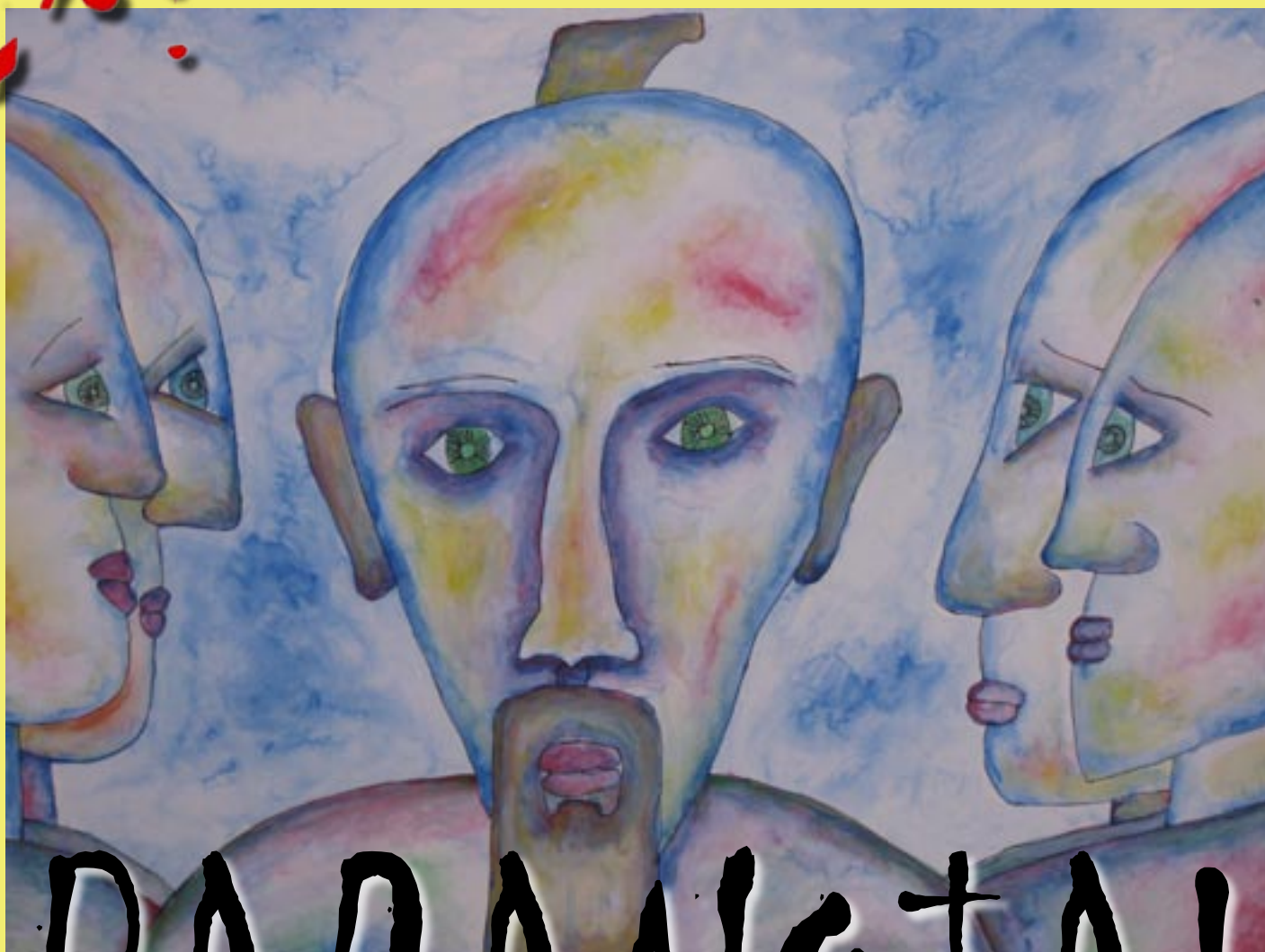


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the magazine for democratic psychiatry



PARANOIA!

The Paranoia Network

Relaunch issue

Now quarterly



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democratic psychiatry, psychology,
and community development

Incorporating the
Newsletter of Psychology
Politics Resistance

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EDITORIAL

This is the first issue of the relaunched magazine. Some of you may know that two years ago the Executive Editor, Terry McLaughlin, unexpectedly announced that he could no longer fulfil his role because he was ill. Almost as suddenly, Terry passed away. This was not only an emotional blow to everyone who knew and loved him, but also quite disastrous for our organisation. We had come to rely on Terry to a very great extent, and in the event he had neither the time nor the energy to collect together and neatly organise all of the strands of the magazine's affairs before we lost him. We are very grateful to Terry for carrying the load of getting the magazine out for the years that he did, and he is much missed.

However, this means that an apology is due to anyone who paid a subscription and did not receive an issue in recent times. We are afraid that the subscription list appears to be one part mislaid, one part quite out of date, and the last part does not register the number of issues sent or owed. So we have no idea who has received more issues than they paid for or who is still owed. We hope that you will forgive us this chaos and we can start afresh, this time – short of acts of God or war, floods and riots – guaranteeing that the distribution end of things is properly managed. (If anyone wishes to dispute what they are still owed, please contact our Business Manager, Peter Bullimore.)

We are able to make this promise of proper management due to Pete Sanders of PCCS Books stepping in with an offer to run the business end of everything: from layout to overseeing printing to distribution. PCCS Books is a well-established company publishing in the field of 'alternative' mental health therapies and already performs the same role for another magazine. Under this agreement, the Asylum Collective keeps full editorial control but will no longer be able to disrupt

the distribution. And, as was originally the case, the magazine will again be produced quarterly.

Subscriptions or copies of the magazine may now be ordered from the PCCS website, by phone or by mail. However, contributions to the magazine should be sent via one of the Editorial contacts. (See facing page for addresses.) And if you want a back issue, contact *Asylum's* Business Manager.

Although we do already have a fair amount of material for future issues of the magazine, we certainly do now have to plan ahead. Generally, we like to organise each issue around a theme, so when someone sends us material it will probably be sorted into a file to see the light of day an issue or so hence.

Asylum magazine will not survive unless people keep contributing words and graphics. We very much welcome the participation of groups, perhaps to collaborate closely for one issue; this gets their own message out to our readers and, coupled with a bulk-buy, provides the group with an excellent and ready supply of publicity.

Neither will *Asylum* survive without subscribers. Go ahead, treat yourself, or a friend: for the price of a round of drinks – subscribe! Better still, make a bulk purchase (at a reduced price per item). Bulk-buying is an essential role: helping to distribute the magazine and reaching a new audience.

Contribute! Subscribe! Distribute! Join *Asylum* magazine in the last great struggle for civil rights!

You can see that this issue of *Asylum* takes the theme: Paranoia. Cutting through the discredited diagnostic and therapeutic mumbo-jumbo of 'medical model' psychiatry and mental health care, between them our contributors describe the experience, explain it, and offer some down-to-earth ideas about combating it – mainly by means of self-help group work. Although we say so ourselves, this relaunch issue (a collectors' item!) constitutes a valuable, handy, non-nonsense and quick reference to the topic in question.

Phil Virden, Executive Editor

paranoi'a, -noe'a (-nea), n. Mental derangement, esp. when marked by delusions of grandeur etc. [Gk (-noia) f. PARA1 (noos mind) distracted]

Since they change over time and in various authors' writings, there are always difficulties in giving clear definitions of words. However, as a start, modern psychiatry emphasises delusions of persecution. And by 'delusions' is meant mistaken ideas not easily explained in terms of the person's actual experiences – strange views not shared by many others, and classically only believed by the paranoid person themselves.

The word 'paranoia' has a Greek origin but comes to us via Latin, and more immediately from the German. The original Greek is Para 'beside' and Noia 'the mind'. In today's Greek the best translation is 'distracted'. The word was first used around the 4th century BC by famous Greek writers, for example, Aeschylus, Plato and Euripides. By 'paranoia' they meant mental derangement, in general.

The term began to acquire a more technical meaning in psychiatry when, in 1764, Vogel used it to define the presence of systematised delusions – a whole framework of very mistaken ideas. Nevertheless, since then there has been considerable variation in definitions and meanings.

Since Kraepelin (around 1900) a distinction has been

made between 'paranoid schizophrenia' and 'pure paranoia'. The latter is a state in which the person's logic remains intact yet some of his key beliefs are abnormal, based on some clearly false premises, without an associated more widespread disorder of the mind – hallucinations and general illogicality, etc. Such a person is able to survive in society well enough: if one can avoid touching on the systematised deluded beliefs, nothing appears wrong with him. The difficulty psychiatrists had was that of drawing a line between eccentric persons with, as it were, strange bees in their bonnet, but nevertheless still able to live fairly adequately, and others with varying degrees of inability to survive, even amongst people who could tolerate their eccentricities.

Whereas the earlier use of the term associated it closely with delusions of grandeur, nowadays 'paranoia' is rather specifically associated only with false ideas of persecution. Of course, if one is persuaded of one's very great importance, and others are not, this will inevitably result in feelings of persecution ...

Finally, it does seem relevant to mention that many drugs can produce a deluded and paranoid condition. Certainly this is so with amphetamines. Most psychiatrists would also argue that phenothiazines, for example, can often moderate paranoia.

**Professor Alec Jenner,
Emeritus Professor of Psychiatry, Sheffield**

HERSTORY OF MADNESS

Eleanor Longden



One day, when you were eighteen years old, you realised that you had become the wrong person and were living the wrong life. You wished you could go back a decade. Grow up again. It felt as if your childhood had fled, its thin arms flailing, as if you had watched it go and heard it hanging in the air, with a silence and its secret loss. You felt you should have collected things by now. You should have accomplishments and responsibilities. Wisdom and urbanity should be pinned to your chest like a medal tacked on a tunic. Everyone else in your life seemed adult. Only you were merely in disguise. 'Nothing' was a word you associated with yourself.

These others were impervious. They scintillated. They were flip and funny and intellectually daring, fluid and electric, clear, metallic and unwavering and 'what you see is what you get' (except it never was). Maybe nobody else would have noticed these things, unless they were looking closely. But you were in the habit of looking closely. It was confusing for you, for while you joined them, and were one of the happy few, all the time you felt you were merely in a play with a part that was not known to you. At times you would dwell in the centre of the stage. At others you were lost in the wings: a prop, a standby, a face in the crowd, or a shadow with no claim on anyone. You had a paleness about you, and a staved-off sadness. At other times you felt black and sluggish and lethal. Even when you smiled you still looked sad.

You spent much of your time sitting in the garden, which had been abandoned and long since overgrown, hidden behind the lecture theatres. You went there partly because it was always empty but mostly because you loved its untamed beauty and the earthy, pagan wildness of its sudden twists and niches. It was a Tennyson garden, a skewered fairy-tale with rumours of the future in it. You loved its gently curving cavities, the way the path unfurled, and you loved the gentle sting of the grass against your bare legs, and the way the air suffused and shivered as if in fever. But most of all you loved the roses. They were coarse and wild, unlike the blowsy, pampered blooms that were grown in the main gardens, where the earth was tilled and as straight as a hair parting. You felt that if you held a mirror above them it would mist over with their breath. They dotted through the bushes in clusters of small red explosions. Like Aztec hearts, the garden laughs with roses. You were studying Eliot at the time, and you would often bring slender volumes of verse to the garden after lectures, and settle down amongst the drone of the bees. 'Footfalls echo in the memory,' you read, 'down the passage which we did not take, towards the door we never opened, into the rose garden.'

Your true friend was Julia. The two of you sat in your room, smoking cigarettes, drinking endless cups of coffee and

exchanging perspectives which you passed from hand to hand like the proverbial eye. She would sketch a circle of two and invite you in, and you liked her quiet intensity – although 'like' wasn't the right word to describe such tormented charm. Yet she had a certain merriment and a talent for invention. She didn't care what people thought: she had escaped, though from what wasn't quite clear to you. Maybe she'd just withdrawn from them, almost completely; maybe that was her version of liberty, to purchase some cheap brand of absolution (cheap; an enticing word. Most things in your life were expensive and unexciting.) These ideas hovered above her, like the haloes over saints of darker ages. She was like them, angular and fleshless. But in your second term Julia began to cut her arms with a compass and talk about God and the Devil and the corners of emptiness that needed to be filled. She had a look of unvarnished time, unrecoverable and unredeemed, mimicking something, something in her head, some character or picture which only she could see. She appeared beautifully mad to you, like something from a poem. Indeed, it was startling to realise how starkly beautiful madness could sometimes be – how reasoned, how untainted, how coolly watchful and commanding.

But they took her out of University, though you couldn't understand why since her grades had always remained high. It seemed impossible that she had just gone. All that vitality had to go somewhere. You felt that she lingered behind in your room, unfinished: a silken skein of loose ends that refused to be untangled and tidied away.

It was about then that you heard your first voice. In one sense the voice belonged to the world of dreams, for you felt it made you step sideways out of your own time, only to wake and find that it was Later and that the world had gone on without you. Yet, with your identity in such limbo, the voice seemed like a link with your true sense of self. It persuaded you of your legitimacy and your right to pronounce. It showed you that you were entitled to your own scenarios and your own conjuring and callousness. It was your background noise, your sickness and its cure, and your Nirvana: momentary, unreal, yet there. The voice gave you permission to dream – brightly coloured dreams without sound, where your body would stiffen and empty itself of feeling.

You found you were beginning to attract the attentions of male students who were fascinated by your aloofness and eccentricity. They tried to seduce you with cheap verse and cheaper wine and some of them would bring you flowers, though they were always hot-house, stilted ones, stifled and

sweating in layers of cellophane, not wild and clamouring like the roses. You later discovered that a group had placed bets on who would be the first to have you. You felt the weight of your own emptiness, lost in the dark, lost in your own skull, and you began to fantasise about this twin who would be your missing half, who would heal and complete you and make you whole. You felt utterly alone, your heart pumping in the syrupy, fleshy blackness inside your body. This was taboo, pulsing and intimate: a dark fragment like a bruise and a compelling curiosity, yet distorted and horrible.

To the irritated envy of your friends you succumbed to the attentions of the President of the Student Union. You persuaded yourself to be in love, although you had never expected love to feel like this. In books, love was silver-sweet and a marriage of minds. People fell in love, but then landed softly with wedding bells in their ears. Yes, you felt as if you were falling, with a clutching of handholds and potential salvage. But then suddenly all poise was lost and you would plummet headlong, loudly and without grace, gathering speed and grazes. You were aware that your youth and naïveté pleased him. He was older than you, and he paraded you to his friends and revelled in his ownership and the innocence you had lost. You knew you were not the first, for he made no secret of his many partners, and you were aware of meeting women at parties who ran their eyes over you incredulously when they found you were his girlfriend. Then they would fix their guileless eyes on him, sloth and sullen expectation flickering on their faces like temporary static. You felt suffocated by the sensual haze and cocoon of breath and skin that he spun around you. Your body no longer felt your own, and you began to worry about your health, silently and relentlessly, whenever he left your room in the mornings, leaving you cringing and shivering on your bed.

She is increasingly preoccupied with obsessive, abnormal worries about contracting the HIV virus, which she seems unable to rationalise. She says these thoughts are torturing her and she does not know what to do to reassure herself. I believe this may likely be the result of command hallucinations.

