A first, gut response when I heard the word ‘Mad’ was a shudder and a rejection. In sound you do not hear the case – lower or upper, the word is pure sound carrying culturally relevant symbols. It conjures images, ideas, faces, eyes, reactions. It is not neutral, for ‘Mad’ means something to everyone. I cannot jest about it, and for sure I cannot call anyone ‘mad’ – nor claim it for myself. Perhaps it comes from being *there*, having seen the other side, been called so. What may seem ‘mad’ to another made perfect sense to me when I was *there*: what others saw as my ‘madness’ then. I know there is a logic going on – regardless of whether it makes sense to another.

I write this piece with this attitude, as I walk amid peers, amid families, among contributors to my research, and also the ordinary citizens of my country, as one of them. We are a segment of humanity that suffers the sheer inhumanity and injustice of this unequal world – a world which wants to trim us all to one size. I walk in reflections, in reverie, tuned to sounds of people’s helplessness amidst the cruelties of daily life, as families covertly medicate loved ones, as heartbreaks, crop failures and exam failures push farmers and young people to suicidal leaps, youth are murdered to defend family ‘honour’ … tales of never-ending loops of injustice, which only connect with one another in seamless continuity, offering no respite, no exit and no deliverance.

*Is ‘mad’ only a word, not experience?*

We all know the word ‘mad’ as an inherited construction from earlier generations and with it a way to look at people. It is not like the word ‘cloud’, or ‘rainbow’, or ‘flower’. There is a disturbance inherent in it. Is it anger, or deep suffering? It seems to reveal an attitude of incomprehension and impatience, rather than an attempt at understanding someone. It is certainly not a noun, only an adjective; an emotion, not a state of being. Someone may have a mad moment, or a mad phase – they don’t *become* mad. They do not change permanently into a phase. They remain who they are at a fundamental level. I seek that core in everyone and rejecting the word...
'mad' in all its variants comes to me from that heartfelt location. Naturally now, it seems a great dilemma to encounter ‘Mad’ politics, or to embrace it.

Ever since I entered the domain of Mad Studies, trying to understand the field and its players due to doctoral research, I am troubled and puzzled by the long history it comes with. Had I not had this opportunity, would I ever have known about the resistance against psychiatry, which is hardly present in the world I come from? Two decades of patient- hood never made me question psychiatry, for I believed it would bring me to a clearing. Even when I ‘recovered’, among the first acts I performed was to write about myself, in the belief that possibly I was one of those rare exceptions who could. So it became a little bit of an identity assertion – and carving a new identity, instead of a patient’s identity. The next thing was to look for others who trod the same path. That proved a little humbling, for it brought me down a notch or two to know that I was not so unique after all. It also pointed at a fork in the road – from a personal to a social project. This makes me think at times that if I took such a long path to unravel the colonial nature of a medical specialty, how many others will have to labour alone, and for how long, before they come to similar clarity? How can people look beyond a hegemonic discourse? Who will understand that the discourse is what dominates and not a solution to their suffering? Rather than being embraced as an equal, asserting one’s identity as ‘Mad’ in such a scenario can only lead to further isolation, or further domination from above.

Searching a name to call myself

I never look upon myself as a psychiatric survivor, because in ‘survivor- hood’ I hear a victim’s voice. I see myself as someone who, by dint of labour expended over decades, emancipated herself. There were passing friends but not a single peer. Later when peers appeared, I could not comprehend their ideas, for mine seemed such a personal journey to overcome suffering and rehabilitate. It was a much longer journey of inquiry whose path appeared through the labyrinth of research that introduced the radical perspectives going around the globe, research I have done alone at home, for decades. I write this to highlight the relative lack of a social movement questioning psychiatry, which can reach most psychiatric patients. And considering the size of India, the geographical separation between people and the social differences due to education, worsened by local factors like caste, religion, language, gender, and other identity-based conflicts, keep people away from one another more so, while radical ideas remain confined to a minuscule few.

