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**the magazine for democratic psychiatry**



**USERS' ACTION  
PETER LEHMANN  
SURVIVOR HISTORY  
and more ...**

# Asylum

the magazine for democratic psychiatry  
Volume 17, Number 4, Winter 2010

An international magazine for  
democratic psychiatry, psychology,  
and community development

Incorporating the  
Newsletter of Psychology  
Politics Resistance

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**Back Cover Picture:** close-up *Flying Free* silk painting by Jo Shenton: <http://www.saa.co.uk/art/joshenton>

Asylum magazine is a forum for free debate, open to anyone with an interest in psychiatry or mental health. We especially welcome contributions from service users or ex-users (or survivors), carers, and frontline psychiatric or mental health workers (anonymously, if you wish). The magazine is not-for-profit and run by a collective of unpaid volunteers. Asylum Collective is open to anyone who wants to help produce and develop the magazine, working in a spirit of equality. Please contact us if you want to help.

The views expressed in the magazine are those of the individual contributors and not necessarily those of the Collective. Articles are accepted in good faith and every effort is made to ensure fairness and veracity. © The Asylum Collective, on behalf of contributors.

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# EDITORIAL EDITORIAL

Readers may know that in 2008, due to the sudden death of its Editor, *Asylum* magazine went into crisis and stopped publication. The re-launch was last March. However, people still kept sending in material and so this issue is made up of submissions from the last few years. Readers have sent in lots of great stuff – thanks very much for that. We always welcome contributions. We are also aware that we haven't always been able to respond as quickly and as efficiently as we would have liked. We are now reorganised and we do our best! And yes, we know that the *Asylum* website has long been out of date, and are just now working on it. Already some vital information has been updated (e.g. about subscribing).

Since the re-launch, and in response to feedback, we have tried to include shorter articles (and in a more readable typeface). Some readers like each issue to be specific to one topic, but we hope this general edition appeals to everyone.

*Asylum* 17.4 was put together by Jim Campbell and Helen Spandler. They selected some of the best material submitted in the last few years. We take another look at service-user views and action on crisis services (Soteria and the Leeds Survivor-Led service) and also include articles about Survivor Movement history, labelling, identity and stigma, alternative perspectives on the *Diagnostic and Statistical Manual*, and panic attacks. We are always interested in ongoing critical work by radical mental health workers, and include a submission from the Midlands Psychology Group. We also include a Letters page, providing interesting views on articles in *Asylum* since the re-launch.

We hope you enjoy this edition and find food for thought and encouragement in the struggle for a more decent and reasonable mental health system. We are acutely aware that this struggle will intensify in the midst of ongoing threats to our public services and welfare system. We are always keen to share with readers new and creative ways of campaigning and protesting about mental health issues. For the first edition we hope to feature Mad Pride who held a demonstration in Hyde Park against cuts to services and benefits on 26th October (see page 26). For next year, we are also working on a special issue on Spirituality (edited by the Spiritual Crisis Network), and one to mark 100 years of the diagnosis 'schizophrenia'.

So we'd like to encourage all our readers to make sure they send their subscriptions for 2011! Please continue to contact PCCS Books for this and for bulk-buying. And please do keep sending in ideas, material, letters, pictures and poems. Without your submissions, your help with distribution and your ongoing support, we could not survive.

## **The Therapeutic State extends its reach: Community Treatment Orders**

Just as we are about to wrap this issue for publication, the topic of CTOs is again in the news. Against much opposition, from right across the mental healthcare spectrum, CTOs were introduced in late 2008. By means of this legal device, released patients judged not to comply with prescribed treatments may be compulsorily taken back into hospital and treated. A CTO lasts for six months and can be renewed immediately: there seems to be nothing to prevent a person from being subjected to a CTO ad infinitum.

The Care Quality Commission found that during the first year of operation more than 4,000 people were subjected to a CTO. One in every five patients was recalled. This is at least ten times the number predicted by the Department of Health.

Eighty-one percent of the patients in the research sample had a diagnosis of schizophrenia or another psychotic disorder and 12% were diagnosed with a mood disorder. Almost all were prescribed some form of injected antipsychotic medication. Everybody knows these drugs are toxic and can be both psychologically and physically dangerous – for example, they are well-known often to cause distressing 'side effects', not to mention obesity, diabetes and TD. The fact that such compulsory treatment is becoming commonplace is very disturbing.

The rationale for CTOs was that they would deal with 'revolving-door' patients. And yet 30% of the patients in the sample did not have a history of refusing to take their medication or of failure to co-operate with community services. CQC thinks that a reason for the higher-than-expected numbers could be that, in the current 'risk aversion' and 'blame' climate, some psychiatrists 'play safe' by putting patients on a CTO as a preventative measure. This is undoubtedly an important factor, but surely another reason is simply the shortage of NHS beds and alternative crisis facilities. Bed shortages, a lack of crisis houses and inadequate support in the 'community' could also mean professionals feel the need to use such compulsory measures when discharging patients.

CQC is also concerned that there are disproportionately more patients on CTOs from some of the black and minority ethnic (BME) groups. Of course, there is already over-representation of BMEs in the general psychiatric population, so that figures ... (See [www.cqc.org.uk](http://www.cqc.org.uk), 27th Oct 2010)

Jim Campbell, Helen Spandler and Phil Virden

# A SMALL ACT OF REVOLUTION

## Bill Bailey

Discovering how to enjoy moments of existence becomes a small but important act of revolution.

The social matrix within which we entrap ourselves has been corrupted by others to serve their interests. In order to insure maximum exposure to this invisible web that exists between human beings, states of anxiety, fear and inadequacy are encouraged as default settings. Thus we can better respond to authority, marketing, advertising and tools of social manipulation used by those who exploit us. Human beings are objectified, turned into objects that are more easily organised. Yet consciousness can *never* be object. It is forever *subject*. That is the key contradiction. It is also a primary element of self-knowledge.

Moments of enjoyment are revolutionary because they deny objectification to those who would use us. To enjoy a sunrise, a spring flower, the way trees bend in the wind, a rain-wet leaf, sexual creativity, writing a poem or tracing a pen on paper, thinking of oneness with the universe or delighting in the smile of a child – these are moments of humanity when we are pure subject. It is no longer necessary to buy, possess, lust for or hunt down the thousands of trivialities we are taught to value but which have only ephemeral value, if any at all. So-called possessions must be hidden away, protected or defended. Enjoyment only gets better as it is shared with another revolutionary brave enough to relax, despite the shock waves of fear humming along the social web. In a world where all values have price tags, you can step forward into a world where everything is free. It is an act of re-evaluation *of the whole world*. Thus it is also an act of freedom.

We individually define the world – all of it.

To succumb completely to the social matrix as it exists means we accept the assessments of others with regard to our status and value, whereas our true status and value can only be defined by ourselves. Therefore we are required by the matrix to submit to the bogus authority of others, but the submission is always our own choice. Nowhere does the matrix allow us to enjoy – unless it is to ‘enjoy the fruits of our labour’ or time they define as ‘free’ (weekends, evenings, holidays, etc.), which are never free because we tremble every moment with invisible anxieties about what we should do or what we should be during our ‘free time’. The moment we *begin to realise our humanity* we are in revolt against all these lies.

Within the matrix we are defined by our use – and only by that. We are used by others to enhance their status or wealth or to otherwise advance their interests. We encounter this all the time, and even finding it within so-called ‘friendships’. Listen to fellow humans or try to understand their meanings and being, and you move again into a different realm – one shared by enjoyment and pleasure. Seek trust or love or wisdom with another existence prepared to give as much to you, and you are also a revolutionary – one who threatens the very structure of the matrix that endeavours to entrap us from birth.

For those who do not understand these matters, the effort of living in this world is profoundly maddening. *Alienation* is the honest term that should be used by those who define lost souls as ‘depressed’, ‘obsessive’, ‘paranoid’ or just plain ‘crazy’. The alienated are driven mad by the host of lies and double meanings they face as they try but fail to calcify their inner subject-selves to the authoritative demands of a matrix deaf to their cries of confusion. Then, as parody becomes farce, they are told by the psychiatric community that it is their own fault! In a further surreal development, they are forced to ingest drugs which will magically *force* them into submission to a cruel, impossible acceptance of a reality that cannot possibly exist – one where what is, is not, and what is true, is false. Meanwhile they continue to be shaken to pieces by the fears and anxieties imposed on them by a matrix desperate to convince them that this is the way to freedom and progress and the realisation of the human dream.

Of course ‘the normal’ don’t escape, either. In truth, no one is ‘normal’. Those normal folks who comprise nations that manifest their ‘civilisation’ by barbarous brutality in dominating and extracting wealth from the weakest are themselves fraught with anger, fears and inadequacies that burble just beneath the surface.

Therefore I invite my mad comrades to join me in extracting the maximum enjoyment from *this* life. We can stand erect in our own territory, owned and governed by no one, free also to delight in the enjoyment of others. The more you can enjoy beautiful things or the beautiful interactions between other free people, the more you are undermining a seriously malicious and destructive web of depraved deceit, ugly beyond my ability to describe it.

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# PANIC ATTACK: A WINDOW FOR WISDOM

... Walking among the fires of hell,  
delighted with the enjoyments of Genius;  
which to Angels look like torment and insanity ...  
William Blake: *The Marriage of Heaven & Hell*

What a wonderful opportunity for the discovery of our deep, hidden soul comes with the sudden, chill horrors of a panic attack. What seems at first a disastrous affliction can turn into a benediction. Spontaneous, unprovoked panic attack, in my experience, is not an illness: it is an opportunity.

And I do speak from experience. I have been there. In theatres, in movies, in lifts, on aircraft, on leaving the house, on the streets of the city, for no reason at all, anywhere. I have felt the world quiver, shake and begin to dissolve around me, leaving me gasping for breath, sweat dripping off palms and soles, bowels melting, heart racing for cover, mind fleeing from the cold footsteps of madness, drowning in a sea of vague horrors. Death settling its wet, cold blanket over me ...

There is no doubt, panic attacks are truly frightening. Those who have never experienced one can never really understand what it feels like. It is like an internal earthquake – and you can never really feel free of the fear of the next bone-rattling tremor from the depths of your being. And often when it comes the bowels begin to flow like sulphurous lava. However, when we consult the great book of Nature, we see that destructive volcanic activity has its positive and creative side, raising land from the sea, growing vast mountain ranges, and replenishing the earth with subterranean lava flows, rich in nutrients.

So many of the books on so-called Panic Disorders seem to have been written by people who have never experienced the symptoms they so coolly attempt to explain away. Many others, written by sufferers, try to teach the reader how to 'overcome', 'control', 'get on top of' or otherwise 'defeat' their symptoms. And the rest prescribe various drugs or natural remedies, based on the assumption that the symptoms have organic origins. All of these approaches treat the symptoms as a problem, an illness, and therefore something to be overcome, eradicated by one method or another.

My approach, which is based on a combination of mystical insight and psychological understanding, is quite different. It is certainly not for everyone. In fact, many people may find my approach more disturbing than the symptoms themselves, for it involves the death of one sort of self – the very self which seeks to 'get on top' through remedy, cure, control of, or escape from its fears – and the birth of another, deeper, more profound sense of identity.

Let me attempt to put my approach as simply as I can. The self that finds itself being swamped by sudden, inexplicable feelings of dread and panic, setting off the electrochemical preparations for imminent flight or fight, is a false self, an image of identity which the greater psyche is attempting to dissolve. The self threatened in a panic attack is *an ideal self*, a self made entirely of thoughts. Every

single mystical tradition in the world states that the one impediment to spiritual insight and wisdom is the human sense of ego identity: 'Die before your death' is the slogan of all major mystics from time immemorial. For the mystical poet William Blake this ego is 'the Spectre; the Reasoning Power in Man. / This is a false Body: an Incrustation over my Immortal / Spirit; a Selfhood, which must be put off & annihilated always ...'. Spontaneous panic attack is a sign that this false ego identity based on thoughts needs to die in order that a new sense of identity may be born.