You were beginning to struggle with your madness, both with its horror and its cruel allure. At times you felt frenzied and terrified, gazing at the world through smoked-glass in which everything was shadowed and grotesque. Yet this was coupled with a beauty and a brilliance: you felt as if your body had the power to snatch the senses inward, that you could grasp whatever a fiery or desolate mood might teach and make it a crucible for imagination and experience. You were like a dreamer in your own fluid body. Your visions took you to the edge of the world, and sometimes you felt that if you died it would not matter because you had known what it meant to be truly happy. You had an idea that if the bad could be cast out, then you could harness the good for your own benefit. You were unsure how to go about this, and yet you were never helpless or hopeless. You were full of hope: it was the hope that killed you. You visited a tutor who had always been kindly and

patient with you, and who you had always admired for his wise, cerebral air. He talked to you in his office about Sartre and Descartes. But just as you began to proffer your own timid views he made such an aggressive pass at you that you fled the room in tears. You avoided him after that, but were uncomfortably aware of the many detours that he made past your room in the evenings, and of his lurking presence in the college bar. He even sat in on two of your seminars, slumped in the corner like a blasted stump, and only coming to life to put you down in front of the other students.

Your boyfriend was sympathetic at first, then impatient. Your tears and long silences disturbed him, for he wanted you as you used to be, which was capable and sane. Once you were light on your feet, now you cast a shadow; and he did not want your darkness. One day he came into your room and found you desperately gouging your arm with a piece of glass because you felt you needed punishing, though for what you could not say. You were aware of his horror and disgust but you could not defend yourself, not even when he slapped your face to try and make you speak. You knew he was shouting at you, but you could not hear what he was saying, the words incomprehensible, tumbling from his screaming mouth like strings of clotted newspaper printed with nothing. You could not help giggling at this pompous outrage: it was he who was hysterical, not you. 'Sorrows come not single spies but in battalions,' you quoted. 'Divided from herself and her fair judgement, without the which we are pictures, or mere beasts!' and then you laughed again. You had been studying Hamlet last term, but he had forgotten, or did not care to remember, for he threw you a look of such contempt that you drew back. 'You're as mad as Julia!' he shouted as he drove away. 'You fucking psycho!'

After that, he told people about you. He must have done, for your friends ceased to be friends and people who you had only known in passing began to whisper about you behind your back, and occasionally across the room you'd hear a torrent of laughter, and watch as their eyes slid mockingly over you. You became a sad, lonely figure, who was forced to sit alone in lectures and who was spat at outside the student bar. No one came to your aid, but only watched as one girl wrenched your arm around and tore at your sleeve so their small and sickly eyes could gloat over your wounds more clearly. Later a group of them surrounded you and goaded you to burn your arm while they watched. Abusive comments were sprayed across your door in bold, black letters. There, in that context, they were not just cheerless graffiti, scribbled and abandoned, but took the significance of prayer or command. You began to keep to your room and would rarely leave it. You were silent and defiant, dry-eyed and desperate. In a way you admired yourself. You got through the days.

'How could you let yourself get like this?' said one friend, after she found you crouched in your filthy room, screaming at the voices to leave you alone. 'How could you ... ?' She trailed off, her implication unfinished, but you could tell from her

insouciance, her cool indifference and her eyebrow language that what she really meant is: 'Could I end up like you?', as if your madness was labile and therefore contagious. You began to wonder if you really were contaminated in some way that everyone could see but you, and you began to wash yourself obsessively, occasionally even drinking boiling water mixed with disinfectant in a desperate bid to become clean and rid yourself of this invisible infection that was ruining your life. Later you began to monitor your every move to make sure you did nothing to endanger another, even picking up other people's litter in case it should cause a fall, a cigarette butt that might cause a fire. This would be your penance and your striving for grace: anything for your friends to like you again, for Julia to come back, for your degree to be salvaged, for your boyfriend to kiss you again and the tutor not to. Your actions weren't for nothing, but for everything, for everyone.

She ruminates obsessively over feelings of guilt and displays irrational anxiety of causing harm to others and protecting people from harm. She also exhibits obsessive-compulsive fears and abnormal anxieties that she is 'contaminated'. This is a young lady with chronic intermittent obsessive-compulsive thoughts presenting with an exacerbation of low mood and psychosis.

Once, with the sun at its scorching best, you went and sat in your garden. It was still and hot and the air was waiting. You sat and just breathed, slow in, slow out, and then you saw a boy sat on a bench, a few yards away from your own. He had a loose-limbed elegance and he sat a little apart from his friends. You saw he was watching you, his warm brown eyes darkly spiced like cinnamon, and you were about to pull down your sleeve to hide the scars, but then didn't bother. He had a sad, serious smile, and when you caught his eye you felt a rush, because you had exchanged recognition and a wordless embrace. But then the bell sounded, calling them to their ten o'clock lectures, and you watched them as they walked away. The serious boy glanced back at you once. Who knew where they were, the people you could love? They may as well have been nowhere, as you were to them. You too were a missing person. You never saw the boy from the garden again.

On examination Miss Longden appeared apathetic and unable to initiate or complete a course of action. She appears emotionally flat, and seems to find it hard to elicit responses. Her emotional affect is extremely abnormal.

The voice began to get worse, but in a way you didn't mind because you could not blame it for hating you so much. The voice was a flagrant type of phantom. It held you in its gaze with suns and moons and unprincipled poetry. It was white-hot and ruthless, lacking in scruples and standards yet with an ungoverned passion and elusive smile. Yet you felt that it spoke the truth: you too despised your weakness and your inability to take control. But sometimes you would miss the voice when it wasn't there – for it was the only company you had. In your loneliness you would often script whole

conversations with your friends, in your head, which was now the only place they still existed. They were inflatable and filled with air, and they would be reassuring and silver-sweet. Except that you didn't know what they really would have said to you, for you only had your own words. Your face, in the mirror, was pinched and pale. As white as a sheet. And you felt white, flat, thin. You felt threadbare. But what will you do when you're so flat, so white?

Only one person still visited you, a first year psychology student whose revulsion was tinged by fascination. Susan would talk to you at length about your experiences, picking away at your psyche. Sometimes she would write things down. One day she knocked on your door and introduced you to two people you had never seen before. 'Look,' she said to these others. 'Positive first-ranks, don't you think?' Her voice sounded positively regal. The students conferred in hushed voices, their heads bobbing like sparrows, and you were aware of Susan promising to closely 'monitor' your symptoms, and immediately inform a doctor when you got worse. As these embryonic psychologists proposed their own definitions of your distress, you heard words like 'paranoid', 'thought insertion' and 'reality testing'. It was like being pillaged then discarded, bruised and dripping, as they rifled through thoughts you didn't know you'd had, and spun a lengthy-paced, clandestine story you'd had no part in. A boy leaned in closer to get a better look at you, scrutinising for signs of rot. His expression was a strange blend you couldn't decipher, a mixture of tenderness and disgust. You stared back dumbly. Why did everyone want to either injure or guard you? You were an invalid, or at least one who has been invalidated: no identity, no point. You felt like you were eighty years old. You were eighteen.

When attempting to explore her mood and mental state Miss Longden appeared quite guarded. She has formal thought disorder and paranoid thoughts that people do not like her; she continually reports the sensation that someone is listening to her thoughts and taking them out of her head. Her apathy and withdrawal are a source of concern, as she isolates herself and prefers to stay in her room.

For the third time you summoned your courage and ventured to the campus GP to ask timidly for a counsellor to help sort through the skeins of your ravelling self. The doctor was uninterested, barely looking up from his desk, but he promised to put you on a waiting list to see a psychiatrist. In the meantime he prescribed tablets. You took them dutifully, but found the effects so dense and numbing that you vowed never to have them again. They made you sweat, shake and vomit. And besides, you knew a clear head was essential if you were ever going to negotiate this strange subconscious world and complete the degree you were sacrificing your sanity to acquire. You had recently gone to a tutorial, but the room fell silent when you walked in, and you were aware of the way the other students were staring and silently despising you. Your old rival, Ian, was there. In your absence he had usurped you,

as the star pupil. You did not contribute to the discussion, although you always used to excel at them, and when the essays were handed back you saw that yours had been failed, although you didn't even remember writing it. The tutor was disappointed in you, and the others smirked – particularly Ian who was relishing your fall from grace. 'That's finished you, Psycho,' he whispered as he left.

Her concentration and motivation are poor. There is evidence of persecutory delusions, as she is extremely paranoid, and preoccupied with the idea of something watching her and willing her to fail.

You returned to the doctor, and were dismissed again, just as casually. You went to your garden and moaned with horror when you realised that a recent downpour had slashed the rosebushes, leaving the stalks straggling and naked and the petals crushed and unclean. The roots of the trees pierced the ground like bleached bones. You stumbled back to your room, numb with desperation, where you cowered on the floor, howling like an animal. Finally you smashed your vase against the wall, because there was something so perfect about the way that flawless orb smashed into a hundred pieces, flying like prisms through the air. You remembered what the doctor had told you, about 'prioritising patients', and decided that your only option was to make them take you seriously. You used some of the shards of glass to saw through the skin at the top of your left shoulder, because you had an idea that you wanted to sever your arm. But there was too much blood and it was too thick, too dark: you couldn't see what you were doing. So you went to the kitchen and took a bottle of bleach with which you doused your right arm before striking a match and setting it alight. Your emotional enema. Over. Already it seemed impossible, although you knew you'd done it.

Her insight is extremely limited as she states that she is 'relieved' to have burned herself and made the bizarre statement that the injuries will 'help sort things out'. She told me it functioned as a release of tension. I suspect she has intermittent command hallucinations telling her to harm herself, although she denies this.

The doctor kept asking who you were. This sounded like the sort of thing your philosophy tutor always pondered over, and besides they were calling you by the wrong name, so in the end you didn't answer. You could hear a nurse saying what a shame it was – how you were pretty, you were intelligent, and you had let it go to waste. 'She's from a good home,' said one. You felt guilty, as if you had committed a crime. Even here you weren't going to fit in. You weren't even mad in the right way. A young, tired-looking doctor came in and jerked your forehead back with his hand. You tried to focus on his face but it was impossible; at once he had a ghastly skull's smile, then his features would obliterate, as if soaked in water. 'Completely psychotic,' he said, 'Look at her pupils, they're fixated. Come here,' he tells the others, 'take a look.' They all leaned in to inspect your feverish, twitching eyes, and you could sense the dislike and pity in their faces, as if you had deliberately betrayed

yourself and been given a magic lamp to rub for beauty and success, but then chosen madness and degradation as the third, final wish. Your story itself now seemed outmoded. It was an archaic story, a folktale. It was a story that could never happen these days. Occasionally you tried to smile, or even laugh. Your cheerfulness was a performance, a clutch at normality. But they did not smile back, so you stopped. 'It would actually be better for her if she had cancer', says the consultant, glancing up from her notes, 'At least it would be easier to cure.'

She did not relate appropriately at interview. There was evidence of disturbed thought/perception. My concern was that she was distracted and preoccupied, as Miss Longden did not acknowledge me until I repeated her name three times. Her cheerful affect is also incongruent to the experiences she describes.

Later they took you to the clinic to look at your arms. 'People like you!' the nurse hissed at you, 'You make a mess of yourselves and expect us to clean it up.' Her teeth may be clenched, but it is hard to know. She seems to have the type of teeth that are permanently clenched. Your arm was hanging useless at your side, a limp mass of blisters and raw, charred flesh, but the nurse poured disinfectant on it and began to scrub. The skin slid off and soon there were puddles of blood on the floor. You were sobbing in a dry, desperate sort of way, and tried to explain that this was your stigmata. Your voice sounded like ghosts or dying animals: thin wails of exhausted pain. But the nurse was oblivious. She swaddled your wounds in gauze and pushed you out of the door. 'You'll live,' she said.

I have extreme concerns about her physical safety. Examination showed over 40 cigarette burns on the left anterior forearm, severe laceration to the left shoulder blade and extensive third degree burns on the right interior forearm. There is further evidence of lacerations to the abdomen, the lower jaw and excessive bruising on both legs. Yet despite this severity she shows scant regard for the potential catastrophic consequences of her actions, as she will not voluntarily allow staff to attend her injuries.

The voice wore on, but you had been ordered to ignore it, and if you made any reference to its crooked smile then you were punished with a needle, for you must fight your psychic civil war alone. They wanted the voice unmentionable, refusing to name it. As a result the voice was crueller, darker, harder to hear, and hungrier. You started to scream at the nurses, then cry and plead. You wanted to tell them that it makes sense now: that you've worked it out. You didn't want this, you never wanted it. You didn't want that sterile degree, to live in that ghetto of constipated, middle-class morality, with its stupid, selfish pleasures and tepid fulfilments. You couldn't strive for yourself any longer. Your entire life lay behind you at a great distance, the colour of hell-flames, burning in your head like a Sodom at which you dared not look. Your story ought to begin where you began – sometime long ago, distant in space, and bruised and tangled. But they cajoled you to take the pills, which lay on your hand, sweaty nubs of sulphur-yellow. When

you threw them away, they told you that you had no choice. You refused again, so they said that you must sit in the annexe for a while to think about it. You could tell that 'the annexe', once you were inside, was nothing but a padded cell. The air was thick and curdled, with heavy, reeking sediments sinking in the corners, and your mouth tasted metallic from the blood in it. You were aware of being watched through the grille in the door, though no one responded to your requests for water or cigarettes. Your eyes were so gently closed. What you expected was sudden realisations and resurrections. Not this silence. Not like this.

Staff are concerned that Miss Longden does not have full insight into the seriousness of her condition. She has requested to leave the hospital on several occasions and required detailed explanation as to how dangerous her behaviour has been ... After the first fortnight on the ward she appeared to deteriorate. She was complaining of hearing voices. She was agitated, tearful, withdrawn and monosyllabic. Her medication has been increased to 12 mgs, but she refuses to take her dose for even a trial period and demonstrates poor compliance.

They treated your story like the antics of some primitive tribe: real but implausible. This left you wordless, burning in obliterating, outraged silence. 'You must realise that this is abnormal: it has no basis in reality,' they said. Later, 'You're supposed to be intelligent. You must realise how stupid you sound.' You'd wanted them to be the happy end to your story, but then you realised that they were not the ends of their own. How could the answers lie in their tick-boxes, their assessments, their notes and charts and academic endeavours? Their metaphysics of the mind is lifeless and defunct, worshipped on an eerie alter of a science which silences.

After that you resolved to tell them nothing more. Your story will be secret and without sound, and you will keep your pain to yourself, loyal even in outrage. You would shift within the awareness of yourself, in a world just beyond reality. And you would go on, you would persevere, be silent, suspended and rarefied. You would not think or talk, or make any sign or sound that could alter your rigid course. You would fling back your shoulders, charge, meet them alone. Drum roll, flash of lightning. Onward. Your darkest yearnings would be pinned to the war that you'd heard being waged on the edge of the unknown; for you also wanted to know, and to be part of the fighting host. Because you knew that very slowly they were killing you – even though they would never let you die – and

you wanted an invisible wreath of vengeance on your grave, garlanded with roses. You were a circle of neon stars, a bouquet of sunlight, desire in tiny crystal bottles. You were snatches of old popular songs and short circuits and bad dreams, like light on waves, melon-coloured, like a conversation that had moved away from the imprecision of words. You were guileless blue eyes and soulless smiles and whole worlds rested on your head. And you were dreaming that you were awake, even though in your dreams of this place you were always lost. For you now knew what you couldn't learn before: that there is never only one, of anyone, and it was your life on a blended web of yarn, good and

bad together. You had been so used by others you hadn't known how to experience your own self. It was your brief moment of escape, of watery moonshine and pretended flight. Above your head were a hundred suns, a hundred moons. Tentatively, you reached out for one. But it was no use and they would neither glitter or shine for you. Because you knew that it was no good, not really; that this was not creative, or a search for identity, or even catharsis. For they have told you so, they have shown you. You are schizophrenic. And of all the moments, out of all of them, that was the worst.