As I write this, I think of scores of people, and wonder who among them would like to echo the word ‘Mad’ back to me. The only images that come to mind are the well-heeled, sophisticated, globally mobile, urban Indians; the tiniest minority among them. When I remember the crestfallen faces of people standing in long queues in government hospitals at the crack of dawn, of parents fervently struggling to get medicines in the hope of a relief for their children, of young people craving to be heard, of fathers/husbands who are fearful of their child’s/wife’s ‘psychotic’ fury, I know what the word ‘mad’ means to them. I doubt any one of them would want to claim it for themselves or their loved ones. Everyone wants to distance themselves from the experiences, or from even a hint of any experiences that could associate them with a stigmatizing identity.

Few have the courage or wind in their sails to first identify, then fight oppression at a personal level, and thereafter social. The struggles of being alive in a decent manner in the third world are so big, that to think of dealing with any systemic violence is not only beyond our comprehension, but also beyond the scope of our resources. As a society in which a majority struggle for the essentials of food, shelter, safety, livelihoods, clean water, air, housing and so
much more, day-to-day living produces enormous challenges. If anyone perchance overcomes a diagnostic oppression while being aware of it, in all likelihood whatever it will take us to rebuild our life from that shattering is by itself such a daunting climb, that we would be vary of doing anything with mental health ever again.

All that I am saying is that ‘Mad’ as an idea or as a response to an oppression has only a symbolic presence in our society, and then not in a truly radical, emancipatory or visionary manner; it is an identity category that a few uphold. And sadly enough when we choose ‘Mad’ as an identity or self-representation in a society where the business of living produces an absurd/mad behaviour at every juncture, it does not evoke camaraderie, respect or solidarity, but rather a fear and a distance from those who truly need the emancipatory vision of ‘Mad’ politics.

There are two issues that I set out to distinguish here: the issue of ‘Mad’ as an identity category and the politics of Mad Studies. Whereas I reject and steer clear of the former, I resonate with the latter, without feeling a need to position myself as a ‘Mad’ person. Neither do I accept ‘Mad/mad’ as a description for others nor myself. I believe, in the context where I am situated, and possibly other locations, the ‘mad’ word evokes what Fricker (2007:4) calls an ‘identity prejudice’: a label for prejudices against people of a certain social type. ‘Mad’ clearly produces a certain ‘othering’; based on cultural stereotypes and the majority of people distance themselves from anyone labelled ‘mad’. Where they don’t adopt a social distance, a benevolent paternalism often enters into in their descriptions of ‘such’ people – ‘poor … unfortunate him/her/them’. I prefer to use the word ‘mad’ within inverted commas, along with other words that label a person in different categories of ‘madness’. I believe ‘mad’ is someone’s view of another, not an objective truth about anyone – nor is it permanent or unchangeable. There are many complexities in the day-to-day lives of people who negotiate the micropolitics of mental health, often struggling to be heard. Having personally experienced these individual and group struggles makes me desist from using ‘Mad’ as an identity label, or even a tool of resistance anywhere.

Experience teaches me that in India the community of mental health activists who oppose psychiatry in India, is somewhat fractured, and frequently people do not support, embrace or even recognize one another unequivocally. This makes a number of us seem like lone wolves or solitary warriors, speaking a language with limited social recognition or connect. For example, in response to one of my published pieces of writing one person wrote in a social media message – ‘Excellent … It is up to each of us to change perceptions and change the world’. The attitude that words like these reveals is what I have called the ‘lone wolf syndrome’ above. It lacks a realization that organizing together is the most important resistance we need to focus on. If we really believe that singlehandedly we can change perceptions or change the world, this only indicates our deeply entrenched neoliberal individualism and self-aggrandisement. This does not augur well for collective action, and betrays our collective capability for organized struggle.

It is from this personal self-reflection that I derive the sensibility of resisting the ‘Mad’ label in India. I also wish to urge caution about our organised resistance. We could respond to every idea as an act of concern, caution, foresight and cultural meaningfulness, lest we end up choosing precisely that which distinguishes us as the very category we fight against.

**Micropolitics of mental health**

‘My wife Kirti is bipolar Madam,’ and I think you may be able to help us’– Sameer, 41.

