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Peter Beresford, Jasna Russo

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MADNESS IN THE
TIME OF WAR

Post-war reflections on practice and research beyond the borders of psychiatry and development

Reima Ana Maglajlić

Introduction

In the ‘Milkman’ (Burns, 2018), there is a passing reference to a murder that takes place in the midst of The Troubles in an unnamed Northern Irish community where the novel is set. Everyone in the community is aghast – a murder?! A non-Troubles related life-taking?! In our community?! Experiencing and causing death became one of the key experiences of The Troubles. But – outside of it, for no obvious political, or other conflict-related reason? How to make sense of it? While it wasn’t the main part of the story’s arc, this snippet from the novel really stayed with me. A life-altering event and responses to it shaped so powerfully by the context in which it takes place – one which alters almost all experiences of everyone within it, in that point in time. Relationships with madness during and after the war may be equally shifting, surprising and pause giving.

Experiences which happen during a political conflict impact the people in its midst. One of the sparks for the conflict usually involves some form of othering – how and why I am different than you, not as good, dirtier, barely human. People who start claiming it are not strangers; as the conflict spreads, your neighbours, teachers, colleagues, even your loved ones may express and act upon this view. You flee or are exiled from your home. Before you do, if female (minor or adult), you may be raped – even imprisoned and raped repeatedly until you become pregnant and carry the pregnancy to term. If male, you may be pushed into being a soldier despite still being a minor – or a very scared adult. You can be imprisoned and tortured. You watch your home, your village, your town, your country change and burn. People with a surname very similar to your own are killed just because they have certain religion or a particular background and on such a scale that it is labelled as ethnic cleansing. You flee or you try to stay and survive – in the case of Sarajevo, Bosnia and Herzegovina, through the longest siege in modern warfare (1992–1995). While it all lasts, you don't know when it will end, or how. Once it ends, it doesn't bring peace. For many – regardless of whether they bought into the conflict or not – it doesn't bring resolution, a better tomorrow, nor justice. Anyone who
survives such experiences, directly or indirectly, lives with them from that point on. However, the degree of difficulty and distress they cause to individuals and communities can change, with or without support.

In this chapter, I shall attempt to talk about the relationship between madness and political conflict through the lens of mad studies. I will start by explaining my own experiences and positionality in relation to madness and political conflict, the terminology I use and why I decided to use autoethnography and border thinking to structure my analysis of these experiences. I will also offer a brief explanation of why experiences of political conflict and madness in Bosnia and Herzegovina (BiH, in further text) are relevant for this topic. In the final two sections of this chapter, I will offer evidence for two key conclusions. First, the knowledge on the intersection between mad studies and political conflict through the lens of mad studies is yet to be developed. The hold of the medical – or bio-psycho-social – view of madness still dominates. Second, this is not the only dominant professional knowledge and practice in relation to madness and political conflict – development studies and practice have proven to be equally colonizing in relation to such experiences.

Positionality, terminology and methodology: For the past, present and the future

Part-Bosnian, I have spent a lot of time over the past 20 years working on the reform of health and social care services in Bosnia and Herzegovina through activism, practice and research. This included support for the development of local and national organizations run by people who use(d) mental health services in BiH. I met very few who described their experiences in any other way. Most of those initiatives now no longer exist. The one which remains is ‘Fenix’ in Tuzla, North-East BiH. The majority of my experiences, in BiH and in general, intertwine with the experiences of people who were considered mad prior to the war or experienced severe distress because of the war. As a result, they frequently experienced prolonged confinement in psychiatric services. All those experiences impact how they engage with others. They struggled to live with their families and within their communities just as much as their families and communities struggled to live with them. I am also a former wife of a former Croatian independence war (1991–1995) soldier who, like many of his peers, struggled to come to terms with his wartime experiences.