However, this psychological process of death and rebirth has its discomforts. For example: a baby will learn to identify itself with the image of its mother or carer. And as long as this person is present, all is well. But when the mother leaves the room, it must feel to the baby as if its very self has gone. And it shrieks in an agony of anxiety. In the very same way, the adult psyche experiences panic and anxiety when the thought-structured ego-image – formed at its core, says Freud, from the internalised image of the parents – starts to dissolve. Panic attack is our internalised parents leaving the room. But in both cases – the newborn child and the mature adult – nothing is really wrong. They are both simply situations which experience and understanding will clarify.

The ideal ego-image we have been trained since childhood to accept as our true identity is only the surface tip of a psychic iceberg, nine-tenths of which lies in the dark. The hidden psyche or soul is that deep and dark realm of our being we are yet to discover. It is the unknown land of our true soul-character we fear to explore. When we believe that the ego, the tiny sunlit tip of our being, is the sum total of our psyche, when we have identified ourselves with the thoughts of this willing, choosing, rationalising self, then any rising of the psychic water line will feel precisely like an impending death. And we will experience all the symptoms of panic – just like the baby whose mother has left the room – as if our very being was in imminent danger of dissolution, death or madness.

With those who suffer panic attacks, the greater iceberg of the psyche is growing weary of this reduction of its reality to a tiny peak, lit by the light of conscious awareness. This bright peak of ego experiences itself as a detached and isolated island immersed in the waters of the unknown, which threaten to submerge it in darkness. To escape from this limiting and restricting view of itself, the greater psyche sends us – the lucky ones, that is – waves of psychic energy to dissolve the illusion of isolation and detachment, to drown our false sense of self, and show us who we really are, below the water line.

Panic attacks most often come when there is a sense of restriction – in a theatre, a crowded room, a lift, a railway carriage, a plane. What begins the fear is a sense of being trapped, and a corresponding desire to escape to safety. However, feeling exposed can also bring about the same response. The one element common to both situations is the need to escape from the necessity of the present reality, whether of containment or exposure. This is the spectral spirit-self of ego, a self made of thought chasing thought, trying to separate itself from its own present experience, to simply float away like a free-flying cloud, in order to feel safe and secure. Of course, since the ego is an idea and not an entity, this is impossible. This futile attempt to

detach and flee from the present reality of a situation *is* the panic feeling itself. The unexamined belief that the tip of the iceberg of the psyche can actually separate and detach itself from the necessity of present experience *is* the panic. And when the impossibility of this desire is clearly seen, the panic ceases, transmuting fear into awe.

As well as images of drowning, a panic attack can also make you feel as if you are on fire. As the waves of panic flowed up my legs and body, I sometimes felt as if I had been dropped in a vat of boiling oil. There is a quotation from a medieval mystical text, known as the *Theologia Germanica*, which seems pertinent to this experience. It says: 'Nothing burns in Hell but self-will'. The painful fires of Hell, it says, are exactly the beatific lights of Heaven, but seen through the eyes of self-will. And that which is burning in the anxieties of a panic attack is the ego-self, the illusory agent of self-will, trying to find security by separating itself from its present experience – and in the process turning Heaven into Hell.

Another way of approaching this topic is by way of mythology. The greater hidden psyche is also the realm of Nature, our psychic Nature. And the ancient Greek God of Nature is Pan, from whose name we actually derive the word panic. Hence a panic attack is really a Pan-ic attack, an attack by Pan who rules the dark forests of the hidden psyche. In this mythological approach, the detached, sunlit peak of ego becomes the flighty, wispy nymph, whose detached and spiritualised sense of unsullied purity and innocence attracts the lusty energy of Pan. A Pan-ic attack is the ego-nymph, a vaporous spectral image ungrounded in the deeper psyche, fleeing for its life from a rape threatened by the spontaneous powers of hidden Nature. One thing all sufferers of panic attacks readily confess: it makes one excruciatingly aware of the presence of the natural body – its palpitations, sweatings and shakings. Our physical nature, the realm of Pan, is brought sharply to our attention.

This understanding would suggest that any response to anxiety and panic attack which depends upon strengthening the heroic will of the detached nymphic mind – that is, those approaches which employ terms such as 'defeating', 'overcoming' or 'mastering' the symptoms – can only result in a more powerful relapse in the future since the real issue, the illusory desire of the spectral ego for safety and control, has simply been ignored.

But perhaps the best metaphor I have seen for anxiety and panic attack comes from a Hollywood movie, *Contact*. This was made in 1997 and starred Jodie Foster.

The scene I have in mind comes towards the end when the Jodie Foster character is strapped into a safety harness attached to a seat in an alien-designed spaceship which, it is hoped, will take her to the ship's designers. As the countdown proceeds the seat begins to vibrate. And the vibrations escalate. Those shuddering vibrations are a good analogy to anxiety, which has the same dreadfully shaky feeling. But the problem was that the seat and safety harness were not part of the aliens' design – they were added by earth scientists 'as a safety feature'. As the vibrations increase, the Foster character, by now nearly shaken to pieces, notices that a good-luck charm she was given has shaken loose from her pocket and floats serenely before her face. She releases her safety harness

and is liberated into perfect tranquillity, just in time to see the safety seat torn from its moorings by the vibrations and smashed against the ceiling of the space vessel.

This scene is a perfect representation of the paradox of panic and anxiety, which are the products of a desire to be safe and secure, to protect our ego-identity and its mistaken belief in 'control'.

The island peak which demands the security of its defined boundaries as the psychic water levels rise, the flighty nymphic mind which wishes for separation and safety from the rape-attacks of Pan – like the Jodie Foster character strapped so unhappily into her safety seat – these are images of the ego demanding security. Peace and tranquillity returns to the psyche only when the dangers of pursuing security are recognised – when we disconnect ourselves from the vibrating chair of egoistic 'safety'. Panic and anxiety are nothing other than the false identity of the ego pursuing its own illusory safety. Abandoning all desire for psychological security we float, freed from the vibrations of anxiety.

*Unfortunately we do not know who wrote this article. If you contact us we will credit you in a later issue.*



*Stress head*  
Yew carving by Jo Shenton

# The Dead Sheep in the Water Tank: Some thoughts on ending stigma

*Terry Simpson*

I had an unexpected row with a friend when I expressed some slightly negative views about 'Time To Change', the multi-million pound anti-mental health stigma campaign. The original figure quoted for this was £18m, and some of the big national charities are involved. Even the Institute for Psychiatry at the Maudsley is pitching in, so isn't this a great chance for a grand coalition to tackle stigma and discrimination once and for all?

'I thought we were all supposed to be on the same side now?' my friend said. So what follows is my attempt to clarify my thoughts on the subject.

It seems to me that mental health stigma in our society starts with the way people are diagnosed and labelled as having this thing called 'mental health problems'. People so judged are set apart from the rest. They are stigmatised. And when labels have such negative connotations in the popular imagination as 'schizophrenia' or 'personality disorder', then widespread discrimination is likely.

The obvious thing to do is to stop all this at source. Stop labelling people with diagnoses and you'll be a long way down the road towards ending the problem. I'm not saying stop supporting people, or treating symptoms. But leave it at

that – don't go on and surmise some condition 'behind' what you actually see.

I think there are certainly ways that people can be helped with abusive voices, wildly disordered thoughts, delusions, hallucinations, and so on. These seem to me to be real causes of terrible suffering and we have to help each other cope with them. Each person will need a unique kind of help, according to the particular circumstances of their life and experience. The point has been made many times that we won't be free from these kinds of bad experiences until we live in a more benign human world. Putting mental health labels on our experiences simply does not help.

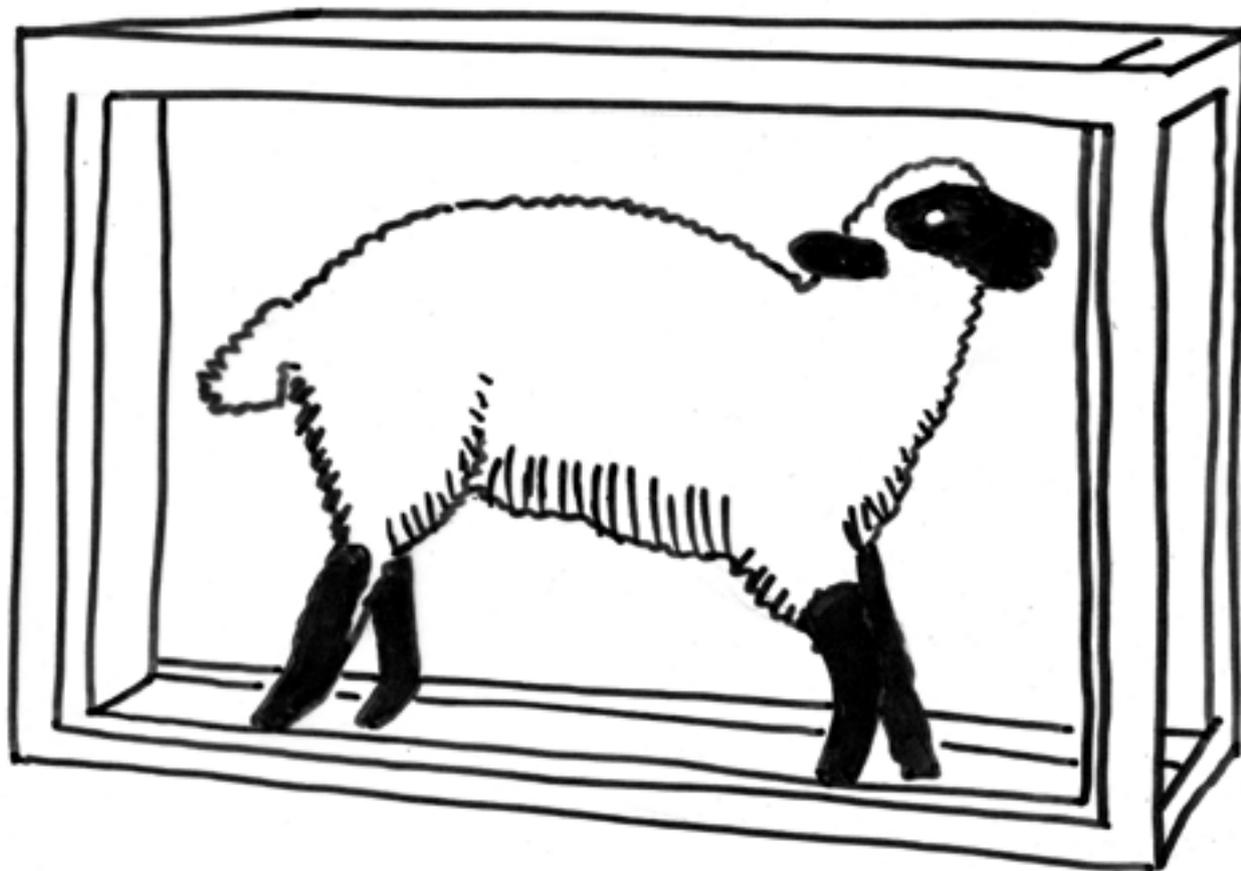
To carry on diagnosing people and still try to rid society of stigma is like trying to keep a water supply clean when there is a dead sheep in the storage tank. You can get better and better filters, and can spend more and more on purifying the stinking water as it comes out of the tap. With enough finance, and a sophisticated enough system, you could probably eradicate all traces of impurity. To me this is like trying to make concepts like 'bipolar' or any other label acceptable to the general public. But however great your filter system, it doesn't solve the basic problem. And that is going to get worse and worse as the corpse decays and bits of rotting matter seep down through the pipes!

