist norms.

## **Affective Injustice and Psychiatric Coping**

**Zoey Lavalley and Anne-Marie Gagné-Julien**

In this paper, we use the concept of affective injustice to demonstrate 1) how the institution of psychiatry can enact a particular form of emotional harm on Mad People through psychiatric tools for coping, and 2) how collective coping tools developed by Mad People can be understood as a form of resistance or counter-practice to 'psychiatric coping'. Affective injustice, in broad terms, refers to "injustice faced by people specifically in their capacity as affective beings."<sup>1</sup> The concept has been elaborated in various ways to explore how social and structural injustices cause harms to individuals and communities specifically related to affectivity.

One way that affective injustice is perpetuated is through "pernicious norms governing the experience and expression of affective states."<sup>2</sup> We propose that psychiatry enacts affective injustice in this way, by enforcing dominant emotion norms that are grounded in sanist expectations and perspectives on 'emotional wellbeing' and 'appropriate' emotional response. Psychiatric diagnoses pathologize Mad forms of affectivity by imposing dominantly socially-valued norms for emotional experience and expression. And the forms of coping provided by psychiatric treatment (namely, medication and psychotherapy) enforce these dominantly valued ways of affective life by focusing on internal emotion regulation, exploiting cognitive and pharmacological resources to alter or control emotional experience. For example, among other things, CBT teaches people how to positively reappraise a situation to transform distressing emotions into "positive emotions," and one aim of medication is to reduce or suppress certain emotional states. These tools can be helpful, but because they are individualistic approaches to coping, they risk obfuscating the link between psychic distress and structural injustice (e.g., poverty, racism, sanism) by prioritizing changing individual emotional experience without acknowledging or addressing the external conditions producing or exacerbating suffering.

After developing a picture of affective injustice in psychiatric coping, we argue that alternative forms of coping practiced by Mad People can be a tool of affective justice. Mutual aid, emancipatory peer-support, recovery communities, and Mad activism are forms of collective coping that can be viewed as modes of resisting affective injustice perpetrated by psychiatry (that is, perpetuated by the coping tools predominantly provided by psychiatric and dominant therapeutic treatment). These collective practices can be strategies for affective justice because they make space for the kinds of emotional experience and expression that are pathologized by psychiatry (e.g., suicidality as an

emotion that one can almost never express in institutional or clinical contexts without the risk of diagnosis, or coercive medication and treatment). Not only do these spaces allow people with lived experience to explore alternative, non-dominant emotion norms (e.g., through storytelling), but these forms of coping are collective rather than individualistic. They recognize how structural and social conditions are inextricably linked to experiences of psychic distress, and thus, can have the function of offering a place for Mad People to encounter political ideas and organize with other Mad People.

1. Archer, A., & Mills, G. (2019). Anger, affective injustice, and emotion regulation. *Philosophical Topics*, 47(2), 75-94.
2. Gallegos, F. (2021). Affective injustice and fundamental affective goods. *Journal of Social Philosophy*, 1-17.

### **Applying a Neurodiversity Movement Lens to Living With Obsessive-Compulsive Disorder** **Steph Ban**

I draw on my own experiences with receiving therapy for obsessive-compulsive disorder (OCD) as well as my background as a disability rights activist to argue for a model of OCD that is not solely focused on cure as the goal. In my experiences with therapy for OCD, I was encouraged to think of OCD as something external to myself and something I had to constantly fight against in order to act in accordance with my “real” self and thoughts.

This never sat right with me, given my experiences being developmentally disabled from birth and having seen the futility of attempting to “fight” my cerebral palsy or vision impairment. I entered autistic communities as an adult, and there I learned strategies for managing distressing traits (like sensory issues and overwhelming emotions) that did not rely on a cure or demonization of disability. I build on work from Eli Clare and others who nuance discussions about the usefulness of cure.

I acknowledge that my disabilities have facets I find painful, frightening, and unhelpful, and I would not choose to experience those aspects. But I do not have a choice, and so drawing on neurodiversity-affirming strategies that I learned in autistic communities, I can both acknowledge traits that I experience as negative and recognize that they are a part of my experience, and not somehow external to me. I wonder what would happen if I treated the distressing aspects of my OCD the way I treat the distressing aspects of any of my other disabilities, recognizing that I do not need to fight any aspect of myself to have a fulfilling life. This approach is in line with scholar Sofia M.I. Jeppsson’s “Realist Solution” in treatment of mental illness, where patients do not need to distinguish between themselves and their mental illness in order to live and identify in ways that make sense for them.