‘Madam, I do not have anything, but my husband doesn’t understand’ Kirti, 37.

‘I feel lighter after talking to you, …(for)nobody asked me in all these years why I jumped into the lake. It seems as though nobody wants to know’. Yash, 25
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‘I never wanted to specialize in pediatrics, but my father wanted me to. In me he sees the fulfillment of his dream of becoming what he could not. So he started sabotaging every decision I wanted to make for myself, including taking an exam to enter into a specialization of my own choice. When I took up an internship in a hospital he informed my seniors that I was on drugs for schizophrenia. One senior resident asked me quietly whether I was on medication. When I asked him why, he said, “your father called and told us about it.” He made it impossible for me to work there’. Ajit, 26

As a peer therapist I am not listening for any hints of ‘illness’, but looking for the roots of suffering. Everyone who watches a loved one suffer, suffers thus and wonders what they can do. A majority take the familiar road of ‘treatment’, and when in years it does not produce the outcomes hoped for, another search for alternatives begins. This is how some knock at my door. In the beginning it is difficult for anyone to understand why I say they are not ‘mad’ – for them their actions and behaviours, or those of their loved ones certainly seem to fit the description.

By the yardstick of where I am, neither the idea of ‘recovery’ nor the term ‘peers’ mean much. Few believe that people can ‘recover’, or that it is feasible or within everyone’s reach. The landscape resounds with simplistic, biomedical representations of mental ‘illness’, or at most, a rights driven perspective to delivering mental health services, another guise for pushing the Global Mental Health agenda. The vast majority of stakeholders within mental health, which includes psy-professionals led by psychiatrists, and other groups such as patients, caregivers, non-governmental organizations (NGOs), bureaucrats, legal experts, etc. demand more psychiatric knowledge, information, access to treatment, and enhanced infrastructure. People unquestioningly believe the organized rhetoric of the ‘treatment gap’ which ominously points towards a rising incidence of mental illness or panic mongering that we are socially under-equipped to deal with the vast numbers who are going to be afflicted. In 2017, our Mental Healthcare Act was passed in the Parliament, a seemingly democratic legislation, which few understand, has only given more power to the psychiatric profession. The word ‘recovery’ does not appear in the Act at all. The social clock ticks audibly and everyone from politicians, the media, the youngsters and kin of those labelled are scouring the internet – self-diagnosing, or looking at others through diagnostic lenses. The anxiety to be diagnosed, medicated and educated is all pervasive.

What are they all looking for? For confirmation or for signs of an ‘illness’? The influx of the internet in a society with limited education and a nominal ability to question authority has made the task of global psychiatry rather congenial. Any mental health issue is just a google search away, and there is an avalanche of patient groups on the internet and social media, parroting psychiatric propaganda and knowledge with zest, confidence and belief. Moreover, the internet is full of self-administered tests so that ‘[w]ith self-help quizzes and professional diagnostics mirroring each other, we may be “quizzing ourselves sick”’ (Reynolds, 2018:9). Many of the young people I interact with have first been ‘diagnosed’ by their families, or themselves, via these ‘helpful’ internet quizzes and have later consulted psychiatrists, seeking confirmation of their beliefs.

Challenges of traditional societies

Traditional societies often have a set of problems stemming from tradition, which is of the essence here. To question tradition is to threaten social order. India has traditionally been an agrarian society in which village communities formed the social ecosystem and everyone who
was part of that network was taken care of. Villages often had common resources, a village
doctor or ‘vaidya’ among them. They would take care of all health needs of the people and
make appropriate recommendations to deal with illness or other health conditions. A doctor’s
occupation was accorded an honourable status due to this ability to relieve suffering and bring
healing. Doctors and teachers have been venerated in our society, and both have been very
closely integrated within the communities they lived in. Somewhere at the back of the col-
lective unconscious of Indians we still believe in these values. With biomedicalization fur-
ther accelerated by the neoliberal agendas that recently independent countries have eagerly
embraced, most patients and families still look up to doctors as savours, healers and ultimate
arbitrators of their wellbeing (see Nagarajan 2018). One cannot argue with another that their
doctor is wrong, misleading, or does not know how to deal with their problem; it is quite
unthinkable.