Her compliance is variable. She is guarded, paranoid and non-committal. Her rapport is poor and she refuses to discuss her experiences with staff ... I explained that she is having a psychotic episode and Dr X believes she has a form of schizophrenia, most likely paranoid



Picture: Warwick Edwards Steeples

schizophrenia.

You had been put into 'The Annexe' again because your frenzied screaming disturbed the other patients, as did the way you stubbed cigarettes on your arms, slashed your face with broken glass and smashed your forehead against the wall until it split open and you lost consciousness. And you were surly and uncooperative with the nurses, for you only took medication when forced to, would not bathe or eat voluntarily, and were unwilling to discuss anything except your voices, which was forbidden. You were heavy and sodden and swollen, and all you could do was lie still, your eyes flickering yet fixed on nothing.

Suddenly, all around you were roses. But they were not as you remembered. These things were monsters, a slaughterous shade of red and shining with the same wetness as blood. You were drowning in their crimson faces. The thorns ripped your skin, already bruised and inflamed from the needles, your head filled with blackness and the sound of silence, and the last thing you remembered was the sigh of the rose petals as they drifted down and enveloped your breaking heart.

NOTES ON PARANOIA

Peter H Donnelly

1) T: An Island of Widespread Far Right-wing Politics, and a Police-state

This area of T has nearly destroyed me. I have been terrorised and abused by the people, police, social services, and local community here, because I am a highly intelligent original thinker, and because I speak out against authoritarianism, abuse, and social injustice. Most of the people in T are racist and have far right-wing opinions, and in my opinion they are the scum of the earth. I am better than all of them put together, and they are simply jealous of me and my achievements.

If I could afford it, and didn't have loyalties to my very good friends and family here, I would leave T for good and never return, because living here has nearly driven me to suicide on many occasions. People here are extremely reactionary, ignorant, and have an island mentality.

The local fascist party writes letters to the Chief of Police and gets permission to march in the streets, along with their mirror-image, the authoritarian extreme left, who march on the opposite side to them. The vast majority of the police, social work, and mental health professionals here are extremely ignorant, unethical and corrupt, as T is a law unto itself, and takes no notice of the general wider consensus of law and order of the rest of the country.

This area of T is full of misfits and losers, has a culture of very low wages and tipping hats to the bosses, and it is the cesspit and arsehole of the country. If you are reading this and don't live in T, then consider yourself extremely lucky.

2) Topsy-Turvy World

In 1991, because I refused to work in low paid work, where there were no health and safety regulations, and the workers had no rights, and had to work harder and faster all the time for the same pay, and because I wanted to read books to improve my vocabulary, and used pot as a sedative, a social worker called X [ed: name disguised] came into my flat, under false pretences, saying she was a friend of my dad and his partner. She did nothing but bully, interrupt, insult me, and call me a liar when I told her I was abused and heard voices. And then she said that maybe the person was right to abuse me. She also expressed sympathy with the Nazis in 1930s Germany.

X is very ignorant and shallow, and is basically incapable of emotional feeling, and she is a police state robot. By getting the Police to put cameras in my flat, and to terrorise me, she nearly destroyed my life completely, and I am permanently damaged by what she and others did to me.

Who will give me back the time I spent being confined to my flat, terrorised and tortured by her, people like her, and some of the police? How can it be that people like her work in the mental health system, who have no skill and natural ability with people with mental health problems, whilst I have great skill, unique knowledge and a natural ability with people with mental health problems, and yet people like X are allowed to get away with abusing me and destroying my life?

I have talked to other people who have had X as a social worker, and they all say bad things about her, that basically she insults, abuses, bullies, and destroys lives. She has to be removed from social work, before she causes any more damage to people with mental

health problems, because she just hasn't got the intelligence to understand, nor the skill to relate to psychiatric-diagnosed people.

3) Paranoia, Semiotics and Politics

Paranoia can be a more honest and accurate way of seeing people and things. It is a very receptive way of feeling and thinking. However, it can be very selective too – very subjective, in that the so-called paranoid person sees other people, signs, and things as directed at, for or about them. This doesn't always have to be negative. I sometimes think that messages in the media are just for me, or people like me, and this gives me a purposeful and good feeling, as if others are listening to me, working with me, or care about me and others like me.

When I am a passenger in a car I sometimes read people's faces. Sometimes I see compassion, intelligence and appreciation, and at other times I see aggression, ignorance and animosity. When people are engaged in driving their cars their unconscious and the nature of their character and will is connected in operation, and it is more open and exposed. This is one reason why 'road-rage' can easily occur. The so-called paranoid person is an observer of social and personal meanings – maybe as a way of avoiding the role of being the observed and objectified. But the intention is to observe equally with others, or interact and connect with others, on some kind of free and equal basis.

There are some people who will use their own paranoia, and induce it in others, so as to dominate, abuse and control others; they believe that paranoia gives them a higher and superior awareness, and exposes everyone's weaknesses and imperfections. This is projective, not receptive paranoia. It is not attentive to others nor does it seek to interrelate and interact with others, or build on strength, potential and a positive attitude.

When psychiatrists and others accuse and label someone 'paranoid', they idealise human nature, society and community. In reality, a society and community will always discriminate and find scapegoats or out-groups, so as to justify its self-righteousness and somewhat mythologised or idealised image.

Scepticism about human nature or society, or having different political views from the mainstream or the state, can very easily get labelled as paranoia. And in some cases psychiatric incarceration occurs without proper trial and assessment. The most overt examples of this are in Communist China and the old Soviet Union. However, it also happens in democracies, when people with libertarian or radical views get accused of being paranoid, psychotic and out-of-touch with reality. The state and society constantly get away with abusing, terrorising, and torturing people diagnosed with mental health problems. And yet if the diagnosed person complains or protests about this, then he gets labelled 'paranoid'.

4) Paranoia-Inducing Projection and Internalisation

To begin, I want to say something about paranoia-inducing, paranoia projection, and the internalisation or introjection of this. Some people who hold social power will try to induce paranoia in people diagnosed with mental health problems. They do this because they get a kick out of it, it makes them feel superior in terms of power and awareness, and it makes them feel and think that they have a better grasp and understanding of reality.

For example, whilst it may be argued that the drug cannabis induces paranoia, there is also the reality of the discrimination against the drug and its use, because it is illegal, and which can also induce paranoia.

By persecuting, hounding and terrorising individuals, this can be a way of making the victimised person feel frightened, angry, paranoid or upset. These are all ways to control and label the person as 'having symptoms of so-called mental illness'. This may also be a projection of paranoia – perhaps a mass paranoia – upon individuals or small groups. This projection of paranoia can then become internalised by the person, but it could also be an awareness of what could happen if this discrimination and abuse to induce paranoia became extended to actual or greater violence, became more extreme and got out totally of hand.

There is also the matter of sensitivity with paranoia. Some people who are labelled 'paranoid' may have a sensitivity to their local surroundings, and be sensitive to some aspects of social and cultural animosity, that others cannot see or admit to about themselves, or are simply unaware of. Paranoia can be a more social way of thinking, because it is connecting to others, albeit in a negative way.

One opposite to paranoia is the denial of the abuse of power, of repression and oppression in society. A 'normal' person may be tolerant towards abuse and oppression, whilst the so-called paranoid person is aware of it and protests against it.

Paranoia can also be part of a creative process, where a detail or details get enlarged or exaggerated for atmosphere and effect. Whilst there may be corresponding so-called delusional thinking, once the blocks or delusions have passed and the person is able to see the whole picture this can then be part of a personal, cultural, social or political critique.

Labelling someone as paranoid can simply be a denial of the duty to protect individuals from persecution, discrimination, abuse and oppression. On the BBC TV programme, 'The Doctor Who Hears Voices', a member of the Manchester Hearing Voices Group said she was frightened that aliens were going to take her away, remove her eyes, and blind her. This might mean that she is frightened that she could be sectioned (or incarcerated) in a psychiatric hospital if she tells others about the voices, and that she could become alienated and have her perceptions and thoughts about the experiences of the voices taken away from her by psychiatric force and drugs.

What is curious is that, in my experience, paranoia can be taken as a personal criticism by another person – particularly a parent or other family member – even though the critical aspect of the paranoia is not directly about that person. Again, this might be because the paranoia is warning people of what could happen, if things became extreme or out of control, because it highlights the so-called sane person's denial or tolerance of abusive power and repression, and because it is, in a way, seen as mad, irrational, and delusional. It is at the least, an extension of the so-called sane person's intolerance of another person having a different opinion or experience.

Paranoia that is clearly delusional can stem from the fact that harm, abuse, and bullying have been done to the person in the past, and that events somewhat overlap in the mind. What the person needs is to understand is that events are separate but that they are also somewhat interconnected and interrelated.

Paranoia can also be about the person needing love, reassurance, and protection, and about his or her way of expressing that need. It may also stem from the way that children or young people can be threatened or told that bad things will happen to them if they misbehave. This can induce paranoia in the child or in later life.

5) Paranoia, the Creative Dialectical Method, and Recovery

These observations, findings, and ideas are from my own experiences

of paranoia and recovery. The Creative Dialectical Method uses creativity to unite opposing factors, in order to create a synthesis and a new thesis, and by integrating both the subjective and objective experiences of the person, with regard and respect for the person's privacy and confidentiality.

I don't claim to have invented this method or approach completely, as it has been used by others up to a point, such as The Hearing Voices Network. But I have built upon that foundation of new knowledge, and added my own contributions to it. The Creative Dialectical Method may not be suitable for everyone but it does have some overall value and use for people diagnosed with mental health problems, and it very much describes my own mind and my own way of thinking, feeling, and healing.

Certain things can induce paranoia deliberately, and then shun the responses, by covering up, denying, or hiding the root cause of it, and then labelling it as mental illness. Paranoia is caused by many factors, but largely by others distorting or misrepresenting reality, usually as a part of bullying, mistreatment or abuse. Abusers set up different versions of reality – that the person who has been bullied, mistreated, or abused, wanted or deserved the abuse; this can make the person feel that they are under further attack from others. The way that abusers tell their victims that they are very bad people can be internalised and projected onto others, in that others are seen as very bad, the way that the person themselves was seen and treated in that way.

Not all paranoia should be prevented – some paranoia is a good thing. It's a good thing if it is wary of violence and extremism, because it's about protection, care, and concern for one's self and others. It's also a good thing if there is a process to it of eventually integrating the facts with the concerns of one's own and others' well-being and welfare. Sometimes the end-factor in this process can be a political or social critique, or asserting and expressing one's feelings and thoughts with others on a more personal or interpersonal level. This is a process of creativity and some recovery. There are many different ways to achieve this, but it involves flexibility, ordering, structuring, and some randomness and fluidity with the facts, and both rational and imaginative thinking.

Very rarely, paranoia can lead to the paranoid person threatening or committing violence, but on the whole, people diagnosed psychiatrically as paranoid are not a threat or violent. The so-called sane fear of other people's paranoia depends on which way you look at it. So-called sane people are sometimes frightened that psychiatrically diagnosed people will become arbitrary and irrational, and that anarchy and violence will result from this. Some psychiatrically diagnosed people see sane society and psychiatry as abusive, violent, and arbitrary in its labelling and bad treatment. The paranoid person fears that harm or violence will be done to him, and sometimes acts in terms of avoidance, or what he sees as self-defence.

It may not be a good idea to label people as paranoid in the first place – although I appreciate that psychiatrists and other mental health professionals have to label people, up to a point, in order to assess, diagnose and treat them. But I am critical and concerned with the way we treat people who are labelled as paranoid. I think we need to get some kind of balance between relating to them, and in a way believing what they say, whilst at the same time looking for other causes and reasons – if this is not always or generally the case, why they believe that others, or strange forces, are out to harm them. What isn't helpful is to militate against the person's so-called paranoid delusions, by just telling them that it isn't true, and that

they are simply mad, paranoid, and deluded.

This is the crux of the matter. Even though their fears may be based upon some false assumptions, we should relate to the person's concerns and fears with our own experiences, observations or examples. This prevents polarising the paranoid person's fears and concerns, as if they are totally different or opposed to the fears and concerns of people in general; this humanises their fears and concerns. This has to involve a process in which the paranoid delusions are not rejected or denied, but worked through to their wider meanings, and integrated with a more rational way of thinking. This is a dialectical process which leads to more rational thinking, knowledge, and understanding, whilst at the same time it does not try totally to separate and oppose delusion and rational reality. Instead it seeks to create some kind of synthesis and new thesis.

In the past, when I suffered from delusions, in the throes of a mental breakdown, and in psychiatric hospital, the psychiatrists who first assessed me acted as if they believed me, and related towards

me in that manner. This made me feel a whole lot better – that someone else believed me, or could at least relate in some way to what I was experiencing, saying and believing. This also helped the whole process, of integrating my so-called delusions with a more rational way of thinking.

However, I found that later psychiatric routines and assessments did not aid or help this process since the psychiatrist set out completely to deny, invalidate, and suppress my so-called delusions. He did this by means of high doses of psychiatric medication, and with negative remarks and criticisms.

I am not totally against psychiatric medication because it has helped me when I had been very unwell in the past. In small doses I found it beneficial to some kind of wellness or recovery. But I am critical of using psychiatric medication to try to completely suppress the person's experiences – such as hearing voices – because we have to work through the wider meanings of such experiences, and work towards a creative, integrative, dialectical, and holistic recovery.

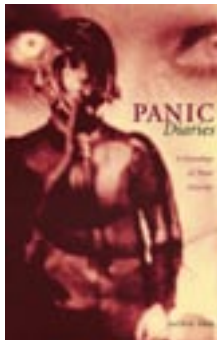
Book Review

Panic Diaries:

A Genealogy of Panic Disorder

2006. Jackie Orr

Duke University Press, Durham and London.



Review by Paul Henderson

This is a very interesting book. Partly this is because of its wider content and partly it is due to the author's use of her living experiences as a victim: a double whammy of panic disorder and of the American psychiatric system. As a subject of a research programme conducted by the psychiatrists, Orr had to keep a diary of her panic attacks. Her use of this diary in the text of the book, interspersed with meticulously researched and well referenced academic material, lifts the work out of a purely scholarly treatise (on which it would stand well on its own merits) and sends it in a literary direction. The book is of burning relevance (no puns intended) as we watch the scenes enacted around the 'war on terror' throughout the world. As well as all this, it is a gripping read.

Orr sets out the parameters in the Prologue. 'In a society of unspeakable madness,' she asks, 'how does a mad woman tell a history of what has come to be called a "mental disorder"? And, immersed in a merciless language of non-madness, how will we ever hear her?' This is a story about panic, but also about knowledge and power. It focuses on the symbiotic connections ('entangled fields') between social science and psychiatry, the U.S. government and the military, the mass media and the transnational drug industry, and the management of what 'panicked bodies' can be heard to say.

The story starts with a discussion about the panic caused in 1938 by the CBS radio dramatisation of the science fiction novel by H.G. Wells: *The War of the Worlds*. The main feature of this broadcast was its realism. It was introduced

to the listeners as an urgent news item, cutting in on a regular programme, an announcement of the arrival in New Jersey of Martians equipped with high-tech death rays. The programme set off a nationwide panic resulting in people fleeing their homes, massive traffic jams, clogged telephone lines and other symptoms of a terrified population. From this event sprung a major research project sponsored by the Rockefeller Foundation and the Federal Radio Education Committee, written up by Hadley Cantril in 1940.