Many autistic activists have correctly pointed out that along with negative aspects, autism can also have positive aspects, for example: heightened attention to pleasant sensory experiences, deep focus, and interests that bring deep joy. I do not think OCD can be reframed positively in this way (at least, not while it is defined as causing distress inherently), but I suggest that there is value in seeing it as just another form of intensity that I and other neurodivergent people experience. I follow LaMarr Jurelle Bruce in viewing OCD as a “mad methodology” rooted in questioning and care, inseparable from my ways of writing, thinking, and being. I hope to think and write an affirming model of OCD into existence as an extension of care to the mad and neurodivergent people who may share similar experiences.

### ***calls: a mad stories project***

**Michele Marie Desmarais and Fraser Mackenzie**

Rooted in lived experiences, Decolonization, Indigenization, Mad Epistemologies, and Mad Arts, our project generates, collects, and considers the philosophical, poetic, musical, and other storying artifacts that arise in living responses to the topics raised in the call for workshops on Madpeople's Coping Mechanisms: "we want to focus on psychiatric problems from the perspective of those dealing with them, how they experienced the problems, how they figured out ways to cope with or handle these problems, and why, based on the person's own experiences and interpretations, these strategies were helpful."

In our workshop on *calls: a mad stories project*, we will share decolonized, Indigenized, and Mad perspectives on the nature of relationality, Stories, and Story Medicine, as well as the power these have in our lives. In doing so, we resist the dominant culture's tendencies to impose a genre, mode, linear narrative, or triumph/tragedy plotline, on our stories. Selections from the project will instead reflect vivid fragments, mad mapless voyages, stories who swim away, night songs from the ocean edge becoming wave, star, medicine.

Finally, through the practice of Mad Arts and employing arts-based research approaches, we will identify some emergent themes in *calls*, particularly those that relate to helpful, Mad positive, decolonized, life approaches and strategies.

We bring to *calls: a mad stories project*, our lived experiences of madness and our expertise in community mental health peer support (Mackenzie), Indigenous Health Humanities, Indian philosophy/psychology (Desmarais), songwriting and music (Mackenzie), and poetry (Desmarais).

### **Intellectual Humility**

**Michael Dickson**

Several years ago I participated in a study in which participants were shown a video of a rotating mask, some kind of plastic halloween mask. Apparently it is common for viewers to see the mask as always convex. I reported what I saw—when the mask is convex, I see it as convex; when it is concave, I see it as concave. Ho hum.

Being an academic myself, I ask questions of those who run these studies. They don't tend to answer in advance (which is fair enough), but after, once they realize that I also speak the language of whys and wherefores, explanation, inference, and knowledge, they often are willing to talk. At that time, I wasn't aware of the role that these illusions were supposed to play in the study and diagnosis of schizophrenia, and I asked why they were interested in my perception of the mask. The phrase that they used (echoed much later in Costa et al. 2023) was "sensory-perceptual deficit".

By then, my perceptual life had been described in such terms for over 25 years, and I filed this latest case in the category of 'ways that I misperceive'. But later, it struck me: Why is *my* perception 'in deficit'? After all, I'm seeing what is allegedly 'really there'. Those who see the concave mask as convex are missing something, not me.

As trivial as it sounds, this revelation, or rather, its aftermath, became a crucial part of how I began to cope with what psychiatrists had often described as 'misperception'. It

isn't that I came to see myself as occupying some epistemically privileged position in virtue of seeing concave masks as concave. The point was more general, and was applied as much to myself as to others. It was a point about intellectual humility, both as a mechanism for coping with challenging perceptions and beliefs and as a virtue in inquiry.

In retrospect, I was grasping at this idea about a decade earlier, having written a paper (Dickson 2007) calling 'intuition' into question as a form of evidence in philosophy. I presented the paper in several venues. It did not go well. Two notable recollections are being called a 'philistine' in one venue, and being told, in another, that I was wrong because (and this phrase was seriously uttered by a serious philosopher) "intuitively, intuition is a form of evidence". I came away suspecting that I must be missing something and dropped the project. I later came to realize that both I and my interlocutors were missing the same thing—intellectual humility.

