

Group Therapy: Mental Distress in a Digital Age

[A User Guide]

Edited by Vanessa Bartlett



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Foreword

Mike Stubbs

Director, FACT, Liverpool

Witnessing abuse, disease and war on TV in the background as I write this, as observer, perpetrator and victim; we are watching and bombing ourselves. As most striving seems to lead nowhere, we need to reassert a reality of non-economic value, creating places for the anarchic, irrational and questioning in an attempt to remind us of what being mentally healthy might feel like.

If art holds the power to speak beyond cultures, language and belief, artists assume a licence to move beyond conformity, ideology and custom, thereby demonstrating openness to universal conditions, material circumstances and perception. In accepting responsibility for who we are, we can enable others to feel more comfortable and be more comfortable in ourselves. We share this struggle in making sense of the world and *Group Therapy* has been a remarkable journey for many collaborators, creating ripples of self-awareness across our organisations, associations and loved ones.

Experiment and research lie at the heart of FACT's values and programmes, following on a rich tradition of combining art and practice-based research, which builds on collaborative projects with a broad range of communities. Pioneering examples have included a creative programme with military veterans with mental

health issues and the *In Hand* app designed with young people for young people. Recent media commentary provoking fear around young people, cyberbullying and the Internet can serve only as a reminder of how important it is that we build these alternative digital strategies for well-being. While making *In Hand* we collaborated with Mersey Care NHS Trust, who I thank along with the artists in this exhibition for taking a leap of faith and helping us to approach mental health care from a different perspective.

Group Therapy probes beyond assumptions of progress and remedy; instead we hear the direct voices of artists, writers and curators, all prepared to put themselves on the line in their approach to subjects which concern and affect us all. The resulting work demands imagination and completion by us the audience, and our consideration of sanity, health and well-being as contextual, circumstantial and products of our own making. We are the problem. To change, we need to open up to experiences and interactions beyond ourselves.

John Dewey, in *Art as Experience*, states that experience starts with an impulsion:

Impulsions are the beginnings of complete experience because they proceed from need; from hunger and demand that belongs to the organism as a whole and that can be supplied only by instituting definite relations (active relations, interactions) with the environment.¹

Informationally overloaded, continually updating multiple digital identities, we are dissolved, disintegrated and exploded into a nomadic unstable topology of ceramic ribbon and microfluidic channels. Split personalities and stress are the new normal, yet in

becoming 'post-human' we continue to deal with age-old issues of poverty, inequality and suffering; whether art world or health care, we are part and parcel of the same system.

Group Therapy is part of this process, and at some level might be considered a new form of preventative medicine in itself, as 'real' innovation seeking to further break down binaries of mind/body or self/other. We are the real-time experiment, do not despair.

Notes

- 1 John Dewey, *Art as Experience* (London: Penguin Books, 1934), 61.

Introduction

Vanessa Bartlett



Installation view of Graham Harwood's *Rehearsal of Memory*

This is a collection of essays about personal well-being in a contemporary age. At its core is a conviction that mental health is not just a medical issue, but is deeply impacted by the social relationships, political conditions and technologies that structure our lives. This book is published to coincide with the exhibition *Group Therapy: Mental distress in a digital age* held at FACT (Foundation for Art and Creative Technology) and co-curated by Mike Stubbs and myself. It is written in part by the artists, psychologists and health professionals involved in making the exhibition.

Using provocations and personal testimony derived from first-hand experience, the writers in this book seek to challenge some of our conventional perceptions about mental health. We move away from the idea that mental illness is a condition that impacts on a small cohort of individuals living at the edges of society and exhibiting pathological behaviours. Instead we address ways that all of us experience mental distress through pressure at work, status anxiety and common experiences of guilt or negativity. While this is not a new approach to mental illness (there is a rich tradition of critiquing psychiatry that we often allude to in this collection), we consider it in relationship to some

issues specific to late capitalism and our technologically driven society.

I have entitled this book ‘a user guide’ because I believe that useful knowledge about mental health comes from many places other than the textbooks of doctors and psychiatrists. All of the contributors are experts either by education, professional training or as a result of their own lived experience. Most of the writers are somehow all three of these things. I want to thank them for the bravery and honesty they have employed in writing about their own experiences. This kind of openness should inspire all of us to have more frank conversations about our own mental health.

While this ‘user guide’ is not intended to be overly instructive (a collection of resources is provided at the end of the book if you need some day-to-day support with your mental health), it does harness the ability of artists, designers and others working creatively and experimentally in their own field to contribute to the contemporary conversation about mental well-being. Familiar trends in art discourse, particularly socially engaged practice, have primed contemporary art audiences to consider artworks an active process that can have transformative impacts on their audiences. For Grant H. Kester, writing in his book *Conversation Pieces*, dialogue among diverse communities has become suitable material for making art that can serve as a catalyst for social change.¹ Likewise art theorists such as Jill Bennett have put forward the notion that aesthetic experience is a ‘means of apprehending the world via sense-based and affective processes – processes that touch bodies intimately and directly but that also underpin the emotions, sentiments and passions of public life’.² This book contains a collection of practice-based accounts of first-person

mental health experience that I hope will have an impact on attitudes to mental illness far beyond the gallery walls.

The product of a creative research process that has taken place around the eighteen-month development of the *Group Therapy* exhibition, this book includes several contributions from individuals who would not consider themselves to be engaged in arts practice. Rather, the book and the exhibition use the arts as a platform for engaging practices from fields such as clinical psychology, design, architecture and even individuals who blog about their own mental health. As part of the curatorial process we have always maintained that the subject matter of this exhibition demands the convergence of multiple disciplines in an art context in order to produce risk-taking conversations about mental health that might not arise in clinical practice or academic discourse. FACT, with its track record of interdisciplinary programming and commitment to social engagement, has been the perfect location in which to play out these experimental conversations.

This exhibition takes place on the twentieth anniversary of Graham Harwood’s *Rehearsal of Memory*, FACT’s very first outreach commission, which engaged prisoners from Ashworth High Security Mental Hospital in the making of a CD ROM artwork. This brave and ambitious project has in many ways set the tone for *Group Therapy*, through its questioning of a hypocritical system that draws distinctions between those who commit violence as individuals and those who do so on behalf of the state. As Julian Stallabrass has asserted in his essay on the project:

The life of Ashworth’s patients, their confinement, their control by drugs, the regulation of their activities, their treatment of others with brute instrumentality, and their self abuse is merely

at the extreme end of a spectrum that characterises technological, administered, capitalist society as a whole. Few are not compelled to live out large portions of their lives in places and doing tasks that they would rather not ... many, in pain, harm themselves by cutting into or starving their bodies; none escape implication in a system in which, say, buying a diamond for a loved one, or a bar of chocolate, fuels barbaric civil war or slavery.³

This message is key to what I hope audiences will take home from *Group Therapy*. We live in a society that is fuelled by consumption. Many of the products that we buy are made in factories that use aggressive slave labour. Yet most of us turn a blind eye to this issue as we continue to work long hours to buy more consumer products that ultimately we don't really need. This is just one of the many 'crazy' facets of a society that does not provide long-term well-being for the many, but is designed to deliver riches for the few. It is one of the socio-economic dynamics that needs to shift if we are to create a society where everyone can enjoy psychological well-being equally.

This book is structured around three key issues and how they relate to mental health: *Society*, *Technology* and *Creative Practice*. Longer essays take on the role of conceptual and theoretical provocation which is intended to encourage critical thinking about social and political attitudes to mental health. A number of shorter pieces speak directly to some form of practice or experience, such as blogging about mental health or doing digital art therapy. There is a range of voices accommodated in this volume, from a young art project participant to a senior visual cultures theorist. I hope that the resulting polyphony adds depth and texture to our investigation of mental health.

Part One sets the tone for the book by exploring links between contemporary society and well-being. In the 1960s Scottish psychiatrist R. D. Laing made his name by critiquing the crudely drawn line between insanity and rationality. In *The Politics of Experience*, he focused particularly on the contradictory notion of normality in an existentially distorted world: 'What we call "normal" is a product of repression, denial, splitting, projection, introjection and other forms of destructive action on experience ... It is radically estranged from the structure of being.'⁴ Laing in many ways remains a controversial figure (his alcoholism and free use of LSD with psychotic patients perhaps overshadows his intellectual legacy), yet all three of the contributors in this section are in some way indebted to the lineage of radical critique that he pioneered. Three writers, Peter Kinderman, the vacuum cleaner and Mark Fisher, address how sociopolitical conventions and contemporary ways of being cause disruption in the psyche.

In his essay 'Seeing things differently', **Peter Kinderman** draws on his experiences as a clinical psychologist to describe how the human brain, an organ that he calls a 'learning engine', develops in response to environmental stimuli. He argues that poor mental health is less often the consequence of a biological brain-based problem, but is more likely to be the product of challenging life experiences that teach the subject that the world is a hostile place. If individual mental health is a direct result of perspective, which is in turn shaped by environmental conditions beyond our control, might we assume that medication and diagnostic labels are not the most helpful form of mental health rehabilitation?

In 'The right to k(no)w' artist **the vaccum cleaner** gives a vivid account of the fifteen-year process that he underwent to gather medical records from his entire history of psychiatric care. The material was used in his performance piece *Mental*, where the theme of institutional power was explored using fragments of doctors' notes and personal memory. Under the Data Protection Act patients have a legal right to access their own medical records, although the process of exercising that right can be fraught with bureaucratic and emotional challenges. His example creates an image of the ways that individuals with serious mental health issues become powerless subjects in the complex medical systems that have been created to manage mental health.

For **Mark Fisher**, capitalist economies are not only a stimulus for high levels of chronic stress and anxiety, but are also sustained and maintained by the medicalisation of distress. He suggests that if unhappiness and discontent can be framed as chemical brain imbalances that can be treated by prescription drugs, this forecloses the possibility of objection to a political system that produces injustice and inequality. In his essay 'Reflexive impotence, immobilisation and liberal communism' he foregrounds the predicament of young people caught in the mechanics of capitalism and the role that new technologies might play in their passive acceptance of the political status quo.

In **Part Two**, four writers offer their perspective on the complex relationship between mental health and the digital world. As technologies become more sophisticated, they are applied to all aspects of human life including gambling, shopping and of course dating and digital sex. Mental health care is no exception and in recent years we have seen blogging, biomapping and app building all used to service positive mental well-being. Many examples of

these technologies are curated into the *Group Therapy* exhibition, as a means of understanding them alongside contextual discourses around privacy and selfhood. For example, documentation of the *Samaritans Radar* app, an algorithm that sent notifications to people's Twitter followers when they posted language that suggested suicidal behaviour (and that was later taken offline in response to protests), is included as a reminder of the complexities that can arise when we outsource mental health care to data and digital systems. In a climate of financial austerity and increasing demand for mental health care, how much should we trust the assertion that digital is good for our mental health and not just a cheap remedy for a complex social problem?

To open this chapter **Seaneen Molloy** and **Charlotte Wealthy** present accounts of their experiences of using social media and apps to support their mental health. In 'Blogging mental health', Seaneen describes the experience of documenting her bipolar disorder for a large public audience and its subsequent impact on her sense of privacy, selfhood and her perceived obligation to her audience. In 'Using apps to support my mental health', Charlotte Wealthy explains how working with other young people on the *In Hand* project at FACT has helped her to build self-awareness in digital space.

In 'Talking back: mental health and social media', **Victoria Betton** explores the ways in which social technologies such as Twitter give patients and service users a platform for self-expression, something that is so often lacking in mainstream clinical environments. While employed as a senior manager in an NHS trust, Victoria used Twitter to converse with patients and clinicians in a way that she suggests overcame the hierarchical barriers encountered in her professional life. While she is ultimately cautious about the power structures that can encroach into online space (increasingly, 'social

media guidelines' are being issued to clinicians by their employers), she is able to frame social media as part of a long heritage of self-publishing and advocacy that has allowed patients to oppose the mainstream mental health system.

To close this section **Benjamin Koslowski**, the exhibition designer for *Group Therapy*, applies knowledge gained while designing architectural spaces for mental health hospitals to ideas about privacy and personal space online. While working on designs for Forth Valley Royal Hospital, Ben noticed that one of the major requirements for this environment was for it to accommodate different forms of distress: 'a noisy and busy environment easily overstimulates and causes anxiety in a depressive patient, while manic patients are frequently understimulated'. The tension between surveillance and individual comfort (patients must be observable by clinical staff yet also at home in their own environment) prompted Ben to consider parallels with online space. In 'Mental health in a digital age: lessons from architectural design practice', he focuses on the way privacy in physical space might influence design thinking in digital space.

Part Three addresses the relationship between art and mental health in a way that I hope challenges some of the familiar assumptions about art education and outreach. While the rhetoric of social inclusion in the arts often comes from a place of good intent, it is also always in danger of compromising the most experimental and enriching aspects of the artistic process. As Hannah Hull, a socially engaged artist and collaborator on the vacuum cleaner's *Madlove* project, points out, the assumptions made about art projects that engage mental health service user groups include:

art is therapeutic for target groups; being part of an art workshop has a socialising effect; exhibiting art gives a sense of achievement; seeing art made by target groups promotes social inclusion; buying art made by this group is charitable and demonstrates social awareness.⁵

There has been a conscious attempt throughout our curatorial process to avoid framing specific audiences who need to be 'fixed' by art. Rather, we have focused on the potential for individual and systemic change that can occur when art is innovative rather than prescriptive. This thinking is reflected by **Clive Parkinson**, who in his essay 'A brightly coloured bell jar' recounts his experience as an arts consultant in a hospital, where the chief executive considered one artwork too dark and dispiriting to be included in his arts for health remit. Clive argues that art in a medical or therapeutic environment must overcome the often prescriptive agendas of its commissioners and thrive on the uncertainty and difficulty of the artistic process.

These arguments in favour of complexity are echoed in **Amanda Cachia's** essay "'Disabling" the museum: curator as infrastructural activist', which deals directly with the issue of access in museums and galleries. There is a tendency in the contemporary museum (as well as the art gallery) to address audiences with physical and mental health issues as a specialist category. While this approach is often well meaning, it can also have the effect of reaffirming difference. With a curatorial practice that often focuses on the subject of physical disability, Amanda challenges museums and galleries to 'think about how access can move beyond being a mere practical conundrum, often added as an afterthought once an exhibition has been installed, to become a dynamic, critical and creative tool in art-making and curating'. At its core the essay contains a critique of the concept of 'normality' that is highly pertinent to the way this publication deals

with mental health. It is only when museums and galleries begin to see access as a universal issue that impacts on everyone (not just those with a disability or diagnosed mental health condition) that we can create exhibitions that truly understand their audience as diverse and complex in their mental and physical make-up.

Both **Paul Dean**'s and **George Khut**'s short practice-based contributions deal with the artistic use of technology in therapeutic and healing environments. In 'Doing digital art therapy', Paul Dean recounts how a group of young people who were struggling to understand how emotions might evolve slowly over time (perhaps as a result of the instant gratification they were accustomed to from digital media) learned a different sense of time through the practice of writing letters. In 'Experiencing the body beyond pathology', artist George Khut describes how his project *The Heart Library* (one of the works in the *Group Therapy* exhibition) offers audiences a way of experiencing their body beyond the notion of pathology, which preoccupies so much of Western art and medicine.

The questions posed in this publication are timely and urgent and may (we hope) propose some insight into each of our reader's internal worlds, social relations and perceptions of selfhood and difference. Written in a year when there have been several reported deaths as a result of cuts to disability benefits and when overall funding for mental health has continued to fall, *Group Therapy* provides an important opportunity to rethink what it means to be mentally well, both individually and for society as a whole.

Notes

- 1 Grant Kester, *Conversation Pieces: Community + Communication in Modern Art* (London and Berkeley: University of California Press, 2004).
- 2 Jill Bennett, *Practical Aesthetics: Events, Affects and Art after 9/11* (London and New York: I.B. Tauris, 2013), 2.
- 3 Julian Stallabrass, 'Rehearsal of Memory', https://www.courtauld.ac.uk/people/stallabrass_julian/essays/rehearsal_memory.pdf (accessed 4 December 2014).
- 4 R. D. Laing, *The Politics of Experience* (New York: Pantheon Books, 1967), 11.
- 5 Hannah Hull, 'Innovating Art Outreach', <http://www.hannahhull.co.uk/Innovating%20Art%20Outreach%20oby%20Hannah%20Hull.pdf> (accessed 7 December 2014).

The Deviant Majority

Dora García

In *The Deviant Majority (from Basaglia to Brazil)* (2010) García addresses revolutionary reforms in psychiatry that grew out of the political ferment in Brazil of the late 1960s. The piece is structured around three meetings: with the ex-Psychiatric Hospital of Trieste's theatre company Accademia della Follia (Academy of Madness), comprised of people 'with and without' psychiatry experience; with Rio de Janeiro's Freaked on the Scene Theatre of the Oppressed; and with activist Carmen Roll, a former member of the German Socialist Patients' Collective (SPC). In an interview, Roll expounds on the SPC's antagonism towards asylums in the early 1970s, rooted in the group's belief that the social relations initiated by capitalism were responsible for physical manifestations of madness. The psychiatric experience of the professional theatre companies featured adds depth and truth to their theatrework, and helps them to revise divisions between normality and abnormality, and erase the prejudice and social exclusion associated with mental illness. In this mesmerising piece of cinema, radical thought that may seem far-flung is interlaced with practical programmes achieving successful results.





SHARING YOUR INFORMATION

A COPY OF THIS FORM MUST BE GIVEN TO THE SERVICE USER.

CONFIDENTIALITY

The information you provide, whether verbally or in writing, will be used by Trust staff to assess your needs and provide services. This means that, as well as your care coordinator, other people such as administrative staff and managers will need to see the information so that services can be arranged. Only the people who need the information to help us assess your needs and arrange services will see it. We understand that it may be difficult for you to give us some very personal information about yourself, but we can only provide the right services if we know exactly what your situation is.

Information about you may be recorded in writing and stored on computer for this purpose. This means that whenever you contact us again, the person you speak to will be able to find out that you have contacted us before and if you are receiving services. We may also need to use some information to produce statistics so that we can plan services to meet the needs of other service users within the Trust. Information will be kept in accordance with current data protection legislation.

If you have any questions about how the information will be used, please ask your care coordinator.

YOUR RIGHT TO SEE THE INFORMATION

We will give you copies of a care plan outlining your assessed needs and plans to meet those needs. We will ask you to sign the care plan to say that you have been asked about your views, and that you understand the arrangements that have been made.

You have the right to see what information we hold about you on computer, and to see the information on your file that relates to you. You should make any request in writing.

SHARING INFORMATION WITH OTHER PEOPLE

In order to properly assess your needs and provide you with the right services, we may need to ask other people for information about you, for example your carer or GP. We will only ask for information that may be relevant. We may need to give some of the information about you to other professionals, to help them assess your needs. Again, we will only give them the information they need to know.

The people we may need to ask for information about you may include:

- Other staff within the Mental Health Trust
- Your GP
- Any other health or social services staff you have been in contact with
- Housing department staff if you live in council accommodation
- Voluntary organisations who may be providing services
- Any other professional or agency who has been involved in assessing you needs or providing services

We may also need to give the people who provide the services some information. We will only give these people the information they need in order to provide the service.

The people who we may give this information to include:

Society

A standard information sharing consent for medical records. Photo by the vacuum cleaner

Carrie Buried Beneath Catalpa Beans // Mountain Sweep

Quintan Ana Wikswo



CATALPA Panorama Detail

Quintan Ana Wikswo's suite of photographs and texts relate to the Western State Lunatic Asylum, the Central State Mental Hospital and the State Colony for Epileptics and Feebleminded, three US government-run asylums in rural Virginia. She created the work at mass graves, cemeteries and medical facilities using salvaged government cameras and typewriters manufactured during the 1930s and 40s by institutional slave labour.

Under the pretence of providing psychiatric care, these three asylums were used to segregate, persecute and police the lives of people who were deemed to be non-compliant to social norms. With the enthusiastic cooperation of law enforcement, the justice system and the medical industry, a process called 'Mountain Sweeps' encouraged communities to forcibly institutionalise their undesirables. These included 'mongrels' of non-white or mixed racial heritage, 'inferior whites', Native Indians, African-Americans, people with physical and neurological disabilities, unwed mothers and their children, sexual assault survivors and queer people. Through the use of punitive, intentionally inhumane tactics, 'discharge by death' was commonplace.