From this research, Cantril utilised new survey techniques to develop an empirical measure of 'suggestibility'. From the outset powerful bodies from within the state apparatus were fascinated by the possibilities inherent in this concept. We are witnessing the early stages in the systematic management of panic.

As Orr notes, in 1938 'techniques for predicting, measuring, and controlling ... collective mobilization are in their infancy.' This is partly due to the fact that radio is only just beginning to assemble what was previously 'a dispersed crowd'. A related reason is that the coming of the radio broadcast begins to show the possibility of a truly 'mass' suggestibility. Important to Cantril's motivation in carrying out this study, and central to the linkages in Orr's book is (1) the need to isolate panic as a field for empirical research, and (2) to identify what it was about *The War of the Worlds* panic that is prototypical for panic in general.

Out of all of this research, one of the main items to emerge is a notion of the psychological characteristics of the 'panic-prone' person. These are conflated into an 'index' which Cantril confidently asserts as revealing a 'concrete, quantifiable variable in the equation defining the problem of panic'. This brings those people who score appropriately on the index into the realm of social and psychological control. It also constitutes a step towards taking such people out of their social and economic contexts and treating them as 'suitable cases for treatment'.

continued on p. 27

my experience

of paranoia

PETER
BULLIMORE

I believe my experiences of paranoia relate to sexual abuse from when I was five and up to the age of thirteen. I was ritualistically abused by a babysitter who would look after me on a Friday evening. She started to exert her power over me by forcing me to watch horror films in the dark. She would keep giving me glasses of pop and after a while I would say I wanted to go up to the toilet. She would say I could go but I couldn't put the lights on. I would be frightened to go upstairs in the dark and subsequently I would wet myself.

When my parents returned the television was off and the lights were on, and straight away she told them that she had asked me to go to the toilet but I took no notice. Since she was the adult they believed her. I remember that at such a young age I felt that if they believed what she said they would believe anything.

This is how I became so fearful of the woman. And when someone has got you so much in their grip there is nothing they can't do. She started to exert her power over me through more abusive methods. Some of the incidents were sexual, others physical, and some downright disgusting. Sometimes she would bring a friend along to join in. Quite often she would hang me from the banister by a silk scarf, and would only let me down when my eyes rolled.

By then this tormentor held me in an immense grip of fear. This culminated in my becoming paranoid about everything. I felt there was an elaborate plot to harm me that the whole world knew about but no one was prepared to help me. I became very isolated, often locking myself away in my room, fearful of the outside world.

During the school holidays my mother used to tell me I couldn't stay in my room and had to go out. I would go to the local park where there was a putting green and very few people. I would get one club and two golf balls and play against someone or something I could hear but not see. At first I felt this was my imaginary friend, but on reflection it was the first signs of my starting to hear voices.

At first the voices were reassuring, but the problem with abuse is that it always escalates and gets more intense. And this creates more fear and paranoia. One great problem with abuse is that as you get older your body sometimes responds to it. So you worry all week about what will happen, but the feelings can sometimes be quite pleasurable, and this really confuses your mind. When this started the voices took on greater and greater power, and also a sinister turn: the content became violent and destructive. On one occasion I was playing football with a friend when the voices urged me to hit him because they said he was going to hit me. So I punched him in the face and made him cry. I couldn't explain why I had done it, so my mother gave me a smack. This only made me more paranoid about women.

My paranoid ideas became fuelled by the voices to the

point where I was seen as dysfunctional. Once, my mother was cleaning the blades on the lawnmower while it was still plugged in, and under instructions from the voices I turned the mower on and just missed cutting off her fingers. It even got to the point where the voices gave me such paranoid thoughts that I turned a loaded crossbow on my father.

I think the lowest point of the abuse also proved a turning point. This came just before my thirteenth birthday. It was midweek and I was doing my homework when my tormentor called round and asked where I was. She was told I was doing my homework and said she would go up and help me. She came into my bedroom and proceeded to have full sex with me. Fuelled by the fear that I could have made her pregnant, my paranoia really spiralled out of control. Fortunately she didn't become pregnant, and this gave me the courage to tell my parents that I didn't want this lady to look after me anymore – I could look after myself.

My parents agreed to this, and the voices and my paranoia subsided. But I never told anyone about the abuse and its consequences.

From the age of thirteen until I was seventeen I lived a so-called normal life. I left school and started a job in industry. Later I met a young woman and fell madly in love. She was my first love and we started a relationship. After a few months she became pregnant. Then I felt that all I had done through this was to put myself back on a treadmill of pressure. Parental pressure forced us to get married but I never told my wife about the abuse and my subsequent experiences.

We bought a house and our first child was born. Then we had a second child. The years passed and then the recession arrived. I was made unemployed, my wife became pregnant again and we had very little income. It got to the point where we couldn't pay the bills and our home was threatened with repossession. I decided that since I couldn't find any work I would have to find an alternative source of income. This would be through getting involved in crime. Unfortunately for me, to be a successful criminal you have to have a certain mentality: a criminal with a conscience is not a very good one. I would get paranoid about getting caught and being sent to prison and losing my family. The pressure became immense. Then I was fortunate enough to find legitimate work. But even though I worked seven days a week we were still in a lot of debt.

At this point I began to feel that society was conspiring against me. Due to the pressure and the stress, my paranoia increased and the voices returned with severity. One Friday evening I had just been paid and I was walking through the town centre. Suddenly, I was hit with a real booming, dominant voice which kept saying: 'You are Mickey MacAvoy and you are worth millions'. MacAvoy was a local villain who had stolen some gold years before. I foolishly believed what

the voice told me and, thinking I was a millionaire, I walked into a bar and bought everyone a drink, and then another.

When I returned home with no money I couldn't explain to my wife why I had done it. She was outraged. As she shouted and became aggressive towards me I began to have flashbacks of my tormentor. This added fuel to my paranoia. For months my experiences ebbed and flowed, but I still kept what I imagined buried and suppressed.

Eventually, through a twist of fate, with a friend I was able to start my own business. In the first year we had a turnover of £1million. At the time I felt that this could be the end of all the suffering, but it turned out to be only the beginning of a nightmare. My wife loved the great lifestyle she now had. This included a massive house and lots of money. But she wanted me at home as well. We were working eighteen hours a day, seven days a week, and unbeknown to her she became my tormentor. I would be out working late at night and she would ring me saying I was a bad father as I was never at home and never saw the children. So it felt like a woman was tormenting my mind again.

Due to this pressure of work and home-life, which became overbearing, my paranoia was becoming unmanageable and my behaviour began to spiral out of control. Now I am not sure what the significance of white cars was, but if one was to follow me for more than two streets I would turn my van across the road so the car couldn't get past, and then start banging on their windscreen asking them why they were following me. Of course, drivers would get aggressive towards me, too, but I continued to do it. Family members started to tell me I was looking ill, but I took no notice, thinking they were part of society's plot. On one occasion I was driving home late one night, down a country lane. As I looked in the rear-view mirror I really thought I could see 'Freddy Kruger' (a character out of a horror film) in the back of the van. I was gripped by fear. Paranoia was now starting to encompass my entire life.

As my paranoid experiences increased, the voices continually told me they were true. Now it was becoming very difficult to keep my experiences hidden, since they affected my behaviour so much. My paranoia about society, and about authority in particular, was growing rapidly. My wife was interested in fostering a child and arranged for a social worker to visit us. What should have taken me thirty minutes to drive home for this meeting took me three hours, because if I saw someone I thought I knew, I would drive in a different direction, fearful of what they may do to me. When I finally got home the social worker was still there. The voices convinced me that she was a man, a French spy in disguise. It was as if there was a radio in my head giving me messages from lots of voices. I felt that the social worker was another part of society's plot to destroy me.

Now I began to think that I was taking part in a mission that hadn't been fully explained to me, and that the whole world was out to stop me succeeding. I began to receive messages from car registration plates. BWG would mean 'Big White God', and this was a message to me from God, which I had to decode. I kept noticing registration plates with the letters AWF, and believed that this meant there was going to be 'A World Famine', and that I should prepare for it. I had to work out what food could save the world, and decided it would be turnips. I spent weeks buying turnip seeds and hiding them at home so no-one could find and destroy them.

After months, the fear and torment became too much and I finished up in full-blown madness. I simply couldn't see the world as others saw it. I feared for every second of my life, especially when in female company. I was admitted to the local psychiatric unit where, over a period of ten years, I became a revolving-door patient.

During the first admission the first doctor I saw said she wanted to give me a rectal examination. She gave no explanation of why she wanted to do that, and I felt it was part of the plot to get me there to be abused again. I tried to run away and was forcibly prevented and medicated. I was sectioned under the Mental Health Act, given the diagnosis 'chronic schizophrenia', and told I would never work again. During this admission I couldn't look in a mirror since all I could see was a demon. This demon had long hair and a beard and was black around the eyes. Later I could look back and realise that this was really my true reflection, but at the time no one encouraged me to have a shave or a haircut. At that time I was taking twenty-five drugs a day.

During all my admissions I never felt that the staff were particularly helpful, and quite often they increased my paranoia. One psychiatrist told me that because I didn't speak to staff or patients she was never, ever going to let me out of there. I felt this was further abuse by a female.

Once when I had been discharged I had a night terror and woke up screaming. My wife tried to comfort me but I couldn't see her. I could only see what had been in the night terror, and I thought she was trying to hurt me. In turn, I attacked her. This led to me being re-sectioned. Eventually, after many more admissions, my wife threw me out of our home. Again I felt abused by a woman. I then spent some time living on the streets, fearing for my life. I was now utterly convinced that society was out to destroy me 'because of my mission'. Eventually I was given accommodation by the local council.

One night I woke up and saw two monks standing at the bottom of my bed. One of them pointed at me and the other one walked through the bed and entered inside of me. I was convinced that I was possessed by this monk, who was eating all my food, so as to kill me. Within one month I lost a stone in weight. I went to see my worker at the day centre and explained about the monk and the weight loss. So she sent me for cameras to be pushed into every orifice, again making me feel I had been abused by a woman.

My paranoid beliefs were by now well and truly fixed. Somehow I had to work out my mission, to know how it would end. I would imagine that I had been sent messages in newspapers, and would try to decode them so as to understand my mission. All the time this belief was confirmed by my voices. On one occasion I really feared for my safety. I looked out of the bedroom window and saw a car with blacked-out windows. This made me sure I was being watched. I checked again two hours later and it was still there. At this point the voices convinced me I was under surveillance, so I drew all the curtains, bolted the doors and unplugged the telephone. Twenty-four hours later the car was still there. Now I was convinced that this was a major conspiracy. Six days later it was still there and I dared not to attempt to leave home. After two weeks, family members were concerned about my disappearance and attempted to enter my home. In my mind, this made them part of the conspiracy, because they were giving access to the people in the car. Eventually they broke down the door, and I couldn't

understand why they had taken sides with the enemy. My fear made me aggressive, and again I was sectioned. Since I had been put back in a place I feared, this simply reinforced my need to understand 'my mission'.

On being re-sectioned I was allocated yet another female psychiatrist. She continually over-medicated me, to the point where I had to wear towels as bibs so as to soak up the saliva running from my mouth, and my legs bounced up and down on the bed due to drug-induced involuntary movements. When I was summoned to see this psychiatrist I asked her when I would be going home. She said that she wouldn't release me because I never disclosed any of my experiences to the staff, and if I didn't start disclosing to them she would never discharge me.

So I started to tell the staff about my experiences. And as soon as I was included in the ward round the same consultant told me I couldn't be released because what I had said to the staff was too delusional. Once again a female authority held me in a grip of fear. Eventually, after a long time, I was discharged.

Now, through fear of the outside world, I became a very solitary and isolated figure who trusted no one, not even himself. After a period of months living in so isolated a manner, I was referred to an occupational therapist.

This was the start of my recovery, although I was very suspicious at first, especially since the therapist was a woman. However, she started to dispel my fears, both of women and people in authority. The first step was that she never bothered with trying to treat my diagnosis. Instead, she looked beyond it for the person – and found me. I explained

my fears about authority, whereupon she shared a bit of herself about the stresses, traumas and fears she had in her life. In this way I could see her as a human being, not just as a figure of authority trying to control my life. She went on to explore why I would isolate myself on a Friday, and helped me to work through my peculiar fears. Perhaps the most important thing that she did was to listen and to take time to explain that my beliefs and ideas, although bizarre at times, had a certain meaning in my life. She took the time to explain that every paranoid belief or idea must contain a seed of truth.

Still, at times, when my paranoid beliefs became really strong, Sally would become part of the plot and I would try to alienate myself from her. But she would not let me push her away, and she never gave up on me. Through this therapist's persistence and determination, and the self-belief she gave me, I started to understand the relationship between my beliefs and my life experiences.

All of a sudden, I could make sense of what I had previously been told was only a symptom of madness. Society had created my paranoia and compounded it by telling me that I was ill – mentally ill – when all along I was responding to the trauma experienced when I was a child. Once I had made this connection, others could understand my fears, and my paranoia decreased, although it never disappeared altogether. Now I have a clear understanding why the paranoia sometimes returns, and I use this as a warning-sign to address issues in my life. Paranoia is very closely connected to anxiety: if I can understand my anxieties they tend not to manifest as paranoia.

EXPLAINING PARANOIA: PSYCHOANALYSIS *vs* PSYCHIATRY

Phil Virden

Psychoanalysis

Paranoia is not usually the result of an actual illness. Of course there are bound to be somatic correlates (such as markers of unusual arousal and hormonal changes) – as with any emotional state – but at root it is a fraught, preoccupying and confused psychological condition that develops in response to overwhelming stress. Hence, the most convincing explanation of this condition builds on the ideas of psychoanalysis.

Of course, many people find psychoanalytic ideas personally insulting, and like to dismiss them as so much 'psychobabble'. However, this is often (or perhaps usually) without ever reading what Freud said, or really having anything but a prejudiced view about what some people say that psychoanalysts say. Freud was well aware of the function of resistance to his ideas: people tend most vehemently to deny those propositions about their irrationalities which actually hit closest to the mark. This is not to suggest that Freud knew it all and settled every question of psychopathology. Far from it, and far from what he intended, which was that any theory should be modified by lessons learned during the practice of psychoanalytic therapy.

It seemed to Freud that, to some degree or another, each of us is psychologically traumatised and fearful, and that character always develops as a defensive response to that trauma and fear. Anxiety is experienced simultaneously as a crowding-in of threats and pains and yet, since it is a feeling of vulnerability and powerlessness, also as a kind of emptiness. And any pathological response to anxiety is bound to seek its interior or exterior reasons – or rather, 'rationalisations', 'explaining away'. In the first case, the person descends into depression: this is a feeling of essential personal worthlessness or harmfulness which leads to withdrawal, apathy and passive circularity. In the second case, there arise uncontrollable feelings of persecution and an active and projective delusion: this is paranoia.

So Freud recognised that every one of us is always prone to paranoia, especially when we feel under stress: this is a result of the normal conflicts of psychological and emotional development.

So far, so good. Now we come to Freud's conjectures about the development of paranoia within the adult psyche. He considered that the ideal of heterosexual maturity emerges out of two preconditions: (1) an original state of 'polymorphous perversity' (the desire for unlimited pleasure via every body surface and orifice) and (2) love yet hate and rivalry with both parents. The ideal of 'maturity' promises redemption from that deep, constitutive fear of and for the self which is conceived during those inevitable Oedipal conflicts experienced during the 'civilisation' (i.e., socialisation or 'breaking in') of the child.

Doubtless, Freud's thinking about paranoia would have been conditioned both by the very strait-laced homophobia of respectable society one hundred years ago and by his own 'hang-ups'. Nevertheless, what he had to say does follow a certain logic which makes a kind of sense, and certainly he poses the kinds of questions that preoccupy people, and which they cannot sometimes keep from running through their minds.

