



ORIGINAL ARTICLE

Stories of the Silenced Manifesto and Mad Studies: an experience of biomedicine and mental health

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Abstract

This paper delves into a discussion about my experience of living with schizoaffective disorder and how I am shackled by biomedicine. This paper outlines a series of concepts that, like Mad Studies, emancipates and provides a commensurable space for mental health service users to have a voice and to be heard. The discourse which promotes this space is what I call the Silenced Manifesto. Throughout this paper, I unpack the meaning of the Silenced Manifesto which builds upon the importance of the discipline of Mad Studies. Ultimately, this paper is about the effects of biomedicine on my mental health. Firstly, I discuss the method used in my research, that is autoethnography. Then, I give a background of the concepts of the Silenced Manifesto and Mad Studies, the theoretical backbones of the paper. Then, I back up my argument with a narrative of what it is like to be a cog in the wheel of biomedicine. In particular, a narrative on how I am labelled and assessed and therapeutically treated within the biomedical paradigm. And I query if biomedicine and its scientific arm of psychiatry are in fact applicable and appropriate to mental health, its diagnosis and definition and its treatment.

Keywords

autoethnography, mental health, biomedicine, Mad Studies, Silenced Manifesto

History

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Introduction

I have been living with schizoaffective disorder for 25 years – half my life
I have been an inpatient and an outpatient many many times
I have been suffocated, disempowered, and somehow.... loved
I have had periods of relative wellness and relative illness.

My everyday lived experience includes extreme anxiety and paranoia.

This article delves into my experience of living with schizoaffective disorder and how I am shackled by the dominance of the biomedical realm. This article outlines the discipline of Mad Studies, to emancipate and provide a commensurable space for mental health service users to have a voice and to be heard (Biehl 2005; Fixsen 2021; Millet 1990). The discourse which promotes this space is what I call the Silenced Manifesto. Throughout this article, with the use of autoethnography, I will unpack the meaning of the Silenced Manifesto, which builds upon the importance of the discipline of Mad Studies. Two facets of the madness experience facing me include measurement and colonialism. Biomedicine embodies both these concepts. Through the Silenced Manifesto and Mad Studies, my research sets out to break through the glass ceiling and straight jacket of the mentally ill (Scheff 1974), to enable the silenced to be heard, better understood, and empowered (McMahon 2017; 2020).

Background

The official biomedical definition of schizoaffective disorder is outlined in the fifth edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (*DSM-5*). The *DSM-5* is assumed to be a valid and reliable source for psychiatric diagnosis (McMahon 2020: 40, 42). The official biomedical definition of schizoaffective disorder according to the *DSM-5* is a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania (American Psychiatric Association 2013: 105-110).

The biomedical diagnosis of schizoaffective disorder is guided by psychometric measurements, which can include an MRI (magnetic resonance imaging), EEG (electroencephalography), or CT (computed tomography), and blood tests (Pagel et al 2013; Pagel et al 2014). Other components of diagnosis include the scientific measurements of psychology and neuropsychology, incorporating the factors of experiential, environmental, and behavioural measures, and observable, neurobiological, and genetic determinants (McMahon 2020: 278). According to biomedical scientists, these biomedical psychometric measurements create psychometric 'facts', which are deemed as valid and reliable and thus scientifically grounded (Lea 2008; Lock and Nguyen 2018; McMahon 2020). However, according to advocates of Mad Studies (whose position will be discussed below), psychometric 'facts' are not validated facts at all (Boyle 1993; LeFrançois et al 2013). Even though it is possible for diagnosis and treatment to be some version of non-biomedicine (Porter 2002), psychiatric history and, in my experience, my diagnosis and treatment have been biomedical, mainly pharmaceutical. Biomedicine, within the realms of Mad Studies is critiqued as poor science (LeFrançois et al 2013; Szasz 1976). As a potentially therapeutic concept, and according to Mad Studies, it is fundamentally lacking.

Building upon the personal experiences and writings of others, such as Millet (1990), my autoethnography of living with a major psychotic illness is a journey of my experiences of being an inpatient in three different psychiatric wards, in different Australian states and

territories, over the years 2012, 2014 and 2015; and as an outpatient. Ultimately, it is a story of how my life has been stripped bare by my illness and the institutions which now control it.