I use the term ‘mad studies’ to refer to ‘a project of inquiry, knowledge production, and political action devoted to the critique and transcendence of psy-centred ways of thinking, behaving, relating, and being’ (LeFrancois et al., 2013:13). In this chapter, references to psy-centred ways of thinking, behaving, relating and being will include both institutions and community mental health services. When referring to those practices, I shall utilise the terminology utilised by professionals and other people who engage with them (such as mental health practice, community mental health, psychiatric wards and hospitals). I shall refer to the experiences that may lead to contact with psy-centred practices as ‘madness’, ‘distress’ or other terms and phrases that describe a relevant experience, particularly if they are used by people who experience them. I emphasise distress because it, together with sadness and feeling strange and surreal, dominates during and after a political conflict compared to the more positive feelings that madness may otherwise cause.

Much like madness, political conflict refers to the complex social phenomena that attracts varied conceptual understandings of it (Skoog, 2015). Schock (1996) offers a so-called conjectural model to understanding and analysing violent political conflict. The model hypothesises that a violent political conflict is generated through the interaction of economic inequality
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grievances and political opportunities to generate violent conflict. It reconciles the tension observed by Schock between the economic discontent frameworks for understanding conflict and political opportunity ones. This chapter focuses on such, conjectural, violent political conflict and warfare.

Highlighting and clarifying the terms to be used in the text is relevant not only in an attempt to step away from psy-centred thinking, behaving and being or in relation to the complex geographies and histories of violent political conflicts around the world. It is also relevant in relation to the dominance of development practices in the ‘war-torn’, ‘post-war’, ‘developing’ or ‘low and middle income’ contexts – just some of the labels used to describe countries and contexts that have experienced political conflicts. All those terms have been developed and we share them in English, a frequent medium through which the dominance of psy- and development practices and concepts has been asserted over madness and all other aspects of life in countries experiencing violent political conflicts.

The intersection between the development and the psy-understandings of madness can and should be explored as a form of colonialism (Mills, 2013); hence the relevance of border thinking (Mignolo, 2012). According to Mignolo, effects of colonialism are ‘most damaging, far-reaching, and least understood’ (Alcoff, 2007:80).

The modern foundation of knowledge is territorial and imperial … It was from and in Europe that the classification of the world emerged and not in and from Asia, Africa or America – borders were created therein but of different kinds.

(Mignolo and Tlostanova, 2006:205, 206)

In my experience, not all of Europe is allowed to classify itself, either; some parts of the continent are more European than others, in terms of geography, skin colour, passports and the ability to internationally foreground articulations of knowledge of oneself. According to Mignolo (2012), theories and practices already exist which ‘sit’ at the borders, if not outside of, the colonial matrix of power. Such a border is defined by epistemic difference and geographical stance. Border thinking primarily emerges from the people’s anti-imperial epistemic responses to the colonial difference. In relation to madness and war, such an exploration examines what practices and understandings of these two experiences, namely, war and madness – if any – can and do exist outside the dominant psy- and development frameworks.

In order to identify what may sit at the borders, or outside the dominant psy- and development frameworks, I utilised a form of autoethnography, defined by some as critical self-study that enabled me to take ‘an active, scientific and systematic view’ of my experiences (Hughes et al., 2012:209). I am able to do this as I am privileged with relevant insider knowledge (Chang, 2008). Methodologically, it is in large part reliant on personal memory, which can be unreliable and unpredictable (Chang, 2008:71). This may be remedied by utilizing interviews and other forms of ‘text’ (photographs, journals and recordings) to help with recall and analysis (Ellis et al., 2011). To prepare this chapter, I first constructed the so-called critical incidence accounts – emic (insider) biographical narratives which are analysed etically (from the outside) (Boufoy-Bastick, 2004) to identify what sits at the borders of psy thinking and doing. I also revisited the results of a rapid review of literature on social work and political conflict I conducted for my other work (details are provided below, as they are relevant). I also conducted an analysis of the four key studies on the reform of mental health services in BiH (Federal MoH and MoH RS, 2009; HNI and SWEBiH, 2000; HNI and SWEBiH, 2003; SIDA, MoH FBiH and MoH RS, 2017). In triangulating the information from these different sources, I hope I avoid one of the
key pitfalls of such ethnographies – seeing only what serves one’s purpose and providing claims
beyond evidence (Thomas, 1993 in Wall, 2008).