In Freud's view, paranoia is specifically a disguised form of homosexuality. Given love of oneself, love of one's own sex, of the similar, is inevitable. However, there is a taboo on that idea which makes it unbearable; hence it turns into hatred of the self for having the thought or feeling; but it is also intolerable to hate oneself, and so the hatred gets projected onto others and returns as a feeling of persecution. This happens because when a boy moves towards the heterosexual desire of his maturity it is under the threat of castration (i.e., he is also forced to submit to authority); but if he refuses to acknowledge this threat it is repressed, along with his femininity and his desire for the masculine object; to the extent that it is repressed rather than sublimated into the male bond, his homosexual feelings always return. The defence against homosexual desire is paranoia: the man denies his desire and instead asserts his antipathy to it; this hatred finds its justification as the projection of an enemy; this, in turn, is generalised as a feeling of persecution. And '...[i]t is the most loved person of their own sex that the paranoiac fancies as their chief persecutor.'¹

Every Freudian agrees that dealing with anxiety is the basis to the development of the personality, and that to be anxious is to be flooded with a feeling of dread and yet at the same time emptied, to be overwhelmed and confused by unacknowledged or unnameable fear, and to feel bereft of love and succour – of the love of the (m)other.

However, in the light of their therapeutic work, some analysts came to believe that Freud's ideas needed modifying. Freud had already pointed out that pain and anxiety are not differentiated during the first year or so: to escape pain one cannot at that early age 'remove oneself into an image'. At

the same time, the infant is at first completely egocentric and relates to that part-object which gives pleasure: he or she relates not to the mother but to the breast. It seemed to Melanie Klein that this gives rise to the primary paranoid-schizoid attitude in which, due to painful yet inevitable interruptions in the flow of pleasure (first of all, milk), the infant cannot but project his own fears onto others conceived as persecutors: he develops an overwhelming fear of his own annihilation. Hence, paranoia is the result of the actual intolerable intrusions of another, whether deliberate or involuntary, conscious or unconscious.

The infant responds to the anxiety caused by inevitable separations from the source of his pleasure by means of projects to re-establish the original unity with his mother. He learns to relate to whole objects, and to recognise his ambivalence towards them. Internal conflicts about these exterior objects (parents and others of significance to him) are then moderated, but only at the cost of adopting a depressive attitude in which the child fears that even though he contains his behaviour, his destructive wishes will yet harm the loved object (the person who is loved-and-yet-also-hated). This development is traumatic and yet normal, and even when its resolution is more or less successful it leads to a residual tendency to depressive anxiety. Depression does not manifest as paranoia, it simply derogates the apparently worthless self.

For the main school of revisionists within the psychoanalytic movement, then, it is not sexual repression which is the prime cause of mental order and disorder. The object relations school of psychoanalysis, based in England, conceived of the basic emotional trauma as 'the loss of the object'. It suggested that deprivation of warmth and love is the infant's earliest experience of rejection, and that this leads to disturbances in the person's ability to recognise and react appropriately to the anxiety-provoking circumstances he later encounters; hence, there is less interest in the classic Freudian questions of sexual-instinctual satisfaction.

It seemed to Klein that the development of psychosis is due to major disturbances in the person's earliest relationships and in the development of his active self (the ego). This idea focuses on the ego and processes of relating to the world, especially the world of near others (and the first object for the baby is the warmth and succour of the mother/breast). Ego-psychology is interested in the urge to fulfil the self by mastering or coming to terms with the environment, i.e., as psychopathology, in those developments which inhibit personal autonomy. In particular it is concerned with questions around the impulse to relate, such as problems in relationships like blockings and imbalances in the child's (and later, the person's) permission to be himself. The infant and growing child cannot experience the world as fundamentally kind and supportive if those around him do not tolerate the full expression of his emotional responses towards painful events; he is able to develop only by denying either the

pain, or the events, or both; he splits his energy in a form of dissociation, whereby the painful events are forgotten.

Hence, ego-psychology explains paranoid (or schizophrenic) breakdown as unremitting panic at some moment of developmental crisis, such as adolescence. A person is susceptible to panic if some hidden, unacknowledged or undisclosed trauma already causes him habitually to be visited by intense and overwhelmingly anxiety. Due to his conscious or unconscious preoccupation with his own persecution, the anxiety inhibits the development of his autonomy, and the child (and the person he becomes) develops a paranoid-schizoid retreat from the world. So as to cope with his life, the personality 'splits' and two separate identities develop: the individual alternates between being pleasant and capable ('normal') and then a paranoid victim who identifies with his persecutor and is unreasonably angry and punitive towards others. His 'central ego' has to deal with the practical everyday world as it arises, and yet there is less energy for it to call upon since so much is invested in coping with his emotional pain. The 'anti-libidinal ego' which results from such a severely neurotic or outright psychotic adjustment is not completely lost to awareness, but the 'libidinal [loving] ego' is lost because it suffered too much pain. The 'bad objects' (the images and voices of those who caused the pain) are introjected,

and the anti-libidinal ego maintains its paranoid-schizoid position. Unless the person is somehow enabled to express all his hateful and hurtful emotional energy within a loving or accepting relationship, this will only continue. And yet, of course, his paranoia militates against happy and easy personal relations, and he is more likely to move further into isolation and deeper into crisis.

After working with children for many years, Klein was persuaded that everyone's primal anxiety is for his own integrity. She argues that when the infant is deprived of the mother or breast:

... [he] reacts with a temper tantrum and the fantasy that goes with the tantrum is to tear everything out of the mother's body ... The child then fears retaliation for these impulses, i.e., that everything will be scooped out of its own inside.²

Thereafter, the child (and later the neurotic or psychotic adult) not only fears and is frustrated by the loss of succour but becomes over-anxious for the integrity of his body. He begins to fantasise restitution, the wish for protection and for his indestructibility from the 'bad' forces that he imagines are within him and around him. Hence, the psychotic has not overcome his juvenile pre-ambivalence towards others: he is unable to tolerate a relationship with another person that is both loving and hating – he either loves absolutely or he hates absolutely; he is in full retreat to a paranoid-schizoid position.

In this view, functional mental disorder ('mental illness') is essentially a panicked response to unacknowledged and unresolved loss and grief. Moreover, Klein suggests that the development of a psychosis depends upon such severe anxiety that it becomes impossible for the child to properly learn and use symbols. Since he needs secure early distinctions – such as that between what is experienced as inside and what is outside – without the easy and effective use of symbols (mainly speech) it is very difficult for the child to negotiate his world. An infant takes in language with the mother's milk, when he is absolutely dependent and can only properly learn to tolerate his inevitable pains and frustrations if he is rewarded by compensating sustenance, touch, love and reassurance. Excessive and confusing pain and frustration at an early age makes the child anxious and confused about himself, about others, and about the world as a whole. He cannot symbolise and represent his own experience to himself with any confidence or realism. This accounts for the psychotic's hallucinations and delusions (his retreat into fantasy); it also accounts for the solipsistic and literal employment of metaphor, including hysteric symptoms.

The development of a psychodynamic can only proceed in a line from one's earliest experiences, and whether that development is normal, seriously neurotic or psychotic depends crucially on the parents' (especially



Picture: Warwick Edwards Steeples

the mother's) helpful or unhelpful responses to the infant's earliest spontaneous movements, gestures and expressions. DW Winnicott³ suggested that the relationship between the mother and the child must have been so disturbing to the person who becomes psychotic that his major concern when he was an infant was compliance; and since all of his experience and knowledge depended on the veto of a disturbed mother this could only lead him to perceive himself as false or unreal. In other words, so as later to become psychotic the child must be deprived of maternal empathy or sensitivity to his needs for warmth, succour and approval. Winnicott agrees with Klein's formulation, that the person who has no fundamental sense of self-worth enters the depressive position and is liable to feelings of guilt and self-blame. And mania and paranoid delusion are forms of denial, defences against profound loneliness when there are no internalised 'good objects' to give the person any sense of a valued identity.

Whether one will admit ideas like these or not, in biochemistry or genetics there is absolutely no evidence for 'the medical model'. Neither can medicine cure any functional mental disorder. And so it does seem most useful to consider clinical paranoia not as some kind of a 'mental illness' which randomly incubates within, or descends upon, some unlucky persons and not others. More likely it is an anxiety-driven, panicked and irrational defence against the actual intolerable intrusions of another or others, of real experiences and profound feelings of insufferable loss or persecution – simply those intrusions or persecutions which are not privately or publicly acknowledged, or indeed, for one reason or another, are privately, publicly or officially denied.

Psychiatry

Since members of families and officials have their own private and sometimes secret and motivated interests, if these are at odds with the truth that a complainant struggles to express, it is not at all necessarily the case that someone's complaints of persecution are quickly and easily validated or invalidated or otherwise explained. Although we may recognise that some people are absolutely preoccupied by feelings of persecution, and express their overwhelming feelings in a bizarre manner, the best hypothesis is that those feelings are nevertheless based in real events – simply events that are not easily spoken about, or which nobody wishes to hear. And in the current set-up, it is not a painstaking and impartial judge and jury but mainly other members of the family and harassed psychiatric officials who make every judgement about whether or not an individual's fraught sense of persecution is based in real events, and may or may not be worth listening to, deciphering and investigating.

In practice, in this exercise of social power and authority, judgements are usually made in haste and 'on the hoof'. And

by the time a doctor is called in, or the police, the individual concerned is usually so agitated that it already seems too late for anything other than 'rubberstamping' a diagnosis of paranoia (usually 'schizophrenic'). In these routine, hasty, rule-of-thumb judgements about sanity and insanity, plausible complaints of persecution are differentiated from implausible mainly by polling the opinions and reasons offered by those who claim to know the individual very well: generally, by consensus, or at least the consensus of 'responsible persons', the person is already known as a paranoiac whose fears are silly and quite unjustified. Of course, at this normal level of investigation there is no guarantee at all that the consensus actually knows or admits the whole truth of the matter.

Meanwhile, what settles things quickly for conventional thinking and conventional psychiatry is that the paranoiac takes his oppression far too personally. His ego is too damaged; he is too upset and too distrustful of everyone. Consequently he is unable (at the moment) to keep a cool head, to maintain a full commitment to dialogue and thereby possibly, by means of the qualifying help of rational others, orientate himself by means of a narrative which corresponds sufficiently with reality to allow him to recover his equilibrium and autonomy. However, this does not mean that the diagnosed paranoiac is stupid and does not rumble some or many of the vital secrets or hypocrisies by which oppression really is perpetuated. Too often this includes his own present psychiatric oppression, perpetrated and unacknowledged by that majority of 'experts' and officials who refuse to respond to him with genuinely engaged sympathy and empathy. Moreover, any therapy which fails to acknowledge a patient's valid perceptions of socially uncomfortable truths forfeits the possibility of ever influencing his paranoia. As it stands today, if it immediately finds them implausible or simply uncomfortable, 'medical-model' psychiatry dismisses every one of the paranoiac's feelings and ideas as only 'delusional', or 'largely delusional' – as only the unaccountably weird symptoms of 'a mental illness' which unaccountably descended upon, or incubated within, that unfortunate person.

However, we would all do better to remember that just because a person is paranoid that doesn't mean that someone else is not (or was not) really out to get him.

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RETHINKING

Dave Harper

My relationship with 'paranoia' is multi-stranded. As a clinician, I have worked with many service users who either felt paranoid or were seen by others as periodically paranoid. I've also had a research interest in this topic for nearly twenty years, exploring how service users, professionals and others talk about it. However, I also have a personal interest. My mother, who sadly died in 2001, had some quite serious bouts of depression and paranoia – at times to the point that she sometimes feared that others were planning to kill her. I remember visiting her in the old Lancaster County Asylum, in the late 1970s, and hearing her whisper to me and other family members that the staff were trying to kill her. In later years, when she was terminally ill, she would fear that those close to her wanted to kill her, too. Looking back, I can understand why she might have felt that way, particularly when she felt frightened, alone and in a situation where she was not fully in control.

Psychological approaches to paranoia are very much in vogue at the moment. Cognitive clinical psychologist Daniel Freeman's work on paranoia has even been reported in the pages of *The Sun* – of which more later. While these kinds of approach can be useful to people by helping them develop practical coping strategies, in this article I'd like to take a step back and spend some time considering what we mean by 'paranoia' since that has big implications for how we might address it. I will unpick some of the assumptions that are implicit in the notion, before moving on to examine links between feeling suspicious and social inequality. Finally, I'll look at alternative ways of viewing these kinds of beliefs and fears.

The problem with (definitions of) paranoia

According to traditional psychiatric definitions, like the American Psychiatric Association's DSM-IV, a delusion is a false and irrational belief held by an individual. It is said to be held despite proof to the contrary and what others believe; it is also not accepted by others in that person's culture or sub-culture, and it is firmly held (though it is accepted that this might vary). For a delusion to be considered paranoid (or, in the psychiatric jargon, 'persecutory') the central theme of the belief is that the person (or someone close to them) is victimised or conspired against in some way, and that there is an explicit intention to harm them.

This definition rests on four fundamental assumptions which need to be challenged since I think they get in the way of more helpful ways of looking at beliefs and fears.

1. Traditional approaches are based on a simplistic view of reality

One of the most basic problems with the notion of delusion is the idea that it is possible to conclusively



prove that a person's beliefs are false. However, we know that most people end up with this diagnosis without any independent investigation – probably the most that will have happened is a psychiatric interview with the person, and possibly a family member. The psychologist Brendan Maher has argued that the assessment of the plausibility of a person's beliefs is 'typically made by a clinician on the basis of "common sense", and not on the basis of a systematic evaluation of empirical data'. He notes that 'it is not customary to present counterevidence to the patient; it is not even common to present vigorous counterargument'. (See end of article for all references.)

Many service users find it annoying that they are told they are delusional when no investigation of their claims appears to have taken place, even when such an investigation might be quite straightforward. In my research interviews with professionals I have often been given examples of so-called delusions that either turned out to be true or which at least had a kernel of truth in them. In the scientific literature this is termed 'The Martha Mitchell Effect'.

During the Watergate scandal, the late Martha Mitchell was the wife of President Nixon's Attorney General, John Mitchell. When her husband's role in the cover-up became public knowledge she was often in contact with journalists. Being from Arkansas, she was apparently known as 'the Mouth of the South'! She claimed that Nixon staff kidnapped her and kept her sedated in a California hotel room, so as to prevent her from contacting the press. Other aides tried to discredit her by leaking stories to the press about her having drink and mental health problems. However, Brendan Maher, who coined the term, notes that that the supposed evidence of a mental health problem was cast in a new light when the full details of the Watergate affair became known. In fact, she became a heroine: Nixon told David Frost in a series of interviews some years later that 'If it hadn't been for Martha Mitchell, there'd have been no Watergate.'

When a diagnosis of a delusion is based more on a judgement of plausibility than any proper investigation it means that different diagnoser will probably come to different conclusions. Indeed, this is what we find with many cases of so-called delusion. Anyway, how many of us could say that we have objective evidence for all of our beliefs? Is it even possible or desirable to have 'evidence' for political, ethical, and spiritual or religious beliefs?



As an experiment, it might be worth visiting two websites constructed by people who feel that they are being persecuted by security and intelligence agencies: <http://www.mindcontrolforums.com/pro-freedom.co.uk/> and <http://www.five.org.uk/>

Both sites present evidence for their authors' views, and it is likely that some readers will be persuaded and others not. We saw a similar thing with the conspiracy theories about the 9/11 New York attacks: many people see the same event but come to very different conclusions. So, rather than a simple matter of whether something is or is not true, in the end it comes down to what kind of evidence you find more or less persuasive.