In this article, I explore how the biomedical lens of psychiatry views me and how it positions what I can and cannot do and be. I explore the experience of being tested and measured. I explore how biomedicine has the capacity to stigmatise and dehumanise people with mental health disorders, and how difficult it is to resist the definitions and labels imposed upon me (Scheff 1974). In a sense, biomedicine tries to measure the unmeasurable, and as my former neurologist stated, often inappropriately and over-zealously (McMahon 2020 9-10). Biomedicine also functions to define and confine the mentally ill. Mental health service users are dependent on it, specifically on psychopharmacologic treatment. Although, as Szasz (1976) and Moncrieff and Kirsch (2005) and Whitaker (2004) state, the efficacy of these drugs is questionable.

Methods

Adams *et al* (2015) and Liggins *et al* (2013: 106, 108), state that autoethnography, a qualitative method, is a well-founded, authoritative, and legitimate method that brings to life the experiences of the self, through narrative. It exemplifies and describes those experiences within their social and cultural context. The stories told in an autoethnography add to the growing mass of descriptive, destabilising, testimonial and emancipatory work associated with the culture at hand. How these stories are dialectically revealed are through actions, feelings, thoughts, and language. According to Foster *et al* (2005), autoethnography is a valid method in the exploration and analysis of mental health, that enables a defensible and accountable analysis of the broader biomedical health paradigm. As per Foster *et al* (2005: 1), mental health discourse and autoethnography marry well. They state that “As a qualitative research method, autoethnography is useful for making connections between researcher and participant, deepening interpretive analysis of both common and differing experiences, and producing knowledge drawn from compassionate understanding and rigorous reflection.”

Autoethnography offers a robust method to unpack my experiences of madness and the psychiatric system and its firm grounding in biomedicine (McMahon 2020). It can explore mad people’s cultures, histories, politics, and communities, and can use mad-centred knowledge to critique existing practices (Beresford and Russo 2022: 6-7; Spandler and Poursanidou 2019: 9). Perhaps, as Gadamer said, “it is not truth we are seeking, but understanding” (cited in Liggins, Kearns and Adams 2013: 108). With a destabilised narrative, I describe how I have been interrupted by illness (Richards 2008: 1722-1723), and how I have been disrupted by the dominant hegemonic biomedicine paradigm.

In short, this autoethnography is about unpacking my experiences to gain a greater depth of understanding of living with schizoaffective disorder. The writing below is in part drawn

from my autoethnography of living with schizoaffective disorder, employing a series of my own stories/narratives. Part of this exploration includes an examination of some of the texts I have studied in my stories, including my medical records, which add to the depth of my narratives and the fluid and multifaceted form of my lived experiences on the psychiatric wards (McMahon 2020). Such an analysis also engages in tracing and mapping the power dynamics that weave through the exploration of ideologies of an autoethnographic study of madness (Fixsen 2021; Millet 1990). As per McMahon (2020), my field notes and medical notes add substance to the argument that I am indeed shackled by biomedicine, which support my autoethnographical discussion of disempowerment.

Silenced Manifesto

I have coined the term 'Silenced Manifesto' to describe mental health experience and discourse. The Silenced Manifesto describes and perpetuates and allows for an understanding and unpacking of the phenomena of social empowerment and disempowerment. Here, the Silenced Manifesto explains the position of the mentally ill as silenced and occupying a space of commensurability between the disempowered mentally ill and the empowered science of biomedicine and the State that sanctions it. Biomedicine and the State may be called scientific and political 'colonisers', using measurement as a cultural artefact to validate, authorise and enable their authoritative position. The space of commensurability allowed by the Silenced Manifesto encourages and endorses the colonised mentally ill to have a voice and to be heard. Previously, biomedicine dominated this space and the silenced were left to experience discrimination embodied in a glass ceiling or straitjacket, being disabled and suffocated.

Foucault stated (in Alonso and Koreck 1989: 1), "There is not one but many silences, and they are an integral part of the strategies that underlie and permeate discourses." What are the implicit or explicit silences in the Silenced Manifesto discourse? If I am being silenced, whose voice is being heard? Who are empowered?