In 2009 Wikswo began working at these sites in an effort to uncover the experience of her great-grandfather Lafayette, who was forcibly institutionalised at Western State Lunatic Asylum in Staunton, Virginia. She began following the experience of a 17-year-old girl named Carrie Buck, who was committed to the State Colony for Epileptics and Feebleminded after she became pregnant following a rape by her foster brother. Examinations failed to reveal any disability, but in 1927 the United States Supreme Court upheld the right of the government to sterilise Carrie and others like her, saying ‘Three generations of imbeciles is enough.’

By going to these sites and making thousands of exposures using slave labour cameras, Wikswo has sought to look at the site through the myriad eyes of the people who lost their existential independence – and often their lives. She works to dismantle the dominant aesthetic narrative of the asylum, using poetics and abstraction to locate an elegiac, dignified power often denied to psychiatric patients and to invoke a conversation with disrupted, silenced voices and create a new site in which grief, stigma and pain can emerge alongside disobedience and defiance.

Seeing things differently

Peter Kinderman

I should warn you – there’s an unforgivable cliché coming next ... is the glass half empty or half full? Do you usually see things in a negative or a positive way? Psychological care for people with mental health problems can take many forms – including advice and support, behavioural interventions, psychodynamic psychotherapies and cognitive behavioural therapy, perhaps the most popular current form of psychological therapy. And it might be a cliché, but we genuinely do try to help people change the way they think about the circumstances that cause distress.

Some clumsy popular psychology writers have used the term ‘thinking errors’ to describe the pattern of negative thoughts that constitute mental health problems such as anxiety or low mood.¹ This is, in my opinion, unfortunate, as it implies that people are somehow to blame for their distress, and that the problem is still pathological. But while it’s true that how we think about the world affects our emotions and our behaviour, this is unambiguously not the same as blaming people for their mental health problems.

Models of the world

Cognitive psychologists see people making sense of their world, forming mental models, developing complex frameworks of understanding, and acting accordingly. People are born as natural learning engines, with highly complex but very receptive brains, ready to understand and then engage with the world. We develop, as a consequence of the events and examples we experience in life, mental models of the world that we then use to guide our thoughts, emotions and behaviour.²

There are two main reasons why people might react differently to the same events. First, there is a role for biology. We differ in all kinds of ways, and part of that difference might include differences in the way our brains work. But I believe differences in our biology explain very little of the variances in how people react to events. Instead, I believe certain life events affect one person in one way and another person in a different way because these events will have different meanings for different people - individual meanings derived from our unique prior experiences. If I've experienced a lot of disappointments in life, the threat of unemployment could be devastating. If I've been luckier, perhaps the threat of redundancy will seem worrying, but not insurmountable.

This also explains why I argue that what we believe about the world has causal value, but also that what we believe about the world is the product of our experiences. So if we've been exposed to abuse and negativity, we'll learn to regard ourselves as valueless. If we've been exposed to love, we'll learn to regard ourselves as loveable. I believe that this meaningful belief - 'valueless versus loveable' - has causal power; that what we believe profoundly affects our emotions and behaviour. And so, although of course I recognise that a combination of nature and nurture has shaped this belief, I think the fact it has causal value is a philosophical game changer.

How does this relate to the cliché of the half-full (half-empty) glass, or to the nature of art?

Meaningful models of the world

Psychology, and especially the psychology of mental health, is all about meaning - deep, contextualised meaning. The radical psychiatrist Pat Bracken drew links between art and psychology in a recent article,³ one worth quoting at length:

we can attempt to understand the struggles of our patients in much the same way as we attempt to understand great works of art. To grasp the meaning of Picasso's *Guernica*, for example, we need to understand what is happening on the canvas, how the artist manages to create a sense of tension and horror through the way he uses line, colour and form. We also need to understand where this painting fits in relation to Picasso's artistic career, how his work relates to the history of Western art and the political realities of his day that he was responding to in the painting. The meaning of the work emerges in the dialectical interplay of all these levels and also in the response of the viewer. The actual physical painting is a necessary, but not a sufficient, factor in generating a meaningful work of art. A reductionist approach to art appreciation would involve the unlikely idea that we could reach the meaning of a painting through a chemical analysis of the various pigments involved.

Events, like paintings, mean different things to different people. Genuinely to empathise with a person means understanding things from their point of view, understanding why events would have the meaning they have for them, understanding why the events that they have learned from in their lives would lead them to see things that way. A poor mark in an exam, or even a more

dramatic event such as redundancy, means more to some of us than to others. If we've been loved, we will be more likely to have developed a secure sense both of our abilities and of the belief that we'll be loved even if we fail (and failure is, of course, a human inevitability). If we've been unfortunate enough to experience emotional neglect, practical disadvantage or repeated failure (even if these failures were not our fault), then it's entirely possible that our sense of self-confidence will have been degraded. We will be less likely to be confident in our ability to survive stressors and threats, and less likely to believe that we will be loved no matter what happens to us. Those aren't 'thinking errors', they are the poignant consequences of a ruthlessly efficient brain. We can change these ways of thinking through therapy, but they are not thinking 'errors', they are the meaning-rich consequences of life's experiences.

I think the cliché of a 'half-full' glass is slightly missing the point. There are better analogies from art. I love the work of Lucian Freud (and not because of who his grandfather was; I'm much less keen on psychoanalytic theory). I think there's a lot of truth in the idea that the eyes and hands of artists can express the personality of a sitter in greater clarity than can a photograph. Not 'glass half full' or 'glass half empty', but more contextual and meaningful depth. Even when photographs do capture truths - for instance Dorothea Lange's iconic 1936 photo of Florence Owens Thompson, *Migrant Mother* - they reflect that deep and contextualised meaning, the emotional significance of the events, through art rather than science. Poetry, similarly, captures meaning. A scientist might report that there is 50ml of fluid in a 100ml container; a poet would say that the 'glass is half full'.

**We develop,
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A new way of understanding

It is a time of significant change in the field of mental health. The publication of DSM-5,⁴ the fifth edition of the American psychiatric diagnostic manual, has proved controversial,⁵ and has led many to question the creeping medicalisation of normal life and to criticise the poor reliability, validity, utility and humanity of conventional psychiatric diagnosis.⁶ Reviews of the ineffectiveness and adverse effects of many psychiatric drugs⁷ as well as of the effectiveness of evidence-based psychological therapies⁸ has led many to call for alternatives to traditional models of care. We must move away from the ‘disease model’, which assumes that emotional distress is merely a symptom of biological illness, and instead embrace a psychological and social approach to mental health and well-being that recognises our essential and shared humanity.⁹

I receive a fair number of unsolicited letters. One read:

Rather than engaging with the patients on the ward, the staff instead shepherded them around like sheep with bullying commands, threats of ‘jabs’ (injections), and removal to an acute ward elsewhere in the hospital, if they did not co-operate. The staff also stressed medication rather than engagement as a way of controlling the patients. And the staff closeted themselves in the ward office, instead of being out and about on the corridors and in the vestibule where they should have been. The staff wrote daily reports on each patient on the hospital’s Intranet system; these reports were depended upon by the consultant psychiatrists for their diagnoses and medication prescriptions, but were patently fabricated and false, because the staff had never engaged or observed properly the patient they were writing about in their reports. The psychiatrists themselves were rarely seen on the ward, and only consulted with their patients once a week.

We must move away from the ‘disease model’, which assumes that emotional distress is merely a symptom of biological illness, and instead embrace a psychological and social approach to mental health and well-being.

This distressing view of the nature of psychiatric care was recently echoed by Professor Sir Robin Murray, writing as chair of the Schizophrenia Commission, who suggested that ‘the message that comes through loud and clear is that people are being badly let down by the system in every area of their lives’.¹⁰ On the other hand, we have seen growing evidence of the effectiveness of evidence-based psychological therapies such as cognitive behavioural therapy, helping people with a wide range of problems. All this has led many to call for radical alternatives to traditional models of care.

The World Health Organization describes health as ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’. The European Commission takes a step further, describing mental health as something that enables people to ‘realise their intellectual and emotional potential and to find and fulfil their roles in social, school and working life. For societies, good mental health of citizens contributes to prosperity, solidarity and social justice.’¹¹ The European Commission, interestingly, also suggests that ‘the mental condition of people is determined by a multiplicity of factors including biological, individual, family, social, economic and environmental’. It cites

I believe that our thoughts, our emotions, our behaviour and, therefore, our mental health are largely dependent on our understanding of the world, our thoughts about ourselves, other people and the future.

the role of 'genetics, but also gender, personal experiences, social support, social status and living conditions' in our mental well-being.

I agree. My role, my job, my profession is helping people fulfil their potential as human beings, not treating illnesses. In fact, doctors - medical practitioners, psychiatrists - have always prized an element of their profession that goes beyond merely treating the patient and the illness in front of them.

Of course, we must address the issue of biology. Every thought

I have involves a brain-based event. All learning involves changes in associative networks, depolarisation thresholds, synaptic biomechanics, even gene expression.¹² My view is not an anti-brain, anti-psychiatry model. But I believe that my brain is a learning engine - a biological system that is the servant of learning. I am not the slave of my brain, my brain is the organ with which I learn. So of course every thought involves brain-based activity. But this isn't the same as biomedical reductionism. Our biology provides us with a fantastically elegant learning engine. But we learn as a result of the events that happen to us - it's because of our development and our learning as human beings that we see the world in the way that we do.¹³

Everybody recognises that there are changes to the way that our brain functions which affect our thinking, our moods, our behaviour. Most cultures in the world are familiar with a range of chemicals - cannabis, alcohol, even caffeine - that affect our psychological functioning because of the effects they have on our brain. And it's perfectly reasonable to suggest that individual differences in people - even differences as a result of genetics - will have measurable influences on their behaviour and thinking in later life. There's nothing un-psychological and certainly nothing un-scientific about understanding that biological factors can affect our psychological functioning, and thereby affect our moods, our thinking, our behaviour.

I believe that our thoughts, our emotions, our behaviour and, therefore, our mental health are largely dependent on our understanding of the world, our thoughts about ourselves, other people and the future. Biological factors, social factors, circumstantial factors - our learning as human beings - affect us as those external factors impact on the key psychological processes that help us build up our sense of who we are and the way the world works. It naturally follows that we should aspire towards a psychosocial vision for mental health care services.¹⁴

In such a vision, services would be based on the premise that the origins of distress are largely social and environmental. The guiding idea underpinning mental health services needs to change from assuming that our role is to treat 'disease' to appreciating that our role is to help and support people who are distressed as a result of their life circumstances, and how they have understood them. Biological factors, social factors, circumstantial factors - our learning as human beings - all affect us; those external factors impact on the key psychological processes that help us build up our sense of who we are and the way the world works.

THE GUIDING IDEA UNDERPINNING MENTAL HEALTH SERVICES NEEDS TO CHANGE FROM ASSUMING THAT OUR ROLE IS TO TREAT 'DISEASE' TO APPRECIATING THAT OUR ROLE IS TO HELP AND SUPPORT PEOPLE WHO ARE DISTRESSED AS A RESULT OF THEIR LIFE CIRCUMSTANCES, AND HOW THEY HAVE UNDERSTOOD THEM.

Services should also replace 'diagnoses' with straightforward descriptions of problems. We must stop regarding people's very real emotional distress as merely the symptom of diagnosable 'illnesses'. A simple list of people's problems (properly defined) would have greater scientific validity and would be more than sufficient as a basis for individual care planning and for the design and planning of services.

Services should radically reduce the use of medication, and use it pragmatically rather than presenting it as 'treatment'. We should sharply reduce our reliance on medication to address emotional distress. Medication should be used sparingly and on the basis of what is needed in a particular situation - for example, to help someone to sleep or to feel calmer. We should not look to medication to 'cure' or even 'manage' non-existent underlying 'illnesses'. Instead, services should tailor help to each person's unique and complex needs. Problems do not come in neat boxes. Services should be equipped to help with the full range of people's social, personal and psychological needs, and to address both prevention and recovery. We must offer services that help people to help themselves and each other rather than disempowering them: services that facilitate personal 'agency' in psychological jargon. That means involving a wide range of community workers and psychologists in multidisciplinary teams, and promoting psychosocial rather than medical solutions. Where individual therapy is needed, effective, formulation-based (and therefore individually tailored) psychological therapies should be available to all.

Similarly, services should offer care rather than coercion. When people are in crisis, residential care may be needed, but this should not be seen as a medical issue. Since a 'disease model' is inappropriate, it is also inappropriate to care for people in hospital

wards; a different model of care is needed. As with other services, residential units should be based on a psychosocial rather than a medical model. In those instances where compulsory detention is necessary, decisions should be based on the risks that individuals are thought to pose to themselves and others, together with their capacity to make decisions about their own care. This approach is already the basis for the law in Scotland.

Mental health teams need to be radically different. Teams should be multidisciplinary, democratic and based on a psychosocial model. A psychosocial approach to service delivery would mean increased investment in the full range of professionals able to deliver these therapeutic services. Peer professionals, namely people with lived experience of mental health problems, will be particularly valuable, as will those skilled in practical issues such as finding employment or training. In the multidisciplinary teams delivering these services, psychiatric colleagues will remain valuable. An ideal model for interdisciplinary working would see leadership of such teams determined by the skills and personal qualities of the individual members of the team, rather than by their profession. It would not be assumed that medical colleagues should have 'clinical primacy' or unquestioned authority.

And, in my opinion, mental health services should be managed alongside other social, community-based services. The psychological, emotional and behavioural problems that are commonly referred to as mental health problems are fundamentally social and psychological issues. Psychologists, therapists and social workers must work closely alongside GPs, public health physicians, nurses and psychiatrists. But mental health and well-being is fundamentally a psychological and social phenomenon, with medical aspects. It is not a medical

To promote genuine mental health and well-being we need to protect and promote universal human rights, as well as addressing issues related to abuse and assault.

phenomenon with additional psychological and social elements. It follows that the correct place for mental health care is within the social care system.

We must establish the social prerequisites for genuine well-being. Our mental health is largely dependent on our social circumstances. To promote genuine mental health and well-being we need to protect and promote universal human rights, as well as addressing issues related to abuse and assault. Because experiences of neglect, rejection and abuse are hugely important in the genesis of many problems, we need to redouble our efforts to protect children from emotional, physical or sexual abuse and neglect. More generally, if we are serious about preventing mental health problems from developing, and about promoting genuine psychological well-being, we must work collectively to create a more humane society: to reduce or eliminate poverty, especially childhood poverty, and to reduce financial and social inequality.

Notes

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Peter Kinderman is Professor of Clinical Psychology at the University of Liverpool. He has published widely on the role of psychological factors as mediators between biological, social and circumstantial factors in mental health and well-being and in particular psychological factors in psychotic phenomena such as delusions and hallucinations. He is also interested in the application of such psychological science to public policy. He was twice elected chair of the British Psychological Society Division of Clinical Psychology. His latest book, *A Prescription for Psychiatry* (Palgrave Macmillan, 2014), presents his vision and manifesto for the future of mental health services.



Description of 'Psychos Sensation' using the visual language Emoji created by DoCoMo in the late 1990s

Psychos Sensation UBERMORGEN

Everything that is relevant in a relationship between a psychiatrist and a patient boils down to an effortless sensation. Automated psychiatry happens within my doctor's practice. The location of this room is the third Viennese district, the embassy district in the heart of Austria's capital. The room is located in a Gruenderzeit building on the fifth floor with a view of the Belvedere, a historic building complex with an enormous garden. A slight haze covers the sun. I can see through the window into the distance but the room is dark, with dark-brown furniture; everything is dusty, calm and soothing. In the corner there are two very large leather chairs facing each other at a 45 degree angle. The conversation cloud hovers two feet above the tip of my stretched-out feet and allows for a comfortable indirect communication.

Sometimes my psychiatrist dozes off and I stop talking and let my eyes sweep over the Belvedere structure, the gardens and further into the distance. The room is not actually here; the room belongs to Vienna but the room is everywhere. It is the room and not only the machine or the sleeping psychiatrist that define my reality. The software and the sleeping psychiatrist do not care where they are, they do not think and dream as far as I am concerned. I have to do the work. I am the user. The software, the machine, ICD-

10, the drugs and the psychiatrist are my instruments of gradual formulation of diagnoses while speaking.

Drugs are a more or less stable chemical compound; in a way, at least conceptually, they never change. Only when they come into contact with a user or another chemical element or compound do they dissolve and start to interact. The reaction is very specific since each user is a different individual. They are global drugs but we are individual users. We are not good and we are not bad. We are well and not well. We become well or not well. Subject and object merge in psychiatric practice. The chair becomes subject and the user turns into an object; the psychiatrist takes a radical position and transcends into an indifferent difference machine. Prescriptions demand the highest level of exactness in an otherwise obscure, inaccurate and nebulous field.

psychossensation.xyz

The right to k(no)w

the vacuum cleaner

If I placed my medical records end to end they would take about ten minutes to walk along; however, it took me fifteen years to collect that amount of paper - between 1998 and 2013, just over 2,500 pages. Actually it's probably more than that, but a number of hospitals destroyed my records after seven years, and one hospital lost a large quantity.

Three years ago I began making a performance called *Mental*, the basic premise of which was to tell the story of my adult life from my experience, and counter that with the perceptions of those who have worked for the state and corporations I had come into contact with. Telling my side of this story was easy - that just involved my memory. I consider my ability to recollect things that have happened to me to be excellent, unless I have had Haloperidol¹ forced into my system. Of course I would have never have known if they had injected me with Haloperidol unless I got a copy of my medical records...

Telling the other side of the story was slightly more complex. It was complex for a few reasons.

First I had to get a copy of the damn medical records.

Under the Data Protection Act, once you have submitted an application for your medical records, you are supposed to get your files back within 40 working days – eight weeks to you or me. In reality it took 260 working days – basically a year.

Under the Data Protection Act you are entitled to a copy of your medical records. To apply for them you write to the data manager of each place that has collected information about you. You include a copy of some ID, like a passport, a list of other relevant information such as your address at the time, NHS number and when you came into contact with that hospital. You also need to send a cheque for £10 to cover the cost of the administration and postage. It's a laborious task when you have been in over eight hospitals, not the kind of thing that I have the patience or ability to do, which is why I made my producer do it. Under the Data Protection Act, once you have submitted an application for your medical records, you are supposed to get your files back within 40 working days – eight weeks to you or me. In reality it took 260 working days – basically a year. This included making a call to the director of West London NHS Health Trust to explain that 'Sorry,



Mental - An autobiographical performance by the vacuum cleaner

we have lost the records from when you were in hospital' (for a year) was not going to cut it. Imagine being in hospital for a year and the amount of highly personal information you would have given over, only for it to be lost by some administrative error or incompetence or because the hospital you were in was a bit old fashioned and was appalled by the idea of an ex-patient reading their notes (I reckon it was the last reason). Eventually they found them in the back of a cupboard on a micro file. No that isn't made up for Kafkaesque delight; it's the actual reason they gave me.

The other difficult thing about getting a copy of your medical records is reading the bloody things. Which presents a number of challenges.

Reading challenge 1: I am not good at reading. I didn't read my first book until I was 19 when I was in hospital and had time to kill. I still find it hard, the words swim around the page, my mind drifts off and I have to start the ... and I have to start the sentence again.

Reading challenge 2: Doctors' handwriting. You've seen it on a prescription; imagine a couple of hundred pages of that shit. I became a sentence reconstruction master very quickly.

Reading challenge 3: In terms of my mental health, one of the things I struggle with is that my sense of self can be really warped. I can go from being ultra positive to having the kind of perception about myself that by comparison makes Twitter trolls paragons of good bedside manner. Which is partly why I've enjoyed being trolled on Twitter. I find being insulting easy. A Twitter troll once told me I'd made him cry and that I should apologise. I replied and told him to have his tear ducts surgically removed so that at least one part of his body wouldn't pump out liquid when he's on the Internet on his own in a dark room.

Anyway, back to me. Not all of the records about me were bad, some were nice. Some were shocking. For example, I saw this therapist for a year, twice a week when I was in this particular hospital. I thought we got on OK. Apparently not... She wrote quite clearly that she would be happy to see the back of me after our sessions had ended. I didn't see that coming. Why would you tell someone your deepest secrets, about sexual abuse or family trauma, if the woman you're pouring your heart out to thinks you're a selfish little knob shite? That's right, you wouldn't. Good job I only found that out a decade later. What I'm saying is that both the opinions that some medical staff had of me and some of the messed-up shit I've done wasn't a good bedtime read. Some days I'd read something and that would be me done for a few days.