In this talk, I propose to distinguish intellectual humility from skepticism (which has also been a successful strategy, and is closely allied to intellectual humility, but is not the same thing), and to describe how it might enable one both to engage in a *form* of potentially helpful 'reality-monitoring' (while dispensing with "clinging to the Mainstream World" in the sense of Jeppsson (2022)) and to be (one may hope) a better philosopher.

#### References

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- Dickson (2007) "Intuition in Metaphysics: Seeming Is Believing?", *Philosophical Topics* 35:43–65.
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## **Rethinking Suicidality in the Context of Suicide-Affirmative Healthcare: A Survivor's Perspective**

**Michele Merritt**

Suicidology, like other mental healthcare fields, has shifted from internal/biological models to more social and holistic explanations. Despite these changes, suicide rates have mostly stagnated. Moreover, there remains a stigma attached to suicidal persons which I argue is fundamental to this lack of positive change. Suicidal persons are deemed *mad* and in need of immediate intervention, which constitutes a specific form of discrimination that Alexandre Baril has dubbed "suicidism." He argues that a key feature of this marginalization is an "injunction to live." Because no person *in their right mind* would wish to die, anyone expressing this desire is categorized as insane, irrational, and incapable of making sound decisions.

As someone who has experienced suicidality for most of my life, I provide autoethnographic data confirming Baril's account of suicidism, both as I have experienced it in mental healthcare settings and in social interactions. I also show how punitive treatment often results from disclosing suicidality, despite constant calls for suicidal people to "reach out." Furthermore, I argue that the disciplinary ideology that underpins suicidology intersects with and is subtended by many other systems that are similarly governed by

carceral logics, such as child welfare in the U.S. Despite research demonstrating that these punitive practices do not improve outcomes, and indeed, often make things worse for those experiencing suicidality, suicidist ideology persists.

I begin by examining how suicidologists tend to explicate the phenomenology of suicidality. This methodology is largely third-person and rarely from an *emic* or insider perspective. As Baril notes, suicidal people under-contribute to the knowledge pool surrounding suicide – we are *hermeneutically marginalized*, which is a form of epistemic injustice. Suicidal persons are conspicuously absent, ironically, from discussions of what suicidality is like. It is assumed either that we did not survive, or if we did, we are “good patients,” and therefore, non-suicidal. This binary erases living suicidal persons, and hence misses an opportunity to learn from us regarding our survival strategies and coping mechanisms.

Thus, my account provides insight into what “suicide affirmative healthcare” – something Baril argues for – might be like. An underdeveloped aspect of his account is that it does not fully explain how such a model might lead to fewer suicide deaths. Here, my narrative is once again useful, as someone who lives with and effectively manages suicidality. A tenet of suicide affirmative healthcare is that one ought to be free to explore the desire to die in a safe and caring environment. I examine this suggestion in the context of my interactions within healthcare settings and in community with suicidal persons. I concur with others who have noted that being forced to perform life-affirmation can be more harmful than helpful, and that knowing death is a “live option” can contribute to the ability to overcome that desire. Most importantly, my account shows that being truly *heard*, rather than dismissed as crazy, irrational, or in need of “fixing” has been more life-affirming than any suicidist intervention.

### **Mad Camp as a site of Mad Activism and Movement – our collective coping mechanisms Mia Joy and Patrick Salas**

Mad camp emphasizes a frustration with the socio-normative framework upon which mad experiences are interpreted and treated in the western world. Treatment of madness reflects as a microcosm of the underlying issues with our collective level of consciousness in the western world: what leads people into states of madness to begin with? traumatic childhood experiences, disconnect or dissatisfaction with the current trajectory and state of the world... what if instead of suppressing, diagnosing, and medicalizing extreme states we allowed them to unfold unimpeded by our limited worldview. Madness can be seen as an authentic expression of the psyche intended to turn the lens back onto the madness within consensus reality with a pressing need to grow the mad movement. As it exists now it is scattered between the consumer, peer recovery, psychiatric survivors with sparse and at times divergent goals and aims. The purpose of mad camp was to provide a space for validation, for uncovering and greater self-understanding, and serve as a launching pad for deconstructing the existing system reimagining mental health treatment. We discuss Mad Camp as a space for reconnecting to our Mad Movement as peers and as activism.