"I am now convinced I am disabled. I am coming to believe that I am all the labels people are bestowing on me. I am lacking. I am stupid. I am powerless. I am silenced". (Field notes, 24th March 2012 in McMahon 2020: 10)

I am branded by my mental illness. Branded by the labelling of such which precipitates a misrepresentation that suffocates me. Labelling can lead to negative outcomes (Gorman, Shimrat in LeFrançois *et al* 2013: 152, 269, 339). The more the person living with a mental illness believes and internalises the labelling of subhuman, sub-citizen, and social misfit, the more they will believe they are devalued and lacking (McMahon 2020). And thus, it is a self-fulfilling prophecy; the individual living with a mental illness internalises the language, culture, politics, psychology, economy, and interpersonal relationships bestowed on them.

Via the Silenced Manifesto, all these factors are given space, a possible commensurable space, to flourish. The culture that labels those living with a mental illness perpetuates and the individuals become part of the culture defined as the lacking (Cohen 2016, 2018; Scheff 1974).

We have been silenced by our diagnoses and labelled, both historically, with the history of discrimination and difference, and now (Bhabha 1996). We are/have been silenced, suffocated and disabled in more compounding ways than living with the original disability, if it can be called that. The labelling and silencing have perpetuated and enhanced the position of lacking for the disabled; it has a snowball effect. The silenced become more silent, and the disempowering discourse becomes more entrenched. Thus, the Silenced Manifesto creates a social dynamic which breathes life into a disempowering discourse, liberating the marginalised (Alonso and Koreck 1989; McMahon 2020; Walker 2006).

By working through my lived experience, I have been able to explore and examine and encounter the space where trauma and resilience preside, and where those traumatised find a space for their recovery to be empowered. I have been freed by the commensurability of the Silenced Manifesto, where I have found a therapeutic space between biomedicine and my lived experience. This therapeutic space can potentially empower me to engage in a more positive way with the biomedical discourse that fundamentally influences my life (LeFrançois *et al* 2013). In a meld in the space where social science meets medical science (Geekie and Read 2009: 179) exists a discourse created to support political tools for development and disarmament of unjust and discriminatory power relations (Sue *et al* 2020). The Silenced Manifesto stands for and supports this empowering discourse.

The discourse of the Silenced Manifesto describes the commensurable space for creating and merging a reality between various and sometimes competing realities, as marrying my lived experience with biomedicine. The Silenced Manifesto stands for creating an existence where the psychiatric hegemony can marry with the marginalised mentally ill (Walker 2006).

The Silenced Manifesto creates space for Mad Studies.

Mad Studies

I am mad. I am a subject of dispute and of Mad Studies.

A background to Mad Studies was the emergence in the 1990s of Mad Pride. As described by Curtis (*et al* 2011) and Glaser (in Beresford and Russo 2022: 4-5), Mad Pride originated in Canada, spread internationally, and was based on 'reclaiming' the language, meaning and ownership of madness. It rejected the biomedical model and was deliberately

confrontational. It sought to 'visibilise' the history and realities of psychiatry and the experience of survivors through protests, demonstrations, cultural events, walking tours and mass media campaigns.

Mad Studies is connected to Mad Pride. According to LeFrançois *et al* (2013: 337), Mad Studies is a meld of activism and intellectual activity. Mad Studies is defined as a field of scholarship and theory about lived experience, history, cultures, and politics. Mad Studies is associated with a break in historic structure, a break in our historic hegemonic existence embodied in the socio-cultural and political structural phenomena of white, masculine, heterosexual, middle/upper-classed, Christian, and able-bodied perspective. Mad studies is born from and somewhat a reaction to this hegemonic foundation, describing, perpetuating and representing the phenomena of colonialist power structures, where biomedicine and psychiatry have power over the mentally ill (Beresford 2020; Cohen 2016).