This methodology chose me, much more than the other way around. In order to prepare
for this chapter, I started writing snippets of memories which were, at first, free associations in
relation to the chapter theme, utilizing the lenses of border thinking and mad studies. Which
stories do I remember, which stories stand out that talk of these experiences beyond what was
already captured or beyond the mainstream? Those that made it into the chapter will appear
in italics throughout and, hopefully, offer further insight into the two key points noted in the
introduction.

Memory is also important when relevant initiatives fade or disappear from written or other
records – particularly if not available in English. One example concerns the memory I have of
visiting a four- to six-person group home in Sarajevo, initiated by a German charity immedi-
ately after the war in the late 1990s. It provided support for people who have spent most of their
lives in long-term institutions, to help them to remember or learn how to live in the commu-
nity. The local council promised to gradually take over its funding, but this never materialised.
The staff there hoped I could help them lobby the local government to ensure its continued
work. After initial reservations, all people who lived there started to share their lives with the
local community. The charity decided to close it down in the early 2000s. There needs to be
some memory, some record that this existed and mattered, shaped someone’s life. We need to
understand why such practices emerge and why they disappear.

Bosnia and Herzegovina (BiH) matters – and not just to me

I chose not to go into further details of the conflict, the ever-shifting numbers of casualties
and numerous atrocities against children and adults during the 1992–1996 conflict across the
whole territory of the country of roughly 3.5 million people. I wrote of those details in my
other publications. The sources for many of the interpretations and numbers of atrocities are
also relevant. Some involve non-BiH authors offering analysis and interpretation of the statistics
of war horrors for their own scholarship or for particular ‘users’ (for example, international or
supranational organizations). Others involve BiH authors which regularly get challenged as pro-
viding the view of only one (ethnic or other) side of the war.

BiH has wider relevance in relation to madness and political conflict. It is one of the rare
post-conflict and middle-income contexts – the latter being a relevant ‘identifier’ in the sphere
of development practice – which introduced a countrywide development of community-based
mental health services in the immediate post-war period (Cerić et al., 2001; Račetović et al.,
2017). Those experiences are particularly relevant as mental health is now identified as a global
development priority (The World Bank, 2016). This translates as follows – unless activists and
scholars within the field of Mad Studies establish contact and support their peers in war and
post-war contexts, their stories will be co-opted and subsumed within a triangle of psy-centred,
traditional (for example, cultural or faith-based) and development practices. And it will all be
done with the best of innovative intentions by mental health and development professionals.

Histories, madness, political conflict and the post-war
development in the BiH context

Former Yugoslav socialist health care system relied heavily on institutional care, including psy-
chiatric institutions. In BiH, they were initiated immediately after WWII (Cerić et al., 2001). If
BiH hospitals didn’t have capacity to take people in, they were sent to the larger institutions in
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Croatia and Serbia (Pajevic et al., 2010). Some psychiatrists played a particular role in the BiH war and, for example, in the Srebrenica genocide. Dr. Radovan Karadzic, wartime President of Republika Srpska (‘Serbian Republic’, one of the two BiH entities created during the war) used to be a psychiatrist at the Sarajevo Clinical Hospital. Many other senior figures in the Serbian Democratic Party (a party created by the Bosnian Serbs) were psychiatrists, too (Kaplan and Walter, 2012).

People who were in psychiatric hospitals during the war were, at least on one occasion, used and mistreated for political purposes. On 28 May 1992, Serbian forces ‘off-loaded’ (Pajevic et al., 2010:308) 164 people who were at the time ‘residents’ at the nearby Jakeš hospital in Tuzla, NE BiH, which during the war became an area predominately populated by the Bosniaks. All of the 164 people showed signs of neglect, hunger and lack of hygiene (ibid.). Local psychiatrists organized emergency care and housing for all of the people. By the end of the war, some of the 164 people died, while others were either supported to return to their communities or returned to remaining institutions elsewhere (ibid.).