2. Conventional theories see delusions as abnormal in some way, but they are not as abnormal as we are led to believe

'Brits Are Paranoid!' screamed the headline in *The Sun* on 2 April 2008. This accompanied a story about Daniel Freeman's research, which claimed that 'more than one-third of Brits are paranoid.' This illustrates a second problem with the way 'delusions' have been viewed. If many more of us than expected are 'paranoid' then in what sense are such beliefs abnormal? Indeed, surveys of the general public regularly reveal high rates of belief in supposedly irrational phenomena. For example, a 1995 Gallup survey reported that 45% of people surveyed believed in telepathy, 45% believed in the ability to predict the future, 42% believed in hypnotism, 39% believed in life after death, 39% believed in faith healing and 31% of people believed in ghosts. It is even harder when it comes to judgements about others' motives. Another Gallup survey, in 1994, found that 24% admitted lying at least once the previous day, and 64% thought they had been lied to. In a further Gallup survey, in 1997, 60% felt that 'one could not be too careful in dealing with people', whilst only 37% felt 'most people could be trusted'.

One objection to this might be that surveys of belief in ghosts or whatever is one thing but that's not the same as psychiatric research. However, Emmanuelle Peters and colleagues at the Institute of Psychiatry conducted some interesting studies using the Peters et al. Delusions Inventory (PDI). This is a questionnaire survey of beliefs that would be regarded by a psychiatrist as delusional but which is deliberately phrased using everyday words rather

than psychiatric jargon. Their studies found much overlap between the general population and those actually diagnosed with delusions. Using the PDI, a whole series of surveys have been carried out on the British, French, Dutch and New Zealand publics: anywhere between 3% and 20% of those populations hold beliefs which would be regarded as delusional. In another study, nearly half of British college students reported an experience of paranoia, including a clear statement that they felt there had been a planned intention to harm them – the key criterion for a diagnosis of a paranoid or persecutory delusion. Daniel Freeman noted that 'a conservative estimate is that 10 – 15% of the general population regularly experience paranoid thoughts.'

What are we to make of these surveys? They show that such experiences are not nearly so unusual or abnormal as we are led to believe. Given that that many people are not accessing mental health services, they suggest either that there are great numbers of undiagnosed people who need help (an assertion made by some psychiatrists) or, more plausibly, that many people hold such beliefs and do not require help from the mental health services. As with the Hearing Voices movement, I'm sure there is a lot we could learn from how people are able to cope with such beliefs without seeking help from mental health services.

Of course, it might be argued that there is some difference between beliefs in the general population considered paranoid and delusional and those of mental health service users. However, a couple of studies suggest otherwise. In one investigation, Peters and her colleagues reported that although 'psychotic in-patients' had higher scores on the PDI measure than the general population, there was also considerable overlap between the two groups. In other words, some members of the general public actually scored higher on the delusions survey than those who were psychiatric patients. Where the two groups appeared to differ was that the general public were less preoccupied with, distressed by, and convinced by their beliefs. Thus, in contrast to conventional wisdom, it did not seem that the problem was whether you held 'delusional' beliefs per se, but rather whether they were getting in the way of your life or causing you distress.

Peters and her colleagues conducted a further study where they compared members of new religious movements (Druids and Hare Krishnas), non-religious people, Christians, and 'deluded people' by their scores on the PDI measure. They found no differences between the members of 'the New Religions' and 'deluded people', in terms of either the number of beliefs held or the strength with which they were held. The only differences between the groups were the degrees to which the participants were preoccupied with their beliefs and how distressed they were about them. Thus, whereas traditional psychiatric approaches assume that the problem is holding a belief generally considered a delusion, this research indicates that the key issue is the relationship people have with their beliefs – in other words, whether your beliefs get in the way of the life you want to lead.

The notion of beliefs being seen as normal and abnormal is an interesting one, anyway. For example, when one looks at the issue of religious faith it may be

the mental health professionals who are 'abnormal' since it is a fairly routine finding that they tend to be less likely to have a religious faith than the general population. For example, Tom Smiley asked British clinical psychologists in the South East about their religious beliefs, and then compared the results with the UK population as a whole. He found that whereas 61% of psychologists identified as having no religious belief, agnostic or atheist, only 28% of the population as a whole did so. Likewise, only 31% of the psychologists identified themselves as Christian, as against 64% of the general population. Thus, in relation to religious belief, it is psychologists who are in the minority! This is even more likely in the USA where a greater percentage of the public hold religious beliefs.

3. Delusions are seen as meaningless, and yet they are full of meaning

Just as the mental health services were historically more interested in whether someone heard a voice rather than in what the voice said, the assumption has generally been that beliefs viewed as delusional or paranoid are without any meaning. However, there is mounting evidence that such beliefs are full of meaning. One study reported that those with a diagnosis of delusions scored highly on a measure of 'purpose and meaning in life', suggesting that these beliefs may actually give people a meaning in life even though, in the case of those who feel paranoid, the meaning may not be very pleasant. Perhaps this is not surprising. If you are unemployed, poor and living alone on a frightening housing estate, with little else to do, it may be preferable to imagine that you are Jesus, or more likely that you feel watched and persecuted. Other research has reported finding links between the themes in a person's 'delusions' and their everyday life or past.

There is an important correlation between paranoid beliefs, social inequality and victimisation. In a study carried out in El Paso, Texas and Juarez, Mexico, across the border, Mirowsky and Ross found that those with the most paranoid beliefs tended to be working class Mexican women – precisely those who were in social positions most characterised by powerlessness, exploitation and the threat of victimisation. When a person is not fully in control of her life – for example, when at any moment she could be sacked from her poorly paid job (and perhaps deported) – in a very real sense others do have her in their control and she may well feel as if she is persecuted. This is one reason why professionals working with people from minority ethnic populations talk about 'healthy paranoia', i.e., an understandable wariness of others, particularly those in authority, and borne of prior negative experiences. Perhaps this also explains the reported link between being an immigrant or a refugee and holding paranoid beliefs. Although migration is stressful in itself, and although refugees often flee traumatic situations, research suggests that one of the main causes of paranoid feelings is the reception by the host community – for example, whether one's reasons for

travel are believed and whether one can access work and accommodation, etc. Racism also plays its part. A number of studies now suggest racism may be one of the causes of the high rates of psychosis amongst the black population; in an article I wrote with John Cromby we discuss emerging evidence that discrimination and victimisation are also linked to the development of psychotic experiences.

4. Anyway, who gets to decide what is 'unusual'?

Of course, a key assumption when we say someone has a delusion is that this is a fact rather than an opinion. Yet what is really going on is that one person's evaluation of another is proposed as a statement of an objective fact. The psychiatrist Suman Fernando puts this well:

In the process of making a diagnosis, judgements are hypothesized as symptoms and illnesses – as 'things' that exist in some way separately from the people who make the judgements and from the people ('patients') who are said to 'have' them.

In other words, when we say that someone has a delusion, we are usually either saying 'that idea is implausible', or 'I don't understand that idea', or even 'that idea is dangerous'. The processes by which we come to these judgements occur between people in conversation, and it is likely to be influenced by everything which makes us different from each other. However, in traditional research it is assumed that one can diagnose someone as delusional without reference to the views and opinions of the diagnoser.

Some years ago, David Ingleby wrote about this. He argued that it was not possible to understand someone without crediting them with a basic degree of plausibility; the more 'charitably inclined' we were to someone, the more likely we would be to see their actions as making sense.

However, the fact that the process of judgement is obscured in traditional accounts is not the only problem. A related problem is the issue of the power to define reality. In the diagnostic interview, one person's version of reality (the mental health professional) is viewed as much more valid than the other's version of reality (the service user).

When trying to help people who are frightened about being persecuted, these four assumptions simply lead us into a dead end. To get out of this dead end, we need the same kind of revolution in the way we think about 'delusions' as the Hearing Voices Movement brings to the way we think about hearing voices.

Towards an alternative approach

Firstly, we need to find an alternative to the notion of 'delusion'. The shift from 'auditory hallucination' to 'hearing voices' is good because it is descriptive and is open to different interpretations. I do not think the term 'unusual beliefs' is any better – unusual to whom? And



'unshared belief' assumes that the notion is not shared by others, and yet often it is.

Rather than seeing paranoia as a kind of belief, John Cromby and I have argued that it makes sense to view it as a kind of story embodied within us as a result of our experiences in life. By connecting apparently unconnected happenings, such a belief may help someone to make sense of a confusing world when they feel influenced by forces beyond their immediate perceptions.

In therapeutic work in this area, it is important to keep two principles in mind. First, that people should be free to believe whatever they want, subject to the usual constraints of a democratic society (i.e., not impinging on the rights of others). Second, that it may be more helpful to focus on the 'fit' between a person's beliefs and the lives they wish to lead rather than on changing the belief itself. Rather than assuming that the person needs to become more rational, and trying to eliminate the belief in some way (e.g., through the use of psychiatric medication), the focus should be on helping the person to manage their beliefs and fears whilst negotiating their life in a world which may not share those beliefs.

In following this approach we need to acknowledge the subjective, social and political nature of our judgements about beliefs. We need to be sensitive to how the belief fits into the person's history and life. Jacqui Dillon, chair of the Hearing Voices Network (HVN), puts it nicely: 'Instead of asking what is wrong with people, we should ask what has happened to them.'



We need to apply what we know from the work of the HVN, Marius Romme, Sandra Escher and others, so as to help people to develop an explanation of their experiences which:

- makes sense to them (i.e., fits with the way they see the world)
- does not unduly distress them
- puts them in contact with a community which shares those meanings
- allows them to lead the lives they wish.

Some moves are already being made in this direction. For example, Rufus May and Evolving Minds in Yorkshire have both done some interesting work. Also, Tamasin Knight has argued that we could usefully draw on coping strategies found in different communities, ranging from Alien Abduction communities to New Age spirituality. She has written about how, at one point, she felt that tap-water was contaminated. She argued that, rather than focus on whether this belief was true or not, a more pragmatic approach was simply to drink bottled water. She makes the point that one of the best ways of coping with distressing beliefs is to focus on the life you want to lead, and to try to not let your fears prevent you from living that life:

Some years ago I became very distressed as I

believed I had a physical illness that would kill me in the not too distant future. I later became able to cope with this by thinking that if this was the case, then I should do the things I felt were important and enjoyed right away, rather than leave them to the future. By getting involved in activities I felt were important and worthwhile and building up my social network, the unpleasant beliefs I experienced became less central and troublesome in my life.

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PARANOIA & RECOVERY

Angelina Cosgrove

Is recovery from paranoia possible? If you ask a consultant psychiatrist, the answer's probably 'No' or 'Very unlikely, and definitely not without medication!' I often wondered how psychiatrists gained such control over our minds when surely the best person to understand them is us. So, I ask again – is recovery from paranoia possible? The answer is a resounding YES!

But what does recovery mean? The dictionary would have us believe that recovery is 'regaining of or possibility of regaining something lost or taken away; the restoration or return to health from sickness'.

I wondered how those words were relevant to me, or even if they were relevant. When I had a breakdown in 2001 I lost my job, I lost some friends, I lost my marbles and I very nearly lost my life. Did I regain any of that? I don't think so. I never got my job back, but once I was well enough to work I had a complete career change and began to work in the field of mental health. I never found those lost marbles but I think I found a few new ones, and I made some new friends on the way. So, no, I didn't regain anything, but I did gain a new life.

During 2001 everything was going wrong. I heard voices of people who weren't there, I saw and felt things that weren't there, and I began to have more intrusive thoughts. I was confused, anxious, paranoid and suicidally depressed. I couldn't do anything at this time. I was almost paralysed by my madness. Washing and dressing was too much effort, and I lost the ability to make a cup of coffee. All I could do was sleep and, when I was awake, fight to make myself feel safe in the hope that I would make it through the day without trying to kill myself. Somehow through all of this I managed to take my children to school and pick them up again: a blessing and a curse. The fact I had no choice but to get my kids to school made me focus on something else. However, I would struggle so hard to walk down the street and, even worse, walk into the playground. It hurt physically and mentally to do this, but I had to do it. My legs used to turn to lead and my usual confident stride seemed to have become the shuffle of an old woman, and I knew that everyone was looking at me. I felt that they could see my thoughts: that they were laughing at me. I felt I knew that they knew I was mad! I believed that my husband and my best friend were talking about me on the phone, behind



my back; that they were plotting something and, in my paranoid and medicated haze, I stopped trusting them.

By 2009, what's changed? I still get intrusive thoughts, and my greatest fear is abandonment. I'm depressed and often suicidal and believe that I should be dead. I see things I know are not there and I become paranoid. I still do stupid, destructive things, like impulsive spending when I have no money, I have disordered eating and occasionally I self-harm. I feel as bad as I did eight years ago, and it would be easy to feel that nothing's changed.

But that's not true. In my depressed state it took someone else to point out how far I'd come. I doubted them and just wanted to hide away and felt hopeless. But when I started to reflect on that it hit me – actually I have come a long way. I may feel the same as I did then, but I am coping with it differently. Intrusive thoughts may tell me I'm a horrible person and shit at my job, but I know it's not true. Paranoia still grips me and I can walk into a supermarket believing that everyone's looking at me, or laughing at me, and I might hear people saying things to confirm that, but I still push through it and do the shopping. I can be suicidal one day and euphoric the next. Sometimes I still see things that are not there and believe bad things are going to happen. But, through all of this, I go to work, I see my friends and I have a good time. Now I'm studying with the Open University, and I cope with two teenagers. I'm passionate about my work. I'm caring and compassionate and treat the people I work with as human beings, looking beyond their diagnoses to the real person.

So, to ask the question again – in 2009, what's changed? I have. What I do now shows me that I am in recovery. Yes, I still suffer, but recovery to me isn't about regaining lost health and a lost former life. It's about gaining a new life. A new life as a mad person, yes; but I am mad and I am proud!

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'Normal' and 'particular' have fluid boundaries

The extent, duration and frequency of psychotic symptoms show great variations and degrees. No one is exclusively sick or healthy. One way of demonstrating this is by considering the other extreme. A perpetually identical mood, level of activity and consistent perception of the same things is almost inconceivable, and if it were possible, it would be extremely boring.

The vast majority of people experience momentary shifts as well as long-lasting creative periods, but also times which are marked by 'unrealistic' self-doubt. People often keep this to themselves. The media and our culture promote a different image of how we should be: forever young and active, and irresistibly beautiful. But once you begin to inquire amongst your friends you hear about unimaginable experiences and many serious crises. It is simply not intelligent to consider all deviations from the norm as precursors of an illness.

Concerning our thoughts and perceptions, from a philosophical perspective it would be odd were we always unhesitatingly to ascribe generally acceptable meanings to certain concepts and observations, knowing that each individual has highly personal and well-differentiated experiences that are relevant only to them. Usually this type of consensual communication works fairly well. But everyone knows that, even during periods of good health, certain words, notions, colours or images can take on different meanings – be that by virtue of a particular artistic interpretation, a literary work, or a bad dream.

Changes in mood, perception and thinking are not necessarily worrisome, per se. But these changes can go so far that any sense of self-assuredness ceases and the person, his or her family, and others can rarely deal with it on their own. The extent of particularity we are able to accept and cope with depends not only on individuals' experiences, but also on the culture in which we live and the image of humanity we espouse. Therefore, it is less than helpful when psychiatry represents a rather narrow image of normality, and in a rather formal manner applies the label 'illness' to many variations in being.