We'll have a chance of ridding our society of stigma once and for all when we lose the labelling that lies behind it. So if anti-stigma campaigns are looking for an overall slogan my suggestion is:

## **DROP THE DEAD SHEEP!**

The website for Time To Change:  
[www.time-to-change.org.uk/](http://www.time-to-change.org.uk/)

For information about the Institute of Psychiatry:  
[www.mentalhealthcare.org.uk/](http://www.mentalhealthcare.org.uk/)



## USER-LED MENTAL HEALTH SERVICES? WE'VE DONE IT FOR A DECADE!

Adam James

*Leeds Survivor-Led Crisis Service has for 10 years run a multi-award-winning non-medical sanctuary for people with mental health problems. It prides itself on being user led. Adam James explains why it has made its mark in mental health history.*

In the early 1990s, Leeds service users gathered in a community centre to share a dream – that they themselves would one day set up and run a mental health crisis service.

The service users used to discuss their disillusionment with psychiatry. They longed for an alternative philosophy of care – somewhere people, when in distress, could receive empathy and social support in a safe environment, rather than medication and symptom control in a medical setting. Moreover, they argued, with their own experiences it was they who were best equipped to provide such care. They were the 'experts by experience'.

In December 1999 the dream was realised when they took on a three-storey listed Georgian building in Halton, Leeds. Dial House became one of the UK's first user-led crisis services.

Now called the Leeds Survivor-Led Crisis Service (LSCS), it celebrated its 10th anniversary in November 2009. You want user-led? Here it is – running successfully for a decade. And there are accolades as well – two awards from *The Guardian*, one from Community Care, while last year it scooped *The Charity Times* award 'Charity of the Year'.

At heart, LSCS is a crisis sanctuary operating from 6pm–2am, Fridays to Sundays. This when most mental health services are closed, and isolation can particularly hurt. Support workers are on hand at Dial House, which prides itself on offering non-judgemental empathy, safety and refuge. The service is an alternative to hospital admission. Strong suicidal feelings are common. Visitors usually have a history of trauma. Those with 'challenging' behaviour are welcomed.

In 1978 American mental health activist Judi Chamberlin published *On Our Own: Patient-Controlled Alternatives to the Mental Health System*. This was a rallying call to fight to establish user-led services, worldwide.

To the disappointment of many people, more than 30 years later such services are rare in the UK. But the Leeds Survivor-Led Crisis Service is an exception that leads by example, getting five to nine visits per night from people in real trouble. 'It's stressful and demanding work,' says project manager, Fiona Venner.

LSCS's six permanent part-time support workers and eight bank support staff are on salaries of £23,000 pro rata. All have experienced mental health problems themselves, and measures are in place to ensure that they can cope. Supervision and support for staff is high. Each receives a well-being budget to spend on counselling, external supervision or complementary therapies.

'If you've got mental health problems yourself then they can be triggered by this work,' says Fiona. 'So we recruit staff who are sufficiently recovered themselves, who

are robust enough. Our staff are high calibre, and they all undergo therapeutic training.'

In the spirit of its founders, LSCS maintains its radical edge. Almost all visitors have psychiatric diagnoses – schizophrenia, personality disorder, depression. But the service distances itself from the psychiatric 'medical model'. 'We are person-centred, and non-medical and non-diagnostic,' says Fiona.

For example, take urges to self-injure. Self-harm is not seen as symptomatic of a medical disorder, but a way of managing psychological pain. So visitors are permitted to self-injure, but within parameters. It must be done in a private room, superficial injuries only, and people must clean and dress their own wounds.

In the context of Leeds-wide mental health provision, the service has made a name for itself as preventing hospitalisation. 'Hospital prevention is a massive role – it's the main thing we do,' says Fiona. 'For example, one visitor who came to us had had 18 psychiatric hospital admissions, the one a year before for overdosing. She never had a hospital admission during the course of the year when she visited us. People often say that if it was not for us they would be in hospital.'

According to the Healthcare Commission's *Pathway to Recovery* paper of 2008, the cost per day for one acute hospital inpatient is £259. At LSCS it is estimated at £178. No in-depth study has been made of the financial benefits of LSCS. 'But we are much cheaper [than hospital admission],' says Fiona. 'And our funders believe we are cost effective.'

Moreover, Jane Wood, Leeds Primary Care Trust's Strategic Development Manager for Mental Health, confirmed to psychminded.co.uk that LSCS has embedded itself as a vital complement to statutory mental health care in the city. 'It's a good alternative to going into hospital during those times when most services are closed,' she says.

Fiona adds that such is the respect that visitors have for LSCS that there has not been one violent incident in 10 years. 'People will not do things to jeopardise their access to the service. And the climate of fear and blame has not affected us as much. Staff on wards are often working in fear – in fear of being hauled up before a panel. We are not like that.'

LSCS has been a beacon in radical user-led services. No surprise, then, that Fiona Venner was a keynote speaker at a conference organised by the Soteria Network in Bradford in November 2009. Soteria aspires to establish a non-medical residential unit for people in psychosis. Like LSCS, it is hoped that the Soteria unit will be person-centred. 'We listened attentively to what the Leeds service had to say,' said psychiatrist Tim Calton, a past winner of the Royal College of Psychiatrists' Research Prize and Bronze Medal, and a key individual behind the Soteria project.

Conference delegates heard Fiona Venner discuss the battles LSCS had to fight to reach its present position – from overcoming NIMBYism and sceptical and sometimes hostile critics, to avoiding what she called 'isolationism'.

When Fiona took over the reins of LSCS in 2005 the service was suffering from desperately poor attendance, with just 15 visitors per month. 'Between 2002 and 2005 we had three managers, and the organisation was in mess,' she says. 'The service had – for good reasons – wanted to be detached from and uninvolved in mainstream mental health services. But it meant it had become isolated.'

One of her first duties was to get her head down and market LSCS. 'Above all, it was just getting the city to know

we are here,' she says.

The Leeds Survivor-Led Crisis Service offers a telephone helpline from 6pm–10.30pm every night. It is staffed by trained volunteers and takes about 5,000 calls a year. Dial House aims to provide a homely environment where visitors can have one-to-one support from crisis support workers, often person-centred counsellors. It has a family room, so parents can bring children if necessary.

There is a weekly Dial House Visitors Social and Support Group. Also on offer is a six-to-ten week Coping with Crisis group for people frequently in crisis. The aim is to provide social contact for people whose crisis is due to chronic isolation and loneliness. Christmas is a difficult time for people with mental health problems, and so there are also Coping with Christmas workshops.

The Leeds Survivor-Led Crisis Service is funded primarily by Leeds PCT, Leeds Adult Social Care, and the Leeds Personality Disorder Clinical Network. Unfortunately, the service is now oversubscribed. 'It is very distressing having to turn people away,' says the project manager.

By working hard, LSCS has demonstrated, above all else, that services can be user led. For this, it has made its mark in mental health history.

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# LETTERS

*In this selection from our mailbag, each makes an important point in response to various articles in the first three editions of the magazine since the re-launch in March 2010. If you also feel strongly about something in the magazine, please do send us a letter!*

## **The Family: The source of paranoia?**

I have to take issue with Pete Bullimore's article 'Human Approaches to Paranoia' (*Asylum* 17: 1). How can he confidently and authoritatively assert the following?

*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.*

Pete's personal experience might be that his parents did not 'behave incorrectly', but for others, I would argue particularly for women, this might be the key to their difficulties. Perhaps the very reason that Pete has managed to 'recover' is that abuse and oppression did not occur within his family unit and he was not subjected to 'incorrect behaviour on the part of the parents'.

Is this magazine simply a vehicle for Pete's highly subjective and personal opinions? If that is the case, then it should be made clear that this is so, rather than emulating an academic style of writing in an attempt to sound knowledgeable.

It is my highly subjective and personal opinion that my own madness stems from abuse and oppression within the family unit and 'incorrect behaviour on the part of the parents'. However, I do not promulgate this opinion as a fact that is applicable to all. After all, 'Every psychotic experience is different and tells a particular story'.

Jane Maccallaugh, Sheffield

**The Editor replies:** *Thanks very much for your comments on this important issue. It is understandable that you feel upset. However, Asylum is meant to be a 'forum for debate', and on the inside of the front cover we do state that the views expressed are those of individual contributors and not necessarily those of the Asylum Collective. In this instance, perhaps inserting the word 'always' might make the required difference to Pete's formulation, i.e., '... there is no evidence that the cause is always incorrect behaviour on the part of parents.' Perhaps there is a reader out there who could write and tell us exactly what the current state of the evidence seems to be?*

# LETTERS CONTINUED

## Medication: A common dilemma

I asked for help to get off my medication after reading articles like those in issue 17: 2 of the magazine, but then I had another crisis in February this year in which, after ten years of being OK, I thought I was an alien. Does this mean I need medication in spite of the side effects?

Instead of sulphiride and sodium valproate, which I was on before, I was prescribed Olanzapine by a psychiatrist I never met. Now I don't know whether to take the drug or not. I came off two other drugs that were prescribed – a sleeping pill and an anti-anxiety pill, as it was supposed to be addictive. I did that off my own bat, with no guidance from anyone.

My chosen psychiatrist happens to be one of the 'critical' psychiatrists, but even he has signed me off to primary care. I don't know what is the wisest thing to do. My GP supports my staying on medication. I imagine this is a common dilemma among service users.

Unlike physical care consultants, psychiatrists just sign you off with no long-term follow-up or advice about how long to take a prescribed drug. I don't want to damage myself by taking the drugs (as is suggested by the articles in that issue of your magazine) but equally the people around me don't want me to have a crisis again – and I'm not keen myself. I feel 'between the devil and the deep blue sea'.

Another strange thing is that there is a different psychiatrist attached to each team in our trust. There is one for primary care, one for the crisis team and one for the recovery team, and each works differently. I think I am alone in our trust in having the option to stick with one psychiatrist because I once asked for a second opinion, as I did not get on with my first psychiatrist.

Hilary Pegg

**The Editor replies:** *Are there any readers who could throw some light on this very important matter? My immediate reaction is that you sound rather isolated. Whether or not medication is used, I favour the method of trying to talk out problems. Do you have access to any self-help or voluntary groups, where, rather than hearing only the snap decisions of NHS officials who believe in the medical model, you might meet people whose experiences are similar to yours and might have a quite different take on what you could do? It may also be helpful to view the YouTube videos recommended with Catherine Clarke's article on 'Side Effects', in Asylum 17: 3.*

## Hearing Voices: Who is telling us what voices ARE?

In the Autumn 2010 issue of Asylum (17: 3), Marius Romme has an article entitled 'Voices Are Emotions'. Had Romme called it 'Voices as Emotions' this could provide food for thought and possibly be helpful. But it seems once an Expert by Profession, always an Expert by Profession. By this I mean that, despite his long association with Experts by Experience, and his co-editing *Living with Voices: 50 Stories of Recovery* (PCCS Books, 2009), Romme has to provide, as it were, the ultimate and authoritative conclusion.

Romme was instrumental in the emergence of the Hearing Voices Network (HVN). An important and distinguishing feature to me had been that HVN was non-judgemental when it came to people exploring and understanding their voices. Now Romme states that voices *are* emotions and voice hearers 'have to learn that they must take responsibility for how much longer they will remain a victim'.

Romme backs this up with quotes from several recovered voice-hearers, but it seems to me that he is undoing what has been so valuable in the HVN – by handing interpretation back into the hands of the professionals. I can envisage Mental Health Services applying this new dogma in a way that could be no less oppressive and unhelpful than what has gone before.