In the aftermath of the war, a common response to the devastated housing and public service infrastructure in the mid-1990s would have been to rebuild mental health institutions. However, several things aligned so that another path unravelled for the BiH mental health services. The local WHO office was staffed by Italian Psychiatrists, who were aware of the importance of deinstitutionalization. Two key figures among BiH psychiatrists, Ismet Cerić and Slobodan Loga, were educated at the Maudsley Hospital in London, UK and also recognised the value of initiating community mental health services. People who were involved in radical practices elsewhere in former Yugoslavia, such as Vito Flaker from the School of Social Work in Ljubljana, Slovenia (who was involved in the Society for the Protection of Madness in Ljubljana in the 1980s) also got involved in supporting the reform. In one of the two main BiH entities (BiH has 14 layers of governance, 13 of which have authority to issue mental health legislation and policy), European funding was used to initiate Community Mental Health Centres (CMHC) within primary health care centres. As of 2014, there are 69 CMHCs across the two entities (Project HOPE, 2014). Services offered by the CMHCs vary, depending on local knowledge and resources; from individual psychotherapy, drop ins, group therapy, occupational therapy, to outreach and community crisis support/crisis prevention.

The hold of the psy-understandings and practices on madness during and after the war

Even if one doesn’t directly look for evidence of it, the dominance of psy-frameworks over madness and war is evident. In May 2018, I conducted a rapid review of literature on social work and political conflict. Utilizing the terms ‘social work’ AND ‘political conflict’ OR ‘war’, I searched for relevant articles and dissertations written in English via several search sites, including ASSIA, IBSS, PsycInfo, Scopus, SCIE and Web of Science. I excluded articles published prior to 1990, as well as those which focused on social work education, ‘war on drugs’, ‘war on terror’, ‘gang war’ and the growing US literature on Military social work. Despite the review not being directly related to madness, the majority of identified articles (274 out of 345) stressed the relevance of psy-understandings of people’s experiences. Studies focused on the psycho-social understanding of the impact of war on the ‘mental wellbeing’ of children and young people (e.g. Diab et al., 2015) or on studying these experiences through the PTSD label (e.g. Khamis, 2005). Indeed, the dominance of psy-frameworks and interpretations across all ages has been thoroughly documented (Attanayake et al., 2009; Betancourt et al., 2013; Johnson and Thompson, 2008; Seal et al., 2007). Medical labels, such as the post-traumatic stress disorder (PTSD), tend to dominate the ways that war-induced madness is understood and responded to (Foa et al., 2008).
Such understanding hasn’t been without professional criticism (for a summary, see Kienzler, 2008). In his overview of war and mental health literature, Summerfield (2000:232) stresses that the reframing of war-related distress as ‘psychological disturbance is a serious distortion’ of those experiences. Even interdisciplinary fields like global mental health have been criticised for over-reliance on the psy-frameworks (Mills and Fernando, 2014; Whitley, 2015). Critics have stressed that the individualization of the experiences of madness during political conflict and their processing through a psy-lens usually ignores their relational and social dimensions (Summerfield, 2000; Richters, 2001). Instead, they call for ‘social healing’ (Richters, 2001) through community and group-based mutual support, storytelling, as well as employment of social justice instruments, such as local and international war tribunals.

However, law is not necessarily an instrument of healing. Conceptions and mechanisms of ensuring social justice remain divided at the borders of different countries, societies and cultures, as well as across genders and social classes (Amadiume and An-Na’im, 2000). For example, Doucet and Denov (2012) note that in Sierra Leone, forgetting may be a culturally preferred way to ensure reconciliation and collective healing after the war. On the other hand, Amadiume (2000:41), citing both the South African Truth Commission and the tribunals for the genocides in BiH and Rowanda, condemns the policy of silence and denial of memory about Biafra, which, according to Amadiume, denied the Biafrans ‘the right to tell their truth and expose the wounds of the past’.

Attempts at alternative understandings tend to be framed by professionals – whether local or international – and remain within the dominant professional frameworks. For all intents and purposes, a commendably collaborative effort between international scholars (including a lead author from the US, as well as those from Palestine) recently resulted in a mixed-methods exploratory study which ‘develop[ed] and validat[ed] a quantitative measure of a new construct of mental suffering in the occupied Palestinian territories’ (Barber et al., 2016: e0156216). The theme and category they use to sum up the experiences of 68 Palestinians in the West Bank, East Jerusalem and the Gaza Strip is powerful – they call it ‘feeling broken or destroyed’ (ibid.). This phrase is likely to resonate with anyone who experienced war or other forms of prolonged political conflict. And yet, the article and the category remain bound by both positivist and psy- frameworks. While Palestinians who took part in the study emphasised that the political context plays the central role on how they felt, the authors still refer to it as one of the ‘domains of functioning’. Later in the article, authors describe how they measured ‘trauma-related stress’ using the PTSD Symptom Scale.