I know many artists who converse more intensively with their souls than I do, and who say that they could not create without these paranormal abilities. Psychiatry today bears the risk of characterising all unusual emotional life, which had positive connotations during the Romantic period, as pathological and apt to be stamped out. (Prof. Emrich, Chairman of the Dept of Psychiatry, University of Hanover) Maybe many experiences have to be considered as ill, since they are no longer accepted as eccentricity or originality in everyday life. (Dr. Schubert, Theologian, Hamburg)

Theses for an empathic understanding of psychosis

There is no irrefutable and generally accepted explanation for psychotic experiences. All we can know definitely is



that any explanation pointing to a single cause is short-sighted – irrespective of whether this cause is biological, social or psychological. Every scientific attempt to reduce these complex processes to one cause has proved wrong, and has caused much harm. This applies as much to 'the schizophrenic mother' as to 'metabolic disturbances of the brain'. Schizophrenia is much more than a brain disease!

Given that a great number of people in numerous situations and in every culture experience psychosis, we can assume the following: it is a part and parcel of our human potential, for now and the foreseeable future, and that we tend to move between levels of reality during crises, when we step outside of our usual selves with our moods and thoughts. Therefore we should spend less energy on trying to determine, once and for all, the general cause of psychosis. Rather we should try to understand it as it pertains to each individual and his or her particular situation.

Every psychotic experience is singular

Every psychotic experience is different and tells a particular story. Psychosis is always an individual process which can only be understood, within the social context, by means of subjective explanations. A diagnosis may be relevant for communicating among professionals, but it does not create a new 'fact'. Diagnosis should never convince us that we are treating an illness in lieu of a unique human being.

Psychotic experience is innate to every human being

Every human being carries the potential for experiencing psychosis. Depending on the degree of sensitivity or insouciance, a greater or lesser degree of stress may be required to induce the flooding with stimuli, or severe isolation, which in turn may trigger psychosis. But no one is absolutely protected. If he considers his dreams or recollects particular moments during childhood, everyone can have an inkling of the psychotic experience.

There are many similarities between psychosis and dreaming. Unconscious material breaks a path through into awareness. Wishes and fears coalesce. As much as there are wishful dreams and terrifying nightmares, there is also desire and the fearful aspects of psychosis. A major difference is that when we dream we are protected by sleep, but we have all had similar experiences while we were awake.

And when a small child perceives the whole world in

an egocentric manner, relating every tension to itself, we recognize that this is a necessary phase of development. When an adult does the same thing we consider that he or she suffers from paranoia. However, regression to transitional forms of child-like perception can also make sense in the context of the psychological development of adults.

Crises and risks

Psychoses tend to occur during times that are crucial for the individuals concerned. Crises are an unavoidable part of life. By 'crisis' is meant a phase in which the person tries to anchor himself anew – events such as growing apart from the parental home, establishing a serious relationship with a lover, the birth of a child, entering the world of work, as well as many other transitions and separations. Such a phase is invariably associated with a greater sense of insecurity and of the need to find oneself anew. Particularly sensitive people may experience such phases as profoundly threatening. It cannot be the goal of treatment to avoid crises like these, at all costs. This would only lead to a risk-free and basically dull and underdeveloped life. It is much more important to engage those individuals who experience psychosis in long-standing therapeutic relationships which permit rapid and effective intervention during any crisis.

Human themes

Fundamental human conflicts are reflected not only in the occasions, but also in the basic themes of most psychotic experiences. Such themes may be the difficult struggle towards irrefutable singularity, the narrow path between dependence on others and unavoidable loneliness, the balance of closeness and distance, orientating oneself in an increasingly confusing world, confronting the finality of the transcendence of life, etc. People frequently find it hard to reconcile the expectations and concerns of others, or the unspoken norms and rituals of the past, with their own experienced realities. This makes for a lack of fit between self-image and the views of others.

Particularly sensitive individuals are considerably more unsettled by these themes and conflicts than others. But it helps them when we don't consider and treat those basic conflicts, themes and tensions as signs of an illness, and encourage them instead to form a connection with those personal life-struggles.

Different by nature?

The more sensitive the person, the easier it is for him to be 'beside himself' in a time of crisis. Both lack of affirmation and particular stressors can make a person seem more vulnerable 'by nature'. It seems obvious that people have different degrees of sensitivity, from birth onwards. And it would be surprising if heredity plays no role at all. But there is no scientific evidence at all for 'predispositions' to any types of human behaviour, due to some kind of measurable

genetic or biochemical difference. There is simply no evidence for the inheritance of a 'psychotic personality' or a 'predisposition to become psychotic'.

Vulnerability in both directions

A schizophrenic psychosis must be understood as a state of extreme vulnerability, with the risk of being flooded by both stimuli from the outside and impulses from within. Consequently, a flight into a different or peculiar reality may result as a form of self-protection. This permeability works in both directions: internal material manages to escape without hindrance, issuing as visions or voices; and actual external stimuli, tensions or conflicts, which are filtered out or repressed under 'normal' circumstances, reach the inside without the chance of being warded off. In general, lest everything becomes 'psychologised', therapy should not limit itself to the inner world when analysing the sources of anxiety-provoking stimuli. Instead, one should take seriously the real dangers in the person's life.

The body as a mirror of the soul

Where there is emotion, the body always participates in many ways. Even more so during existential crises of psychotic proportions: heart rate, blood pressure, brain metabolism, etc., respond to pressures of all kind. During a crisis these systems can develop a dynamic of their own: blood pressure can remain elevated, changes in brain metabolism can make the person more vulnerable to the future flooding of stimuli – akin to a biological scar. In general, bodily changes are not generally the causes of mental disturbances; rather, they are over-shooting self-regulatory mechanisms which attempt to counterbalance them. That is why a narrow definition of illness is misleading, and it is a mistake to rely only on somatic-medical expertise. All the same, medication can be used effectively against these physical responses.

So it is inappropriate, short-sighted and not at all helpful to regard psychosis as 'purely organic'. If he chooses to understand himself and his psychotic experiences in a more rounded manner, the dogmatic insistence that psychosis 'is the result of a sick brain' only pushes a person towards non-compliance with medication.

An active response

The various therapeutic schools agree that many factors come together to trigger a psychotic experience. On its own, this view fails to recognise that active responses must always be considered. A human being is not simply an object, and psychosis is not simply reactive. Rather, it always involves a mental construct, the expression of an active response, a struggle with oneself, with certain contradictions, and with untoward circumstances. The self remains essentially intact and carries on, but at another existential level. This idea receives support from most therapeutic schools but it remains neglected in practice.

Particular aspects of mania and depression

While cognitive or schizophrenic psychosis often has an impact on self-perception, depression and mania are primarily an expression of insufficient self-worth. Along with a background of a meagre store of self-assurance, additional slights and failures combine with excessive expectations to lead to a depressive episode. The depression further fuels the vicious cycle of self-devaluation. Yet even at the heights of mania, self-assurance is not really boosted; self-devaluation is merely delayed, often occurring in response to inevitable negative feedback from the environment.

Personal standards

Rather than experiencing a lack of them, people who tend towards extremes of this nature are generally over-constrained by norms: they feel powerless to resist the expectations of others. During a depression this is obvious: the superego (conscience) appears to suffocate the self. But, contrary to appearances, even people who tend towards mania have internalised the social norms rather deeply. During mania they challenge accepted standards in provocative ways without actually relinquishing them: the superego seems inoperative, but the self cannot fill the vacant space. People who have experienced mania need encouragement between episodes, so as to help harmonise their idiosyncratic aspects with their regular self, rather than always saving them up for the manic phase.

Protective measures

Both conditions – mania and depression – are not merely emotional disturbances. In a way they are also stabilising, even if only briefly and unsuccessfully: attempts to restore an inner emotional balance. By challenging the expectation of others as well as one's own norms, mania brings a sense of relief, and especially by defending against the fears of precisely this eventuality. But it does this at a high price: such a psychological defence cannot succeed in the long run. Depression protects the self by attenuating despair, by freezing it, as it were, and also by countering self-destructive tendencies with a kind of inner paralysis: it is typical of the vicious circle of depression to anticipate every evil in the world within oneself. To organise one's own failure at least gives the appearance of 'being in charge'.

Biological and psychological scars

Psychological imprints, biological experiences and cerebral metabolism are in a complex and subtle interrelationship during affective psychosis. Changes in brain metabolism are not causal and are not, of themselves, responsible for extreme emotional volatility. Rather, they are the consequences of enduringly traumatic psychological experiences. Obviously, changes in brain metabolism might further aggravate the vulnerability for certain conditions. In which case, it may be reasonable to use medication for relief. Nevertheless, the person's background and his self-assessment remain crucial.

Opportunities

When it comes to an affective psychosis, i.e., one for which there is no discernible biological cause (such as dementia, or a blow to the head, etc.), the decision to use medication must also be embedded in psychotherapeutic considerations. A quick reduction of symptoms seems tempting to all parties, but that never reaches far enough and it leaves too many opportunities untried. The fact that a person can emerge from a depressive episode at all is equally as important as how the depression comes on. Similarly, whether he or she arrives at a better understanding of the self during the process is just as important as whether or not someone ascends into mania.

It is important to accompany the person through his or her mania or depression, and to use that horrible time to find out as much as possible about the self, so as to avert further episodes. When properly supported, a person can learn more about himself during a few weeks of mania than during several years of living 'normally'. This does not often occur during the first attempt; it requires patience. Prolonged participation in psychotherapeutic groups can support a balanced mood and better self-reflection, simply through the presence of members who present the repressed side of the cycle.

Disarming the prejudices

Those who experience psychosis, and their families, are usually surrounded by others who have very prejudiced ideas about the condition. Most commonly people imagine that someone who experiences psychosis is unpredictable, dangerous, lazy, dumb and incurable; they think that he has 'a split personality' and that his parents bear the responsibility for the illness. These ideas are unfounded.

- On average, persons with psychotic experiences break the law less frequently than the general population; they are significantly less dangerous than people under the influence of alcohol and drugs.
- Aggressive outbursts may occur during psychotic episodes, but generally they can be foreseen.
- Rather than committing crimes themselves, people with psychotic experiences are generally more at risk of abuse and violence; they are not unpredictable, but rather perplexed by what others perceive as reality.
- Some people experience several realities during psychosis, or interpret the actual complexity of the world differently from other times. The notion of 'a split personality' is incorrect and confusing.
- Struggles and confusing interactions occur in all family relationships – with or without mental illness. While psychosis is linked to feelings of oppression, to actual abuse at some time or another, and to high levels of current stress, there is no evidence that the cause is simply incorrect behaviour on the part of parents.

THE PARANOIA GROUP

Peter Bullimore

A time ago some of us decided to set up a group for people who experience paranoia. Of course this was always going to be a bit tricky and many people said to us that it couldn't work due to the nature of the experience.

We decided to run the group in an old school building which is used for training sessions related to learning disability. It was important to hold the meeting in a place not associated with mental health issues, a place where people entering the building could as easily be workers as people attending a group. We booked a room and sent out a flyer advertising 'A Paranoia Group for Support and Education'. A colleague said to me that they thought calling it 'a paranoia group' was too direct, but I couldn't imagine calling it anything else.

Going into a group for the first time can be pretty nerve-racking for anyone, so we tried to make this as easy as possible. On the flyer we included a contact number, so that people could ring up and I'd give them details of the venue and could explain clearly what was going to happen in the first meeting. I'd say that it was going to consist of an introductory workshop on 'what paranoia means to you'. I also gave people the option of meeting me or Chris, the other facilitator, on a day before the group, so that they could get a feel for how things would be.

Chris and I put together a ten-week programme, but we were not necessarily going to adhere to it. We were using the programme mainly as an icebreaker. Eleven people turned up at the first meeting. Soon there were thirteen people attending regularly. I had thought we might see the same people who attend our Hearing Voices Group, but it turned out to be a completely different clientele. This included a policewoman who's never been in the psychiatric system and a guy who hadn't previously been out of his house for three years.

The diversity in the group is fantastic. It makes a real difference that some members of the group are used to being a part of the mainstream community. They are able to offer significant support to some of the other members for whom paranoia can be totally debilitating. In the group meetings we are looking at problem-solving and coping strategies. We talk about warning signs and triggers and the knowledge and skills that people have developed to respond to them.

One woman in the group talked about how she always thinks her neighbours are talking about her. In one of the meetings, J mentioned that she had done a lot of gardening the previous weekend. I said to her, 'Well, it was lovely weather wasn't it – I bet there were a lot of people around.' And she replied, 'Oh yes, all the neighbours were out. Some were having a barbeque.' When I asked her how long she had been outside in the garden, she said about

three hours. And so I asked her, 'In those three hours, did you think other people were talking about you?' She said, 'Well, come to think of it now, I didn't.'

B had not been out of his home for three years, and explained why he had decided to attend the group. He used to think that he was the only person who had paranoid experiences and unusual beliefs. Since attending the group he has been able to start visiting his mum who was in a nursing home and he hadn't seen for many years. Now he helps out with training and has a part-time voluntary job.

The policewoman who attended the group and who had never spent any time in the psychiatric services told how she had seen fellow officers assault a prisoner in custody. She had threatened to report her colleagues and had been threatened in turn that if she did she would pay the consequences. She went ahead with the complaint and subsequently was bullied and victimised by fellow officers. In the end she left the force. But after leaving she was constantly followed by the police everywhere she went. Of course, this led her to believe that she was being persecuted by people in authority – but her fears were real.

When we had been running a couple of months a certain middle-aged lady attended the group and she shared her experiences of paranoia. But it was clear in her mind that it was her husband creating those fears. Eventually she was admitted to hospital for twenty-eight days. After being discharged she returned to the group and told us how much she had enjoyed her stay in the psychiatric unit because people looked after her and believed her. During her time in the unit she didn't feel paranoid at all, but when she returned home her husband convinced her again that she was suffering from paranoia. I felt that the best advice I could give her was that she should think about leaving her husband because he was trying to control her through mind games. A month later she found her own flat and a job and filed for divorce. She no longer attends the group since she is living a fulfilling life without fear.

Our group has gone from strength to strength and we now have seventy-five members. Better than this, many of them now help teach mental health professionals.



International Paranoia Network

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At every step in her discussion, Orr raises the question of the funding bodies for the research and the interests that they represent. In the case of the Cantril project, she notes how market research and government funding mesh in with the Rockefeller Foundation, ostensibly a philanthropic institution, but whose founders made their fortunes in business and industry. She also relates how Cantril, in his application for funding, pointed out how the work was an almost unparalleled source of data for the educator interested in the power of propaganda.

One member of the research team, Theodor Adorno, raised objections to the underlying presumptions of the project, which were oriented towards showing 'the effects on listeners', rather than questioning 'the structure of the radio broadcast industry, or the wider society, or the social functions of radio'. Adorno suggested that only a certain type of funding would come from this – funding of use in manipulating the effects of radio on listeners. It is probably significant that in 1940 the Rockefeller Foundation refused to continue funding Adorno's work.

The Second World War and its aftermath, the Cold War, gave rise to further rich opportunities for the political management of panic. Cantril recognised that, with the end of the war, conditions would be 'ripe' for panic. However, in 1943 he pointed out that 'if a psychological approach is properly understood and adroitly carried out, the need for military measures will be considerably minimised.' Psychiatrists

and sociologists agreed on the centrality of psychiatric strategy and tactics in the pursuance of war. As Orr puts it: 'The social scientist begins to emerge as a self-conscious soldier of knowledge, ready to serve the militarized requirements of civilian communication, command, and control.'