AE Plumb

**The Editor replies:** *The problem of Expertise and Authority is certainly important. (In my view, Experts and Authorities always present us with problems and do not so often provide us with unquestionable solutions.) I'm sure you would allow that there is no doubt that Marius Romme means well and has done much to help many people, but that doesn't mean we all have to agree with everything he says! As I mentioned in response to the first letter, this magazine is meant to be a forum for debate. I have some ideas about the issue you raise, but I'm sure many of us do, so maybe someone else would like to respond?*

write to Asylum ...

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# Soteria: As viewed by (ex-)users and survivors of psychiatry

Peter Lehmann

For the majority of (ex-)users and survivors of psychiatry, the particular elements of the Soteria approach are of great interest: no psychiatric violence, no models of illness and disorder, abstinence from the arrogance of 'experts', a critique of Big Pharma, a critical attitude toward neuroleptics, the delivery of humane support, and the integration of the wealth of the experience of the (ex-)users and survivors.

In 1995 I was a member of the Board of the German Association of Users and Survivors of Psychiatry (BPE). We were asked by a psychiatric journal whether we would be willing to participate in a survey about improving the quality of psychiatric treatment. We agreed to take part but changed the questions because we Board members could not agree that any type of current psychiatric treatment could be considered to have 'quality'. The following are some of the questions we put to 665 members of the association, who were sometimes more critical of psychiatry, and sometimes less:

- Did the psychiatrists address the problems which led to your admission?
- Was your dignity respected at all times?
- Were you fully and comprehensibly informed of the risks and so-called 'side effects' of treatments?
- Were you informed about alternative treatments?
- What do you think was lacking, to the detriment of good quality psychiatric care?

Over 100 members of our association responded to the survey. But only 10% of those who answered said that psychiatry had helped them find a solution to the problems that had led to their psychiatrisation. Ninety per cent said that their dignity had been violated. In response to the question concerning information given about the risks and 'side effects' of treatments, not one single person replied 'Yes, they had been informed'.

As for a qualitatively acceptable psychiatry, the following fundamental criteria have to be fulfilled: the dignity of men and women must be observed, there must be warmth and humanity, company, a relationship of confidence, not fear. Many (ex-)users and survivors viewed many aspects of the psychiatric system as unhelpful or useless: e.g., the presence of violence, the use of psychiatric drugs, coercive measures, electroshock, doctors with fixed ideas who believe that they know more about their patients than they themselves ...

People wanted alternatives so that they could make their own choices. The following suggestions were made: alternative drugs (e.g., homeopathic remedies), self-help, runaway houses (like the Runaway House in Berlin) and other alternatives like those developed by Mosher and Laing, soft rooms like those in Soteria (Peeck et al., 1995).

I have no doubt that today, 15 years later, the answers would not be very different.

## What does Soteria represent?

The essence of Soteria is its humanistic approach and its independence from the medical model, with all of its consequences. Volkmar Aderhold, a German psychiatrist like his co-authors, and a friend of Loren Mosher, 'the father'



of the Soteria approach, describes it in the book *Alternatives Beyond Psychiatry*:

*Mosher was a life-long sceptic of all models of 'schizophrenia,' primarily because they stood in the way of an open phenomenological view. He saw the phenomenon (which is usually called 'psychosis') as a coping mechanism and a response to years of various traumatic events that caused the person to retreat from conventional reality. The experiential and behavioural attributes of 'psychosis' – including irrationality, terror, and mystical experience – were seen as extremes of basic human attributes. (Aderhold et al., 2007: 146)*

Abstinence from the medical model, with its tendency to see human problems as technical difficulties of one sort or another, was accompanied by abstinence from the arrogance of 'the expert'. This can be seen by how workers would qualify for the Californian Soteria House:

*About seven full-time staff members plus volunteers worked there, selected for their personal rather than any formal qualifications, and characterized as psychologically strong, independent, mature, warm, and empathic. Members of the Soteria staff did not espouse an orientation that emphasized psychopathology, deliberately avoided the use of psychiatric labels, and were significantly more intuitive, introverted, flexible and tolerant of altered states of consciousness than the staff on general psychiatric inpatient units. (Ibid.: 147)*

On many occasions former residents went on to become staff members. Aderhold and colleagues write about the avoidance of violence and overwhelming abstinence from neuroleptics, both of which are consequences of the medical model, as well as from the belief that it is possible to be an expert in finding solutions to other people's life problems:

*Neuroleptics were considered problematic due to their negative impact on long-term rehabilitation, and therefore used only rarely. Specifically, during the first six weeks at Soteria these drugs were only given when the individual's life was in danger and when the viability of the entire project was at risk. However, benzodiazepines were permitted. If there was insufficient improvement after six weeks, the neuroleptic drug chlorpromazine was introduced in dosages of about 300 mg. Basically, any psychiatric drugs were supposed to remain under the control of*

*each resident. Dosages were adjusted according to self-observation and staff reports. After a two-week trial period, a joint decision was taken whether it made sense to continue the 'medication' or not. (Ibid.)*

It is well known, and not surprising, that with less psychiatric drugging, less psychiatrisation, better social integration and better personal development, in the long term the Soteria results were somewhat superior to conventional psychiatric treatment (Bola et al., 2005). Psychiatry often makes a patient's condition chronic or even causes premature death.

In 1980, in his final book about Soteria, written nearly a quarter of a century after finishing the follow-up project of Soteria (1971–1983), Emanon (1974–1980), Loren Mosher and Voyce Hendrix pointed out the basic Soteria approach by means of general guidelines for behaviour, interaction and expectation:

- Do no harm.
- Treat everyone, and expect to be treated, with dignity and respect.
- Guarantee asylum, quiet, safety, support, protection, containment, interpersonal validation, food and shelter.
- Expect recovery from psychosis, which might include learning and growth through and from the experience.
- Provide positive explanations and optimism.
- Identify plausible explanations: emphasise biography, life events, trigger factors instead of vulnerability; promote experiences of success.
- Encourage residents to develop their own recovery plans: consider them the experts.

(Adapted from Mosher & Hendrix, 2004)

Isn't this list nearly identical with the wishes and demands of the members of the German association of users and survivors of psychiatry? Or with the recommendations of the European study *Harassment and Discrimination Faced by People with Psycho-social Disability in Health Services?* (At the behest of the European Commission, this was developed by associations of (ex-) users and survivors of psychiatry and their families from the UK (Mind), from Austria, Germany, Spain, the Netherlands and France, and in conjunction with a Belgian research institute. (See [www.enusp.org/documents/harassment/recommendations](http://www.enusp.org/documents/harassment/recommendations))

### **Soteria and further consequences**

In modern times, psychiatrists sometimes call their units 'Soteria'. This goes with the offer of so-called atypical neuroleptics instead of traditional ones, or the offer of a room where psychiatric workers and inmates can brew up together. I speak from my experiences in Germany. The word 'Soteria' refers to the Greek goddess of safety and deliverance from harm, so it is not copyright and anyone can use it for their own purposes.

From my point of view, and considering the original approach, not only does the separation from medical models and toxic psycho-drugs belong to Soteria, but also its separation from the industrial psychiatric-pharmaceutical complex. On this level, Loren Mosher was an example to his colleagues, making his Soteria approach still more sympathetic to users and survivors of psychiatry, who are interested in recovery, personal development, health and freedom.

In 1998, in a letter to its President, Loren Mosher

explained why he was resigning from the American Psychiatric Association:

*In my view, psychiatry has been almost completely bought-out by the drug companies. The APA could not continue without pharmaceutical company support of meetings, symposia, workshops, journal advertising, grand rounds, luncheons, unrestricted educational grants, etc., etc. ... What we are dealing with here is fashion, politics, and money ... I want no part of a psychiatry of oppression and social control. (Mosher, 1998)*

Of course, there is good reason to believe that all the other mainstream organisations of psychiatrists have also been corrupted by drug company money. Mosher said in another paper:

*In my view, American psychiatry has become drug dependent (that is, devoted to pill-pushing) at all levels – private practitioners, public system psychiatrists, university faculty and organizationally. What should be the most humanistic medical specialty has become mechanistic, reductionistic, tunnel-visioned and dehumanising. Modern psychiatry has forgotten the Hippocratic principle: Above all, do no harm. (Mosher, undated)*

'Do no harm' was also the basis on which Loren Mosher supported the report *Coming Off Psychiatric Drugs* (Lehmann, 2004), a book with first-hand reports of (ex-)users and survivors of psychiatric drugs from all over the world. It also had additional articles from psychotherapists, physicians, psychiatrists, natural healers and other professionals who provided information to help people with withdrawal from psychiatric drugs. In his preface Mosher addressed the problem of mind- and body-altering psychiatric drugs, and withdrawal symptoms:

*Most patients had never been warned that the drugs would change their brains' physiology (or, worse yet, selectively damage regions of nerve cells in the brain) such that withdrawal reactions would almost certainly occur. Nor were they aware that these withdrawal reactions might be long lasting and might be interpreted as their 'getting sick again'. ... However, because the drugs were given thoughtlessly, paternalistically and often unnecessarily, to fix an unidentifiable 'illness', the book is an indictment of physicians. The Hippocratic Oath – 'Above all, to do no harm' – was regularly disregarded in the rush to 'do something'. How is it possible to determine whether soul-murder might be occurring without reports of patients' experiences with drugs that are aimed directly at the essence of their humanity? Despite their behaviour, doctors are only MDs, not M-deities. Unlike gods, they have to be held accountable for their actions. (Mosher, 2004: 16–17)*

### **Conclusion**

Like many others, because of his criticisms of mainstream psychiatry, Loren Mosher was often ignored. In 2003 he claimed:

*I am completely marginalized in American psychiatry. I am never invited to give grand rounds. I am never invited to give presentations. I am never invited to meetings as a keynote speaker in the United States.* (cited in: De Wyze, 2003)

Of course, he was appreciated by organisations of self-confident users and survivors of psychiatry. For decades now, the original Soteria approach has been received positively and integrated into other approaches such as the Berlin Runaway House (Wehde, 1991: 46–50), and also by the self-help movement. Regina Bellion, a German survivor of psychiatry, wrote a report, 'How We Discovered the Soteria Principle', concerning the approach of mutual support in their group. She concludes:

*We try to recognize a psychosis early on, as soon as it appears as a speck on the horizon. We can have an impact against such a little speck, each in our own way. We have to be vigilant and pay attention to ourselves. In fact, we have to be constantly on the alert. During good periods it may be enough to take one critical look at myself per day. I have a whole catalogue of precautionary measures and I have to stick to them. Up to now we have been lucky. Since 1993 none of us has been hospitalised, there have been no suicide attempts, and none of us has been prescribed neuroleptics. Of course, we all sometimes hear voices or see something that can't really be there. We take that as a sign that things are getting to be too much and that we have to take better care of ourselves. And we are getting better at it all the time. Loren Mosher would definitely be pleased.* (Bellion, 2007: 82–3).

And Kerstin Kempker, former leading worker in the Runaway House, explained why Soteria and comparable approaches have been so important for creating alternatives beyond psychiatry:

*Without the Dutch runaway-houses and Uta Wehde's intensive engagement with their concept and practice, the Berlin Runaway-house would not exist. Without antipsychiatry from the early 70s, Laing's Kingsley Hall and its 'children' – Soteria, Emanon and Diabasis – we would not have that evidence to lean upon: that the normal psychiatric measures are not necessary, and instead, what is most helpful is life within a warm and aware community, where everyone has equal rights.* (Kempker, 1998: 66)

This is why Soteria is a rather good idea from the perspective of users and survivors of psychiatry.