The construct of feeling broken and destroyed emerged through the interviews and an attentive exploration of local characterizations of suffering. The article can be commended for aiming to present local cultural understandings of own experiences, captured by and expressed through Arabic language. The authors do note that people who expressed such feelings did not ‘specifically elicit reports of mental suffering’ (ibid). Nonetheless, the authors ambition for future work rests in a perceived need and value in ‘elaborat[ing] and quantif[y]ing the correlates or predictors of this type of mental suffering’ (ibid). Politicians and professionals remain central to the interpretation and processing of war experiences among the civilians and soldiers. Making mental health a global development priority just gave such interpretation a first-class seat to travel across the globe, as opposed to opening a space to develop new ways to address the impact of war on people who experience it.

Professional control over how experiences are framed, explored, interpreted and labelled is also evident in the four key studies on the reform of BiH. Table 23.1 provides an overview of the study methodologies, key findings, and the role that people who use mental health services
### Table 23.1 Review of methodology and findings from the four key studies on the reform of mental health services in BiH

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<tbody>
<tr>
<td>Number of people who use mental</td>
<td>50 people, contacted via 5 CMHCs in the Federation of BiH (FBiH)</td>
<td>67 people contacted via 13 CMHCs across BiH</td>
<td>213 people contacted via 50 CMHCs across BiH</td>
<td>486 people, contacted via 13 CMHCs (356 people), 3 Hospitals/Clinics (92) and 1 Institute for Substance Misuse across BiH (28)</td>
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<tr>
<td>health services who took part in</td>
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<td>the study</td>
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<tr>
<td>Study methods</td>
<td>Semi-structured interview</td>
<td>Semi-structured interview</td>
<td>An international client satisfaction questionnaire (103)</td>
<td>Questionnaire from the WHO Study on Pathways to Care</td>
</tr>
<tr>
<td>Other engagement in the study?</td>
<td>No</td>
<td>One person with the experience of using mental health services was a member of the overall research team of 7. She helped create the interview guides, conducted the interviews with her peers, analysed the findings and helped promote the results.</td>
<td>One person with the experience of using mental health services as in the previous study was one of the 15 interviewers. Only professionals were part of the research team.</td>
<td>No</td>
</tr>
<tr>
<td>Key findings</td>
<td>Most people would prefer to receive psychotherapy as opposed to medication.</td>
<td>Both people who use CMHC services and professionals working there noted the prevalence of problems due to the war, especially poverty and social issues (lack of stable housing options, unemployment and poverty, in particular). People who contact the CMHCs are those directly affected by the war – refugees, internally displaced, former soldiers, civil war victims. Issues that led them to contact CMHCs include sleeplessness, nightmares, loss of family members. This also frequently leads to family problems. The most important method of work in the CMHC is ‘conversation’ (p. 18). People mentioned being hospitalized as refugees while abroad. When asked why they visit the CMHC, people answered by using their psychiatric label. PTSD or war was noted by 15.5% (17). Two-thirds (65%) noted that they were hospitalised in the past and ‘some’ (p. 29) people noted that this was a bad experience for them, as they were beaten, tied, had food withdrawn from them. Advantages of the CMHC are the warmth and humanity of the staff (59.1%), contact with people who have similar experiences (11.8%) and group activities (11.8%). A lack of peer support organizations is noted as the least favourable thing about the CMHCs.</td>
<td>The study and the results focus on where and from whom people seek mental health support. Nearly half (46.8%) of people first sought help from their GP. 6.5 percent noted that their first source of support was a religious healer, 1.5% that it was a herbalist and 0.6% relied on homeopathic support first and foremost. 18.5 percent had secondary psychiatric services as their first point of call.</td>
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played in each study. No people who have personal experience of using mental health services were members of the research team in the first and the last study.