A combination of these things meant it took me eleven months to read all the medical notes before I was even in a position to be able to construct a narrative out of it. The one advantage of this process was that it seemed to help my current talking therapy. Being placed back into my past enabled me to make links and reflect on this past, which is an important part of the therapeutic process. Or that's what my therapist observed anyway, and I agree with her. Luckily I don't think my current therapist thinks I am knob, or if she does, she is the best liar I've ever met.

A slight change of subject here, but if the police wanted to access my medical records they'd need to find out who my GP is and obtain a disclosure order from a court. This process takes about a week. If you have signed a sharing of information consent form, which is pretty much the default within the NHS trust that looks after my mental health, your nurse, doctor or administrator can freely share this information with:

- anyone else in the health trust
- your GP
- any other medical or social staff you have contact with
- local authority housing staff
- any voluntary organisation you engage with

or

- any other professional or agency who has been involved in 'assessing [your] needs or providing services'.

With the development of care.data - the new NHS mega health database - access to private and confidential records can be done at the click of a mouse. The police have already stated their wish to have 'back door' access to it.

I don't trust the cops in general; they've spied on me for being a political activist and campaigner. No that's not paranoia. I've got a copy of my domestic extremist file, which I got under the Data Protection Act. They - the police - have treated me in an exceptionally unprofessional manner when I've been at my most mentally distressed.

Why should a group of people who will shoot a black man without a gun in a taxi and then stand up in court and say 'yes my Lord, he had a gun' have access to my medical records? Especially when they get them at about ten times the speed that I have access to them. Don't tell me it's for my own safety. Don't tell me that people with mental illnesses are safe with the police, because that only shows two things: one, you're a fucking moron, and two, you love being lied to.

The other thing is, when you write a diary, it's private. You can call your best mate a freak and they'll never know, it's private, and that's a healthy thing. We all have dark thoughts. In a professional

WHAT I'M SAYING IS THAT BOTH THE OPINIONS THAT SOME MEDICAL STAFF HAD OF ME AND SOME OF THE MESSED-UP SHIT I'VE DONE WASN'T A GOOD BEDTIME READ. SOME DAYS I'D READ SOMETHING AND THAT WOULD BE ME DONE FOR A FEW DAYS.

THERE IS A BIT IN MY NOTES WHERE THEY TALK ABOUT ME BEING CHILDISH, THAT I'M DEMANDING THINGS THAT AREN'T POSSIBLE. WOULD THAT DOCTOR HAVE USED THOSE WORDS IF HE KNEW IT COULD GET BACK TO ME? DOUBTFUL.

medical relationship this isn't the case. And we all know that a small percentage of people who work in mental health should be sacked because they've had their empathy bone removed at birth. Imagine if doctors and nurses were aware that it wasn't just other doctors and nurses who would see what they wrote (on the off chance that they do actually read each other's observations). Imagine if those taking notes knew that the person they were writing about would see it, and that it wouldn't be a Herculean task of administrative diligence for them to be able to get a copy. There is a bit in my notes where they talk about me being childish, that I'm demanding things that aren't possible. Would that doctor have used those words if he knew it could get back to me? Doubtful. You'd hope a more sensitive choice of words would be made. Would he have framed my demands for something other than being knocked out by drugs as unrealistic, or would he have framed my criticism as an obvious yet sad outcome of the lack of funding in mental health? Maybe. Would the doctor or the nurse have had to position their understanding of me in a more humane way? You'd fucking hope so.

One of the problems with being mentally distressed is that it is equally as confusing as filling in a form for Disability Living Allowance or some other type of benefit. You get lost in words that bear no connection to reality, or words that don't and can't do justice to what you're experiencing. This experience is compounded by a lack of clarity, honesty and humanity in the health care that you are being provided with. Key to stopping this is addressing the culture of emotional distance in those who are supposed to be getting you through your confused and distressing state, not reinforcing it with coldness and indifference.

I have a right to my medical records and a right to know what is being done to me and about the state of mind of those caring for me - especially if I have no legal right to choose how I'm being treated. I would hope I also have the right to dictate who can and can't see my medical records. Making my performance piece *Mental* was my story and I get to tell it however I want.

Notes

- 1 Haloperidol is an antipsychotic medication used in the treatment of schizophrenia, acute psychosis, mania, delirium, tics in Tourette's syndrome, choreas, nausea and vomiting in palliative care, intractable hiccups, agitation and severe anxiety.

the vacuum cleaner (James Leadbitter) is an art and activism collective of one. Through site-specific performance, street-based intervention and film, the vacuum cleaner empowers his audience to address sociopolitical issues including consumerism and mental health discrimination. From one-man shows to large-scale participatory actions, his approach is variously subtle and extreme, but always candid, provocative and playful. His work has been exhibited throughout the UK, including commissions from Tate Modern, ICA and the Nottingham Contemporary as well as BBC4, Channel 4 and Arte. He regularly presents work internationally both on the streets and in art spaces.

Twelve

Melanie Manchot

Twelve is a multi-channel video installation developed over the course of two years in close collaboration with twelve people in recent recovery from substance misuse. Built over a slow process of regular workshops and exchanges, the work is at once cinematic and intimate, performative and rich in affective stories and gestures.

Methodologies of collaboration and co-authorship are explored in *Twelve* through its content and form, as highly participant-authored and real-life narratives are given a cinematic framework. Filmed entirely as single continuous takes, each sequence focuses on one participant who conceives and performs their own content, while formally each scene refers directly to a precedent from the history of cinema.

The work employs narrative and performativity as tools for speaking of the challenges to one's sense of self, of transformation and the mutability of subjectivity. Obsessive gestures - cutting grass with a pair of scissors, cleaning one tile for a very long time - sit alongside spoken memories and thoughts. Journeys without departures or arrivals are key framing devices as is the overall circular/non-linear structure of the work.

The installation of the project is crucial in producing a *mise-en-scène* where the individual voices create a collage-like ensemble of stories and gestures. Devised individually and complete in their own aesthetics, in the installation these scenes are brought together in a viewing architecture that refers to the layout of group therapy. Through its precise use of formal devices, the work aims to articulate the complex relations between individual and collective structures in recovery as well as in therapy more generally.

Twelve was commissioned by Portraits of Recovery and produced through generous funding from the Wellcome Trust. The full installation, comprising up to twelve channels, is the subject of a national touring show, supported by Arts Council England, from spring 2015 to summer 2016 at Peckham Platform, London; Castlefield Gallery, Manchester; Aspex, Portsmouth; and Towner, Eastbourne.



Reflexive impotence, immobilisation and liberal communism

Mark Fisher

By contrast with their forebears in the 1960s and 1970s, British students today appear to be politically disengaged. While French students can still be found on the streets protesting against neoliberalism, British students, whose situation is incomparably worse, seem resigned to their fate. But this, I want to argue, is a matter not of apathy, nor of cynicism, but of reflexive impotence. They know things are bad, but more than that, they know they can't do anything about it. But that 'knowledge', that reflexivity, is not a passive observation of an already existing state of affairs. It is a self-fulfilling prophecy.

Reflexive impotence amounts to an unstated worldview among the British young, and it has its correlate in widespread pathologies. Many of the teenagers I worked with had mental health problems or learning difficulties. Depression is endemic. It is the condition most dealt with by the National Health Service, and it is afflicting people at increasingly younger ages. The number of students who have some variant of dyslexia is astonishing. It is not an exaggeration to say that being a teenager in late capitalist Britain is now close to being reclassified as a sickness. This pathologisation already forecloses any possibility of politicisation. By privatising these problems - treating them as if they were caused only by

It is not an exaggeration to say that being a teenager in late capitalist Britain is now close to being reclassified as a sickness.

chemical imbalances in the individual's neurology and/or by their family background - any question of social systemic causation is ruled out.

Many of the teenage students I encountered seemed to be in a state of what I would call depressive hedonia. Depression is usually characterised as a state of anhedonia, but the

condition I'm referring to is constituted not by an inability to get pleasure so much as by an inability to do anything else *except* pursue pleasure. There is a sense that 'something is missing' - but no appreciation that this mysterious, missing enjoyment can only be accessed *beyond* the pleasure principle. In large part this is a consequence of students' ambiguous structural position, stranded between their old role as subjects of disciplinary institutions and their new status as consumers of services. In his crucial essay 'Postscript on Societies of Control', Deleuze distinguishes between the disciplinary societies described by Foucault, which were organised around the enclosed spaces of the factory, the school and the prison, and the new control societies, in which all institutions are embedded in a dispersed corporation.

Deleuze is right to argue that Kafka is the prophet of the distributed, cybernetic power that is typical of control societies. In *The Trial*, Kafka importantly distinguishes between two types of acquittal available to the accused. Definite acquittal is no longer possible, if it ever was ('we have only legendary accounts of ancient cases [which] provide instances of acquittal'). The two remaining

options, then, are 1: 'Ostensible acquittal', in which the accused is to all and intents and purposes acquitted, but may later, at some unspecified time, face the charges in full; or 2: 'Indefinite postponement', in which the accused engages in (what they hope is an infinitely) protracted process of legal wrangling, so that the dreaded ultimate judgment is unlikely to be forthcoming. Deleuze observes that the control societies delineated by Kafka himself, but also by Foucault and Burroughs, operate using indefinite postponement: Education as a lifelong process... Training that persists for as long as your working life continues... Work you take home with you... Working from home, homing from work. A consequence of this 'indefinite' mode of power is that external surveillance is succeeded by internal policing. Control only works if you are complicit with it. Hence the Burroughs figure of the 'Control Addict': the one who is addicted to control, but also, inevitably, the one who has been taken over, possessed by control.

Walk into almost any class at the college where I taught and you will immediately appreciate that you are in a post-disciplinary framework. Foucault painstakingly enumerated the way in which discipline was installed through the imposition of rigid body postures. During lessons at our college, however, students will be found slumped on desks, talking almost constantly, snacking incessantly (or even, on occasions, eating full meals). The old disciplinary segmentation of time is breaking down. The carceral regime of discipline is being eroded by the technologies of control, with their systems of perpetual consumption and continuous development.

The system by which the college is funded means that it literally cannot afford to exclude students, even if it wanted to. Resources are allocated to colleges on the basis of how successfully they

meet targets on achievement (exam results), attendance and retention of students. This combination of market imperatives with bureaucratically defined 'targets' is typical of the 'market Stalinist' initiatives which now regulate public services. The lack of an effective disciplinary system has not, to say the least, been compensated for by an increase in student self-motivation. Students are aware that if they don't attend for weeks on end, and/or if they don't produce any work, they will not face any meaningful sanction. They typically respond to this freedom not by pursuing projects but by falling into hedonic (or anhedonic) lassitude: the soft narcosis, the comfort food oblivion of Playstation, all-night TV and marijuana.

Ask students to read for more than a couple of sentences and many - and these are A-level students mind you - will protest that they can't do it. The most frequent complaint teachers hear is that it's boring. It is not so much the content of the written material that is at issue here; it is the act of reading itself that is deemed to be 'boring'. What we are facing is not just time-honoured teenage torpor, but the mismatch between a post-literate 'New Flesh' that is 'too wired to concentrate' and the confining, concentrational logics of decaying disciplinary systems. To be bored simply means to be removed from the communicative sensation-stimulus matrix of texting, YouTube and fast food; to be denied, for a moment, the constant flow of sugary gratification on demand. Some students want Nietzsche in the same way that they want a hamburger; they fail to grasp - and the logic of the consumer system encourages this misapprehension - that the indigestibility, the difficulty *is* Nietzsche.

An illustration: I challenged one student about why he always wore headphones in class. He replied that it didn't matter, because he

wasn't actually playing any music. In another lesson, he was playing music at very low volume through the headphones, without wearing them. When I asked him to switch it off, he replied that even he couldn't hear it. Why wear the headphones without playing music or play music without wearing the headphones? Because the presence of the phones on the ears or the knowledge that the music is playing (even if he couldn't hear it) was a reassurance that the matrix was *still there*, within reach. Besides, in a classic example of interpassivity, if the music was still playing, even if he couldn't hear it, then the player could still enjoy it on his behalf. The use of headphones is significant here - pop is experienced not as something which could have impacts upon public space, but as a retreat into private 'OedIpod' consumer bliss, a walling up against the social.

The consequence of being hooked into the entertainment matrix is twitchy, agitated interpassivity, an inability to concentrate or focus. Students' incapacity to connect current lack of focus with future failure, their inability to synthesise time into any coherent narrative, is symptomatic of more than mere demotivation. It is, in fact, eerily reminiscent of Jameson's analysis in 'Postmodernism and Consumer Society'. Jameson observed there that Lacan's theory of schizophrenia offered a 'suggestive aesthetic model' for understanding the fragmenting of subjectivity in the face of the emerging entertainment-industrial complex. 'With the breakdown of the signifying chain,' Jameson summarised, 'the Lacanian schizophrenic is reduced to an experience of pure material signifiers, or, in other words, a series of pure and unrelated presents in time.'¹ Jameson was writing in the late 1980s - the period in which most of my students were born. What we in the classroom are now facing is a generation born into that ahistorical, anti-mnemonic blip culture - a generation, that is to say, for whom time has always come ready-cut into digital micro-slices.

If, then, something like attention deficit hyperactivity disorder is a pathology, it is a pathology of late capitalism - a consequence of being wired into the entertainment-control circuits of hypermediated consumer culture.

If the figure of discipline was the worker-prisoner, the figure of control is the debtor-addict. Cyberspatial capital operates by addicting its users; William Gibson recognized this in *Neuromancer* when he had Case and the other cyberspace cowboys feeling insects-under-the-skin strung out when they unplugged from the matrix (Case's amphetamine habit is plainly the substitute for an addiction to a far more abstract speed). If, then, something like attention deficit hyperactivity disorder is a pathology, it is a pathology of late capitalism - a consequence of being wired into the entertainment-control circuits of hypermediated consumer culture. Similarly, what is called dyslexia may in many cases amount to a *post-lexia*. Teenagers process capital's image-dense data very effectively without any need to read - slogan-recognition is sufficient to navigate the net-mobile-magazine informational plane. 'Writing has never been capitalism's thing. Capitalism is profoundly illiterate,' Deleuze and Guattari argued in *Anti-Oedipus*. 'Electric language does not go by way of the voice or writing: data processing does without them both.'² Hence the reason that many successful business people are dyslexic (but is their post-lexical efficiency a cause or effect of their success?)

Teachers are now put under intolerable pressure to mediate between the post-literate subjectivity of the late capitalist consumer and the demands of the disciplinary regime (to pass examinations etc.). This is one way in which education, far from being in some ivory tower safely inured from the 'real world', is the engine room of the reproduction of social reality, directly confronting the inconsistencies of the capitalist social field. Teachers are caught between being facilitator-entertainers and disciplinarian-authoritarians. Teachers want to help students to pass the exams; the students want us to be authority figures who tell them what to

do. Teachers being interpellated by students as authority figures exacerbates the 'boredom' problem, since isn't anything that comes from the place of authority a priori boring? Ironically, the role of disciplinarian is demanded of educators more than ever at precisely the time when disciplinary structures are breaking down in institutions. With families buckling under the pressure of a capitalism which requires both parents to work, teachers are now increasingly required to act as surrogate parents, instilling the most basic behavioural protocols in students and providing pastoral and emotional support for teenagers who are in some cases only minimally socialised.

It is worth stressing that none of the students I taught had any legal obligation to be at college. They could leave if they wanted to. But the lack of any meaningful employment opportunities, together with cynical encouragement from government, means that college seems to be the easier, safer option. Deleuze says that control societies are based on debt rather than enclosure; but there is a way in which the current education system both indebts *and* encloses students. Pay for your own exploitation, the logic insists - get into debt so you can get the same McJob you could have walked into if you'd left school at sixteen...

Jameson observed that 'the breakdown of temporality suddenly releases [the] present of time from all the activities and intentionalities that might focus it and make it a space of praxis'. But nostalgia for the context in which the old types of praxis operated is plainly useless. That is why French students don't in the end constitute an alternative to British reflexive impotence. That the neoliberal *Economist* would deride French opposition to capitalism is hardly surprising, yet its mockery of French 'immobilisation' had a point. 'Certainly the students who kicked off

With families buckling under the pressure of a capitalism which requires both parents to work, teachers are now increasingly required to act as surrogate parents, instilling the most basic behavioural protocols in students.

the latest protests seemed to think they were re-enacting the events of May 1968 their parents sprang on Charles de Gaulle', it wrote in its lead article of 30 March 2006:

They have borrowed its slogans ('Beneath the cobblestones, the beach!') and hijacked its symbols (the Sorbonne university). In this sense, the revolt appears to be the natural sequel to [2005]'s suburban riots, which prompted the government to impose a state of emergency. Then it was the jobless, ethnic underclass that rebelled against a system that excluded them. Yet the striking feature of the latest protest movement is that this time the rebellious forces are on the side of conservatism. Unlike the rioting youths in the banlieues, the objective of the students and public-sector trade unions is to prevent change, and to keep France the way it is.

It's striking how the practice of many of the immobilisers is a kind of inversion of that of another group who also count themselves heirs of 68: the so-called 'liberal communists' such as George Soros and Bill Gates, who combine rapacious pursuit of profit with the rhetoric of ecological concern and social responsibility. Alongside their social concern, liberal communists believe that work practices should be (post-) modernised, in line with the concept of 'being smart'. As Žižek explains,

Being smart means being dynamic and nomadic, and against centralized bureaucracy; believing in dialogue and cooperation as against central authority; in flexibility as against routine; culture and knowledge as against industrial production; in spontaneous interaction and autopoiesis as against fixed hierarchy.³

Taken together, the immobilisers, with their implicit concession that capitalism can only be resisted, never overcome, and the liberal communists, who maintain that the amoral excesses of capitalism must be offset by charity, give a sense of the way in which capitalist realism circumscribes current political possibilities. Whereas the immobilisers retain the form of 68-style protest but in the name of resistance to change, liberal communists energetically embrace newness. Žižek is right to argue that, far from constituting any kind of progressive corrective to official capitalist ideology, liberal communism constitutes the dominant ideology of capitalism now. ‘Flexibility’, ‘nomadism’ and ‘spontaneity’ are the very hallmarks of management in a post-Fordist, control society. But the problem is that any opposition to flexibility and decentralisation risks being self-defeating, since calls for inflexibility and centralisation are, to say the least, not likely to be very galvanising.

In any case, resistance to the ‘new’ is not a cause that the left can or should rally around. Capital thought very carefully about how to break labour; yet there has still not yet been enough thought about what tactics will work against capital in conditions of post-Fordism, and what *new language* can be innovated to deal with those conditions. It is important to contest capitalism’s appropriation of the ‘new’, but to reclaim the ‘new’ cannot be a matter of adapting to the conditions in which we find ourselves – we’ve done that rather too well, and ‘successful adaptation’ is the strategy of managerialism par excellence.

The persistent association of neoliberalism with the term ‘Restoration’, favoured by both Badiou and David Harvey, is an important corrective to the association of capital with novelty.

For Harvey and Badiou, neoliberal politics are not about the new, but a *return* of class power and privilege. ‘[I]n France,’ Badiou has said, “Restoration” refers to the period of the return of the King, in 1815, after the Revolution and Napoleon. We are in such a period. Today we see liberal capitalism and its political system, parliamentarianism, as the only natural and acceptable solutions.⁴ Harvey argues that neoliberalisation is best conceived of as a *political* project to re-establish the conditions for capital accumulation and to restore the power of economic elites.⁵ Harvey demonstrates that, in an era popularly described as ‘post-political’, class war has continued to be fought, but only by one side: the wealthy. ‘After the implementation of neoliberal policies in the late 1970s,’ Harvey reveals,

the share of national income of the top 1 per cent of income earners soared, to reach 15 per cent ... by the end of the century. The top 0.1 per cent of income earners in the US increased their share of the national income from 2 per cent in 1978 to over 6 per cent by 1999, while the ratio of the median compensation of workers to the salaries of CEOs increased from just over 30 to 1 in 1970 to nearly 500 to 1 by 2000 ... The US is not alone in this: the top 1 per cent of income earners in Britain have doubled their share of the national income from 6.5 per cent to 13 per cent since 1982.⁶

As Harvey shows, neoliberals were more Leninist than the Leninists, using think-tanks as the intellectual vanguard to create the ideological climate in which capitalist realism could flourish. The immobilisation model – which amounts to a demand to retain the Fordist/disciplinary regime – could not work in Britain or the other countries in which neoliberalism has already taken hold.