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### About Peter Lehmann

#### Critic of psychiatry is awarded the degree of honorary doctorate

Anyone who pays attention to the violation of human rights by psychiatry, to the users and survivors of psychiatry movement, and to alternatives beyond psychiatry will invariably encounter the name Peter Lehmann.

A social-pedagogist, he was born in 1950 in Calw (Black Forest, Germany). He underwent involuntary psychiatric detention and treatment in the 1970s. He has worked for the rights of psychiatric patients, and their world-wide networking, during the last 30 years. Among many other organisations, he was a founding member of the European Network of (ex-)Users and Survivors of Psychiatry, of PSYCHEX (Switzerland) and of the Runaway House, Berlin. Based on his own experience, his books, such as *Coming Off Psychiatric Drugs* and *Alternatives Beyond Psychiatry*, describe current self-help possibilities for individuals experiencing madness, as well as the risks and harms of psychiatric drugs and electroshock, alternatives beyond psychiatry, and strategies toward implementing humane treatment.

In acknowledgement of his 'exceptional scientific and humanitarian contribution to the rights of the people with psychiatric experience', the School of Psychology of the Aristotle University of Thessaloniki, Greece decided unanimously to award him an Honorary Doctorate. The ceremony took place in September 2010. Peter Lehmann is the first survivor of psychiatry anywhere in the world to to be

honored in this way for pioneering achievements within the realm of humanistic antipsychiatry.

According to Professor Kostas Bairaktaris, in particular this award recognises Peter Lehmann's perennial contributions to a scientific paradigm that counters the dominant medical model of psychology by proposing formalised psychotherapeutic approaches to difficult human problems as if these were technical difficulties of one sort or another. Since the end of the 1970s, Bairaktaris has himself played a key role in dismantling the scandalous psychiatric prison on the Island of Leros and, in the mid-1980s, began the processes of de-institutionalisation from the state-run psychiatric facility of Thessaloniki. Professor Bairaktaris is certain that the tribute to Peter Lehmann, which he initiated, will stand as a symbol for the growing significance of the international self-help movement of users and survivors of psychiatry and other socially marginalised individuals.

For more information about Peter Lehmann see [www.peter-lehmann.de/inter.htm](http://www.peter-lehmann.de/inter.htm)

For his lecture 'International Noncompliance and Humanistic Antipsychiatry', see [www.peter-lehmann-publishing.com/articles/lehmann/noncompliance-a.htm](http://www.peter-lehmann-publishing.com/articles/lehmann/noncompliance-a.htm). You can also download his acknowledgement to his companions over the last 30 years: [www.peter-lehmann.de/danke](http://www.peter-lehmann.de/danke).

## One Step Beyond?

*A review by Helen Spandler*

### **Alternatives Beyond Psychiatry**

**edited by Peter Stastny and Peter Lehmann**

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*Alternatives Beyond Psychiatry* is grounded in many years of work and activism within and against the mental health system. This provides its validity. Its achievement is in bringing together the shared wisdom and experience of service users, survivors and activists. The book arose out of a co-operation between Peter Lehmann, publisher in Berlin and survivor activist within the international user/survivor movement, and Peter Stastny, Associate Professor of Psychiatry at the Albert Einstein College of Medicine in New York and founding member of the International Network Toward Alternatives and Recovery (INTAR). Both have a long-standing track record of developing alternative services that negate the need for psychiatric intervention and offer autonomous paths towards recovery and self-determination.

As its title suggests, the book does indeed take us beyond a number of limited ideas and practices in mental health. First, it demonstrates how far the survivor movement and radical mental health initiatives have moved beyond 'anti-psychiatry'. Although the various authors in this book do not completely disregard the insights of the anti-psychiatrists (and some of the authors make due reference to the work of RD Laing et al.) their work is only informed by these critiques, i.e., they are not *framed* by them.

The alternatives presented not only move us beyond the potential nihilism of 'anti-psychiatry' and various academic critiques of psychiatry. They also take us further than the reformist strategies of the Italian Democratic Psychiatry

movement, social psychiatry or community extensions of psychiatric institutions (what Robert Castel has referred to as 'merely a form of psychiatric expansionism'). Indeed, the authors are careful not to impose any new replacement psychiatric or psychological 'models' or 'techniques'. Rather, *Alternatives Beyond Psychiatry* prioritises new ways of living with madness and diversity, without recourse to diagnosis, psychiatrisation or undue reliance on medication.

On this count, this book could be construed as 'anti-medication'. But that would miss the point. The mental health system in the West is heavily reliant on medication as a basis for mental health care. The authors make a compelling case that this isn't always necessary and that there are viable alternatives. It would be more apt to say that the book is anti-coercion and pro-voluntarism and informed choice.

*Alternatives Beyond Psychiatry* functions as a powerful indictment of the failings of the mental health system and a rallying cry for more humane and authentic support services. It is driven by anger at a psychiatric system that is seen to invalidate people's experiences and actually prevent recovery. But, rather than dwelling on negativity, it uses this anger to inspire and develop new forms of support infused with hope. We read of the experiences of Dorothea Buck-Zerchin (a 90-year-old woman with 70 years' experience of coercion in the mental health system), Kate Millet's passionate re-instatement of the 'myth of mental illness', survivors' personal accounts of how they survived, about examples of concrete working alternatives (e.g., Soteria House, the Windhorse Project, Hotel Magnus Stenbock, and the Berlin Runaway House) and various practical support tools. From around the world, it offers examples of innovative and creative ways of supporting people through mental health crises, but outside the conventional mental health system.

Yet, this book also goes well beyond 'self-help' by offering examples of legal, community and political action to secure rights and demand alternatives (e.g., the 'Evolving Minds' group in the UK, PsychRights in Alaska, and the international Icarus Project). It also takes us beyond mainstream liberal ideas about 'recovery' and 'social inclusion' by rooting its ideas in the actual practices of mental health activists, users/survivors and their allies. This means that the chapters do not assume our goals should necessarily be 'inclusion' in mainstream society and 'recovery' regardless of mental illness (which at its worst translates as: 'Keep taking your medication, get off benefits and get back to work').

Lastly, *Alternatives Beyond Psychiatry* moves beyond tired academic or professionalised debates concerning the latest competing models or theories 'about mental health'. Packed as it is with stories, information and ideas, it provides an indispensable resource for anyone concerned with improving mental health care and creating a better society.



Peter Lehmann (left) and Peter Stastny (right)

# Mental Illness or Self-Interpretation?

Jeremy Spandler

This article examines two questions: When should you accept a label given to you by a psychiatrist? And if you do, must you then accept that you are mentally ill?

I use 'manic-depressive' as an example of a label, and myself as an example of a person who has been labelled. I have been given the label 'manic-depressive' – although psychiatrists now refer to 'bipolar affective disorder'.

By 'accepting a label', I mean believing that it applies to you. I do not mean pretending to accept it for tactical reasons, such as believing this will help you come off a Section, under the Mental Health Act.

According to what is commonly called 'the medical model' someone is given a label by a psychiatrist because he or she *has a mental illness with a physical cause*, most likely a biochemical imbalance of the brain. In his book *Madness Explained*, Richard Bentall calls this 'the Kraepelinian approach'. Emil Kraepelin was a central figure in the foundation of modern psychiatry, in the late nineteenth century.

Strange as it may seem, the concept of mental illness is actually quite unnecessary to the argument being made. Psychiatrists claim that the people they label as 'having a mental illness' actually have a physical illness, such as a biochemical imbalance of the brain. With no change in meaning, that phrase from the last paragraph – 'mental illness with a physical cause' – could be replaced by the phrase 'physical illness'. It seems that most psychiatrists believe that 'the symptoms of mental illness' to which they refer are *really* the symptoms of a disease or a biochemical imbalance of the brain.

What are these symptoms? A person can either exhibit certain deviant behavioural patterns or he can report certain 'abnormal' experiences to the psychiatrist. The process of psychiatric diagnosis is simply that of mapping those behaviours or reported experiences to 'a specific mental illness'. It can also be seen as the process of attaching a label to a person.

Richard Bentall sets out three assumptions that are necessary for this Kraepelinian approach for psychiatric diagnosis to hold good. These are: (1) that there is a clear dividing line between the psychologically healthy and psychologically disturbed; (2) that there is a finite and countable number of different mental illnesses; and (3) that these types of illnesses must be explained primarily in terms of aberrant biology.

But the complete absence of scientific evidence for each of these three assumptions leads Bentall to reject them, and therefore to conclude that the current system of psychiatric diagnosis must be altogether abandoned.

Yet accepting a label does not necessarily imply accepting the meaning attached to it, or the view of the world of others who use it. For example, people who refer to, and define, themselves as 'queer' do not often accept all the negative meanings attached to the term, or the worldview of anti-gay bigots. Likewise, the decision to accept the label 'manic-depressive' doesn't necessarily imply accepting what a psychiatrist means by that term. A psychiatrist can mean

one thing by using a label and you can mean another.

In what circumstances should you accept a label? I contend that you should do so if it helps you to understand yourself better. Why might this be the case? I turn to my own experiences. As far as I am concerned, my acceptance that I am a manic-depressive means that I accept that my mood swings are greater than most people and that, if I don't manage myself in 'high' periods, I can undergo a psychotic period and end up 'sectioned'. Whilst I can't prove that my mood swings are greater than most people, neither do I need to, since I am not making any scientific claims. Instead, I simply claim that this way of looking at the world is useful for me.

Neither do I accept that having mood swings that are greater than most people is necessarily negative. For example 'high' periods can be extremely creative, and the positive implications of this must be weighed against the risk of having a psychotic episode.

'Manic-depressive' is a label that other people, such as psychiatrists, may attach to me. Psychiatrists see it as a diagnosis of a mental illness. Alternatively I can attach the term to myself. I see this as a self-interpretation. It helps me to make sense of myself as a person. It is part of what I understand myself to be. It is something that I could be proud about or ashamed about.

This is how I understand the Mad Pride movement. It is an assertion of identity and the right to self-interpretation and self-definition. An unwanted label such as 'mad' can be transformed into a valuable and empowering self-interpretation.

To define myself as a manic-depressive is a useful shorthand way of describing how I am similar to some people and different to others: it is useful for understanding myself and for conveying that understanding to other people. I'm not saying that I am seeking one definitive description of my situation and, when I have found it, I need not bother to try to understand myself any better. This tends to be the approach taken by psychiatrists. Once they give you a label (which they call 'a diagnosis') then you are pigeonholed and they think they know how you should be treated.

Self-management may or may not mean taking a mood stabiliser such as lithium or sodium valproate. We need to get to a position where we can have a sensible debate about drugs without the need to refer to 'mental illnesses'. You might come to the conclusion that you want to take a mood stabiliser. But why is it necessary to claim that you have a 'disorder of mood' – that you are ill and that lithium is the treatment? When you want a strong mug of coffee to give yourself a caffeine boost it is not necessary to claim that you have a 'disorder of alertness' – that you are ill and that caffeine is the treatment.

There are other self-interpretations that I find useful because, as I have already said, they help me understand myself better. For instance, I find it useful to think of myself as an introvert, a worrier, analytical, uncoordinated, and 'an adrenaline junkie'. As a temporal being I cannot avoid understanding myself in a continuous process of self-interpretation, experience and re-interpretation. This process is never complete. (The approach I am taking is within the hermeneutical tradition. As a clear exponent, I recommend the philosopher, Charles Taylor.)