There cannot be a discussion of Mad Studies without mentioning those that have questioned psychiatry as a concept and as a science. Beresford and Russo (2022: 2) state that those most closely associated with being against psychiatry were UK psychiatrists R.D. Laing and David Cooper, from Italy, Franco Basaglia, and in the US, Theodore Lidz. They were concerned with making sense of madness, highlighting its personal and social relations and the deficiencies of psychiatry. These theorists are united by a critique of traditional psychiatric practice and reliance on a reductionist biomedical model. Other thinking associated with the movement ranged from Goffman's critiquing of 'total institutions' and their damaging effects, Foucault's understanding of psychiatry as primarily repressive and controlling, to the sociologist Thomas Scheff's interpretation of 'mental illness' as a label of deviance imposed by society's moral entrepreneurs (Crossley 1998; Donnelly 1992; Foucault 1967; Goffman 1961; Scheff 1974). Other theorists of note include Rose and Kalathil (2019), who argue for coproduction between researchers, policy makers and those of us positioned as mad. Also, Sedgwick, a significant original figure in Mad Studies, rejected the prevailing individualistic medicalised model of 'mental illness' and saw societies as driving people into madness and distress (in Beresford and Russo 2022:5; Sedgwick 1982).

According to Beresford and Russo (2022: 2), another key figure that questioned the legitimacy of psychiatry was the critical psychiatrist Thomas Szasz who argued in 1976 that psychiatry was a defunct science, without validation or reliability. Beresford and Russo (2022) argued that "some survivors have valued [Szasz] as a critic of the moral and scientific foundations of psychiatry". Szasz (in Beresford and Russo 2022: 2) argued that "mental illnesses are not illnesses in the same way that physical illnesses are". According to Szasz (1976) an absolute and definitive causation for any mental illness has yet to be established. And no 'treatment' has been deemed as truly effective. According to Whittaker and Cosgrove (2015), the science behind mental illness is problematic. What is problematic is treatment for mental illness that is purely biomedical.

Although the mental health system has always had enormous power over people's lives, from its foundation it has created controversy and so its scientific basis is called into question. This is perhaps hardly surprising given that its 'treatment' repertoire has included large-scale institutionalisations, forced 'treatment' and restraint, and dangerous interventions like insulin shock therapy, brain surgery and electroconvulsive therapy (ECT) (Porter 2002; Whitaker 2004).

According to Beresford and Russo (2022: 1), Mad Studies offers, for the first time, a real prospect of effective opposition to the marginalisation and oppression of people experiencing madness and distress, which is strongly philosophically and intellectually grounded. How does it do this? How does a Mad Studies view of mental illness fare in the biomedical realm?

Mad Studies gives a voice to those who haven't had a voice before. Mad Studies contests the inappropriate language historically used by psychiatry and critiques how this inappropriate and disempowering language has seeped into politics and culture as a whole (LeFrançois *et al* 2013). It challenges the misrepresentation and historical subjugation of biomedicine (Beresford and Russo 2022).

Of relevance to this paper, and according to Beresford and Russo (2022), Mad Studies is fundamentally grounded in an explicit divorce from a simplistic biomedical model and all the theoretical and treatment premises associated with it. It is philosophically grounded and broadly based. It values and draws on other understandings and disciplines, rejecting biomedical dominance (LeFrançois *et al* 2013). It prioritises social understandings: in the case of this discussion a social science critique, disrupting the dominant, biomedical narrative and assumption of mental illness. As well, it has emphasis on first person or experiential knowledge. Although it is survivor-led, it is not limited to survivors (Beresford 2020; Beresford and Russo 2022; LeFrançois *et al* 2013; Rose and Kalathil 2019).

Discussion

There are many stories I can tell about the reign of biomedicine, and how it has disempowered me. Some are noted below. Let me begin, however, with a discussion of biomedicine and its arm, psychiatry. Psychiatry relies on the tools of science, exemplified by measurement, and statistics, and their extrapolation in pie charts and bar graphs. Psychiatric science and its validating measurements, with their magical digits cannot be ignored. The power of measurements and consequent numbers and bar graphs are quite profound (Lea 2008). According to Lea (2008), these digits and graphs can be understood as cultural artefacts and/or factoids. As per Lea (2008) the illuminations of measurement factoids enable mental health to develop a social life with a dynamic of its own. Being influenced by Lea (2008) and Kowal (2006), measurements legitimising diagnosis seem to

create a space of proximity where it is possible to negotiate and exchange between and within, such as between biological science and social science. Kowal goes on to say that this space for legitimising measurements is important as it provides some cognition, some proximity, for negotiation between cultural artefacts and factoids and scientific relics (Kowal 2006; Lea 2008).