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Fordism has definitively collapsed in Britain, and with it the sites around which the old politics were organised. At the end of the control essay, Deleuze wonders what new forms an anti-control politics might take:

One of the most important questions will concern the ineptitude of the unions: tied to the whole of their history of struggle against the disciplines or within the spaces of enclosure, will they be able to adapt themselves or will they give way to new forms of resistance against the societies of control? Can we already grasp the rough outlines of the coming forms, capable of threatening the joys of marketing? Many young people strangely boast of being 'motivated'; they re-request apprenticeships and permanent training. It's up to them to discover what they're being made to serve, just as their elders discovered, not without difficulty, the telos of the disciplines.⁷

What must be discovered is a way out of the motivation/demotivation binary, so that disidentification from the control programme registers as something other than dejected apathy. One strategy would be to shift the political terrain - to move away from the unions' traditional focus on pay and on to forms of discontent specific to post-Fordism.

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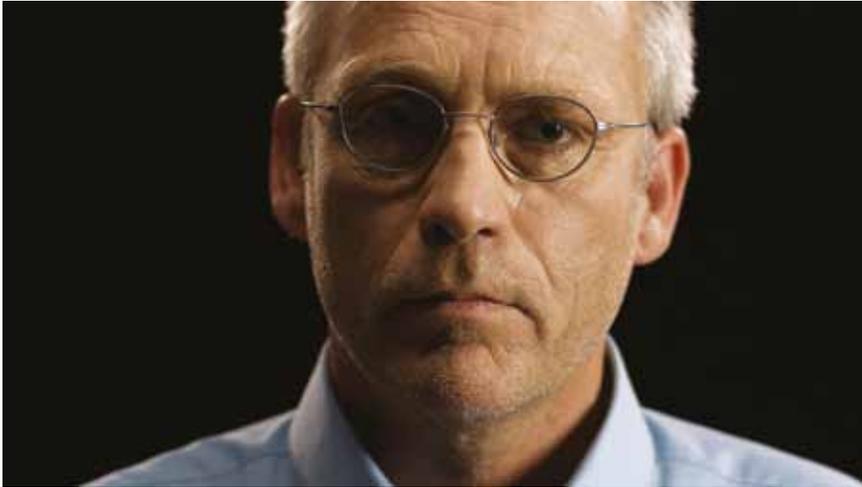
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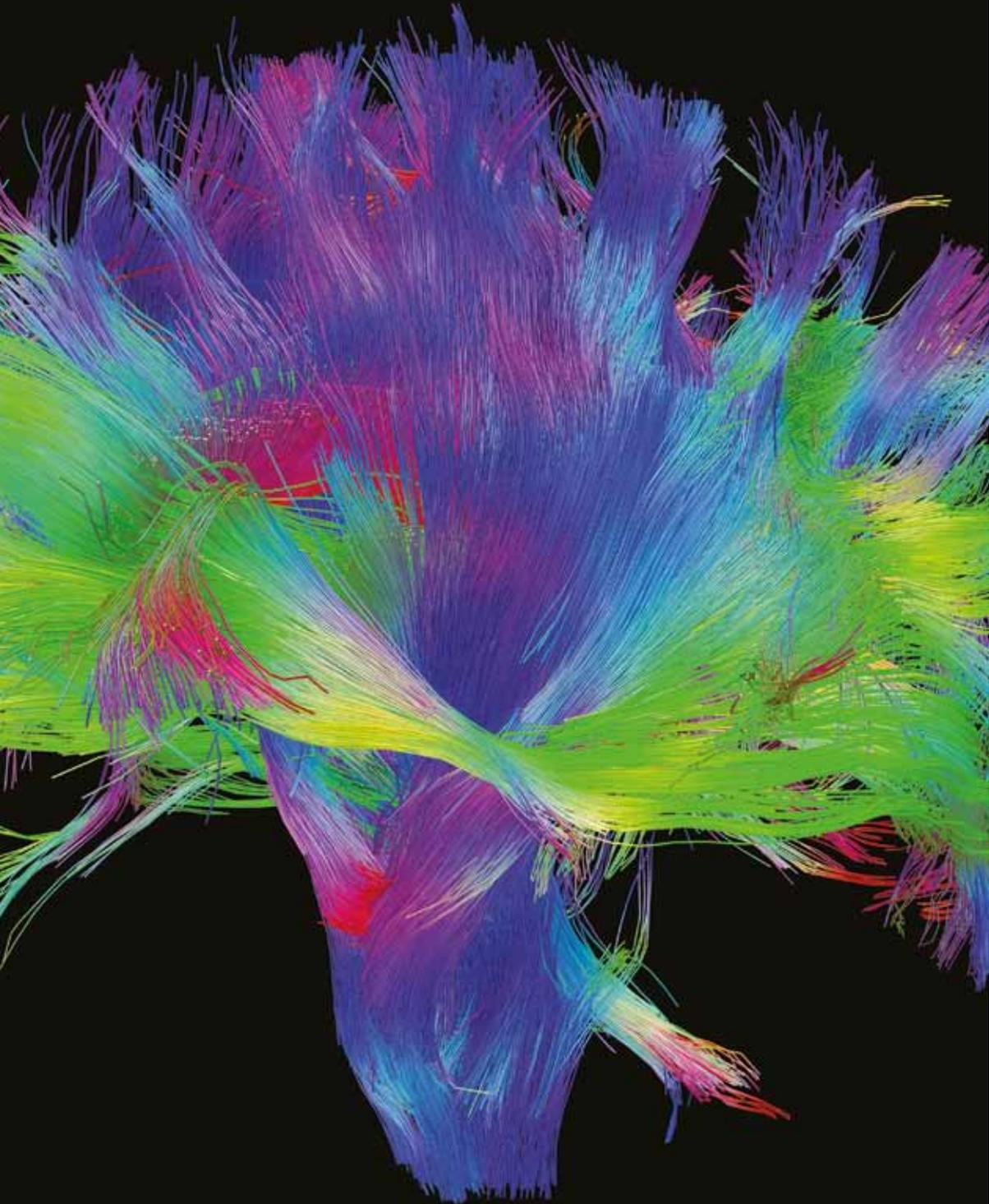
Mark Fisher is highly respected both as a music writer and a theorist. He writes regularly for *frieze*, *New Statesman*, *Sight & Sound* and *The Wire*, where he was acting deputy editor for a year. He is a Visiting Fellow at Goldsmiths, University of London, and maintains one of the most successful weblogs on cultural theory, k-punk (k-punk.abstractdynamics.org).

The Financial Crisis

Superflex



The Financial Crisis (Session I-V) is a 12-minute film work addressing the financial crisis from a therapeutic perspective. A hypnotist guides us through our worst nightmares to reveal the crisis without as the psychosis within. During four sessions - 1. The Invisible Hand, 2. George Soros, 3. You, and 4. Old Friends - the spectator experiences the fascination of speculation and power, fear, anxiety and the frustration of losing control, economic loss and personal disaster. *The Financial Crisis (Session I-V)* was created for Frieze Film 2009, curated by Neville Wakefield, and screened in Channel 4's *3 Minute Wonder* slot in October 2009.



Technology

Katriona Beales research image showing white matter in the brain. Courtesy of the Laboratory of Neuro Imaging and Martinos Centre for Biomedical Imaging, Consortium of the Human Connectome Project – www.humanconnectomeproject.org



Screen grab from Seaneen Molloy's blog *The Secret Life of a Manic Depressive*

Blogging about mental health

Seaneen Molloy

I've been journaling since I was a child. The first thing I looked for in every growing-up bedroom was the best nook in which to hide my diary from prying sisterly eyes. And when I first began to experience symptoms of mental illness in my teens, it was paper that I turned to to help me make sense of what was happening to me. It was a very lonely time. It took until I was aged 20, having already had to drop out of education and work, and then drop into a psychiatric hospital, for the diagnosis of bipolar disorder to be made.

I started my blog in 2007, a few months after my diagnosis. I felt as though I was exhausting the people around me with mental health stuff. I wanted a separate space to write about how I was feeling, in the hope that I could contain it there and stop burdening the people around me. And my life had changed pretty abruptly. I had this new prism through which to see my experiences, and a new language in which to describe them. I felt as though I was losing control of my own story, and for a while, the way to regain it was to invest, perhaps too heavily, in the diagnosis, and let it become my identity.

I used my real name. I wasn't working at the time and didn't feel as though I had much to lose my attaching my name to my words. When I started looking for jobs, it became a problem. I was unceremoniously sacked from a temp job after a few weeks. When

When I checked my blog's referrers (a list of what people had searched for to find it), I found my name along with the company I worked for and its location – they had googled me and found out I had a mental illness.

I worry it places a pressure on people to behave in a certain way or to always be accessible

I checked my blog's referrers (a list of what people had searched for to find it), I found my name along with the company I worked for and its location – they had googled me and found out I had a mental illness. After that, I started to feel more self-conscious. It made me realise

that I was telling the world incredibly personal things. But in many ways, it helped that I used my real name. It helped me to be more honest, and others told me it helped them to see that someone else was going through the same thing.

Blogging can be a powerful tool of validation, both positively and negatively. I mostly received positive, supportive comments, and have made a few friends through blogging. My blog became inexplicably popular, and although I was grateful that so many people found comfort in what I was writing, I also felt a pressure to perform for an 'audience'. The nature of my illness means I exist in flux. Sometimes things will be difficult but, increasingly, as time has worn on and I have learned how to cope, I often feel fine. No matter how I was feeling, I had a sense of misplaced responsibility towards my readers. I felt guilty when I was depressed that people had called me 'inspirational'. It was like I was letting them down. And when things were fine, and I watched my statistics drop as I blogged less, I worried that I was boring. I sometimes found I would share more than I was comfortable with when I was low so that people would respond. I desperately wanted to know I wasn't alone.

Later I found myself writing less and less on my blog and turning instead to Twitter. I feel far more exposed on Twitter and thus I share far less than I would on my blog, despite them being equally public. The responses are instant. For some, this can be helpful, but

And on Twitter, I receive more abuse in a week than I did over years of blogging.

I worry it places a pressure on people to behave in a certain way or to always be accessible. Your words can be retweeted in an instant, and you have far less control over what you've shared than you do with a blog. And on Twitter, I receive more

abuse in a week than I did over years of blogging. I can't remove it, I can't hide it, and the publicness of Twitter means that one nasty comment can quickly escalate. Twitter can also become a popularity contest, meaning less 'articulate' people may feel more marginalised than they already do.

Although I blog less these days, I still find it a wonderful record of where I've been. For the past seven years I've shared every major event with a group of people, many of who have been with me the whole time. It's helped me to spot patterns in my own moods and to understand them.

Social media can be a wonderful way to reach out, but it can leave us feeling vulnerable. It's important to recognise our own boundaries and what we feel comfortable sharing. It can be a great tool for support but instant validation is a double-edged sword. Knowing you're not alone and building a community - wherever that is - can be a powerful tool against mental illness.

Seaneen Molloy is a 'mentally interesting' writer and activist from West Belfast. Her blog, *The Secret Life of a Manic Depressive*, was adapted for BBC Radio 4 and won a Mind Media Award for Best Radio Drama. Her writing has appeared in numerous publications, including the *Guardian* and the *Independent*. She lives in London with her husband, two cats and eight million other people. www.thesecretlifeofamanicdepressive.wordpress.com

Using apps to support my mental health

Charlotte Wealthy

As a young person in the twenty-first century I constantly struggle with social media and the issues that accompany it. Social media was originally set up with the intention of keeping friends and family in contact no matter where they were, creating links for employment and for learning. Unfortunately it is in reality used in other ways. Every time I scroll through my Twitter timeline there are several pictures on there of girls in just their underwear with the caption 'Follow me, I follow back'. Another thing I have found Twitter notorious for is constant spam adverts about losing weight in 'three days'. That is not healthy.

I have experienced problems with self-image in the past and after support am generally quite resilient to the pressures of looking and being 'perfect'. However, I have found that after a while of constantly seeing this, it actually does start to push you to 'lose weight' even though it isn't necessary and would put me right back to the start. I am lucky to have the understanding of how my brain works to identify that a social media detox is needed in order to ground me. But not every young person will have the knowledge to be able to stop and think *how does this make me feel?*



In Hand app created by young people at FACT with Red Ninja and Merseycare NHS Trust

I don't think it is healthy to be comparing yourself to others and giving your Facebook 'friends' the chance to judge you either. All those Facebook friends won't stop you from feeling any less lonely when life gets tough.

However, in among all the problems that emerge from technology, I think there are some positives, some light. Apps are being created to help support individuals with their own health and well-being. I was on the team that created the *In Hand* app, a simple tool to help you focus on where you're at and bring back the balance. *In Hand* has helped me to understand myself better - who I am, what triggers certain moods and to be more mindful of what is going on around me. It is also a very good distraction tool, to draw you away from what is worrying you. These kinds of apps empower young people to use technology in a positive way by teaching them to use these tools as an aid for better well-being so that they can manage their own health independently, and to fight back against the constant pressure of 'perfection' from social media.

Charlotte Wealthy is a student diagnostic radiographer at the University of Liverpool. She was a member of the team of young people who helped to create *In Hand*, a new application for smartphones designed to act as a personal interactive recovery guide, at FACT between June 2013 and June 2014.

Not Eye

Lauren Moffatt



Not Eye is a digital stereoscopic film in black and white that explores the relationship between the eye and the camera, between the body and the machine. The decision to make the film in stereoscopic 3D creates a sort of *mise-en-abyme*. The viewer is placed into a hall of mirrors where the binocular gazes of the characters and the cameras trained upon them are exchanged endlessly. The inherently subjective experience of a 3D presentation viewed with glasses also serves to underline and reflect the themes in the film. The relationship of the masked woman and her interviewer becomes a point of departure for an examination of the relationship between the gazes of subject and institution, between the mechanical eye and the human eye.

The film's central character is a woman who has constructed a helmet fitted with two cameras which replace her eyes. She wears her helmet in public and films everything that surrounds her. Doing so makes her feel protected from the gaze of others. We encounter the woman during an interview with an unknown man. Witnessing a conversation with the protagonist that suggests both therapy and interrogation, the viewer is invited to contemplate whether the woman is emotionally unstable or is in fact making a very understandable attempt to protect herself from a surveillance-obsessed society.



Screen grabs taken from the #dearmentalhealthprofessionals hash tag

Talking back: mental health and social media

Victoria Betton

Employed as a senior manager in an NHS trust, I was introduced to Twitter by a colleague in 2010. I became gradually immersed in the sphere of blogging and micro-blogging. As I began connecting with a diverse range of people accessing and working in mental health services, I observed how parameters and barriers routinely established between these groups of people appeared to have different qualities to those in everyday clinical contexts. In this essay I set out a brief history of people with lived experience 'talking back' to the mental health profession and reflect on how this history of talking back is continued in a space I call the *madosphere*. I argue that social networking sites such as blogs and micro-blogs create conversations about mental health that can be valuable for both clinical practice and for those with lived experience. I end with an example: the Twitter hashtag #DearMentalHealthProfessionals.

The *madosphere* is a term originally coined by a loose affiliation of people conversing about mental health on a now defunct blog entitled *The World of Mentalists (TWOM)*. The irreverent tone implicit within the notion of a *madosphere* alludes to the rupturing of time-honoured relationships that I have been curious to explore and understand. The word *mad* is frequently used as a pejorative

term of abuse in every day life. However, TWOM not only reclaims the word but also employs it to satirise the very people who use it in a negative way. A parallel with reclamation of language by civil rights groups is pertinent; the term not only has a transgressive quality to it, it also nods to the Mad Pride movement, which began in the late nineties.¹ *Madosphere* is a play on the word blogosphere, which denotes a network of blogs converging around the theme of mental health. While the TWOM blog is no longer active, I use the term *madosphere* to indicate disruptive practices in relation to mental health on social networking sites.

On a personal level, I certainly experienced a sense of invigoration in the ability to have online public conversations about the contested nature of mental distress with a diverse range of people who have varied views and experiences. Before my introduction to social networking sites, the chances of participating in discussion that actively challenged the conventions of the clinical institution were limited by lack of opportunity and access. As I began blogging and tweeting, the conversations I could now participate in were outside the predominantly clinical discourses of the institution I belonged to in my professional life.

Online social networking sites have afforded new possibilities for me to connect and converse with people interested in discussing similar issues from around the world. However, the extent to which they actually disrupt the power of the institution is not clear. Rheingold notes the tension between the potential of social networks to leverage ordinary citizens and the potential of institutions to control: 'The odds are always good that big power and big money will find a way to control access to virtual communities.'² During the period of my engagement with this topic clinical institutions have gradually encroached into social

networking sites through a plethora of guidance for clinical staff and organisational policies and toolkits, adding limits to the possibility of free speech. This tension is a continual underpinning theme of conversations in the *madosphere*.

Talking back: a historical perspective on talking back to authority

Records of people talking back to the mental health system go back to the early asylums and workhouses. This is a history that reaches back to self-advocacy in the nineteenth century by activists such as Elizabeth Packard and Clifford Beers, to published narratives in magazines and book in the 1980s by activists such as Judi Chamberlain, and to modern-day self-publishing through micro-blogging and blogs.³ The latter have enabled not only self-publishing, but also a forum to debate, challenge and engage in alternative discourses in the public sphere.

A history of disrupted relationships takes shape in the late nineteenth century, when those considered 'mad' became increasingly segregated from the rest of the community. The introduction of the Lunacy Act in 1845 compelled the authorities to make provision for people to be incarcerated within dedicated institutions. This not only defined them as a group, but which also removed them from the rest of society. Within the institutionalised and divided roles of patient and professional were the seeds of tension and conflict that continue to be experienced and debated in contemporary life.⁴

The Mental Treatment Act of 1930 refocused the role of psychiatry on treatment and rehabilitation from that of custodianship, and introduced a 'voluntary' patient role, while still retaining care within the boundaries of the institution. This was the first major revision of

mental health policy since the mid-nineteenth century and signalled a more relaxed approach to institutional regimes. The 1970s saw a move to treat patients in district general hospitals, closer to home and more firmly within the heart of general medicine. In more recent years, with the re-focus on 'community care' from the 1980s onwards, there has been an increased focus on the individual along with enabling people to live ordinary lives outside institutions.⁵ The 1983 Griffiths Report directed a reframing of power in which quality of care was to be measured by how it is perceived by people accessing services rather than by professionals. This denotes a radical reconceptualising of accountability and responsibility along with an attempt to locate the 'consumer' at the heart of care.

The notion of enabling a 'consumer' or 'user' voice to improve services has continued to be articulated by successive governments, with various statutory obligations upon NHS trusts to consult and involve patients (NHS Constitution, 2013). From Community Health Councils in the 1970s through to the current Health Watch, bodies have been established to gather the views of patients and represent them to institutions. While the *right* to talk back to the profession and to the institution is enshrined in law, the *ability* to do so has been hampered by the very institutional practices that remove power and agency from the people expected to do it. The various quasi-institutional bodies established to represent the views of people accessing services are inaccessible and opaque to the majority of people. The means the ability and opportunity to talk back has continued to be problematic. With the origins of the mental health profession lying firmly within an institutional framework, tensions relating to power, authority and control continue to be contested. The notion of the 'institution', as delineated so clearly by the sociologist Erving Goffman in his seminal ethnographic study *Asylums*, remains relevant today.⁶

A new kind of madness network

Writing in 2005, during the early years of social networking sites, Morrison argued that the Internet created a space where 'information flows are instantaneous and access is enormous ... cross national communication is instant and free ... campaigns of interventions can be put into action overnight'.⁷ She describes the Internet as a 'new kind of madness network' where dissenting views can be debated and discussed, and in doing so anticipates the affordances of social networking sites in use today.