All but one study uses the established medical language and terminology to seek people’s views and share the results. In the HNI and SWEBiH (2003) study, I was the main researcher and, hence, was able to include Halida Vejzagić, one of the members of the National Association of people who use services (which existed at the time) in the research team. She took part in all parts of the research process – creation of the methodology, data gathering, as well as data analysis and promotion of the results. It remains the only study that mentions any other aspect of people’s lives, particularly the impact that the war had on housing, employment opportunities and poverty.

All studies concluded that people appreciated the support provided within the community-based services, particularly when compared to hospitalization and institutionalization. However, from the mid-2000s, external funding for the reform was slowly coming to an end, increasing the on-going pressures on both people who use and people who worked in the community-based services:

I met the staff of one of the Sarajevan CMHCs during the data gathering for the 2002 Assessment of all BiH CMHCs. An all-female professional team, including a psychiatrist, psychologist and several nurses loved their work and felt passionate about their CMHC and people who visit it. They were plagued by the lack of resources they had and a lack of understanding among other services housed within the same primary health care centre. As they saw the value in offering a variety of support, they worked extra hours. Many people who visited the CMHC lived in extreme poverty; the staff would use their salaries to feed people who came to the Centre, as well as to buy toiletries and other supplies that people needed. Many knew that they can’t continue to work this way. They faced challenges by their own families and colleagues from other Health Centre services. When I visited the CMHC again, several months later, most of the staff were on a long-term sick leave.

Nermin (pseudonym) is in his early twenties. He has spent his teenage years as a refugee in the UK, on his own. He is clever, ambitious and eloquent in several languages. He also looks and presents much more as a geezer, than a young Bosnian. He misses his life in the UK. The reason he came back is painful and unraveled slowly. He became mad and was carted off home, to Bosnia, against his wishes. Another kick follows only a year later. Nermin was convinced that, if only he had a job, if only he was able to work, all would be better. He’d feel better, if only there was a job. And now he has found a job – and he is definitely not better, not only according to other people’s opinions.

Cut to low simmering anger, pain and loss, threaded at the floor of every conversation … What was lost, what was warped. Things that cannot be repaired, for which no justice can be found. Helplessness and pain running as a current at the core of everything, peppered with clever and warped humour. Can’t move for it. ‘Šuti, dobro je’ (Hush now, s’alright – a difficult to translate universal Bosnian response to majority of life’s joys, problems and outright disasters).

The Centres still exist, as do collaborative practices between mental health practitioners and people who use services, although only one Association remains of the original seven (including the National Association) run by people who have used or use mental health services. Nonetheless, the psy-understanding and practices still have a hold and it’s due to get
even stronger. In mid-2018, BiH signed a Memorandum of Understanding with the Council of Europe to fund the reconstruction and equipping of six psychiatric hospitals across BiH (Vijesti, 2018).

The trouble with development

How did we come full circle? In part, it is due to the dominance of psy-understandings of madness and political conflict. However, it is also due to the fact that the reform was primarily a development ‘project’. Implementation of all development reforms in BiH and research on them have been rightfully criticized as driven by donor priorities and agendas (Papić, 2001; Sampson, 2004). BiH is not an exception; this is common in wider development practices (Mosse, 2011). Reforms in post-war contexts tend to focus on a specific theme, implemented through short-term projects, lasting one–two years. Frequently, major support is withdrawn after this period, or significantly reshaped. Such changes are set in a top-down manner, rather than based on increased knowledge of the local contexts and people’s actual needs.

One of the key international organisations which supported the reform created a local organization in 2002 ‘to ensure sustainability’ of their work during (organising and providing counselling support) and after the war (support for the development of community mental health services). Within the next year, post-war mental health was no longer ‘sexy’. There were other conflicts and more pressing needs elsewhere. Under new, local, management, and due to a lack of available funding, the organization followed the money and, from 2003, started a project which provided repairs and equipment for children’s hospitals.

Furthermore, mental health reform wasn’t joined up with other reforms. Social care reforms focused almost exclusively on child and family services. Long-stay social care institutions for people with learning difficulties and people with mental health issues provided continued options for institutionalization in this sector (BiH Ombudsman, 2018). Politicization of benefits, particularly for former soldiers, results in further inequalities when it comes to poverty alleviation and in-kind benefits (Hronesova, 2016).