The military itself developed large-scale research bodies. One of these was the United States Strategic Bombing Survey (USSBS) which, as its name indicates, was charged with assessing the impact of mass aerial bombing on the morale of civilian populations in Germany and Japan. 'The bombing of the two populations and the accompanying surveys may be seen as giant natural experiments,' said one academic researcher.

A big question raised by the research bodies was: what if this had happened to American cities? Hence the preoccupation of the social scientists began to be centred on the Cold War and the possible outcomes arising from a nuclear attack. As Orr points out: 'The problem of panic and the destruction of national morale are recognised repeatedly as the main obstacles to the successful conduct of nuclear war.'

Attempts to make the social sciences equal to the natural sciences led to a drive to find quantifiable data, a search for 'reliability' and a stress on the research survey as the appropriate method for the social sciences. Samuel Stouffer, sociologist and author of the book *The American Soldier: Studies in Social Psychology* (1949–50) said: 'If social science is to be taken seriously and receive large financial support, its

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PSYCHOLOGY & 'THE WAR ON TERROR' (2): PSYCHOLOGICAL WARFARE AND PARANOIA

DAVE HARPER

The people can always be brought to the bidding of the leaders. That is easy. All you have to do is tell them they are being attacked and denounce the pacifists for lack of patriotism and exposing the country to danger. It works the same way in any country.

Nazi Hermann Goering (in Rampton & Stauber, 2003)

In a previous article in *Asylum* (Vol.14, no.2, 2004), I discussed evidence showing that psychological knowledge had been used to develop modern surveillance and interrogation techniques. Here, I want to look at how psychology has been used in a more subtle manner in the manufacture of propaganda.

Psychological Warfare: Information and Perception Warriors

The state's security apparatus conducts a number of overt and covert 'psychological operations' (psyops). The British Army maintains a psychological warfare unit, the 15 (UK) Information Support Group. Its name changed from 15 (UK) PSYOPS Group in order to distance its work from the so-called 'black' and 'grey' propaganda operations which it is claimed 'are not practised today' (Jolly, 2001). 15 (UK) Information Support Group has a permanent staff of eight drawn from three services, and a reserve group of 28 other people drawn from the media, broadcasting and publishing. It is mainly involved in setting up radio stations and designing leaflets to drop on enemy troops. In March 2003 BBC News online reported that it had set up a radio station in Basra, run by Lt Col Mason, Deputy Chairman of Choice FM in London. The use of psychological operations by the US military is far more substantial than by its British counterparts.

However, alongside these overt and openly reported operations, it is clear that there are other more covert uses of psychological operations: propaganda for the citizens of the countries sending forces abroad.

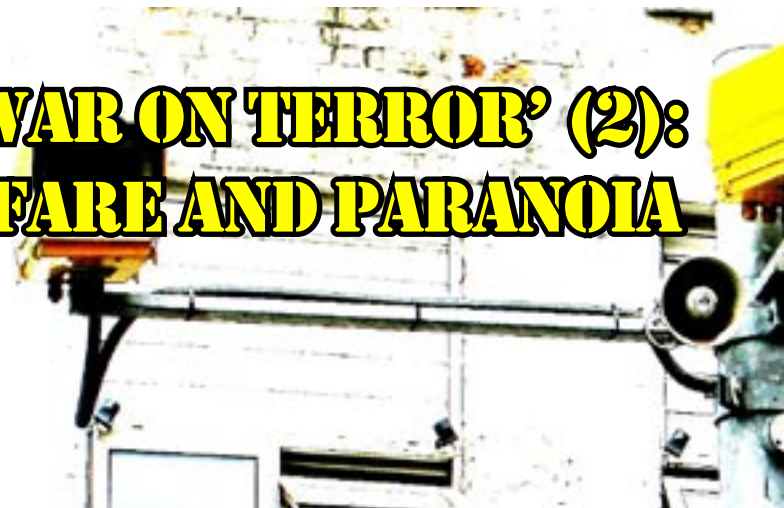
In *Weapons of Mass Deception*, Sheldon Rampton and John Stauber detail a number of these. Remember the story about Iraqi soldiers removing babies from incubators in Kuwait, in October 1990? Nayirah, a 15-year-old Kuwaiti girl, gave tearful witness evidence to the US Congressional Human Rights Caucus. What was not reported at the time was that she was the daughter of the Kuwaiti Ambassador to the US and her evidence had been coached by Lauri Fitz-Pegado, the Vice President of Hill & Knowlton, one of the world's largest PR firms. This company had set up a front organisation – Citizens For a Free Kuwait – to which the Kuwaiti government channelled \$11.9 million in six months (Rampton & Stauber, 2003). The use of such a front is a common PR strategy, well known to those observing how pharmaceutical companies set up 'patients' groups' to campaign for a particular drug company's products

– so-called 'astroturfing'. PR consultant John W. Rendon worked on extensive Iraq-related activities under contract to the Pentagon and the CIA, including the distribution of American flags and the flags of other coalition countries to Kuwaiti residents so as to welcome coalition troops in Kuwait during the first Gulf War. Rendon has described himself as an 'information warrior' and a 'perception manager'. The Pentagon defines this function as 'the combination of truth projection, operations security, cover and deception'.

One of the main targets of such operations, via the use of the media, is the public at home in Western countries. A key technique is to get the media to focus on some stories and to ignore others. John Pilger noted how, in the run-up to the last Gulf War, the media had been distracted by reports of what we now know as a much-exaggerated threat of Iraqi possession of Weapons of Mass Destruction. And so the media failed to recall statements like those made by Colin Powell in February 2001 and Condoleezza Rice in April 2001, that Saddam Hussein had been contained and did not pose an immediate threat (Pilger, 2003).

However, alongside the publication of official reports, it is clear that a more covert PR war has been waged using psychological operations techniques. One example was the February 2003 dossier presented to some journalists in private briefings, written by the UK government's Coalition Information Centre, headed by Alistair Campbell, then the Head of Communications Strategy at No.10 Downing Street. So as to exaggerate the real threat from Iraq, in this now-infamous dossier, decade-old research from a PhD thesis was lifted from the World Wide Web and unattributably quoted, and with strengthened language it was merged with information from the intelligence community. Clearly, the aim was to present something which could be described as 'new evidence', so as to make a case for stopping the UN inspections then being conducted by Hans Blix, and so to enable preparations for the War against Iraq to go ahead. In an article in *The Times* on 15 January 2003, David Cornwell, writing under his pseudonym of John le Carré, noted how successful this campaign had been:

How Bush and his junta succeeded in deflecting America's anger from bin Laden to Saddam Hussein is one of the great public relations conjuring tricks of history. But they swung it. A recent poll tells us that one-in-two Americans now believe Saddam was responsible for the attack on the World Trade Centre. (le Carré, 2003)





It is also clear that, in support of arrests made under current terrorism legislation, like those in HMP Belmarsh, the security services regularly hold unattributable briefings with selected journalists about the current threat posed by terrorists.

It is interesting that many psychological operations at home are conducted by PR agencies. Whilst these may employ psychologists, we can see that the use of psychological knowledge is more subtle – it may be drawn upon to construct more effective messages in order to have psychological effects (e.g. to support military operations), but it can be used by anyone.

In this context, what can be done? For a start, I think we should begin by taking these techniques seriously, analysing them within their political and cultural contexts, understanding their functions and effects, and resisting them either by co-opting them or by exposing them.

Resisting the promotion of cultural paranoia and the fear of the other

In his book *Against the State of Nuclear Terror*, Joel Kovel analysed Cold War rhetoric, and argued that, by projecting hostile intent onto other nations, it helped sustain the military industrial complex and the nuclear state. This has certainly been a tactic in justifying the need for the security state throughout history. Thus accounts of IRA bombing campaigns seemed to justify the role of MI5 and the Special Branch, and with the demise of the USSR as a threat to national security, terrorism has become the officially recognised priority of British security services. Post-September 11, the State's security apparatus has grown massively. For example, the number of Special Branch officers (UK police with responsibility for security, intelligence, subversion and terrorism) increased three-fold between 1978–2003, to 4,247 (see the website: Statewatch.org). I'm not arguing, like some 9/11 conspiracy theorists, that the Security State actively generates incidents like the New York attacks or the London bombings. Instead, I'm making the point that there is a necessary symbiosis between perceived threat and the growth of the Security State. Of course, as soon as one starts to discuss this secret world one can be accused of believing in conspiracies. Interestingly, the recent BBC TV series *True Spies* revealed that many of the stories of surveillance on trades unionists and peace campaigners in the 1970s and 1980s, previously seen as paranoid, turned out to have been accurate.

This generation and cultivation of a broad cultural

fear or paranoia can lead to an increasing emphasis on personal security and safety which can lead to political conservatism. Such a context can lead to the dominance of 'a context of fear' which then organises the experience of life, with people increasingly retreating to the private space of home, guarded by their personal and home security alarm systems, and engaging in suspicion and surveillance through their local Neighbourhood Watch. Noam Chomsky made a similar point in a comment on the US international War on Drugs policy:

The more you can increase the fear of drugs and crime and welfare mothers and immigrants and aliens and all sorts of things, the more you control people. Make them hate each other, be frightened of each other and think that the other is stealing from them. If you can do that, you can control the people. (Noam Chomsky in López et al., 1996).

Adam Curtis' excellent TV series *The Century of the Self* (BBC2, 2002) illustrated the extent of co-operation between big business and the new profession of Public Relations. PR was founded in the USA by Sigmund Freud's American nephew, Edward Bernays. He drew on many of his uncle's insights. Curtis' thesis is that in the affluent post-Second World War West people no longer consumed out of need. Instead, corporations decided to sell by capitalising on people's desires. So, for example, we saw PR practitioners trying to sell cigarettes to women by linking images of smoking with liberation – for women, cigarettes became 'torches of freedom'. Of course, this can also work by playing on people's fears. In his film *Bowling for Columbine* (2002), Michael Moore pushes this further by arguing that there is a link between the promotion of fear and consumer capitalism. In other words, fear sells things.

If fear-generating techniques are used in times of relative peace, they become much more overt in times of conflict. We have only to look at the kind of rhetoric used by the Bush administration when it self-consciously used the language of war. Bush intentionally drew on Them-and-Us rhetoric: either we were with him or against him. The rhetoric of Al-Qaeda follows the same pattern. Researcher Karen Cronick (2002) has shown similarities between the rhetoric of George Bush and Osama Bin-Laden: both urged a dichotomy between 'Them' and 'Us'; both talked of a homeland; both cited the support of religious texts and of God.

Taking action to resist psychological operations

Once we understand the context and effects of psychological operations, what positive action can we take? In one interview, Sheldon Rampton has suggested a number of effective counter-strategies: to understand how propaganda works; to seek information from a wide variety of sources (and not just a narrow diet of mainstream media); and not simply to be passive recipients of the media but to actively engage in the real world and in active means of communication, such as debate and dialogue (Rampton, 2003). To this one might add the need to reveal and question the implicit assumptions underlying political discourse, and

to understand the networks of power and interests at work influencing governmental policy, and to organise education and action campaigns against those networks. This article was adapted from a longer piece in *The Journal of Critical Psychology, Counselling & Psychotherapy* (Harper, 2004a). A more extensive and up-to-date account may be found in my chapter in Ron Roberts' *Just War: Psychology and Terrorism* (PCCS Books, 2007).

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Links on World Wide Web

- BBC TV True Spies: http://news.bbc.co.uk/1/hi/programmes/true_spies/default.stm
- Oxford Research Group: www.oxfordresearchgroup.org.uk/
- PR Watch: www.prwatch.org/
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From the founders of Asylum magazine

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Book Review ... continued from p. 27

“engineering” applications must visibly pay off.’

A further strand in the investigation of panic began to develop in the early 1950s: the controlled laboratory experiment. In an effort to see how people behave under stress, panic situations were simulated in the laboratory, the assumption being that different group behaviours under those conditions could somehow approximate to a ‘real’ panic situation.

The argument was put forward that if the suggested theory of panic was correct ‘it should be possible to illustrate its functioning in the laboratory.’ The line of the studies was becoming clear: Panic results from individuals’ perceptions of their situation, and some individuals are better than others in resolving their problems without recourse to panic.

In a fascinating chapter entitled ‘Keep Calm! for the Cold War’ Orr describes how, from 1951, the American media was most willing to offer up scenarios of a coming World War III. Tied in with exercises on the ‘proper public attitudes and behaviour necessary for civilians, in their own defense’, many articles were written in consultation with top military, economic and political thinkers in U.S. and international affairs. The theme was: ‘Keep Calm in the Face of Atomic Attack’.

An array of tests was assembled to establish the ‘panic-proneness’ of the population and to reduce the potential in a public faced with nuclear annihilation. One ‘highly classified’ organisation speculated on the possibility of developing chemical agents so as to decrease panic susceptibility. Over twenty-two motion pictures designed to be shown in schools were made in 1956.

And it seems that this situation gave rise to the panic condition of Anne Parsons, the daughter of the top American sociologist, Talcott Parsons. Parsons himself was immersed in attempts to put sociology on an empirical and ‘scientific’ basis, and the contradictions between his conservative and mechanistic viewpoint and the emerging panic of his daughter – based on what is going on in the real world – is shown in stark detail. This situation also contributed to the fears of the as yet unborn Jackie Orr. The moving published accounts of Anne Parsons, who subsequently committed suicide, make up a large part of the third chapter of the book. Orr’s diaries come later, although excerpts from them punctuate earlier chapters. Anne Parsons tells of her experiences of the psychoanalytic couch, of being told that she needed to ‘come to terms with her basic feminine instincts’ when she could think of nothing but the threat of nuclear war.

This is a rich and fascinating book, and I cannot possibly do it justice in a few words. I have to leap ahead, to say that Orr describes the situation that arises in American psychiatry with the ending of the Cold War and the widespread public realisation that the enormity of a nuclear war would in fact give rise to the destruction of the whole social world. Whither panic?

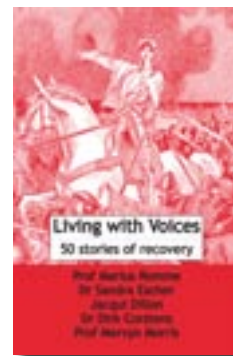
Basically, faced with a decline in the conditions that would give rise to mass panic, American psychiatry adapts. This involves a change in focus from a ‘social psychological/sociological’ orientation to a focus on panic as a disorder of the

personality, or as one researcher puts it, a disorder of the central nervous system. In this manner, links between the individual and the (objectively) scary world out there are pushed into the background. What becomes important is the symptoms of panic and the accurate diagnosis of ‘the disorder’.

Of course, this development is grist to the mill for the ever-eager drugs industry, and the pressure is on to match the relief of symptoms of panic to the appropriate drug for the relief of the symptom. Orr devotes plenty of space to a brutal dissection of the relationship between the drugs industry and the psychiatric research bodies. She exposes what can only be described as torture, both of humans and of animals, in the name of research – and the pursuit of profit. This is where Orr’s ‘panic diaries’ come into play, because, as part of the programme of research for which she enrolls, she has to write a daily diary whilst under medication.

Orr’s Panic Diaries form a part of the structure of the book. As I say, combined with the irreverent attitude of Orr to the social scientific professions – she refers to the author of one learned study as ‘Daddy’ and talks throughout of her ‘dis-ease’ – it lifts the book out of any danger of becoming an academic treatise, pure and simple.

I tried to write a list of the sorts of reader for whom Panic Diaries would be a ‘must read’ but I gave up because the list was too long. Of course, the book relates strongly to today when scare stories about terrorism, for example, are ‘a dime a dozen’ and the state propaganda machine is in full cry. But that is another story.



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