The breadth and reach of public discussion afforded by social media comprises a spectrum of discourse from predominantly personal diary-based narratives through to overtly politicised campaigns for social change. This is reflective of the non-centralised UK movement campaigning for social change in relation to mental health, which can be described as 'a loose coalition of advocacy and activist groups whose members engage in numerous activities designed to promote mutual support, rights protection, alternatives, advocacy, and information flow that will enhance empowerment and choice for people whose lives have been affected by psychiatry'.⁸

Conversing with peers online gives people whose voices have been subjugated access to knowledge, a realisation of shared experiences and access to peer support information that is not mediated by professionals or institutions. Professionals may engage in the conversation but they are not usually in control of it. Morrison's words about consciousness-raising in the liberation movement have direct resonance to the affordances of social media today: 'Private problems are reinterpreted into public issues and participants gather strength to talk back to the power of psychiatry and the mental health system which has silenced then and controlled access to information in the past.'⁹

A striking theme in my interviews with people accessing mental health services and with mental health professionals participating in the *madosphere* is that both report increased empathy towards each other through their practices on social networking sites. Enhanced mutual understanding appears to arise from the practice of sharing a blend of personal and professional information. As Sam, a psychiatrist, explained:

[on social networking sites] you have the daily confrontations with services, and how bad those services can be, what the other side's experiences of services can be, and I think that does really radically change, it certainly shifts your viewpoint. Otherwise I could spend my whole day speaking to doctors and nurses and not get a clear view of what's going on for the person on the other side, from multiple different perspectives.

Talking back to authority: #DearMentalHealthProfessionals

In the context of a clinical relationship, an individual is positioned as an object of psychiatry. Their words and thoughts are relevant in so far as they expose signs and symptoms of pathology, filtered through the lens of biomedical training and for the purposes of diagnosis.¹⁰ Mental health campaigner Judi Chamberlain suggests that arguing against the system is commonly perceived as a sign of illness and that patients quickly learn to suppress the truth of their internal worlds to subscribe to accepted social norms.¹¹ Conversations within an institutional context are shaped and constrained by the respective roles of professional and patient.

The affordance of social networking sites to offer a context for different styles of communication enables people accessing mental health services to share information, knowledge and experiences with each other – knowledge that is self-mediated rather than

mediated through a power exchange from professional to patient. This has potentially challenging consequences for professionals who are familiar with being the expert conveyors of knowledge that comes with the authority of their professional training. Sandra, who accesses mental health services, captures the power of peer sharing and learning on Twitter:

I see people with [diagnosis] come on, they are acting out and doing this and saying that, and you actually see people learning on Twitter about how to be, so instead of coming on and going 'I've just slashed my wrists' or 'I've...' you know, and not everybody learns, but they come on but they may talk about it after the fact, as they may realise they may be triggering other people, they learn interpersonal skills, and then you watch them start recovering, and teaching other people, about sharing stuff.

Social networking sites afford the opportunity to contribute to the public sphere within the safety of personal surroundings, while managing presentation of self-identity. Micro-blogs and blogs require the use of language as a primary tool for managing identity and as a result people may receive validation and accolades as a result of a clever, witty or insightful writing style rather than embodied aspects of identity. This could have particular benefits for people experiencing mental health problems who may be isolated a result of social anxiety or the physical effects of medication.¹² Social networking sites make it possible to restrict information flows and allow people to transcend assumptions and stereotypes while enabling them to take productive risks.¹³ Ellie describes the benefits of social networking that she experiences:

It's good to be able to talk to people, but actually not talking directly to them, I think cos I had mental health problems such as anxiety and depression which means it can be hard

to socialise, but with social media I can just talk to people whenever I want and there's not that anxiety barrier so much.

Social networking sites permit connections to be made while at the same time enabling the maintenance of distance.¹⁴ They expand the tools available to the individual through photos, text and multimedia content, allowing greater control of the distance between the front and backstage areas of the self - what is presented and what is kept hidden.¹⁵

In an institutional context the possibilities for people to talk to each other about the care they access are limited. However, social networking sites offer the possibility for people accessing services to have conversations *with* each other in online public spaces *about* professionals. For example, the Twitter #DearMentalHealthProfessionals hashtag emerged spontaneously one summer day in 2013, initiated by Amanda as a means of giving indirect feedback about her care. The particular capacity of social networking to reproduce, spread and enable searching for information¹⁶ led to the hashtag being reproduced by many people accessing and working in mental health services. On her blog, Amanda reflects on the impact of the hashtag:

The hashtag took off in a way that I never expected. Thousands of tweets were tweeted under it. People tweeted from around the world under the hashtag. People wrote blog posts about the hashtag. I never expected any of this. It was amazing ... It has been over 6 weeks and people are still using the hashtag.

There were a range of responses on Twitter from mental health practitioners to the hashtag. They ranged from those who were supportive and encouraging ('I recommend checking out the #dearmentalhealthprofessionals hashtag. A great example

of best of Twitter to learn from experts as a mental health professional') through to concern and defensiveness ('The #dearmentalhealthprofessionals hashtag is very disheartening. Much criticism. No one happy with much we try to do.') Amanda wrote her own blog post in which she categorised and summarised the main themes explored with the hashtag, ranging from 'tweets of gratitude' such as 'Thank you for persisting when all I wanted to do was die. I'm glad I'm alive' through to issues relating to communication, diagnosis labelling, treatment, medication and inpatient wards. They comprise frank views expressed in a direct style; for example 'Kindly take the term "just attention seeking" out of your vocabulary' and 'I am NOT incompetent because I have mental health issues. Please listen to me.' The themes have echoes of the pleas made by disrupters of past times - a commonality of position, a replay of common themes, a rearticulation of challenges to the system, but which are self-mediated, public, searchable, spreadable and persistent.

Amanda reflects on the mix of opinions and the range of views expressed by people with lived experience: 'A real mixed bag of opinions - showing just how individual we each are in our experiences.' It is evident that they range from a dominant 'patient' paradigm ('You saved my life, I am so grateful') through to a 'consumer' narrative ('listen with your ears and your heart, not a pen and paper') through to a 'survivor' narrative illustrated by tweets such as: 'You have ruined every part of my life with the labels you've given me. How do you think that's been helpful?'

#DearMentalHealthProfessionals is the sum of micro-commentary by separate individuals on their computers, tablets and smartphones; it is people talking with each other as peers and talking back to professionals and institutions. It also has an interplay between the online and offline as characterised by Amanda:

one thing I think is wonderful is when online mental health stuff has an impact offline ... when one mental health worker said she was bringing it [#DearMentalHealthProfessionals] to her team meeting, and one person just tweeted me there now to say 'suggested dearprofessionals tag be turn into a pin board project in our social room'.

My research has given me privileged access to the experiences and motivations of many people accessing and working in mental health services who participate in the *madosphere*. I am grateful to them for sharing their insights with me. While the *madosphere* represents a space and set of practices within a tiny sub-section of the Internet, I believe there are lessons that can be learnt about the affordances of social networking sites to enable people to offer support to each other and improve understanding of mental health and mental distress.

The radical potential to develop a 'new kind of madness network' is in tension with the increased presence of institutions on social networking sites and their attempts to police professional behaviour through policies and guidelines. The capacity of technologies to work to support patients and clinicians is in inverse proportion to the extent to which institutions take action to control conversations in online space.

Notes

- 1 Bradley Lewis, 'A mad fight: psychiatry and gisability activism', in *The Disability Studies Reader*, ed. Lennard J. Davies (London: Routledge, 2006), 3-16.
- 2 Howard Rheingold, *The Virtual Community: Homesteading on the Electronic Frontier* (Cambridge, MA: MIT Press, 1993), xix
- 3 Peter Nolan, *A History of Mental Health Nursing* (Cheltenham: Nelson Thornes, 2000); Andrew T. Schull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven, CT: Yale University Press, 1993); Mark S. Micale and Roy Porter *Discovering the History of Psychiatry* (New York: Oxford University Press, 1994); Linda Morrison, *Talking Back to Psychiatry: The Psychiatric Consumer/Survivor/Ex-Patient Movement* (London: Routledge, 2005).

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- 5 Nolan, *A History of Mental Health Nursing*.
- 6 Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Chicago: AldineTransaction, 1968).
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- 8 Morrison, *Talking Back to Psychiatry*, 58.
- 9 Morrison, *Talking Back to Psychiatry*, 60.
- 10 Morrison, *Talking Back to Psychiatry*, 22.
- 11 Judi Chamberlain, *On Our Own* (London: Mind, 1988), 130.
- 12 Rheingold, *The Virtual Community*, 11; Nancy Baym, *Personal Connections in the Digital Age* (Cambridge: Polity, 2010), 109; Katelyn McKenna, Amie S. Green and Marci E. J. Gleason, 'Relationship formation on the Internet: what's the big attraction?', *Journal of Social Issues* 58.1 (2002): 9-31.
- 13 Paul Resnick, 'Beyond bowling together: sociotechnical capital', *HCI in the New Millennium* 77 (2001): 247-72.
- 14 Rheingold, *The Virtual Community*, 10.
- 15 Zizi Papacharissi (ed.), *A Networked Self: Identity, Community, and Culture on Social Network Sites* (London: Routledge, 2010), 307; Erving Goffman, *The Presentation of Self in Everyday Life* (Harmondsworth: Penguin, 1959).
- 16 Danah Boyd, *It's Complicated: The Social Lives of Networked Teens* (New Haven, CT: Yale University Press, 2014).

With Masters degrees in women's studies and social work, Victoria Betton is currently undertaking PhD research in the field of social media and mental health. She directs an NHS programme of mHealth in Leeds, with a focus on mental health and long-term conditions (www.mhealthhabitat.co.uk). She sits on Mind's External Relations Committee and is a fellow of the Y&H Improvement Academy. Victoria founded the award-winning Love Arts Festival – the first of its kind in England, exploring the relationship between arts, mental health and well-being. Victoria sits on the steering group of the NHS Confederation E-Mental Health Framework project. Her writing includes various published journal articles, an e-book *Social Media in Mental Health Practice* and her blog, which you can find at www.digitalmentalhealth.co.uk. You can find her on Twitter @VictoriaBetton

White Matter

Katriona Beales

White Matter is a mixed media installation, responding to Beales' research into Internet addiction, the black mirror of the screen and its historical antecedents. The Mexica people treasured obsidian, the volcanic black glass-like material, making mirrors and other ceremonial devices as portals to access other realms. Beales draws a parallel between these obsidian mirrors and contemporary mobile telecommunications devices, which also act as portals into vast realms of information.

The installation centres around a moving image work, back projected on to the ceiling of a round room. Cushions are arranged around the base of the walls where the audience may sit. In the centre of the space a raised surface supports hand-shaped black glass objects of similar scale to mobile phones and tablets but with curved surfaces, solid and weighty in the hand. The audience is invited to handle these and use them as viewing surfaces, watching as these hand-held surfaces reflect and distort the projection above them. The audio and imagery in the moving image work were developed in conversation with Dr Henrietta Bowden-Jones, the Royal College of Psychiatrists' spokesperson on behavioural addictions and problem gambling, and one of the UK's leading experts on online addictions. The moving image work consists of a



series of shorts focusing on the blurring between offline and online realities and the tendency to get lost online, subsumed, addicted and immersed within flows of information.

For one of the shorts Beales took the news story of a South Korean couple who played a role-play game called *Prius Online* for 12-hour stretches every day. In the game they nurtured an online girl called Anima, who grew and developed the more interaction she received. Meanwhile, tragically, their three-month-old baby starved to death. The coroner reported that the pair had fed their premature baby just once a day.¹ Beales uses a digitally manipulated image of Anima's face transformed into a topography and rendered in 3D so that we journey over the contours of this unknown landscape, inviting the audience to gaze into some of the dystopian facets of our increasingly mediated lives.

Notes

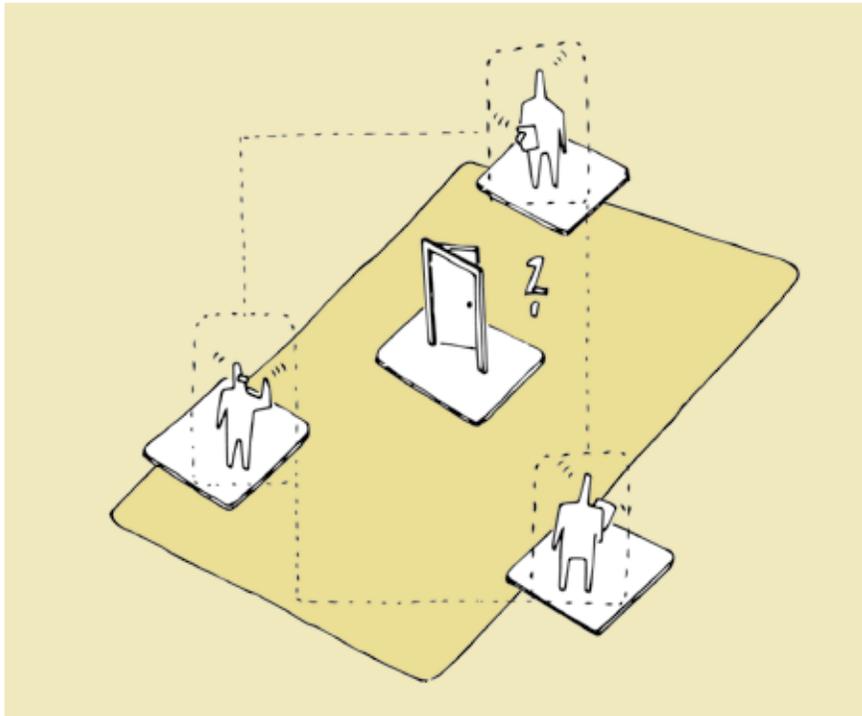
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Mental health in a digital age: lessons from architectural design practice

Benjamin Koslowski

The exhibition *Group Therapy* at FACT raises questions concerning the links between our well-being and our surroundings – our individual social as well as spatial contexts. The various settings we are immersed in seem to have a deep impact on our psychological comfort and mental health. I will suggest here that learning from the spatial contexts that frame everyday individual experience might also help us to better understand our well-being in digital space – the online environments that for many have become part of everyday life. My research is focused on developing frameworks as meta-level strategies to think about ground-level issues affecting people day-to-day: these are designed to help understand the use of spaces, both physical and digital, and how this might lead to the improvement of psychological comfort. Starting with a specific setting, the psychiatric hospital, I consider mental well-being not only as impacted on by our physical surroundings, but also by the digital environments we are increasingly immersed in.

An interdisciplinary research team from the Helen Hamlyn Centre for Design at the Royal College of Art engaged with a cross-section of users of the mental health unit at the Forth Valley Royal Hospital in Larbert, Scotland, from patients to nurses and



Are there doors in digital space?

clinicians. The user-centred research led to the development of a framework as a tool to help position an art strategy alongside a range of design interventions within the existing building.¹ This framework is now being used to brief artists and designers alike, with the ambition of improving the overall quality of the environment and making it more suitable to the diverse needs of its occupants.

The mental health unit is a useful – if extreme – example of the impact that physical surroundings can have on those confined by them; the research brought to the surface a range of tensions at work within the care environment. Some of these are rooted in the individual psychiatric conditions of patients: a noisy and busy environment easily overstimulates and causes anxiety in a depressive patient, while manic patients are frequently understimulated. Other tensions include varying degrees of control over the environment, as well as the tension between welcoming and homely qualities and the neutrality of what is effectively a clinical space. The tension most salient here, however, is the need for patients to have privacy and to be able to retreat, which clashes with the medical need for them to be observed by staff in the unit.

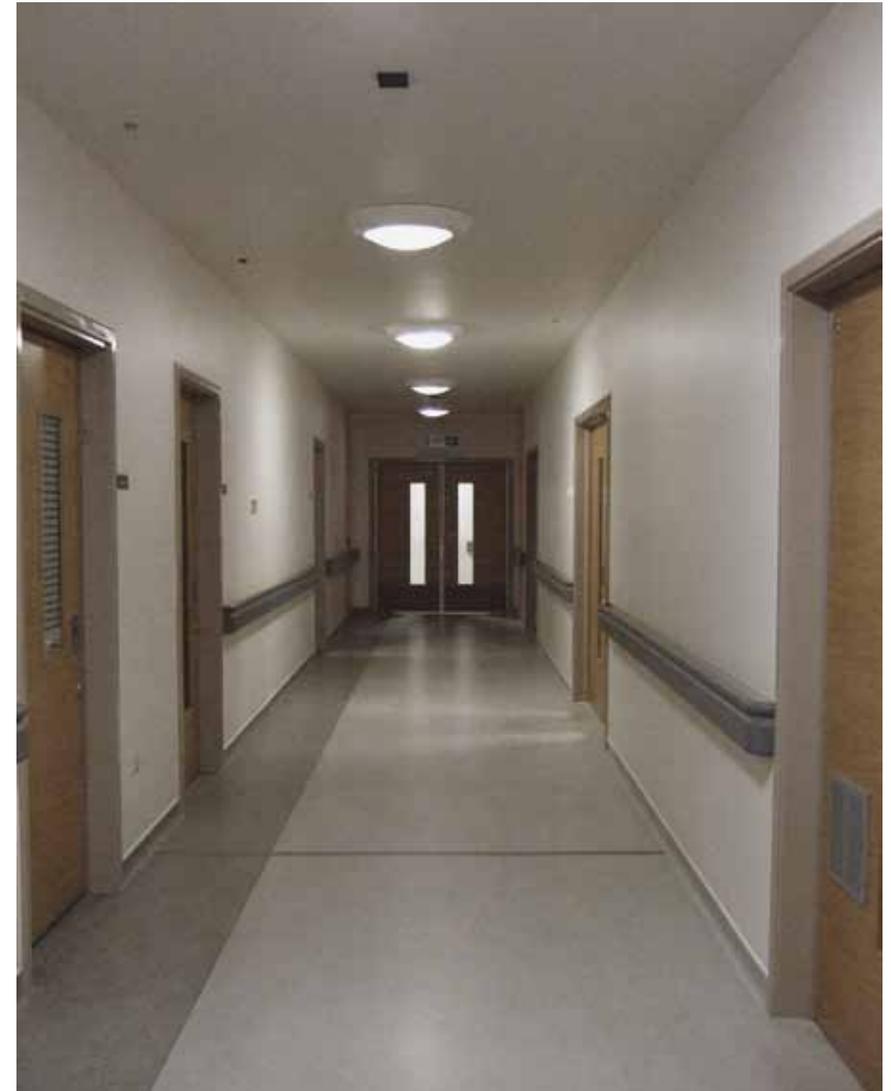
This tension seems to resonate with the everyday experience of individual privacy and surveillance by others: the case study of the psychiatric hospital invites us to consider the relationship between settings and psychological well-being not just in physical contexts, but also in relation to how we inhabit online environments day-to-day. While the mental health hospital might be familiar only to a relatively small number of people, some of these other environments affect a growing number of us, and the negotiation of the threshold between privacy and observation in digital space can have a strong impact on our emotional comfort. The online spaces we inhabit have

a noisy and busy environment easily overstimulates and causes anxiety in a depressive patient, while manic patients are frequently understimulated.

Other tensions include varying degrees of control over the environment, as well as the tension between welcoming and homely qualities and the neutrality of what is effectively a clinical space.

become sites for the constant display of our personality and social interactions, and we seem to be increasingly aware of our individual private space when online. The fact of always being switched on and visible in our use of virtual spaces - for example when we use Facebook, Twitter or Instagram to share updates, opinions and photographs - leaves us vulnerable to the prying eyes of others, while privacy is often gained only at the expense of sociability.² One might argue that the digital environments we navigate share some of the clinical, placeless and featureless qualities of the mental health hospital I studied in depth. Yet the digital spaces we inhabit day-to-day seem to lack the thresholds that guide our physical settings and instead leave us yearning for greater degrees of control over our own privacy: What is the digital equivalent of closing the door behind myself to get a bit of head space?

Both tectonic space and its virtual counterpart impact heavily on our levels of psychological comfort and the ways we feel - and certainly not just within the physical context of the psychiatric hospital. The clear ways in which the thresholds between privacy and observation are mapped in physical spaces offer themselves up to help better understand similar tensions and thresholds that exist in digital space. One might consider the digital realm as a much less contained and controlled environment, where privacy - so important, for example, for the patients in the mental health unit in Larbert - has become an even more abstract notion that is increasingly difficult to defend. Online contexts shift rapidly and audiences are difficult to gauge, while we frequently find ourselves confused over who can see what. Direct sight-lines and varying levels of visibility which are so familiar in physical contexts have become blurred, or simply seem to have no intuitive equivalent in digital space. At the same time, virtual environments offer the potential to be tailored more easily to individual perspectives and



Featureless corridors in the mental health unit create an unwelcoming and disorientating environment

What is the digital equivalent of closing the door behind myself to get a bit of head space?

user needs; unlike physical settings with their embodied codes of behaviour and architectural tactics that have to accommodate simultaneously many people with often vastly differing needs, digital spaces can create more immediately responsive settings better suited to the individual. Considering this potential, it is crucial for us to begin to think about the strategies that help to facilitate greater degrees of comfort online: new ways of thinking and frameworks are required to help establish what privacy really is to individual users in the digital public space, and to offer greater degrees of understanding and control over this.