Mirjana (pseudonym) is a local poet in her early thirties who I met at the Day Centre at the Psychiatric Ward of the Clinical Hospital in Sarajevo. People remember how cool Mirjana was in her early youth, prior to the war and first experiences of the local psychiatric clinic. They remember her poetry and her presence around town. She still lives in her own flat, but it has burnt to the ground – not during the war, but because Mirjana managed to burn it down using a makeshift stove. She doesn’t trust anyone who tries to visit her but loves to visit the Day Centre. When a newly established drop-in shares its space with an office of the community mental health reform project, she likes to pop by the office and to diagnose the staff working there with a variety of DSM labels. They are not fans of her expertise. Professionals describe her as non- engaging, and other people who use services don’t want to spend time with her as she talks too much and doesn’t wash regularly. With all the reforms, no one manages to establish a relationship with Mirjana, until she is carted off to a social care institution where she later dies. This is possible as, despite the reform of mental health services, long-stay institutions still exist in social care.

In the chasm between the psy- and other professional understandings of madness and those caused by development practice agendas, people’s own experiences remain out of sight, unless
telling a narrowly defined ‘success story’ of a particular reform intervention. While many of the reform initiatives provided valuable support and changed the ways in which (some) professionals in BiH engage with and understand madness, there are also people who either fall prey to religious ‘exorcism’ of madness (see Table 23.1) or whose experiences are institutionalized or otherwise marginalized, yet again.

I leave you at the borders

In hindsight, I realize that I have lost a valuable chance to do two things. First, I lost an opportunity to record and archive some of the experiences and practices that existed only for a brief while, details of which are lost to my memory, my existing documentation of the reform, within online repositories, or to the memories and archives of people I shared these experiences with. I already provided one such example earlier in the chapter. Second, any archives of people’s stories I have helped to create were always processed for a particular funder and a particular, professional, political and/or donor, audience. Hence, by necessity, the ones I share here rely on my memory and those reports. While they are memories of how people shared their stories with me, they weren’t committed to my memory or shared with others on people’s own terms, how they want their stories to be remembered.

Stories of war and madness within the discipline of mad studies are yet to be written, related practices are yet to be created. While any blueprints need to be avoided, there are certain ingredients:

- They need to start and remain devoted to the experiences and needs of people who experienced political conflict and madness, at a minimum through co-production.
- Stories of war and madness will have to find a way to stitch across political divisions and manipulations, present in all conflict and post-conflict settings.
- At least some will have to focus on supporting people in distress within their communities – even at the times of severe distress – as well as poverty alleviation and mutual support within the community.
- All those stories and practices will have to carefully circumnavigate psy-understandings and practices, as well as the development ‘project’ format, as funding for such initiatives is likely to stay exclusively based in Western and Northern Europe, North America and Australia. They will also have to carefully navigate collaborative and co-produced practices between people who use mental health services and mental health professionals. In many contexts, including BiH, mental health professionals are ‘a given’, and coproduction is enacted solely through the acceptance of psy-frameworks.
- Understanding of international collaboration will have to be redefined, making it mutual, equitable, inclusive and co-productive, rather than colonial. Collaboration has to be led and initiated ‘from within’, but supported from the ‘outside’. The international aspect of collaboration should focus on amplifying ‘insider’ experiences and voices, so they can be understood and supported more widely.
- Any such collaboration also needs to be intersectional, not least to consider the gendered experiences of both political conflict and its impact on the post-war livelihoods.

Finally, stories of war and madness may not be readily available for immediate sharing, particularly not through words. They will require relationship-building, trust and numerous stumbling attempts (of which this truly is one) over a prolonged period of time. Hence, it will also require new ways of exploring our own experiences through practice and research. Autoethnography
was my current choice – but not an easy one, or one I’d settle for. While some authors (Ellis et al., 2011:273) see it ‘as a political, socially-just and socially conscious act’, in both practice and research, I think mad studies has potential to become much more creative. So – to be continued.

References


Project HOPE (2014). Mapiranje stanja pruzanja usluga u oblasti mentalnog zdravlja u Bosni i Hercegovini.