Me: ‘You never questioned whether the medicine is working for you or not?’
Megha: ‘Oh no not at all definitely, not at all I haven’t questioned the medicine … but …
what is happening, what is happening?
Me: ‘I mean but listen … you have been on medicine for long time, right? It’s almost 25 years
… do you see that it has worked for you in any meaningful way or do you…”
Megha: ‘Yeah, yeah I trust my doctors and I think this has worked for me.’

Psychiatrists in India have few critics. Violations and inhuman stories about their treatments
are audible if not rampant, yet the scale of numbers is such that their numerical insuffi   ciency
becomes a bigger issue than the day-to-day violence their methods inflict (see Davar 2012,
2015). This is the micropolitics I refer to, which individual patients/families have to negoti-
tiate, surrounded by a macro environment that offers next to no alternatives for them, other
than what they are already oppressed by. This is the backdrop to our cogitations about ‘Mad’
politics.

Carving a ‘mad’ identity

‘Mad’ activism, scholarship and views occupy a tenuous position in society. Whereas in the
Global North (North), where ‘Mad’ struggles have incubated and germinated, they appear
to have gained a modicum of respectability, presence, recognition, following and possibly
bargaining power,” this is not the case for rest of the world. It is beyond the scope of this
writing to analyse the cultural differences that lead to such disparities between the North and
the South, but it may be remembered that societies of the South are highly unequal societies,
unlike the North where centuries of industrialization and planned development have facilitated
access to a relatively decent, dignified life for a majority of people. In the midst of such diver-
sities, any representation of ‘Madness’ in one part of the globe cannot simply mirror the social
complexities of another part of the globe.

In India there is a relative absence of social critique of psychiatry, and this cannot be stressed
enough. In fact, psychiatry commands pride of place in the public mind, and appears quite
unassailable. But our society being as unequal as it is, brings in many interlinked issues in
aspects of social representation, in particular class privilege. In a fragmented, iniquitous and
class-conscious society when someone dares to adopt a label that is otherwise a social taboo,
they do not usually belong to a socially oppressed or marginalized segment of society. Their
ability to defy social mores is usually an outcome of class privilege, which goes unrecognized.
If a humble, small town or economically necessitous person thinks of calling herself ‘Mad’
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publicly, she would in all likelihood end-up being lampooned and ostracized further. But if the same thing is done by a person who is in a more powerful position, due to education, financial resources, family connections and/or global mobility, people would just shrug and think, ‘well this is what she wants to do’. While there is no doubt that the identity model contains some useful insights, it can also end up reifying group identities and obscuring the fact that we need distributive justice in society.

Fraser (2000:109) reminds that identity is constructed dialogically, through a process of mutual recognition. Recognition from others is essential to the development of a sense of self. To be denied recognition – or to be ‘misrecognised’ – is to suffer both a distortion of one’s relation to one’s self and an injury to one’s identity. There is no doubt that in the initial decades when ‘identity’ became a tool of resistance, it empowered millions of people worldwide on grounds of race, colour, ethnicity, gender and much else. But that phase seems over. We are at a juncture where the politics of identity has reached a phase of maturation; voices once at the margins are increasingly being heard. In mental health, this moment has still to come in all parts of the world. But when we look at this issue within the large umbrella of identity politics, it must be borne in mind that there are no level playing fields. There are major differences between and within the North and the South; differences due to other interlocking variables such as class privileges, as I noted earlier. People within the North or South are not equally marginalized, neither can any group in any location represent all.

Identity politics inadvertently undermines group cohesion among marginalized populations and entrenches social class, confusing vast numbers of people about its message. A lack of consensus about one’s social location and identity mostly ends up further consolidating psychiatry’s powerful position in society. Fraser fortifies this argument saying that

the identity model serves as a vehicle for misrecognition: in reifying group identity, it ends by obscuring the politics of cultural identification, the struggles within the group for the authority – and the power – to represent it. By shielding such struggles from view, this approach masks the power of dominant factions and reinforces intragroup domination. The identity model thus lends itself all too easily to repressive forms of communitarianism, promoting conformism, intolerance and patriarchalism.