Notes

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Benjamin Koslowski is a designer and researcher with a background in architecture. He is currently doing a PhD at the Royal College of Art in London with the Creative Exchange Hub, an AHRC-funded knowledge exchange hub investigating digital public space. His research is into architecturally informed communication design to develop ways of better understanding privacy in online social media; this uses the theatre as a tool to explore shifting relationships in mediated interaction. His work takes great interest in how technology changes our daily lives and the ways in which we relate to other people. In addition to his doctoral research, Benjamin teaches on the undergraduate programme in Interiors at Middlesex University and in the Critical Historical Studies department at the Royal College of Art.

Labyrinth Psychotica

Jennifer Canary Nikolov(a)



The Labyrinth is a physical and mental translation of what it is like to be in psychosis. The *Labyrinth* experience starts when a exhibition visitor enters the labyrinthine multimedia installation.

You walk the path as if you are entering the deep crevasses of a brain. Making way with your arms, you constantly 'swim' through a trajectory of light and darkness, a path that constantly changes in texture and atmosphere.

Unlike a maze, a labyrinth consists of a single path that twists and turns towards a centre. It is believed that to walk a labyrinth is to embark on a spiritual journey towards oneself. The experience of the *Labyrinth* becomes a metaphor for psychosis, of losing and finding oneself, and for how beautiful yet fearful the experience can be. The visitor is forced to leave his or her comfort zone, in order to allow him or her to realise what it would be like to experience such a thing 24/7.



Creative practice

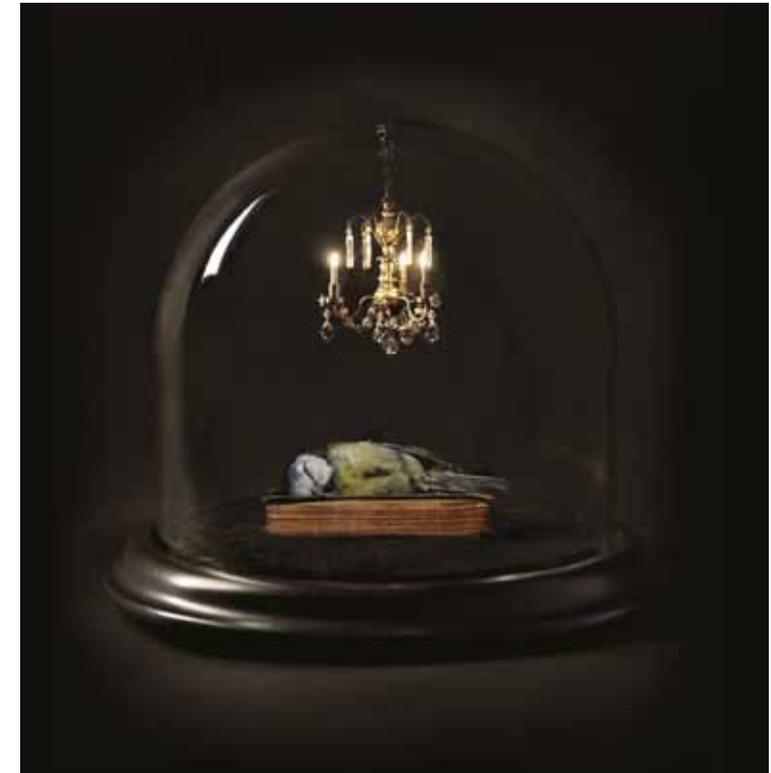
The Heart Library installed in Wonderland: New Art from Australia MoCA Taipei, curated by Antoanetta Ivanova, 2012.

A brightly coloured bell jar, a state-sanctioned aesthetic

Clive Parkinson

Not so very long ago, I had the opportunity to act as an arts *consultant* (not a name I like) to a well-regarded NHS Mental Health Unit that was moving with the times and humanising its environment, ticking all the boxes that the ‘design champion’ needed ticking. It was a fickle business led by a committee of the great and good, overseen by a self-appointed aesthete who on this occasion was also the chief executive of the organisation.

An emerging English artist at the time, Polly Morgan, had kindly offered a piece of her work, not as a public art commission, but to be used as a stimulus by me in a participatory workshop with people having treatment on the unit. The chief executive had other ideas, considering the brightly coloured little taxidermy bird in a bell jar ‘totally unacceptable’ and ‘not in any way art’. My solution to such diktats was to guiltily withdraw from the contract, but that experience set me off thinking about who exactly art is for, and whether art in clinical settings has to be pretty little trinkets and gloss. With considered sensitivity, can’t we share more challenging work? And in a time of state-sanctioned mindfulness, well-being and happiness, isn’t there a little room for the unconventional and uncomfortable in our mental health and in our art?



Polly Morgan, To Every Seed His Own Body, 2006

This tawdry business set off a chain of thoughts that made me begin to question my role in the hospital decoration business, and ask just what kind of baubles does the NHS want? Is it just about the soothing and benign middle ground of a chocolate box interior, or could it possibly be something challenging?

The beginnings of a nasty game

In this essay, I want to share some ideas about the burgeoning global depression we are constantly warned about, in both senses of the word. I will look at our ongoing global financial crisis and the phenomenon of depression, which the World Health Organization tells us will be the biggest health burden on society both economically and sociologically within twenty years.¹ I want to explore some ways that I believe that these concerns reflect both the pathways that have led to the global downturn and the way we perceive depression in our pursuit of the twenty-first-century dream of individual well-being. I will in turn look at how these wider social movements might influence our thinking about arts and health.

During the 1950s, the joint winner of the 1994 Nobel Prize for Economics, mathematician John Forbes Nash Jr (later made famous in the film *A Beautiful Mind*), developed mathematical theories that would influence the development of game theory. By scrutinising poker players' inevitable self-interest, he observed that their strategy relied on being locked into a system where they had to observe competitors' actions. During this same period of research, Nash was working at the heart of the nuclear security industry and applying the same theories to the Cold War nuclear standoff, where both sides distrusted each other and each was attempting to anticipate the other's moves.

Nash proposed that this culture, led by suspicion and selfishness, would create a balanced self-interest that would enable a very delicate equilibrium and maintenance of social order, known as the Nash Equilibrium. His bleak vision seemed to make sense of individualism and the free market, but what Nash's colleagues didn't know was that he was experiencing psychosis and believed he was surrounded by spies and was part of an elite organisation trying to save the world.²

Weapons of selfish power

In 1953 the Scots psychiatrist R. D. Laing left the army and began work at the Glasgow Royal Mental Hospital. Made famous by his rejection of the medical model of mental illness, he would later point out the paradox that while people were being *diagnosed* by their conduct and behaviour, they would inevitably be *treated* biologically.

As Nash was conducting his arguably reductive research in the USA, the young Laing was testing an altogether different kind of hypothesis, but one that nevertheless applied the principles of game theory. Laing had noticed that psychiatrists rarely had conversations with patients experiencing schizophrenia, so as an experiment he worked with 12 patients and spent two months having in-depth conversations with them about their lives. The results were profound. After just a few months all 12 patients were well enough to be discharged from the hospital (although all 12 were readmitted later).

The process raised questions for Laing. Chiefly, it suggested that the domestic and social environment in which people were living had a profound impact on their mental health. He developed a questionnaire that plotted what individuals in relationships secretly thought of and intended for each other, moment-by-

moment and day-by-day. The resulting data was subjected to computer analysis and transformed into a mathematical matrix, which Laing believed showed that people manipulated each other through kindness and love, emotions which he described as weapons of selfish power and control. Laing was becoming more radicalised by his own research and saw the corruption and abuse of governments in exactly the same way he saw families: as dysfunctional and oppressive. Laing attacked what he saw as the elitist structures responsible for controlling and abusing freedom and free will, and in particular the American Psychiatric Association (APA). He accused the APA of propping up a corrupt society and putting labels on people that fitted a political agenda, suggesting that people were being incarcerated for simply being different or speaking out. Fundamentally, he questioned what 'madness' was and asked who were psychiatrists to label people?

In 1973 the psychologist David Rosenhan set out to test the idea that psychiatry couldn't differentiate between the sane and the insane. He conducted the now infamous Rosenhan Experiment in which he and seven students, none of whom had a history of mental ill-health, took themselves off to different psychiatric hospitals across America and, at a specific time, presented to the medical staff saying that they heard a voice in their head saying 'empty', 'hollow' or 'thud'. They would tell no other lies and would act normally. All of them were incorrectly diagnosed 'insane'.

The actions of Laing and Rosenhan inevitably pushed the APA down the path towards a diagnostic methodology that relied on the objective purity of numbers, with notions of subjective human responses largely removed. In 1952 the first *Diagnostic and Statistical Manual of Mental Disorders* (the DSM) was published. This would go on to become probably the most significant tool for mainstream psychiatry in the diagnosis and treatment of mental

illness. It has grown from 106 disorders in the first edition in 1952 to '17 major classifications and over 300 specific disorders' in the fifth edition published in 2013.³

In the wake of Laing's statistical objectification of the family, Rosenhan's exposure of flawed psychiatric diagnoses and the emergence of the 'classification system' of the DSM, questionnaires increasingly became the method of choice for diagnosis. New categories of disorder emerged, taking hold of the public consciousness. People were beginning to self-monitor and if they found a potential diagnosis, it was only a matter of time before they would seek help to *make themselves normal*. And in a self-reflective country like America where the pursuit of happiness is a constitutional imperative, the fact that you can easily find an applicable diagnostic label raises the question: *am I not happy enough because I am sick?*

For the pharmaceutical industry this was a golden opportunity to chemically fix society's imbalances. In 1988 Prozac was introduced and by 2005, 27 million Americans were taking antidepressants - that's 10 per cent of the population, at an annual cost of 10 billion dollars. Use of antidepressants in the US has continued to soar. Today 40 million people globally take Prozac or similar drugs.⁴

The cult of happiness

Perhaps a key to understanding this boom in the numbers of people diagnosed with depression over the last thirty years is that we have been encouraged by those with vested interests to see unhappiness as a symptom, to be ticked off on a checklist of self-diagnosis. The psychotherapist Gary Greenberg, in his book *Manufacturing Depression*, describes this boom in the depression industry:

depression has expanded like Walmart, swallowing up increasing amounts of psychic terrain ... and like Walmart, this rapidly growing diagnosis, no matter how much it helps us ... is its own kind of plague. It could be that the depression epidemic is not so much the discovery of a long unrecognised disease, but a reconstitution of a broad swathe of human experience as illness.⁵

In a society that places a value on science over other forms of knowledge, and on materialism and the free market over other ideologies, it's very easy to be taken in by this market-driven zeitgeist. This pathologising of unhappiness and dissatisfaction as some kind of disease, Greenberg suggests, puts at stake the emotional realities *of what it is to be human*. This in turn has spawned a counter-culture committed to the pursuit of self-improvement and happiness, which might just result in a generation of worried-well automata who are never going to achieve the Nirvana promised to them by the self-help industry; worse than that, who will live in some sedated twilight, fearful of any emotional texture that ruffles the façade of their fragile normality.

But what is this happiness we all supposedly crave? Utopian well-being, once the aspiration of visionary politicians, now seems to be edging towards becoming a mainstream policy objective, devoid of real meaning. While the Office for National Statistics churns out data that measures individual well-being and an All-Party Parliamentary Group on Wellbeing Economics calls for culture and the arts to be at the heart of how we understand mental health, they both inevitably frame well-being in the language of the free market. The MP David Lammy, in his foreword to a recent report of the APPG, comments, 'wellbeing evidence can not only help target public spending more effectively at improving people's lives, but in many cases has the potential to deliver significant long-term savings by reducing demand on public services'.⁶

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Creativity: divergence and convergence

So, what of our creativity in this medicated, flattened out, consumerist society? In 1958 Professor E. Paul Torrance devised a methodology for measuring the creativity of children, a test that is still used today and is widely held up as the gold standard of creativity measurement. In short, Torrance developed something similar to the IQ test, though his test didn't measure intelligence but rather creative thinking and problem solving. Working with 400 children from Minneapolis on a range of creative tasks, he explored the notion that there is never one right answer to a problem, and that to be creative requires divergent thinking, in which you generate as many wild ideas as possible, and then convergent thinking, in which you combine and refine those ideas.

Since the 1950s millions of children worldwide have taken this test, and Jonathan Plucker of Indiana University recently re-analysed the original Torrance data. He found that the correlation of lifetime creative accomplishment is more than three times stronger for childhood creativity than for childhood IQ. In other words, those adults who did well in the creativity test as children grew up to be more creatively accomplished adults.

An analysis of over 300,000 Torrance scores for children and adults found that scores had been rising until 1990; since then, however, scores have dropped slowly and consistently. Further scrutiny of the Torrance findings has highlighted the lack of creativity in US schools, which are predominantly focused on national testing, standardised curriculum and rote memorising. As creativity is also being eroded from the curriculum in the UK, this is something we should be deeply concerned about.

In their article 'The Creativity Crisis', Po Bronson and Ashley Merryman take this theme further, but with an emphasis not

on art classes per se, but with a more general view about how thinking creatively across the curriculum is the key to flourishing. 'Creativity isn't about freedom from concrete facts,' they comment, 'rather, [it's about] fact-finding and deep research [that] are vital stages in the creative process.'⁷ This is reflected in research by Mihaly Csikszentmihalyi and Gary G. G. Gute, who found that highly creative adults tended to grow up in families embodying opposites.

Parents encouraged uniqueness, yet provided stability. They were highly responsive to kids' needs, yet challenged kids to develop skills. This resulted in a sort of adaptability: in times of anxiousness, clear rules could reduce chaos - yet when kids were bored, they could seek change, too. In the space between anxiety and boredom was where creativity flourished.⁸

This idea of a space between 'anxiety and boredom' is crucial. I want to take this a step further and propose that, instead of striving for this elusive happiness, we simply re-visit just what it is that art offers humanity. Do we think that art and creativity are just like other forms of medication, something to sedate and pacify us? Is our art and health agenda just about making us smile and proving our worth in relation to raised levels of serotonin? I want to suggest that we are complicated social creatures, confounded in equal measure by science and religion, and victims of sophisticated marketing. And this confusion needn't be a bad thing; in fact the Torrance research affirms that our questioning minds are an asset, and that uncertainty and diversity are things that we could potentially thrive on. While I'm not suggesting that antidepressants aren't an effective tool in the management of clinical depression, I am suggesting that perhaps we are in danger of letting medication take away complex and difficult thoughts; and that complexity is a natural state within our emotional lives, our creative lives and, consequently, the arts

Do we think that art and creativity are just like other forms of medication, something to sedate and pacify us? Is our art and health agenda just about making us smile and proving our worth in relation to raised levels of serotonin?

and health agenda. Plotting this path from game theory to the medicalisation of day-to-day stress and anxiety and the emergent boom in the happiness industry has left me with a very clear impression that attempts to control our mental health can be highly political and highly profitable.

Dr Richard Smith, one-time editor of the *British Medical Journal*, argues that ‘more and more of life’s inevitable processes and difficulties – birth, sexuality, aging, unhappiness, tiredness, and loneliness – are being medicalised’ and that ‘medicine alone cannot address these problems’.⁹ Phil Hanlon *et al.* in *Perspectives in Public Health* take this argument further, suggesting that ‘faith in science has morphed into an ideology best called scientism. Under scientism, what really matters is that which can be supported by evidence, can be counted or measured and, above all, can be shown to be value for money.’¹⁰

So how can the arts realistically be part of contemporary health and social care, particularly when this work is subservient to a prescriptive health agenda, fixated with pathology and morbidity? If we are to move away from superficial gloss towards a more meaningful, high-quality arts and cultural experience, we may need to take a more critical look at our own practice. Dr Samuel Ladkin, in *Against Value in the Arts*, suggests that ‘It is often the staunchest defenders of art who do it the most harm, by suppressing or mollifying its dissenting voice, by neutralising its painful truths, and by instrumentalising its potentiality, so that rather than expanding the autonomy of thought and feeling of the artist and the audience, it makes art self-satisfied.’¹¹

The all-prevailing management culture that dominates the health and care sectors is mirrored in the arts and cultural sector too. The artist David Pledger, in *Re-evaluating the Artist in the New*

World Order, provides us with a compelling critique of the systems that have seen more money put into marketing and management than into artists, with the artist being at the very bottom of the food chain. Yet shouldn't the artist be at the heart of public debate, scrutinising, curious and enabling, questioning dominant ideologies and giving voice to those most marginalised by those in power? Pledger astutely suggests that 'managerialism sees itself as the antidote to chaos, irrationality, disorder, and incompleteness'¹² - but aren't these the essential elements that are central to the arts?

So where does this leave Polly Morgan's small and exquisite bell jar? It certainly doesn't have the wow factor of the anonymous lumps of badly conceived corporate art that our cavernous glass and steel hospitals/warehouses seem to insist on. No, Polly's work is intimate, maybe a little disconcerting, and it certainly might open up some challenging conversations. But in the processing system of our NHS, is there time for conversation, and if the artwork is a little unsettling, might that provoke disagreement, and in turn might that inflame passion - and in this scenario, where opinions are raised and frustrations expressed, could those responsible for management begin to lose control of their carefully ordered systems?

Are we claiming that engaging with the arts cures illness? While growing evidence suggests that, either as participants or audiences, the arts contribute to improvements in our health and well-being - which the cult of measurement would no doubt approve of - *we are not staking a claim on defeating death...* Our work is not scientism and it should not be understood in these reductivist terms; yet at every turn, artists working within a health context are encouraged to reduce their practice down to the measurable constituent parts for efficacy's sake.

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FIXATED WITH
PATHOLOGY
AND MORBIDITY?**

Public health researchers Lang and Rayner, in the *British Medical Journal*, ask how we can ‘reframe thinking about mental health, social exclusion, and inequalities in health’ without placing democracy at the heart of our thinking, where people have ‘a sense of – and actual engagement in – shaping society and life, particularly when we live in a world in which so many people are excluded from control’.¹³ Herein lies the key. In our unequal and market-driven world, can we learn from the past to influence our futures – and is there a danger that if we understand the impact of the arts in terms of deficit and disease and not assets and potential, we may just become a pseudo-science? Art is political – our mental health and well-being are political too. The arts have the power to change mindsets and challenge outrageous inequalities – and just how we evidence this reach might best be understood through the very practice itself. Art gives us voice and helps makes meaning of this world, and I would suggest that a healthy degree of pessimism might just be the response we need.

An earlier version of this essay was presented at ‘The Art of Good Health and Wellbeing’ conference in Melbourne in 2010, and at Durham University’s Centre for Medical Humanities in 2011. I am indebted to the filmmaker Adam Curtis whose film *The Trap: What Happened to Our Dream of Freedom* (2007) was the starting point for this essay.

Notes

- 1 World Health Organization, *Investing in Mental Health*, http://www.who.int/mental_health/media/investing_mnh.pdf (accessed 6 November 2013).
- 2 This portrayal has been echoed in Adam Curtis’ *The Trap*, http://www.disclose.tv/action/viewvideo/145347/The_Trap_Fuck_You_Buddy_BBC/
- 3 Lorraine Smith, ‘The DSM-V: simplify, clarify’, *Psychiatry* 2.8 (2005): 12–13.
- 4 As published by the *Guardian* Data Blog, <http://www.theguardian.com/news/2013/nov/20/mental-health-antidepressants-global-trends> (accessed November 2013).
- 5 Gary Greenberg, *Manufacturing Depression: The Secret History of a Modern Disease* (London: Bloomsbury, 2010), 17.