It seems to me that the move to replace the term 'manic-depression' with 'bipolar affective disorder' is significant. In my view, there are two reasons why psychiatrists and their supporters are so keen to abandon the term 'manic-

depression'. Firstly, it does not sound sufficiently 'medical'. Perhaps more important, *it is insufficiently negative*. While 'manic-depression' has negative connotations due to the way it is used, 'bipolar affective disorder', because of the use of the word 'disorder', is negative *by definition*. If you are disordered there is something wrong with you. However, if it is an open question as to whether manic-depression is positive or negative, then it becomes an open question as to whether treatment is required. If psychiatrists were to take this seriously they would have to stop treating illnesses and start dealing with the problems of living that people present to them. Some psychiatrists do this already but this is in spite of the training they receive, not because of it. Bentall recommends this approach and calls it 'post-Kraepelinian'.

What precisely does my alleged illness of bipolar affective disorder consist of? Basically, my mood swings are greater than most people and this can lead to difficulties – mania and depression. I'm also taller than most people and this can also lead to difficulties – I'm clumsy and I bash my head. It makes equal sense – or more accurately equal nonsense – to talk about my suffering from 'a tallness disorder'. As a tall person, I might want to be careful not to bash my head. And as a person subject to greater-than-average mood swings, I might want to try to moderate them or minimise their effects. 'Treating an illness' simply does not apply to either case. I accept that I have greater-than-average mood swings, therefore I am happy to define myself as a manic-depressive. But being different to a norm is *not* an illness or disorder. Therefore I don't define myself as suffering from bipolar affective disorder.

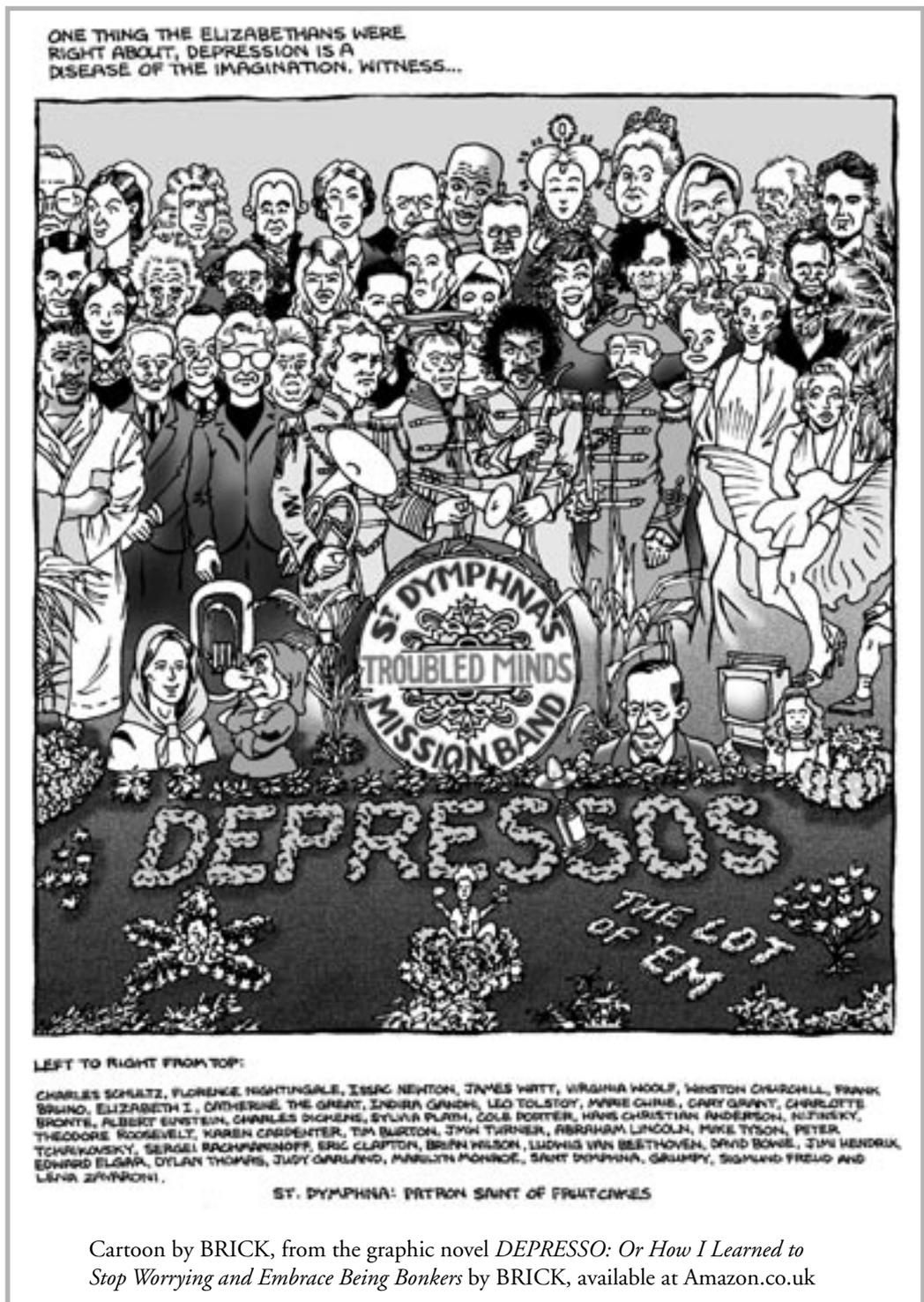
Most psychiatrists believe that manic-depression is caused by a biochemical imbalance of the brain. But even if my brain biochemistry were different to that of most people that would not prove that I am ill. To be different to a norm is not necessarily to be ill. It is only because manic-depression is already defined negatively, as an illness, that everyone is encouraged to agree with that idea.

This approach to diagnosis, labelling and stigma also has interesting implications for the issue of recovery. Some people in the user movement believe that it is axiomatic that we should aim to recover from our 'mental illnesses'. This is not how I see it. My aim is to stay out of hospital by managing my 'highs'. But, since I value my mood swings, I do not wish to recover from manic-depression. I don't consider that my condition is the problem. I

see my problem as losing control of my 'highs', becoming psychotic, being a nuisance to others and ending up 'sectioned'. This is why I'm reluctant to take a mood stabiliser. I believe it is for the person himself or herself to decide what problems they have, how they are going to deal with them and the treatment (if any) that they want. Some people want to recover, but it is important not to assume that this is everyone's aim.

To sum up, the acceptance of a label such as manic-depressive does not imply acceptance of the worldview of the psychiatrist. Defining myself as manic-depressive is a useful self-interpretation because it helps me understand myself. But this does not require me to accept that I am mentally ill.

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Cartoon by BRICK, from the graphic novel *DEPRESSO: Or How I Learned to Stop Worrying and Embrace Being Bonkers* by BRICK, available at Amazon.co.uk

# Welcome to NICEworld Midlands Psychology Group

*The NICE presents itself to the world, and thinks itself to be, a body of scientists dedicated to reorganising mankind along strictly scientific lines. The members imagine themselves as vanguards of a new, rational age. In fact, they are nothing but a collection of pseudo-scientists lost in a fog of cant and jargon, who produce nothing more useful than elaborate machines that look terribly impressive, but simply and pointlessly update reports from various committees on a huge board.*

www.davidszondy.com

The National Institute for Coordinated Experiments (NICE) is an organization in a C.S. Lewis novel published in 1945 – *That Hideous Strength: A Modern Fairy-Tale for Grown-Ups*. The quote is from a review of that novel, which explains NICE in more detail. For anyone who is familiar with, and troubled by, our modern NICE – the National Institute for Health and Clinical Excellence – the quote about the novel makes freaky reading.

The Midlands Psychology Group has been observing the workings of NICE for some time, paying particular attention to:

- what is presented and received as scientific evidence
- the conflicting interests of those contributing to the development of NICE Guidelines
- the misguided use of Guidelines to control healthcare in the NHS

Our observations and concerns led to the development of *The Real NICE Quiz*, which was presented at the Beyond Belief Conference at Birmingham in March 2008. Conference material can be viewed along with other articles and information at [www.midpsy.org](http://www.midpsy.org).

## What is a Guideline?

We have presented our quiz to several groups since *Belief Beyond*. The *Real NICE Quiz* begins by asking which members of the audience have read any NICE Guidelines. When presenting to audiences of mental health professionals, it is usual to find that most people have read some of them, although commonly these are the Quick Reference versions. People report that it is difficult to find the time to read through the full Guidelines. We then ask a simple question: 'What is a guideline?' We provide various dictionary definitions which make explicit that guidelines are simply guides, to help make decisions, but never mandatory. This raises questions about the need for compliance, of which more later. We go further, highlighting confusion around the authority of NICE. We indicate that the gist of the following statement is repeated in many NICE Guidelines:

*Guidelines are not a substitute for professional*

*knowledge and clinical judgement. Guidelines can be limited in their usefulness and applicability by a number of different factors: the availability of high quality research evidence, the quality of the methodology used in the development of the Guidelines, the generalisability of research findings and the uniqueness of individual patients ... there will always be some patients for whom clinical guidelines recommendations are not appropriate, and situations in which the recommendations will not be applicable. This Guideline does not, therefore, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patients, in consultation with the patient and/or carer. (NICE, 2004a: 9)*

## Who are in the vanguard of NICEworld?

The Depression Guideline Development Group (GDG) included members from psychiatry, clinical psychology, pharmacy, nursing and general practice. There were also three patients. Barker and Buchanan-Barker (2003) discuss the membership of the Schizophrenia GDG:

*The GDG comprised twelve members but was weighted towards the 'treatment end' of the spectrum – medicine (4), clinical psychology (3) and pharmacy (1). Although nursing (1), service user (1) and mental health charity group representatives (2) were in evidence, none of these members had the status, and professional clout of their distinguished medical and psychology colleagues.*



In addition to comments raised about the composition of the GDGs, there have also been concerns raised about decision-making with regard to the evidence base. There are many articles which highlight the inherent assumptions and limitations of conceptualising and utilising evidence (e.g., Humphries, 2003). Ultimately this can mean that

evidence can be either accepted or rejected depending on its position in the evidence hierarchy. Indeed this is exactly what happened in the Self-Harm GDG:

*... outcome-focused research can be very problematic in any mental health research where the desired outcomes are often unclear and contested. This is particularly highlighted in self-harm. Here research tends to prioritise outcomes relating to 'symptoms' (for example, either stopping or lessened self-harm) whereas survivors may personally focus on improvements in other aspects of their lives. Therefore, such an approach can sideline the needs and views of service users. This was one of the reasons the two 'experts by experience' resigned from the steering group of the panel for the development of the Department of Health Guidelines on the treatment of self-harm ... This panel was unable to view the perspectives and testimonies of survivors, or examples of 'good practice', as anything more than*

*the bottom level of the 'evidence hierarchy'. (Spandler & Warner, 2007)*

We might expect that the views of those with expertise in the selected areas would be heeded by those in the GDGs. This doesn't always appear to be the case. The Critical Psychiatry Network submitted a comprehensive critique to the stakeholder consultation for the ADHD Guidelines. It was met with the following response:

*Thank you very much for your comprehensive and detailed critique of the concept, diagnosis, classification and treatment of ADHD and related categories. Unfortunately, we are unable to dismiss the diagnosis, as we would be left without a guideline to undertake. Your points are, however, well taken and we will share all your comments with the Guideline Development Group. It is important to us (the NCCMH and guideline developers) that critical views, even those that are critical to the very nature of psychiatry, are heard. Thank you again for your comments. (NICE, 2006a)*

### **The different versions of the Guidelines**

Not everyone is aware that there are four different versions of each Guideline. According to the AGREE instrument, 'For a guideline to be effective it needs to be disseminated and implemented with additional materials' (Agree Collaboration, 2001). Kendall et al. (2005), who also refer to the Guidelines as products, explain: 'For all guidelines currently under development or recently published, 10 key recommendations are selected by the Guideline Development Group and listed at the beginning of the NICE Guideline, and represent the main headlines for that particular Guideline.' There does not appear to be any rationale for there being 10 key recommendations for each Guideline. Presumably, different Guidelines have different numbers of important recommendations, and simply deciding on 10 for every clinical area highlights how lost our vanguards seem to have become in their fog of cant and jargon.