(Fraser, 2000:112)

As a researcher explicit about her ex-patient status, I am either met with caution, confusion or curiosity. To some I seem suspect and possibly in remission. If not, then it is attributed to other things such as my classical music training that I have recovered. If in such a milieu I were to further suggest I am ‘Mad’ I doubt anyone would see me as anything but ‘mad’. Is it even remotely feasible for me to operate here as a researcher or peer-‘therapist’ and call myself a ‘Mad’ person? I have noted elsewhere (Sharma, 2019) the prejudice associated with ‘mental illness’ is not confined to current patients; ex-patients are well within its ambit. If an ex-patient additionally goes around calling herself ‘Mad’ – would anyone understand what it implies in a milieu where psychiatry’s wisdom and leadership is unquestioned, hegemonic and a beacon of hope for the vast majority? On the other hand, if I were to position myself as ‘Mad’, who would understand the subversion and not think here is another ‘mad’ person. Since I offer support and services to peers the least I can do is to reveal my calm and healed side to the world, not necessarily the anti-oppressive radical I may be, who brings that approach to understanding their oppressions and not to identity politics.
How ‘mad’ are you – ‘mad’ or ‘Mad’?

‘Mad’ as represented by those who oppose psychiatric hegemony, is a subversion of the labelling or condemning as ‘mad’ and an invitation for scholarship, activism and an alternative representation. Le Francois et al. (2013:10) affirm that ‘madness talk and text invert the language of oppression, reclaiming disparaging identities and restoring dignity and pride to difference’. It is symbolic of collective anger against a dominant, socially embedded worldview. It makes sense at a philosophical level, and I feel a resonance in spirit. But coming from a part of the world where the word ‘mad’ has many synonyms in any number of languages, it is not possible to distinguish between ‘mad’ and ‘Mad’ in my plural linguistic landscape. Here the label ‘mad’ may be seen to be the same as the angry, reclaiming, collective, challenging ‘Mad’. Being in India or possibly anywhere where English is not the only language spoken, one may have to think again before claiming publicly that we are ‘Mad’ scholars, activists, researchers or that one can take pride in a ‘Mad’ label. We don’t raise our voices here by changing the case alone; we need to build a syntax of resistance. But before that we first need to establish the contours of a framework within the scope of which all resistance is carried out and within which we can locate our positions.

People who can look beyond psychiatric rhetoric are a minority anywhere. Barring pockets of visible resistance in industrialized countries, those opposing psychiatry, far from locations of such organized opposition, either remain silent, withdrawn or outnumbered to such an extent that their resistance becomes invisible. The larger community of mental health ex/‘patients’, caregivers and/or stakeholders may not understand what they are talking about or why. To confound the picture further, since they also want acknowledgement, inclusion, recognition and support of the same people as the more dominant and well-resourced psychiatric community, they find themselves on the same fora as the dominant groups. Unfortunately, in this dissonance their voices compete with many others ‘representing’ mental health issues. Few are able to discern or even engage with ideas that reject ‘madness’ as a category, or the challenge such voices offer to psychiatry as a whole. One can imagine this marginalization of radical views to be widely present in the South, especially now that global psychiatry, under the wingspan of the Global Mental Health Movement is projecting a benign, humanistic, human rights oriented perspective – claiming that in treating people ‘respectfully’ it is restoring their dignity, which was taken away by previously inhuman and ‘unscientific’ ways of treating the ‘mentally ill’.

There could be two levels of resistance, even within a ‘Mad’ framework. The first, as I note above, is a collective challenge to psychiatry – an opposition established in the Global North for at least a few decades. The second from my perspective is a need for caution among those who resist psychiatry in the South. I propose that as former colonial subjects, we may also have to be wary of the ‘Mad’ perspectives of our peers from the North – a naïve mirroring of their language, tools, methods and ways is not likely to cut much ice here, if to include our local peers is one of our goals. Here people balk at the mention of the ‘mad’ word, for it evokes a deep cultural stigma. Moreover there is, as yet, no opposition to psychiatry here – to build that opposition, by spreading awareness is perhaps the first act of resistance we need to consider, towards an emancipatory goal of restoring epistemic justice to ourselves and our peers.