To make this space workable, there must be some proximity in the connection between the phenomena of the measured and the unmeasurable (McMahon 2017; 2020). This is relatable to the power of the in-between: occupying space between theory, practice, analysis, and action. This space of the in-between is discussed here as part of the Silenced Manifesto and detailed in McMahon (2020).

I have been measured and poked over the years. Measurement has fundamental agency in the lives of the mentally ill. So much is riding on its use. Measurement illustrates the values and benefits to which the service providers regulate power. It also provides evidence and authority for the valued position that psychiatry has in the socio-cultural, political, and economic world. Some may say that the purpose of measurement is its validation of colonialism (Lea 2008; McMahon 2017, 2020).

As part of taking clozapine, a psychopharmaceutical used with people who have a diagnosis of treatment-resistant psychosis, including, in my case, having treatment-resistant schizoaffective disorder, I am required to be measured, assessed, and have blood taken monthly, as well as having regular electrocardiograms and echocardiograms. Apparently, clozapine can cause heart failure if not taken correctly, another shackle of biomedicine (Cohen *et al* 2001; Merrill *et al* 2005). Due to the risk of taking clozapine, governments monitor its use. Lea argues that the agent of bureaucracy facilitates and precipitates the place of politics (Lea 2008), and here in its place is biomedicine (Hanna 1991). Government mandates include the Queensland Government's (2021) development of the policy paper *Safe and Quality Use of Clozapine in Mental Health Alcohol and Other Drugs (MHAOD) Services*. Other state governments in Australia with clozapine mandates include the Australian Capital Territory, South Australia and Western Australia. And so, I am dependent for my sanity on the government who regulates the use of clozapine. I am left without a choice.

Psychiatry finds itself tied into the biomedical trap of over-measuring and measuring the unmeasurable. Again, biomedicine has reigned, showing its hegemonic discourse (Cohen 2016). During one of my hospital stays, the psy-professionals decided to do a brain MRI to decipher if they were giving me the correct drugs and to ascertain whether the treatment was for the 'right kind' of anxiety, as if this could be measured. They discovered seven lesions on my brain. The neurologist assessed the lesions and declared that they were asymptomatic and not of significance. He stated that medicine over-measures things now and finds things that are of little or no consequence. However, I did have symptoms. I had

spasms in my arms and legs, and still do today. The neurologist dismissed these symptoms as psychiatric in origin. He made me feel that I was making these symptoms up, that my symptoms and disorder were fabricated. I felt disbelieved, disempowered, and ultimately silenced. My voice was suppressed and smothered and ultimately distorted and misrepresented by biomedicine, a frequent happening; a belittling that has been continuing for the 200 years of psychiatry (Bentall 2003). This experience has affected me profoundly. I doubt myself, my own intuition. I am sure I am stupid, and that the psy-professionals know best. Yet I posit the question, is mental health truly measurable? Do psy-professionals actually try to measure the unmeasurable? And for what purpose? (McMahon 2017; 2020).

This over-measurement and indeed measurement of the unmeasurable is endorsed, authorised, and validated by biomedical colonial practice. It is within this space that I was situated in the colonial practice of measurement (Lea 2008; McMahon 2020). I was told that I could do a PhD, though it would take me three to four times longer to complete it. My ability was measured by what can be called colonial tools, neuropsychological tools (McMahon 2020), and judged using what Kowal (2006) calls the coalescent of colonial logic. Such things are assumed to be quantifiable and understandable within the realms of biomedicine – the hegemonic colonising discourse (Cohen 2016). Roman *et al* (2009) referred to such thinking as “medicalised colonialism”. And Szasz (1976: 314) notes the significant psychiatric figures of Kraepelin, Bleuler and Freud as “conquistadors” and who are in fact “colonisers of the mind” (Kerr 1997). Smith (1999) engages with this discussion of the space of colonialism. The Silenced Manifesto, as per McMahon (2017; 2020) allows for the development of “colonial” spatial awareness, admitting and permitting a possible commensurability between the heard (colonisers) and the silenced (the colonised).