- 6 David Lammy MP and Baroness Claire Tyler, Foreword to *Wellbeing in Four Policy Areas: Report by the All-Party Parliamentary Group on Wellbeing Economics* http://b3cdn.net/nfoundation/ccdf9782b6d870of7c_lcm6ized7.pdf (accessed 10 November 2013).
- 7 Po Bronson and Ashley Merryman, ‘The Creativity Crisis’, *Newsweek*, 7 October 2010.
- 8 Bronson and Merryman, ‘The Creativity Crisis’.
- 9 Richard Smith, ‘Medicine’s need for the humanities’, *BMJ Blog*, <http://blogs.bmj.com/bmj/2010/12/30/richard-smith-medicines-need-for-the-humanities/> (accessed 6 November 2013).
- 10 P. Hanlon, S. Carlisle, M. Hannah, A. Lyon and D. Reilly, ‘A perspective on the future public health practitioner’, *Perspectives in Public Health* 132.5 (2012): 235–39.
- 11 Sam Ladkin, ‘Against value in the arts’, *Cultural Value Blog*, <http://culturalvalueproject.wordpress.com/2014/04/11/dr-samuel-ladkin-against-value-in-the-arts/> (accessed 17 November 2013).
- 12 David Pledger, *Re-valuing the Artist in the New World Order* (Strawberry Hills, NSW: Currency House, 2013).
- 13 Tim Lang and Geof Rayner, ‘Ecological public health: the 21st century’s big idea?’, *BMJ Blog* <http://dx.doi.org/10.1136/bmj.e5466> (accessed 17 November 2013).

Clive Parkinson is the director of Arts for Health. Based at Manchester Metropolitan University, it is the longest established organisation of its kind. He is a founding member of the National Alliance for Arts, Health and Wellbeing, and is currently a co-investigator on the Dementia & Imagination project in the UK, which is exploring the links between the visual arts, well-being and sense of community. He is interested in the unexpected outcomes of arts engagement and works in arts and health development in Italy, France, Lithuania and Turkey. He is currently working with people in recovery from substance addiction to develop a Recoversit Manifesto and he regularly blogs at <http://artsforhealthmmu.blogspot.co.uk/>

Madlove – A Designer Asylum – Beta version

The vacuum cleaner

It ain't no bad thing to need a safe place to go mad. The problem is that a lot of psychiatric hospitals are more punishment than love ... they need some Madlove.

Is it possible to go mad in a positive way? How would you create a safe place in which to do so? If you designed your own asylum, what would it be like?

Described as 'Utopian dreamers, eccentric English fantasists and barking mad agitators', artists the vacuum cleaner and Hannah Hull are on a mission to create the most crazy, bonkers, mental asylum we dare dream of.

Through a series of workshops they are speaking to the full spectrum of people with lived experience of mental illness, those that work in the industry, artists, designers and anyone else with an interest. The outcome of these discussions will inform a blueprint for a radical new approach to how mental health hospitals could be designed and run. The hope is to create a desirable and playful space to 'go mad', countering the popular myth that mental illness is dangerous and scary. This temporary asylum will be a reflexive and responsive space for exploring and redesigning madness that will be realised in full in late 2016.



What does good mental health care feel like? - An illustration from the Madlove workshop at the Southbank Centre. Image credit Lewis Campbell

‘Disabling’ the museum: curator as infrastructural activist

Amanda Cachia

I’ve been curating contemporary art since 2001, with my exhibitions always focused on identity politics (such as feminism), social justice and other hard-hitting issues, ranging from war and violence to urban decay and environmental degradation. Since returning to graduate school in 2010, I’ve curated four exhibitions with disability-related content, with several more large-scale exhibitions scheduled for 2015.

So why my turn to disability-related content? Apart from personally identifying as physically disabled, in my fifteen years as a curator working in Australia, the United Kingdom, Canada and now the United States, I noticed that conventional art history does not account for mentally and physically disabled subjects or those with mental health conditions, and their accompanying atypical bodies and brains, through the art museums and their curated exhibitions, through commercial art galleries and biennials, or across the entire exhibition complex structure. I rarely come across any substantial or critical engagement with disability and access in curated exhibitions at large-scale or medium-size museums and art galleries. Of course, a small number of patronising and demeaning representations have appeared in art genre presentations such as ‘outsider art’, but these derogatory constructs have generally failed

to be challenged by art historians, critics, curators and artists. I argue that it is time to offer a revision to the negative constructs by addressing how contemporary art by both disabled and non-disabled artists can resonate with the complex embodiment of disabled corporeality. It is important to build a new vocabulary and methodology around curating disability and access in challenging and stimulating ways.

I have taken cues from several recent texts on contemporary curatorial practice, such as Australian art historian Terry Smith’s *Thinking Contemporary Curating*, which posits that contemporary curating requires ‘a flexible platform-building practice – tied to the specifics of place as well as appropriate international and regional factors’.¹ Compelling because it demands experimentation, this platform-building practice prompts curators as ‘process shapers’ and ‘programme builders’ to work within the resources an institution offers yet also find freedom in public spaces, places, the virtual domain and other institutional infrastructures not typically associated with art. Smith calls these types of curators ‘infrastructural activists’.²

Along parallel lines, museum studies scholars Richard Sandell and Jocelyn Dodd write of an ‘activist museum practice’, intended to construct and elicit support among audiences (and other constituencies) for alternative, progressive ways of thinking about disability’.³ While Smith speaks rather broadly about radicalising museums as institutions and their practices, Sandell and Dodd more specifically address disrupting museum practice for the benefit of the disabled community. What would happen if Smith’s ‘infrastructural activist’ were to dovetail with Sandell and Dodd’s ‘activist museum practice’?

I also challenge the museum to think about how access can move beyond being a mere practical conundrum, often added as an afterthought once an exhibition has been installed, to become a dynamic, critical and creative tool in art-making and curating.

These authors' formulations of the contemporary curator as 'infrastructural activist' within an 'activist museum practice' work well for my agenda, which aims to 'disable' the limiting and pejorative practices of the art museum in a number of ways. I do this by offering exhibitions with non-reductive disability-related content, accompanied by programming that extends the exhibition's thesis, such as artist talks, performances, symposia, websites, publications and more. If the trend in curating is towards the infrastructural activist Smith describes, the community of disability curators and scholars who focus on the myriad political representations, communications and sensorial and phenomenological experiences of the disabled subject will surely find a resounding welcome within a traditionally disciplinary realm.

I also challenge the museum to think about how access can move beyond being a mere practical conundrum, often added as an afterthought once an exhibition has been installed, to become a dynamic, critical and creative tool in art-making and curating. An exhibition can therefore attempt to reveal process in conjunction with final objects as outcome.⁴ The curator might be challenged by access as the concept and/or content of artwork, by focusing on evocative questions such as Can an audio description or sequence of captioning accompanying a film also be a work of art? Is American Sign Language (ASL) a performance? How can touch be incorporated into curating and art-making, rather than just being an interactive feature of a permanent collection tour in a museum? How can subtitles and audio descriptions work together to create an interesting 'dialogue' about access that renders a work of art or a film completely inaccessible for a 'normal' audience? In other words, how can the tables be turned on access, and access for whom or for what? What inherent ethical questions and issues

of agency stem from these possibilities? I believe these alternative curatorial methodologies offer much scope for challenging deeply ingrained reductive attitudes towards disability.

Artists with ‘disabilities’ may question and redefine culture, environment and ‘normative’ practices through the lens of disability in their practice, but this is not just a means to an end. Now we might ask, How is it possible to move beyond disability and yet feel empowered by it at the same time? These goals may seem contradictory. For example, while I believe in how empowering it can be to embrace one’s disability, I want to avoid any ghettoisation either of myself as curator or of my curated artists. As Simi Linton notes, our language is currently deficient in describing disability in any way other than as a problem, so the defining is simultaneously a challenge and a curse.⁵ However, like the problem of ‘visual culture’ that determines the very nature of a museum, what happens if we think of this challenge/curse as an opportunity to articulate a richer and more complex language or just think about an experience of disability or complex embodiment? Barbara Hillyer says, ‘Instead of creating dichotomies between good and bad words, we can use accurate descriptors [...] we can struggle with distinguishing our own definitions [...] the process is awkward; it slows down talk; it is uncomfortable [but] it increases complexity.’⁶

Ultimately, as a curator who just happens to have dwarfism, who works with artists who may or may not have disabilities or identify with them, I must take great care to note the intersectional specifics of their gendered, cultural, racial and generational contexts and avoid the reduction that I work against in my exhibitions. Certainly these difficult issues point to the complexity of not only curating disability-themed exhibitions

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through structure, perceptions, language and artist attitudes and intentions, but also indicate the complex relationships between artists and curators - and often their very different identifications with disability. Despite these challenges, artists with disabilities command agency, and their work deserves to be placed within a general field of art practice so as to integrate the emergent discourse of complex embodiment with critical art and disability studies discourse. How might this happen? The artists and I are struggling to find a zone where our work can be recognised alongside that of our peers.

What would it mean for curators to think about curating access, a domain that has traditionally fallen within the mandate of a major museum's education department? As suggested earlier, I challenge the curator to consider access as the creative concept and/or content of artwork by focusing on possibilities such as whether an audio description or a sequence of captioning accompanying a film can be a work of art and whether an interpreter using ASL is giving a performance. Or how can the prosaic museum wall label be approached strategically and creatively? If wall labels should never conform to a standard template, can audio descriptions, audio transcripts or ASL interpretations extend the parameters of the label? Can the label be an artwork in itself? And how can touch be incorporated into curating and art-making, rather than just being an interactive feature of a static permanent collection tour in a museum?⁷

The questions go on: How can subtitles and audio description work together to create an interesting 'dialogue' about access that renders a work of art or a film completely inaccessible for a non-disabled audience? In other words, how can the tables be turned on access, and access for whom or for what? What inherent ethical

questions and issues of agency stem from these possibilities? Can or should access fall into the hands of curators and/or artists who haven't been exposed to the practicalities of access first and foremost? This is not to disparage the work of professional audio describers, nor to imply that curators and/or artists should use ASL for performance aspects only, undermining the fact that it is a serious language. Rather, these questions are meant to provoke creative ideas around traditional notions of access. I believe we can capitalise on the productive tensions between the very real need for traditional modes of access in a museum – such as the utilitarian ramp, the guided tour of the latest exhibition in ASL, the touch tour for blind visitors – and my notions of curating access creatively. The two separate but intertwined modes of physical and conceptual access can meld in generative ways within the art museum or gallery.

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Notes

- 1 Terry Smith, *Thinking Contemporary Curating* (New York: Independent Curators International, 2012), 252.
- 2 Smith, *Thinking Contemporary Curating*, 252.
- 3 Richard Sandell and Jocelyn Dodd, ‘Activist practice’, in Richard Sandell, Jocelyn Dodd and Rosemarie Garland-Thomson (eds), *Re-Presenting Disability: Activism and Agency in the Museum* (London and New York: Routledge, 2010), 3.
- 4 Beryl Graham and Sara Cook, *Rethinking Curating: Art after New Media* (Cambridge, MA, and London: MIT Press, 2010), 159.
- 5 Simi Linton, *Claiming Disability: Knowledge and Identity* (New York: New York University Press, 1998), 11.
- 6 Barbara Hillyer, ‘Ten years on: re-presenting vital, problematising playing fields’ (Juliet Robson); ‘In the Ghetto’ (Aaron Williamson), *Parallel Lines Journal* (2011), <http://www.parallellinesjournal.com/> (accessed 5 March 2012).
- 7 Fiona Candlin, ‘Curators, connoisseurs and object handling’, in Amelia Jones and Marsha Meskimmon (eds), *Art, Museums and Touch* (Manchester: Manchester University Press, 2010), 114

Amanda Cachia is an independent curator from Sydney, Australia, and is currently completing her PhD on the intersection of disability, phenomenology and contemporary art in the Art History, Theory & Criticism program at the University of California, San Diego. She is the 2014 recipient of the Irving K. Zola Award for Emerging Scholars in Disability Studies, issued by the Society for Disability Studies (SDS). Amanda completed her second Masters degree in Visual and Critical Studies at the California College of the Arts (CCA) in San Francisco in 2012, and received her first Masters in Creative Curating from Goldsmiths College, University of London in 2001. www.amandacachia.com



The Heart Library

George Khut

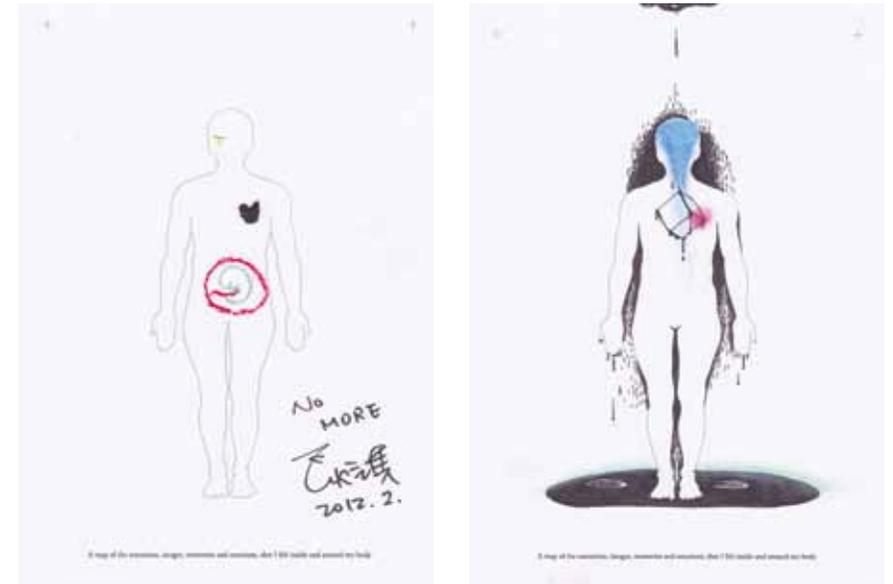
The Heart Library Project is an interactive artwork designed for presentation in hospital and health care settings, schools, museums and art galleries. It combines interactive heart-rate controlled audio-visuals with audience participation to create a unique environment where people can reflect, explore and share experiences connected to ideas of embodiment, body-mind and presence.

Experiencing the body beyond pathology

George Khut

The Heart Library Project is an interactive artwork that combines a heart-rate controlled interactive video projection with a collection of hand-drawn maps contributed by visitors describing their experience in the work. It uses the technique of heart-rate biofeedback training in an immersive creative arts context, to facilitate intimate reflections on experiences of health, self and embodiment.

You enter the Heart Library and connect with the work using a handheld pulse sensor. Changes in your heart rate, which can be influenced through slow breathing and stress or relaxation responses, can be used to alter the colour and sound of large, ceiling-mounted video projections. You see a projected image of your own body floating above you, a peculiar 'reverse' out-of-body experience. Using temperature mapping, the projected video imagery gets redder in colour as your heart rate gets faster, and then goes to yellow, green and eventually blue when have reached your most relaxed state and your heart rate is at its slowest. By voluntarily imagining or remembering certain experiences - exciting or stressful, peaceful or quiet - you can learn to affect the appearance of the artwork.



Hand drawn experience maps taken from *The Heart Library*

A large part of my motivation in beginning this work was a desire to access a way of experiencing and relating to the body that could go beyond Western art and medicine's preoccupation with pathology

Contrary to common belief, a healthy heart does not function like a metronome, but instead varies slightly from one beat to the next. Heart-rate variability decreases with age, and low heart-rate variability is often (but not always) an indicator of physical or emotional stress. Heart-rate variability can be increased in the short term by gentle relaxed breathing, and reduced by mental stresses such as mathematical problems and challenging or unfamiliar situations.

Clinical biofeedback is not treatment as such, but a form of psychophysiological training and self-development. The biofeedback loop between the behaviour being measured (i.e. changes in heart rate) - the electronic signal representing these changes from one moment to the next - and the observing subject provides a scaffold for sensing, differentiating and eventually regulating aspects of our behaviour that for reasons of ill-health or habit we find difficult to sense and therefore regulate. In terms of health impacts, heart-rate biofeedback offers participants insights into the ways that they can learn to voluntarily influence their stress and relaxation responses through the use breath, relaxation and intentional focus.

I've been working with biofeedback-based interactions in my art for over twelve years now. A large part of my motivation in beginning this work was a desire to access a way of experiencing and relating to the body that could go beyond Western art and medicine's preoccupation with pathology, to work with the living being of the viewer as a medium, subject and vehicle for contemplation. In placing biofeedback into the context of an interactive and participatory art project, my goal has been to make available this way of knowing and sensing to a wider public, and to explore how these technologies can be used to reveal

otherwise hidden or under-represented aspects of our experience and subjectivity.

Medicine and advertising tend to frame the body as a thing to be fixed. When we think of aesthetics in relation to the body, it's usually in terms of how we appear to others and how others appear to us. It's important for me that this work offers people a way of experiencing their embodiment beyond external appearances, diagnosis and pathology. In place of these 'medicalised' ways of experiencing and representing 'the body', *The Heart Library Project* offers a set of conditions for exploring and appreciating your embodiment: your ability to influence and be influenced by your nervous system responses, but also to just spend some time 'inside' your body and the moments between each heartbeat.

The Heart Library is also a social experience where friends, family and total strangers bear witness to the simple fact of each participant's being - the moment-to-moment ebb and flow of our emotions and autonomic nervous system reflexes. The interaction takes place inside a semi-private booth installed in a waiting area, so that even if someone is already interacting with the work, other visitors can observe them without intruding on the participant's experience. I'm always surprised at how many people gather around to watch. It's very beautiful to see all these people looking and listening to another person's heartbeat, just being present to this small miracle we call our body. After this interaction we give each participant a sheet of paper with an outline of a body on it and invite them to locate and describe aspects of their experience that they'd like to share with other visitors.

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These social aspects of witnessing and sharing experience, and the fact that our interaction is motivated by curiosity and playfulness instead of any need to ‘get better’, are what differentiates this work from biofeedback in clinical practice – connecting it to a very long history of art as a way of seeing, feeling and re-imagining our place in the world, and our place in time.

George Khut is an Australian artist, academic and interaction designer working across the fields of electronic art, interaction design and health at UNSW Australia, Art & Design. For the past twelve years he has been working with biofeedback technologies, creating intimate, body-focused interactive artwork experiences that re-frame experiences of embodiment and presence. In addition to presenting his work in galleries and museums, he has been developing new audiences for his work in exhibitions and research projects in hospitals, starting with the Heart Library Project at St Vincent’s Public Hospital in 2009, and more recently with the BrightHearts research project with Dr Angie Morrow, Staff Specialist in brain injury at The Children’s Hospital at Westmead, Kids Rehab.

Doing digital art therapy

Paul Dean

Art therapy is an established intervention for many different client groups. It utilises art-making as a form of communication and exploration of issues between a client and a clinician, often via the use of traditional art materials. But what of digital media?

As a digital artist and an art psychotherapist, I often utilise a number of digital techniques in therapy, especially with clients familiar with digital such as young people, as it often speeds up and enables the therapeutic relationship. More recently, however, I have started to question the use of new media for client groups who regularly use digital and wonder if its familiarity is exacerbating some issues.

To explain this further, let me describe a group of young people I recently worked with, all of whom engaged constantly with social media and digital technology as a way of communicating, entertaining and completing school work. In essence, their lives were changeable at a push of a button. They could and regularly did watch box sets of television shows, talked to people instantly on the other side of the world, took and shared photographs and video and listened to music and played games. They all felt familiar with using technology to create and regularly did so outside of therapy.



Artwork by client at the start of digital therapy

This group experienced a range of difficulties – anxiety, low mood, self-harm and suicidal thoughts. Via group and individual work we engaged digital media to create images, poetry, writing and videos. However, a recurring theme of being unable to imagine how the passing of time might influence or change feelings, emotions and thoughts for them surfaced routinely within these sessions. They easily and eagerly used art therapy interventions and quickly created their chosen artwork, but therapeutically their perception seemed rooted in an understanding of emotional change having to be as instant as their digital creations.

I wondered about this for some time and compared their lives with mine at their age, and thought about how technology and its uses seemed to be the element that was so different. I had no mobile phone or Internet. My television consisted, at best, of four channels, and if I was watching a show I waited for a week to find out how the cliff-hanger was resolved. My photographs were on film and to see them I had to endure the delay of sending them to be processed, and the possible disappointment of blurry or black physical prints. There was a weekly wait for the singles chart to inform me of what was new and exciting in the world of music, and I wrote letters to people and waited for their return. In essence, I had an engagement with waiting and sitting with emotions and possible disappointment, which does not seem to be present any more.

I tried to develop the digital techniques we were using to address this. The ease with which the young people engaged with these techniques seemed helpful in terms of the group feeling familiar and safe within their therapy. Early attempts to introduce time and engage the clients in creativity over a period of weeks were met with apathy and a desire to create something new each session. So I decided to go analogue. We kept the technology, but we introduced

the idea of being creative by writing letters. Within the sessions we agreed to write to each other - they would write to me and I would think about their letters and bring them my replies in envelopes the following week.