Given that there are a number of different versions of each Guideline it is worth considering the differences between them. Learmonth (2006) suggests that:

*The Quick Reference Guide and shortened Guidelines are essentially synopses of the full Guidelines, but with all caveats and ambiguities removed. The effect of this is to make them read as hugely more 'authoritative' statements of fact, whereas the full Guidelines allow for far more questioning of both process and outcome.*

The full Guidelines acknowledge, to some extent, the conceptual and methodological problems which fundamentally threaten their validity, whereas the Quick Reference Guides ignore these problems. For example, the *Guideline for Depression* states that:

*... the most significant limitation [with the evidence base] is with the concept of depression itself. The view of the Guideline Development Group is that it is too broad and heterogeneous a category, and has limited validity as a basis for effective treatment*

*plans ... [There are] significant limitations to the current evidence base ... These include very limited data on both long-term outcomes for most, if not all, interventions ... In part, these limitations arise from the problems associated with the randomized control trial methodology for all interventions... (NICE, 2004b: 8)*

In other words, the NICE documentation itself acknowledges that it remains unclear what depression is, let alone the difficulties with the current evidence base and associated methodologies. Despite this, *The Quick Reference Guide*, which is most likely to be the version that the majority of health workers have read, recommends the following:

*In both mild and moderate depression, psychological treatment specifically focused on depression – such as problem-solving therapy, brief Cognitive Behavioural Therapy (CBT) and counselling – of 6 to 8 sessions over 10 to 12 weeks should be considered. (NICE, 2007a: 4)*

A similar example can be found in the full *Guidelines for CFS/ME* which state that:

*Much of the existing evidence is of poor quality, and the review was restricted to those study designs at the top of the evidence hierarchy, i.e., RCTs and controlled trials. Where RCTs or controlled trials are available, widening the inclusion criteria to include poorer study designs would not improve the quality of the evidence, but would introduce the problem of comparing and weighting data from different study designs, making the evidence even more difficult to interpret. (Turnbull et al., 2007: 79)*

Interestingly, there were only eight CBT trials included here as evidence and out of those only three reported benefits for people. One particular stakeholder submission to NICE offers a detailed critique of the evidence for CBT and Graded Exercise Therapy (GET), demonstrating that neither of these is found to be helpful (NICE, 2006b). However, *The Quick Reference Guide* recommends that:

*Cognitive behavioural therapy and/or graded exercise therapy should be offered to people with mild or moderate CFS/ME and provided to those who choose these approaches, because currently these are the interventions for which there is the clearest research evidence of benefit. (NICE, 2007b: 5)*

### **Mission creep and the NICE Guidelines**

The term *mission creep* tends to be used in military arenas. It is defined as 'the gradual process by which a campaign or mission's objectives change over time, especially with undesirable consequences' (www.dictionary.com). This term has been used in relation to the ongoing war in Iraq, whereby the original stated aim of the mission was to remove alleged weapons of mass destruction. Although these weapons were never found, the possibility of their existence was given as the reason for the invasion of Iraq. In other words, the original mission – to find and remove weapons – escalated into regime change and an interminable war of total domination.

A similar but more recent term, *function creep*, has also emerged in relation to business environments.

These terms provide a useful way of thinking about the way NICE Guidelines have evolved so as to influence and ultimately control clinical practice in the NHS. Guidelines generally include an introductory statement explaining that:

*It is intended that the guidelines will be useful to clinicians and service commissioners in providing and planning high quality care for those with depression while also emphasising the importance of the experience of care for patients and carers. (NICE, 2004a: 8)*

However, they also go on to state that 'Clinical guidelines are intended to improve the process and outcomes of healthcare in a number of different ways. Clinical guidelines can be used as the basis to set standards to assess the practice of healthcare professionals' (p. 8). Indeed, the Healthcare Commission and Commission for Social Care Inspection conducted a joint review of adult Community Mental Health services, which contributed to the annual 2005/06 performance ratings for mental health trusts and councils. As part of the review all trusts were required to complete an audit in compliance with the NICE *Guideline for Schizophrenia* (2002).

We have therefore now moved into a situation whereby not only have the Guidelines become mandatory but they are also now used as standards by which to measure services and to hold staff to account.

### **If you don't play NICEly, you may not get picked for the team**

Of course, we are not alone in taking a critical view of the NICE Guidelines. However we are curious about the agendas of some critics. For example, Learmonth (2006) argues:

*Arts Therapies Services are increasingly threatened because we do not feature in NICE Guidelines, and therefore are not on managers' 'tick boxes' for services. It is extremely damaging to the professions that, in the Guideline in question [Depression], we do not exist at all ... It is important to realise that very few people, including decision makers, will have read the full Guidelines, and that most of the information useful both for making a critique, and for building a case for the Arts Therapies, do not appear in the shorter versions.*

But Learmonth is far from alone in decrying the lack of his profession's inclusion in the Depression Guidelines. Psychological therapists from various traditions petitioned the government over Lord Layard's proposals to provide 10,000 more cognitive behaviour therapists, arguing that this ignored 'the benefits to people of other forms of therapy' and that 'other psychotherapy approaches' should be considered (Therapy e-petition, 2007). Over 10,000 people signed this petition. A similar agenda might be attributed to the campaign 'We Need To Talk: The case for psychological therapy on the NHS' ([www.weneedtotalk.org.uk](http://www.weneedtotalk.org.uk)). We are not suggesting that such criticisms are entirely invalid. However we are highlighting the fact that professionals' self-interests

are intertwined with these developments, and that this aspect of the debate appears less well acknowledged.

Of course, we must not forget Big Psy's big brother: the interest of Big Pharma. Given the well-documented activities of drug companies, and their constant search for new markets for their products, it is interesting to consider the views of some people who have experienced some of their treatments. The Seroxat User Group recommends that 'the pharmaceutical industry in the UK be more tightly regulated and to move responsibility for representing and protecting the interests of the pharmaceutical industry out of the Department of Health and into the Department of Trade and Industry (at present the DoH has the responsibility both to protect public health AND protect/promote the economic interests of the pharmaceutical industry)' ([www.seroxatusergroup.org.uk](http://www.seroxatusergroup.org.uk)). This is also a bold reminder of the business and political contexts to these debates, which are often presented as being solely about science and evidence.

Whilst the influence of NICE continues apace it seems imperative to continue to highlight that NICE Guidelines are not constructed in a vacuum, however much they appear to be presented as unchallengeable documents of science and fact. Ultimately, we agree with Johnstone (2006): 'This is why questions about how we respond to human suffering are not simply ones of science or evidence, though that may be a part of it. They are ultimately moral, ethical and political issues on which we all need to take a stand.'

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Cartoon by BRICK, from the graphic novel *DEPRESSO: Or How I Learned to Stop Worrying and Embrace Being Bonkers* by BRICK, available at Amazon.co.uk

WE KNOW ABOUT FREUD AND HIS COUCH, AMERICANS AND THEIR ANALYSTS, CARTOONISTS AND THEIR DAFT JOKES...



DAFT JOKE (No. 2,469)



BUT FOR AS LONG AS THERE HAS BEEN NOWT SO QUEER AS FOLK, SOCIETIES PRIMITIVE AND OTHERWISE HAVE HAD THEIR SHRINKS; STRANGERS WHO MIGHT HAVE INSIGHT INTO WHAT WE CAN'T SEE FOR LOOKING.



# State Regulation: A disaster for service users as well as psychotherapists

Ian Parker

The UK government is planning to regulate providers of psychotherapy. The Health Professions Council is already set to register psychologists, and moves are already afoot to bring in psychotherapists and counsellors. The idea is that this will 'protect the public', and some of the largest psychotherapy and counselling organisations are behind the government on this because this kind of 'protection' will actually reinforce the power these organisations already have to say who is and who is not permitted to engage in psychotherapy. Instead of empowering users of services it is looking now instead as if all state regulation will do is reinforce the protection rackets that rule the roost. Psychiatrists, for example, are already officially registered (through the Royal College of Psychiatrists), but we know very well that this has not stopped abuse of patients, nor has it curbed the pharmaceutical companies who peddle the drugs to those 'professionals' who write prescriptions and enforce 'treatment'.

It is sometimes said that state regulation or 'registration' is needed to prevent another Harold Shipman (the local practice doctor who murdered many of his patients). But the big flaw in this argument is that Shipman was already regulated by the General Medical Council! And the biggest flaw in the scare-story argument here is that 'registered' practitioners are sometimes the most dangerous, and it is those who are outside the registers who do the most creative, supportive and radical work. The user movement has thrived outside official registers, outside official treatment centres, and outside state structures. If anything, here is a lesson in the history of the user movement for psychotherapists, which is that they should ally themselves with the outsiders and refuse to be registered, refuse to be regulated, and refuse to do what the authorities decide upon as legitimate treatment.

There are two key points we need to keep in mind when the government and its supporters tell us that it would like to 'protect' us, and that state regulation of psychotherapy is necessary.

The first point is that this is an issue not only for psychotherapists. And, to be honest, we wouldn't shed many tears if some of them were stopped from practising. But it is also an issue for service users. Why? Because state regulation in psychotherapy is an extension of regulation and surveillance of our lives throughout society, regulation and surveillance that ranges from the millions of CCTV cameras on the streets and in hospital buildings to the thousands of rules that define what you can and cannot do, where you are allowed to protest and what you are allowed to say. We have to ask ourselves when we are faced with a massive increase in diagnoses of 'psychosis' and 'paranoia' how the administration of our everyday lives and encounters with professionals fuels paranoia. We should even ask whether, in this world of bureaucratic checklists and monitoring procedures, we are actually paranoid enough. And in this administered society there are very few spaces left where we have the freedom to speak without it being checked and corrected by those in power. Psychotherapy is one of the few spaces where it should be possible to speak openly,

but the government's plans to 'regulate' this space will effectively close it down. So, this is not an issue of pitying the poor psychotherapists but of defending a space where these practitioners can enable us to speak freely.

The second point is that there are radical approaches in psychotherapy that are especially vulnerable to state regulation, approaches that really do provide the space to speak freely. Some approaches, like 'cognitive behavioural therapy', are unfortunately compatible with state regulation because there is an assumption in them that there is a correct and incorrect way of thinking about the world. Even so, there are therapists working in these frameworks who will still be hard hit by the government proposals – those who work with users rather than against them. Some approaches, like psychoanalysis, are necessarily outside the state and the work of psychoanalysts, if they were to be brought into the Health Professions Register, would be badly compromised. It should be said that there are some psychoanalysts with old-school ties to the Royal College of Psychiatrists and the House of Lords who are prepared to adapt their work to the state regulation agenda. These are the ones we should worry about. The psychoanalysts who should be our allies in the fight against state regulation are those who refuse to 'adapt' people to society, psychoanalysts who are more closely connected to the continental European tradition of work. We should remember here that while psychoanalysis in the UK has been closely allied to psychiatry, many psychoanalysts in France and Italy were allied to the anti-psychiatry movement.

Things are not simple, and it is not clear all the time who our friends and enemies are, and this uncertainty is what the government preys upon in its argument for more regulation. Some professionals who were trained as psychoanalysts, like Ronnie Laing, were supportive of the user movement, and some psychiatrists even, like Alec Jenner, Marius Romme and Franco Basaglia, have been sources of inspiration in the struggle against abusive psychiatric practice. On the other hand, some psychoanalysts now, even the 'European' ones, will not listen to objections to their attempts to diagnose and direct their patients in treatment. All the same, psychoanalysis as such is a practice that is based on 'free association', the attempt to speak freely and discover how we also do the work of power ourselves, and it is this space of 'free association' that is the diametric opposite of any attempt to regulate how people should speak.