And how could such a resistance come about? For a people colonised by biomedical psychiatry, we live a reality where identification with the coloniser is axiomatic. A question of resistance can arise only with an awareness of colonization. This knowledge about colonization, or the ability to recognise one’s ongoing oppression, is a goal whose pursuit is the need of the hour. Unless the subjects of a particular worldview understand their oppression, unravel how they are not safe in their relationship with the coloniser, they can never understand why they
continue to suffer whilst the coloniser prospers. Instead, they continue their self-acceptance of subject-hood and submit, in effect, to a perpetuity of psychiatric practices. Finally, it comes down to the idea of education, or as the social reformer and framer of India’s constitution, Dr. B.R. Ambedkar said, ‘educate, agitate, organize’.

De Lissovoy (2010:203) warns of the problem one has to tackle in an inhuman world, to raise ‘a voice against the truth of power, the dead and finished truth of what is decided, the truth of the inert and incontrovertible’. And though everyone who shares an emancipatory agenda understands power, more significantly he adds that,

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\text{[t]he problem of education is the problem of unwinding the human body and soul from this intricate clockwork of not merely the correct and commendable but also the apparently self-evident and inevitable. It is the problem of rescuing being from what is, a what is that has conquered every other possibility to give itself the status of fact and truth. This what is not just an apparatus of painful training; it is a machine of assimilation and destruction. (De Lissovoy, 2010: 203)}
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For those of us who offer a resistance to psychiatry, this ‘being’ translates as being subjects of psychiatry. Accepting it as a truth people accept what is and that which requires ‘treatment’. The acceptance of mental illness is what needs to be questioned foremost. In what manner can we rally others around this by calling ourselves ‘mad’, ‘Mad’ or ‘Mad proud’ is something I am concerned about, for I know its polarizing potential in my location.

**Holding the hands of peers**

A personal passage is a point of entry into emancipatory resistance; but it need not be the only one. Personally speaking, this spectrum has being a patient at one end, to becoming a healing-oriented collaborator at the other. It passes through stages of becoming an ex-patient, progresses as one slowly starts questioning what is, and learning to distance oneself from the reductionism of mental illness. I wonder whether the differences people have in their self/representations come from the position/s we occupy on this spectrum of psychiatric persecution. There are some who have met the benign arm of psychiatry who completely believed it would bring deliverance someday. There are others who have been violated and coerced into psychiatric subjugation, never believing their labels, yet outnumbered to fight back alone. Perhaps a majority of our peers in the North belong to the latter and a majority of us in the South to the former groups? No two peoples have identical situations, yet we can all find something in common, without privileging anyone and remaining cognisant of our social differences. Perhaps we could make that a starting point for a common struggle?

Being a peer-therapist has been a complex experience and has entailed coming to terms with new realities, for there are social differences even here that I am beginning to understand. One of my findings is that the road to supporting one person make the crossover, from a refugee of psychiatry to questioning psychiatric finality takes time, patience, support and careful mediation of crises. Time and again I have understood how the struggle of a person spills over into their family. In India, you don’t usually work with solitary individuals, but with families closely enmeshed with all aspects of a person’s life. To support one, you interact with all, and help everyone see the situation differently.

Just like a boatman (also called ‘majhi’ in India) helps people cross a river on his boat, a peer who works in supporting others does likewise, by helping those passing through stormy
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passages of their lives. The boatman in India is also presented as a guide who leads you to the other side of the river, giving you a new direction in life. Just like a boatman we hold one person, one family at a time and help them tide over their turbulence, trying to keep ourselves calm through it, for we have waded through the waters many times ourselves.