To begin with the letters were very short, but over a period of weeks they became filled with emotional thoughts, creativity and insight. We continued for approximately six months, and during this period there was a marked improvement in the ability of these young people to engage with time passing and to hold on to different emotions. Ideas for artwork were discussed in our analogue communications and as the process progressed, so did the length of correspondence and the creativity in their content. We exchanged



*Artwork by client at the end of digital therapy
Photos by Weng-Rong Chen ©2012 MOCA, Taipei*

ideas and examples of artists and artwork, which then flowed into the clients' own digital creations, which in turn took time to create. Instead of 10-minute artworks, there was a shift to creation now taking weeks and months. While previously the clients gave a more immediate artistic response, this was now replaced by a more mindful approach. This led to debates, discussion and careful selection of mark-making when engaged in a piece of work. They were becoming interested in time within their pieces and aware of how it affected them on an emotional and therapeutic level too.

Further research is needed on the use of a non-digital creative approach and its impact on a digital-reliant client group. This experience has highlighted the therapeutic use of digital media creatively for me as a clinician, but also the importance of reaching back to a time before instant change as a way of upskilling a generation who have seemingly, in some cases, lost the ability to wait, explore and be mindful within their digital world.

Paul Dean works across three roles as an art psychotherapist: for the NHS military veterans' psychological therapy service; for FACT as a therapeutic support worker and as an artist for its Veterans in Practice group; and for Tom Harrison House, which runs a residential programme for veterans struggling with alcohol and substance misuse. Prior to this he worked at Oldham Children and Adolescent Mental Health Service as an art psychotherapist where he was involved in assessment and therapeutic interventions for children and adolescents who were experiencing a range of mental health issues: substance misuse, abuse, self-harm and suicidal ideation and a whole range of undiagnosable but life-impacting issues. He is a military veteran, a practising artist and a qualified teacher and has been involved with young people and adults within a range of disciplines for the past twenty years.

Me and the Black Dog

Kate Owens and Neeta Madahar

Me and the Black Dog is an ambitious artwork exploring depression through the interactions of a female and a large black dog. With hand-drawn animation at the heart of the work, *Me and the Black Dog* is experienced as a complex immersive installation with sections playing on several screens simultaneously and the audio fragmented and transmitted through a number of speakers.

In the piece, a spoken text avoids narrative structure and sentences collapse into repetition, rhyme and plays on words. The visuals are aesthetically similar to the 1970s' *Roobarb and Custard* cartoons, with crudely drawn, nebulous outlines emphasising uncertainty. The work also includes a specially commissioned music track.

Me and the Black Dog comes from the personal perspectives of two artists, Kate Owens and Neeta Madahar, and aims to challenge how mental illness is perceived, thereby lessening the shame that surrounds it. It centres on cultural references within British folklore to 'the black dog' as a metaphor for dark, malevolent forces. For example, a Viking legend describes Black Shuck, a ghostly dog roaming the East Anglian countryside as a portent of death. More recently, 'the black dog' has come to symbolise the human psyche's darker aspects. Winston Churchill referred to his depression as

'the black dog' and singer/songwriter Nick Drake interweaved associations between 'the black dog' and black moods in his songs.

Me and the Black Dog conveys how the unruly, dark element of one's personality is not necessarily something to eradicate, but can be valued as an intrinsic part of oneself. The accessibility, directness and associations with childhood that characterise animation afford the exploration of early subconscious narratives and the wildness, violence and humour that these narratives often contain.



Members of Freehand and Erica Scourti

Freehand (FACT's young people's programme) is collaborating with artist Erica Scourti and a group of 13–18 year olds. Within the programme team at FACT we knew it was vital that this exhibition included an artwork by young people, since they have grown up surrounded by technology and use it in a way that is completely embedded in their lives. The group worked over several months to research and explore what art means in the context of an exhibition, how we can work collaboratively to create an artwork that communicates what we want it to and how we can portray a collective voice.

The work is the result of an exploration of two questions: does technology impact on mental health and well-being, and is this something that young people even care about? The first thing that comes to mind for most is the Internet. Some of the group admitted that they thought they might be addicted to their smartphone and the Internet. What problems and opportunities does this create for future parents, the workforce and society? Does it even matter? We hope the outcome will be a piece of art that is provocative and allows 'adults' to peek into the minds of young people who are living the real digital reality.

This project is delivered by FACT. MYA (Merseyside Youth Association) has funded this work, supported through the Liverpool Children's Emotional Health and Wellbeing Partnership.



Erica Scourti, *You Could've Said*, 2013

Additional mental health support links

If you need support with mental health and well-being you are not alone. There are lots of places locally and nationally that can offer help.

Liverpool

Liverpool Specialist CAMHS (Alder Hey Children's NHS Foundation Trust)

liverpoolfyi.com

0151 293 3662

Liverpool Specialist Child and Adolescent Mental Health Service is a specialist mental health and well-being service for children and young people aged 18 and under.

Mersey Care NHS Trust

merseycare.nhs.uk

0151 473 0303

Mersey Care NHS Trust provides specialist inpatient and community mental health services for adults in Liverpool.

Wellbeing Liverpool

wellbeingliverpool.org.uk

0300 77 77 007

enquiries@healthwatchliverpool.co.uk

Wellbeing Liverpool is an online directory for mental health and well-being services, activities and groups in Liverpool.

Healthwatch Liverpool

healthwatchliverpool.co.uk

0300 77 77 007

enquiries@healthwatchliverpool.co.uk

Healthwatch is a great place to find local services.

Liverpool Mental Health Consortium

liverpoolmentalhealth.org/

0151 237 2688

hello@liverpoolmentalhealth.org

Liverpool Mental Health Consortium was set up the aim of improving mental health services in Liverpool through service user involvement.

National

Samaritans

samaritans.org

08457 90 90 90

jo@samaritans.org

Samaritans provide confidential, non-judgmental emotional support 24 hours a day, 365 days a year.

Mind

mind.org.uk

0300 123 3393

info@mind.org.uk

Mind provides confidential mental health information services.

Time to Change

time-to-change.org.uk

Time to Change is a programme led by Mind and Rethink Mental Illness, to challenge mental health stigma and discrimination. The Time to Change website offers resources and signposts to services.

Rethink Mental Illness

rethink.org

0300 5000 927

Rethink provides expert advice and information to anyone affected by mental health problems.

Editor biography

Vanessa Bartlett is a researcher, writer and curator currently based between London, Liverpool and Sydney, Australia. She is a PhD candidate at the University of New South Wales, where her research explores digital art as a way of prompting audiences to reflect on their own mental health in the gallery space. Vanessa's writing has featured in the *Guardian* and she has given lectures internationally in Belgrade, Ljubljana and Helsinki, as well as at prestigious UK venues like Tate Liverpool, the Arnolfini and the Science Museum, London.

In the past she has worked as a researcher and producer for two of the UK's most exciting digital media festivals: FutureEverything, Manchester, and Abandon Normal Devices, part of the programme at FACT, Liverpool. She has also curated a number of successful exhibitions, including *Slowness* at Red Wire Gallery, which was highlighted as a must-see exhibition by *Times* critic Rachel Campbell-Johnston.

Vanessa's research is motivated by her personal experience, which she first began to document in April 2010 on a blog called *Group Therapy*. This blog explored the relationship between contemporary art, mental health and technology and laid the conceptual foundation for the *Group Therapy* exhibition. Vanessa is currently in the process of developing a project called *What Can Art Do?* that will serve as a platform for her ongoing work in art and mental health.

www.vanessabartlett.com

www.whatcanartdo.org

Artists' biographies

Katriona Beales

Katriona Beales is a sculptor who also makes moving image, performance and installation. Her work responds to the slippage between offline and online worlds, Internet addiction, the technological sublime and notions of a digital Baroque. Beales completed her MA in Fine Art at Chelsea College of Art and Design in 2012.

Selected awards:

Stanley Picker Award for postgraduate study 2012–13

CCW Artists' Moving Image Fund 2012

Residency at Tokyo Wondersite funded by the British Council and UAL 2012

Shortlisted for the Mark Tanner Sculpture Prize in 2014

Arts Council England Grants for the Arts Award as part of LUX13 Critical Forum 2014

www.rhizome.org/editorial/2012/oct/16/artist-profile-katriona-beales/

www.katrionabeales.com

Dora Garcia

Spanish artist Dora García uses a range of media including performance, video, text and installation. Her practice investigates the conditions that shape the encounter between the artist, the artwork and the viewer, focusing more particularly on notions of duration, access and readability. García's pieces often involve staging unscripted scenarios that elicit doubt as to the fictional or spontaneous nature of a given situation, setting rules of engagement or using recording devices to frame both conscious and unconscious forms of spectator participation. García's work also explores the political potential rooted in marginal positions, paying homage through several works to eccentric and

often anti-heroic personas. She has participated in DOCUMENTA13 (2012), Biennale di Venezia (2011), Biennial de São Paulo (2010), the Biennale of Sydney (2008), Skulptur Projekte Münster (2007) and Istanbul Biennial (2003).

George Khut

George Khut is an Australian artist, academic and interaction designer working across the fields of electronic art, interaction design and health at UNSW Australia, Art & Design. For the past twelve years he has been working with biofeedback technologies, creating intimate, body-focused interactive artwork experiences that re-frame experiences of embodiment and presence. In addition to presenting his work in galleries and museums, he has been developing new audiences for his work in exhibitions and research projects in hospitals, starting with the Heart Library Project at St Vincent's Public Hospital in 2009, and more recently with the BrightHearts research project with Dr Angie Morrow, Staff Specialist in brain injury at The Children's Hospital at Westmead, Kids Rehab.

Kate Owens and Neeta Madahar

Kate Owens is a writer and artist exploring mental health, memory and memoir. She is collaborating with Neeta Madahar on *Me and the Black Dog*. Owens graduated from the University of Wales, Newport with a BA in Film and Photography (1994). She has exhibited internationally and won a Rhubarb Rhubarb bursary with her series *28 Day Flower Diary*, which was published in *The Sunday Times* and shown at galleries Flowers East and Unseen. Owens completed an MA in Creative and Life Writing at Goldsmiths University (2014) writing a fictionalised memoir. Her artists' books are held in the Tate museum collection.

Neeta Madahar is an artist, and meditation and yoga teacher. Her art explores nature, artifice and the self. She is collaborating with Kate Owens on *Me and the Black Dog*. Madahar graduated from Winchester School of Art with a BA in Fine Art (1999) and from the School of the Museum of Fine Arts, Boston with an MFA in Studio Art (2003). She has exhibited widely, including most recently at the Kemper Museum. Her work is held in the Santa Barbara Museum of Art and the Victoria and Albert Museum. In 2008 she was awarded a fellowship by the National Media Museum.

Melanie Manchot

Melanie Manchot is a London-based artist who works with photography, film and video as a performative and participatory practice. Her projects often explore specific sites, public spaces or particular communities in order to locate notions of individual and collective identities. Her work has been shown nationally and internationally including exhibitions at the Whitechapel Gallery, London; MacVal, Musée d'Art Contemporain, Paris; the Photographers Gallery, London; the Brooklyn Museum, New York; the Australian Museum of Photography, Sydney; the Courtauld Institute, London; Museum Folkwang, Essen; and as part of Nuit Blanche, Paris. She has received many awards including the Oriol Davies Award 2012. Her video installation *Twelve* will be presented as a solo national touring show from 2015–16.

Lauren Moffatt

Lauren Moffatt (b. 1982) is an Australian artist working with immersive image-making technologies. Following studies in art, cinema and media theory at the College of Fine Arts (Sydney), Paris VIII University and Le Fresnoy Studio National, she has developed a body of work pivoting around stereoscopic photography and informed by the history of cinema and broadcast technologies. She is interested in how the dimension of depth in digital moving image can be used as a storytelling device. Her works, often presented in multiple forms, explore contemporary subjectivity and connected bodies as well as the limits between virtual and physical worlds.

Jennifer Canary Nikolov(a)

The independent artist Jennifer Canary Nikolov(a) studied fashion design from 1994 to 1998 before graduating with the first version of *roomforthoughts* from the Fine Arts department of the Maastricht Art Academy in 2000. She continued with a Tweede Fase programme (the equivalent of a Masters) at the Sandberg Institute in Amsterdam, which she completed in 2002. Afterwards she was invited to participate in the first experimental curating course initiated by the University of Amsterdam and the Sandberg Institute. Jennifer has curated and shown work in the context of various art and science projects, such as *Battle of the Universities*, *Kloone4000* and *Discovery07*. From November 2007 to April 2008 she worked as an artist-in-residence at the National Psychiatry Museum in Haarlem, the Netherlands.

Erica Scourti

Erica Scourti was born in Athens and is now based in London. Working with text, video and performance, she draws on her own biography to explore digital identity as an entanglement of personal and collective experience. Her work has been shown recently at Hayward Gallery Project Space, the Photographers' Gallery, Brighton Photo Biennial, Munich Kunstverein, Museum of Contemporary Art, Athens, IMPAKT festival and Banner Repeater, and she has presented performances and talks at the ICA, the Irish Museum of Modern Art, DRAF and the Southbank Centre. In spring 2015 she will be in residence at the White Building, London.

Superflex

SUPERFLEX is an artists' group founded in 1993 by Jakob Fenger, Rasmus Nielsen and Børnstjerne Christiansen. SUPERFLEX describe their projects as Tools. A tool is a model or proposal that can actively be used and further utilised and modified by the user.

Ubermorgen

Doing strange things with software and hardware. We live and work in Vienna, Austria exclusively. Our influences are Rammstein, Samantha Fox, Guns N' Roses and Duran Duran, Pfizer's Olanzapine and Hoffmann's LSD, Lindt's Dark Chocolate and Kentucky Fried Chicken's Coconut Shrimps Deluxe. UBERMORGEN's official website is UBERMORGEN.COM and yes, you may use all the stuff from the website and from elsewhere without permission.

the vacuum cleaner

the vacuum cleaner is an art and activism collective of one. Through site-specific performance, street-based intervention and film, the vacuum cleaner empowers his audience to address sociopolitical issues including consumerism and mental health discrimination. From one-man shows to large-scale participatory actions, his approach is variously subtle and extreme, but always candid, provocative and playful. His work has been exhibited throughout the UK, including commissions from Tate Modern, ICA and Nottingham Contemporary as well as BBC4, Channel 4 and Arte. He regularly presents work internationally both on the streets and in art spaces.
www.thevacuumcleaner.co.uk

Hannah Hull is the vacuum cleaner's lead producer and collaborator for *Madlove*. She is a situation-specific artist, creating social sculpture and political interventions. Her work is often dialogue-based and temporal. Her practice invites people to articulate the spaces in between; to disclose new sites, histories and languages. She is interested in empowering individuals to creatively and critically intervene with their world. She delivers and consults on creative practice for social change. Her specialist interest is the use of a critical, contemporary art model for addicts, ex-offenders and the homeless. www.hannahull.co.uk

Quintan Ana Wikswo

Quintan Ana Wikswo is recognised for adventurous projects that integrate her original literature, visual art and performance. After fifteen years as a human rights worker, she developed a fieldwork-based practice using forced labour manufactured government communications equipment at obscured sites of crimes against humanity. Her works have appeared internationally, including three solo exhibitions at museums in New York City and Berlin. Her book of texts and photographs, *The Hope Of Floating Has Carried Us This Far*, is forthcoming from CoffeeHouse in 2015. Her fellowships include National Endowment for the Arts, National Endowment for the Humanities, Creative Capital, Yaddo and the Pollock Krasner Foundation.

List of works

Katriona Beales (UK)

White Matter, 2015

Multimedia installation with glass sculptures, moving image and sound

Developed in conversation with Dr Henrietta Bowden-Jones (Royal College of Psychiatrists, London)

A new commission for FACT

Dora García (Spain)

The Deviant Majority, 2010

Single-channel video, sound, 34 mins

Courtesy of the artist, Galeria Civica di Trento, and Ex-Ospedale Psiquiatrico di Trieste

George Khut (Australia)

The Heart Library Project, 2007

Pulse-sensing hardware, computers, video projector, stereo sound

Acknowledgements: David Morris-Oliveros (visual effects programming) and Caitlin Newton-Brand (creative development)

With support from Australia Council for the Arts

Courtesy of the artist and University of New South Wales, Australia | Art & Design

Melanie Manchot (UK)

Twelve, 2015

Installation environment, three-channel video, sound, 25 mins 24 secs

Commissioned by Portraits of Recovery with funding from the Wellcome Trust

National touring show supported by Arts Council England

Courtesy of the artist

Lauren Moffatt (Australia / Germany)

Not Eye, 2013

Stereoscopic video, mixed media installation

Acknowledgements: Binocle 3D (Director Yves Pupulin) and Expanded 3Digital Cinema Lab Karlsruhe (Director Ludger Pfanz)

Courtesy of the artist and Le Fresnoy Studio National des Arts Contemporains, 2013

Jennifer Kanary Nikolov(a) (Netherlands)

Labyrinth Psychotica, 2013

Mixed media installation

Courtesy of the artist

Supported by Johnson & Johnson Citizenship Trust in collaboration with Fonds Psychische Gezondheid, with additional support from Mondriaan Fund

Kate Owens and Neeta Madahar (UK)

Me and the Black Dog, 2015

Multi-channel animation, sound, 14 mins

Courtesy of the artists

A new commission for FACT in collaboration with producer Jacqui Davies and with support from Arts Council England

Members of *Freehand* (FACT's young people's programme) and Erica Scourti (UK / Greece)

Digital project

Courtesy of Freehand and the artist

A new commission for FACT with Merseyside Youth Association (MYA), through the Liverpool Children's Emotional Health and Wellbeing Partnership and with support from Liverpool Child Adolescent Mental Health Service

Superflex (Denmark)

The Financial Crisis, 2009

Single-channel video, sound, 12 mins 25 secs

Originally presented by Frieze Films and Channel 4 and created for Frieze Art Fair 2009

Courtesy of the artist and Nils Stærk, Copenhagen

UBERMORGEN (Austria)

Psychos Sensation, 2014

Mixed media installation

Acknowledgements: Dr Shird Schindler, Fabio Paris and Domenico Quaranta
Courtesy of the artist and Carroll / Fletcher Gallery, London

the vacuum cleaner (UK)

Madlove, 2015

Mixed media installation

Courtesy of the artist

A new commission for FACT, made possible with support from the Wellcome Trust and supported by the British Psychological Society

Quintan Ana Wikswo (US)

Carrie Buried Beneath Catalpa Beans // Mountain Sweep, 2009–14

Photography and text (16 prints on Mulberry paper)

Courtesy of the artist

This book is published to coincide with the exhibition

Group Therapy: Mental distress in a digital age

FACT, Foundation for Art and Creative Technology, Liverpool
5 March–17 May 2015

Exhibition

Curatorial Team

Curators: Vanessa Bartlett and Mike Stubbs

Programme Producer: Ana Botella

Community and Health Manager: Angharad Williams

Young People and Learning Manager: Louise Latter

Curatorial Assistant: Emily Gee

Exhibition Coordination: Lesley Taker and Amy Jones

Programme Technician: Mark Murphy

FACT Team

Head of Marketing and Communications: Jen Chapman

Fundraising Manager: Lucie Davies

Visitor Services Manager: Joan Burnett

Design

Exhibition Design: Benjamin Koslowski

Graphic Design: Lottie Crumbleholme

Artists

Katriona Beales

Dora Garcia

George Khut

Neeta Madahar and Kate Owens

Melanie Manchot

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Lauren Moffatt

Jennifer Canary Nikolov(a)

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Quintan Ana Wikswo

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Collaborators

Institute of Psychology Health and Society at the University of Liverpool, Merseyside Youth Association, Royal College of Art / The Creative Exchange

With thanks to the exhibition advisory panel: Richard Bentall (Professor of Clinical Psychology, University of Liverpool), Rhiannon Corcoran (Professor of Psychology, University of Liverpool), Paul Dean (Art Psychotherapist, Military Veterans Service IAPT and Veterans in Practice Therapeutic Support, FACT), Andy Kerr (Programme Delivery Manager [Mental Health], NHS Liverpool Clinical Commissioning Group), Peter Kinderman (Professor of Clinical Psychology, University of Liverpool) and Gina Perigo (Public Health Practitioner, Liverpool City Council)

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