After many admissions on psychiatric wards, I have been defeated and subdued. In one ward, I counted nine times when I received the wrong medication, medication that is paramount. When I approached the nurse in charge, I was called a “troublemaker” causing “undue tension in the ward”. She said that I was “non-compliant” and “didn't obey” (McMahon 2020: 232). Obey who exactly? I was a subordinate part of a system which ruled the mentally ill, colonising me and others.

I was thoroughly disempowered and misrepresented, not being heard despite my efforts. My experience was perpetuated under the biomedical agenda. An agenda which limits my autonomy and agency; and often to be unmeasurable, undefinable, incommensurable with the powers that be. There is an underlying *a priori* current of colonial power struggle that perpetuates the underdog. This struggle happens in the space of commensurability between the colonising mental health psy-professionals and the colonised mentally ill. How can those living with a major psychotic illness be empowered when historically they have been starved of power, for example how can the mentally ill live past their colonisation (Fanon 1963; 1965; LeFrançois *et al* 2016)?

Another story of dishonour and disgrace on the ward was when I was near the medication trolley, where nurses distribute the medications. I had experience with knowing medications, as I used to be a nurse. I saw the medications that I was prescribed, as the medication chart happened to be opened on my page. One of my medications included an injection for a severe sedative used for violent and extremely aggressive behaviour. I questioned the dispensing nurse as to why I was being prescribed this drug, as violence and aggression was definitely wrong for me. I have never been violent, let alone aggressive, ever. It was not my thing. The nurse stated that all the patients were prescribed this drug as was the “policy”, pre-empting the potential for any mental health patient to have anti-social and violent behaviour. So, I was being misrepresented, and potentially other patients were being misrepresented. We were silenced and disempowered and labelled and truly colonised. I was so frustrated and upset that I started crying. I was angrily told to “Just stop crying Rachael, stop it”. And then, “You’re causing a scene and upsetting the other patients”. My mental illness was a straight jacket; my voice was crushed. I was silenced. And, most likely, were others.

Those labelled as mentally ill are historically not granted the status of being fully human (Heckenberger 2012), alongside these, historically, the mentally ill have been labelled as sub-human (Foucault 1967; Scheff 1974). Some of us are not even considered partially human (Smith 1999: 26), further silencing us. Historically, psy-professionals have reigned. As stated by Porter (2002), the mentally ill have been burnt at the stake, institutionalised, and excluded from society. This historical subjugating culture persists today (LeFrançois *et al* 2013). I too have been stuck and suffocated and entrenched within the science of psychiatry. I am seen as lacking. I believe I am lacking. I have not been trusted by psychiatric ward staff. They have discounted and refuted and belittled me. I am labelled and stigmatised (Goffman 1963; Scheff 1974)). I am not believed. I am too crazy (McMahon 2020).

After the incident with the injection prescribed for violent behaviour, a nurse pulled me aside to tell me that all the nurses on the ward were kind and sincere and only had my best interests at heart. I calmly suggested to him that the nurses were burnt out. He refuted that strongly. I suggested that the nurses were struggling as the ward was treated as a place where social misfits were hidden from society. This was a well-known urban fact in that town. The ward was overflowing. Patients were sleeping on the floor, in the corridors. And these patients were mostly Indigenous, grossly overrepresented on the ward. Still, the nurse stressed that the nurses were calm, kind, and reasonable.

Historically, the mad have been assumed to be anti-social and devious (Porter 2002). Their motives are believed to be scheming and conniving (McMahon 2020). When I read my medical notes, I saw that the nurses in one ward thought that I was “staff splitting” (McMahon 2020: 233). This means that I was playing the staff off each other, against each other, to get what I wanted. Much like children do to their parents. This is an historically

dominant feature in mental health institutions - that the mentally ill are seen as deceitful and subhuman (McMahon 2020; Porter 2002). As Chamberlin (in LeFrançois *et al* 2013: 30) states, "For too long, mental patients have been faceless, voiceless people. We have been thought of, at worst, as subhuman monsters, or, at best, as pathetic cripples..."