**Embracing politics, leaving the label**

At least we can learn about the power of a label from our experiences of psychiatry, and how that label can rob us of our selfhood. Would I take another label, also framed in psychiatric language, to resist? Do I even want to counter psychiatry? If one believed that psychiatry is only a consensus among certain people whose interests are served by viewing human suffering through a diagnostic lens, can we create another consensus as a viable alternative? Certainly there is no harm trying, but do we want to expend effort in fighting it? What sort of resources would such an enterprise require? Will we ever be able to come close to the kind of resources psychiatry has at its disposal, and the institutional mechanisms to enable them? Would we rather not create an alternative which does not pathologise distress and call it names? This is the invitation from ‘Mad’ politics I have taken up.

To embrace politics means to recognise the polarity of power, and on what axis it rests. If it is oppression, does it merely emanate autonomously from a so-called medical specialty, standing alone by itself? Or does it arise and get bolstered by the global flow of capital? To weave all these disparate ideas together we need an overarching frame, towards which ‘Mad’ Studies appears to nudge us.

**The personal as political?**

Without political consciousness and an emancipatory vision, the personal does not become political. In the initial feminist rallying cry this phrase was used as a consciousness-raising activity, ‘a form of political action to elicit discussion’ (Napikoski, 2019). Until people are philosophically convinced that something is the matter with their treatment regimens, nobody will raise a voice against wrongdoing, for they wouldn’t understand it as wrong. No political consciousness that is unaware of its economic base can have a clear or radical vision, because its goal is not universal but person-centric.

If social emancipation be our goal, then personal empowerment is only the inauguration of a longer struggle. To continue that journey by embracing others, for the personal to become political, we need to challenge the individualism inherent in it. Otherwise narcissism may not permit us to go beyond identity politics. By collaborating with each other will we be ready to build a global axis of resistance. But until we work in that direction with a plan and a path, we underestimate those who we resist. The forces we oppose continue to organise more and more, with a capital base we can never fathom. To oppose them what else do we have? It has to be more than an assemblage of ideas and words from the labels they imposed on us.

We create an alternative to this scale of power by arriving at another social construction, and work out pathways to disseminate it. The new lexicon could respond to the material differences between the North and the South, which are not financial resources alone. These include knowledge, and access-related issues, inherent social inequalities, multiple axes of social injustice in the South, (possibly in also the North in a different manner). Assuming a lexicon is underway, we would be wise to be cautioned by Morrison (2008:xi) who notes that, ‘“[m]ental patients” who resist treatment and insist on speaking for themselves against mental
health practices are particularly feared and misunderstood’. We need not imperil ourselves further by being feared by both our peers and oppressors. Instead the task ahead, as I see it, is to build solidarities against all forms of oppression – whatever is possible wherever, and struggle for a universal emancipation. Nandy (1983:xiii) reminds that, ‘the meek inherit the earth not by meekness alone. They have to have categories, concepts, and, even, defences of mind … within the traditional world views still outside the span of modern ideas of universalism’. Our task appears clear; for among us lie the seeds of the future.

Notes

1 I prefer this to the more sophisticated ‘Global South’ which is spoken of to represent the ‘developing’ countries.
2 It is customary in India to address a woman in a formal role as ‘Madam’ or ‘Ma’m/Ma’am’ instead of using first names. Ordinarily first names are used only within families and friends.
3 Names and other identifying information have been changed.
4 Even though I use this phrase, it is to indicate a professional position, which foregrounds my experiential knowledge. Neither am I a peer nor my work has a clinical connotation or therapeutic claims of psy-professionals. I work with an emancipatory sensibility towards ‘recovery’, while ensuring that people do not linger on as ‘patients’/clients with me for too long.
5 The only services available are pharmacological treatments.
6 Though by all standards from all that I have read, studied and understood this is not the case even in the North.
7 The italics are original.
9 Taken from https://en.wikipedia.org/wiki/B_R_Ambedkar, on 26 January 2019.
10 My personal experiences see the engagement of family as the predominant social network of a person in a vast majority of cases. The role of friends, or any other networks does not appear so significant. I say this with observing both my social, research and counselling experiences. In all cases I have interacted with families.
11 Taken from Archives and Research Center for Ethnomusicology, via vmis.in/ArceCategories/music_in_context_innercat/97. Accessed on 7 October 2018.

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