An example of how I was not permitted to have any agency, as is the case historically for mental health inpatients, is when I wasn't allowed to eat my breakfast in the courtyard. The nurse said to me, "You have to eat at the dining table!". I quietly asked "Why?". She stated, "Because I said! It is policy!". "Why?" I asked. "Just because!" she yelled. I read in my medical notes later (in McMahon 2020: 235) that she commented that I was deviant and conniving, non-conformist and aggressive and I ruined the "peace" in the ward (if it could be called that). Just because I questioned the appropriateness of an age-old policy, which seemed to limit the agency, a healthy agency, and the recovery of an already silenced inpatient. Rehabilitation and healing and the importance of support to find a voice is a historical problem.

I have been hospitalised involuntarily, tricked into "voluntary" hospitalisation, manipulated, and lied to under the realms of just and sanctioned psychiatric treatment. I have been made a fool. On one hospital admission, as part of the practice of submitting all belongings to the nursing staff, I had a chocolate bar, lipstick and tissues confiscated from me. All this was done while the nursing staff was yelling at me to stop waking up the ward. I was sobbing. This example reflects the punitive character of psychiatric treatment even today (McMahon 2020).

Through psychopharmaceutical treatment, I live with significant and embarrassing side effects. I have a mouth of decayed teeth. I have a full upper denture and am likely to get a full lower denture too. This massive decay is due to 25 years of taking medication that dries your mouth. Saliva is a great preventative of tooth decay. The effects of reduced saliva from psychopharmaceutical treatment are not uniformly disclosed by psy-professionals. If I had been told that I would be spending up to \$10,000 (AUD) on dental work, I might have refused to take this drug and considered taking an alternative. Why was this pivotal information not given to me, withheld from me?

Bed soiling. Urinarily and faecally. There it is. This final example carries the most shame for me. I dare not want to tell, though I think it is important to tell to illustrate the grave effects and disempowerment of biomedicine. These are quite damning for me and damning for the reality of being mentally ill and shameful for mental health institutions. I am stripped bare of any dignity; fully mortified. It has affected all my relationships at some time. I have had to wear nappies. I am subjugated by biomedicine and its history and legacy. Psy-professionals act as demi-gods. Failure to disclose side effects is fundamentally, absolutely, and morally wrong. This is a game changer. I shouldn't have to live in constant humiliation. No one should. No one should have to live with the dishonour and disgrace of incontinence. I suffer

from side effects of the drugs I take and the side effects of biomedicine and how the government acts to legitimise and empower psy-professionals in their biomedical work. Psy-professionals are legitimised and empowered in their roles. Do psy-professionals even think about these side effects? Do they even know about these side effects? Nevertheless, it shows a deeply flawed system. Biomedicine amounts to psychological paternalism and entrapment.

Conclusion

It is here that research is paramount; Mad Studies needs to be revered. Voices of the mentally ill need to be heard with a variety of methods. Narratives need to be empowered. Being heard gives authority. Utilising the Silenced Manifesto and Mad Studies brings a way forward to give a voice to nurture the space where dialogue is possible between the mentally ill and biomedicine. This space needs to unpack the complexities of a marriage between mental ill health and biomedicine, if indeed such a commensurable space can exist. A common power-neutral language needs to be used, hoping that a neutral language is possible. Psychiatry needs to recognise that pharmaceutical therapies must be researched to find options with less horrific side effects, or indeed work on treatments that are not drug-based. It is in this space that evidence-based and efficacious treatments have to be developed. By this I mean that biomedicine and the State should be obliged to develop treatments that are actually therapeutic, assessed as working, in a variety of ways, for example pharmaceutically and socially, liberating the mentally ill. There must be viable options for agency and empowerment. My horrible experiences on the wards cry out for an infrastructure where patients can have a voice in a more efficacious way than the current use of a suggestions box. As per Szasz (1976), it is here that the foundations of the validity of psychiatry and its efficacy are questioned.

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