These are matters to be kept to the forefront of discussion when we make any alliance with psychotherapists in the UK now who are complaining against state regulation, and when they would like to involve us in petitions against state regulation (like the one at <http://petitions.pm.gov.uk/psychoregulation> [closed in 2008]), or ask us to be supportive of their own petitions when they speak as psychotherapists or counsellors (like the one at <http://www.petitiononline.com/statereg/petition.html>), or when they have a 'Rally of the Impossible Professions' (like the one in London in September 2008).

I have signed the petitions and attended meetings, and I have done so because one of the resources for a radical alternative in mental health, psychoanalysis, is under threat from state regulation. There are high stakes in these debates, and if the government gets its way every kind of psychotherapy and counselling will be affected. This is now an issue not only for the professionals but also for anyone who uses mental health services and demands something better than what we have at the moment.

# The need for a new category of schizophrenia in DSM-V: A single case study

*Phil Thomas*

## Our chance to influence mental health diagnoses

The American Psychiatric Association's *Diagnostic and Statistical Manual*, known familiarly as 'DSM', was introduced in 1952. It quickly became the world's 'bible' for mental health diagnosis. It is constantly revised, and the fifth complete revision – the very latest in psychiatric thinking – is due for publication in 2013.

And if you go to the DSM-V Prelude website ([www.dsm5.org](http://www.dsm5.org)), and follow the links, you will find yourself at the 'Suggestions' page. Here you are informed that the DSM user community is '... an important and valued source of information regarding problems with DSM'. You are then cordially invited to provide feedback about DSM-IV, and to offer suggestions for the new system of psychiatric classification. Apparently, all suggestions will be added to the DSM-V prelude database for eventual routing to the appropriate work group. As if to emphasise their classificatory credentials, the APA even goes so far as categorising the categories into which our suggestions might fall:

1. Comments concerning shortcomings and limitations of existing DSM categories, but excluding suggestions of how to fix them, as well as miscellaneous suggestions not otherwise classified.
2. Suggestions for specific changes to diagnostic criteria or diagnostic groupings.
3. Suggestions for a new subtype to be added to an existing disorder.
4. Suggestions for a new disorder to be added to DSM-V.
5. Suggestions for deletion of an existing disorder.

It seems to me just and fitting that 'The Land of the Free', the self-appointed universal guarantor of freedom and democracy, should extend the ideal of liberty (that child of the Enlightenment enshrined in the US Constitution) to the contested domain of madness. Are we not all missing something important here? Is this not an opportunity to democratise the world of madness? Is this not our chance, at last, to have our rightful say about madness? Perhaps – but perhaps not.

But before the icy light of dawn disturbs this reverie, imagine some possibilities. You may share my vision. A dream, perhaps, but one rooted in opposition, and through which action may be possible – a campaign, even, to force them to consider the madness of the world we live in, and one that I hope resonates strongly with the purpose of *Folie/Culture*.

I want to share with you my thoughts about how we may make this invitation work to our advantage, to create a new plane of opposition to the real threat of *global* madness, focused on a point of dissent. Yes, we must take this invitation seriously, and before we return bleary-eyed into

the real world, we should seize the opportunity and *make our own suggestions!*

I am serious. So serious, in fact, that I want to present here, for the first time, the results of my deepest thoughts about the matter by describing to you my own recommendation to this important and most powerful group. Who knows, they might just listen to me, and in taking seriously what I have to say, and acting on it, create the possibility for a new world in which strife, famine, war, and the ever-present threat of ecological disaster will be averted. No doubt you think I'm mad for saying this. Perhaps you are right. If so, kick me into the cell, lock the door and throw away the key! But do not rush into making a judgement. Please give me the chance to explain myself.

My proposal is that we add a new category of mental disorder. I will end this article with a suggestion for Category 5, too, that is to say, *for the deletion of all existing mental health disorders*. But for the moment that can wait.

My suggestion is for a new form of mental disorder, a new genus of madness previously undiscovered. I have identified it after many years of careful, detailed study and research. I can find no reference to this condition in the psychiatric textbooks. I have spent half a lifetime searching the medical literature, and can find no reference to it anywhere. Despite this, the condition I am about to describe can readily be identified. I am certain that once I describe it you will instantly recognise the difficult and intractable problem to which I refer. The condition is a serious and potentially lethal disorder carrying great risks. It is much more common in men, especially those over the age of forty. It is characterised by a complete and utter lack of insight, and by delusional beliefs of a particularly dangerous variety because they are commonly acted upon. Perceptual disturbances such as hallucinations are also sometimes associated with the condition. In time-honoured medical tradition, I shall present to you a case history that draws out the salient features of this condition, and then go on to list the key diagnostic criteria that I believe to be pathognomonic of the disorder.

## A case history

The subject of this case report was a 60-year-old, married American citizen. His father had a distinguished military career and after successes in the Texas oil industry entered politics. He became president of the USA, from 1989–1993. And so our subject – the son – was born into a wealthy New England family (in New Haven, Connecticut). His early life appears unremarkable. His family moved to Texas when he was a child because of his father's business interests, but he was sent to a prestigious, elite preparatory school in Massachusetts. In 1964 the subject entered Yale to read for a degree in history. He was a keen sportsman, playing baseball and football, and like his father and grandfather, he became a member of the

University's secret society, the Skull and Bones. He was also a member of the prestigious *Delta Kappa Epsilon* fraternity, eventually becoming its president. He has been described by his Yale tutors as 'an average student'. When many of his age group were conscripted to fight in Vietnam, he left Yale in 1968 to do his national service in the Texas Air National Guard. He trained as an F-102 fighter pilot and was promoted First Lieutenant in November 1970.

At this stage certain difficulties emerged. In May 1972 he went to Alabama and requested reassignment to an inactive unit there. It seems odd that a pilot should request transfer to a unit that had no aeroplanes. His request was denied, and there are no available records for his last two years of national service, leaving a gap in the biography. His pre-morbid personality is described by acquaintances as outgoing and sociable, with a good sense of humour. Despite appearing unintelligent to some people, on entering Yale his IQ was 129, putting him in the bright-normal range.

In 1975 he tried unsuccessfully for a place to study law in the University of Texas, and instead entered Harvard Business School. He left Harvard with an MBA and started work by setting up his own oil and gas company. After a few years this enterprise hit financial difficulties and was bought out by a competitor. But as a result he became a millionaire.

There is evidence that, as a young man, he had problems with alcohol. It is reported that he drank heavily whilst in the DKE house at Yale. Apparently, after leaving the National Guard he drifted aimlessly, and during this period his drink problem seems to have intensified. In 1972 he drove intoxicated back from a party and had a minor accident. When his father came to see what was going on, he tried to pick a fight with him. It is also alleged that in 1974 he spent Super Bowl Sunday at a party hosted by Hunter S. Thompson, whose autobiographical novel *Fear and Loathing in Las Vegas* extols the virtues of a wide variety of drugs, including LSD, mescaline and cannabis. In October 1976, our subject was arrested for drunken driving, convicted, fined \$150 and banned from driving for two years. When questioned later he denied being dependent on alcohol: 'I don't think I was clinically an alcoholic; I didn't have the genuine addiction. I don't know why I drank. I like to drink, I guess', he said.

In 1977 the subject married a librarian, and four years later she gave birth to their first children, twin girls. Over the next few years his drinking caused his wife much concern, and on the occasion of his fortieth birthday, in 1986, he vowed to give up alcohol after she had threatened to leave him if he didn't. Shortly after this he appears to have reached a turning point in his life. He stopped drinking and underwent a religious conversion. He was brought up an Episcopalian, but he adopted his wife's faith, Methodism. These changes may also have had something to do with his father's decision to stand as Republican candidate for the US presidency in 1988. During this time our subject worked as a member of his father's campaign staff and became particularly popular with the Christian political right. In 1999 he announced that he too would contest the presidency, 'as a compassionate conservative'.

The subject's psychosis appears to have had an insidious onset, suggesting that his condition has a poor prognosis with little hope of return to full normality. Sometime in the mid 1990s, he phoned his close friend James Robison, the charismatic preacher and host of the American TV show *Life*

*Today*. He announced that he had heard the voice of God speaking to him, telling him to run for President. So he acted on this imperative verbal auditory hallucination, stood for President, and was duly elected. Shortly after his election, 3000 people were slaughtered in Al-Qaeda's murderous attack on the World Trade Centre. This international tragedy – the new Pearl Harbor – had a devastating effect upon our subject's mental state. At a meeting held with high-level Palestinian officials, including then President Mahmoud Abbas, he is reported to have said: 'God told me to strike at Al-Qaeda and I struck them. And then He instructed me to strike at Saddam, which I did. And now I am determined to solve the problems in the Middle East.'

Since then our subject has persistently claimed that he was on a divine mission. Speaking to West Point graduates, he expressed the delusional belief that we are in a conflict between Good and Evil, and that America is '... firmly on the side of the angels ...'. He also claimed to be aware of a '... wonder-working power ...' abroad in the United States. Interestingly his favourite film is *Field of Dreams*. This is based on the novel *Shoeless Joe* by WP Kinsella, in which an Iowa farmer builds a baseball field in his pastures in response to verbal auditory hallucinations. Our subject, too, acted on his delusional beliefs. In 2002 he sent troops into Afghanistan in order to 'get Osama Bin Laden', clear out the Taliban and impose 'democracy and freedom'. In 2003, acting on the clearly delusional belief that Saddam Hussein had stockpiled weapons of mass destruction, he invaded Iraq illegally. The subject's actions in response to his delusions had catastrophic implications. To date, there have been more than 100,000 Iraqi civilian deaths (source [www.iraqbodycount.org/database](http://www.iraqbodycount.org/database) retrieved 22/10/10) and more than 3,000 US troops killed. (The number of Iraqi wounded is probably not far short of a million.) No weapons of mass destruction were found.

There is also evidence that this form of psychosis may also exist in a socially induced form similar to *Folie à deux*. His close friend, UK citizen TB, shows evidence of very similar psychological problems.

### **World Domination Disorder: The diagnostic criteria**

It may now be helpful to set out the diagnostic criteria for this condition, which I suggest be called 'World Domination Disorder' (WDD).

#### *A. Unusual Beliefs*

1. Belief that you have a divinely inspired mission to rid the world of Evil.
2. Believing (or claiming) to be a democratically elected head of state, and believing or claiming that the majority of the population support you.
3. Acting on these beliefs.

#### *B. Unusual Experiences*

1. Hearing voices, especially of a religious and/or grandiose nature (e.g., hearing the voice of God telling you that you are on a divine mission, and are engaged in a struggle on the part of Good, against Evil).
2. Having the experience that one's actions and will are under the control or influence of God.
3. Acting on these experiences.

### C. Moral Insanity

1. Moral insanity indicated by:
  - a. Failure of (or arrested state of development of) moral imagination (e.g., unable to appreciate the consequences of the wholesale slaughter of Iraqis)
  - b. Evidence that this is a developmental disorder, e.g., of an abnormal pre-morbid personality
2. Inability to distinguish between the values of corporate capitalism and democracy.
3. Inability to distinguish between the values of evangelical Christian fundamentalism and democracy.
4. No insight.

In order to meet the full criteria for the disorder, it is suggested that there must be two items present from each of categories A and B, one of which must be item 3 (acting on these experiences) in either A or B, plus any two items from category C. In order to meet partial criteria for the disorder, there must be two items present from either category A or B, one of which must be item 3, plus any two items from category C.

This suggestion for a new category of mental disorder is put forward in the hope that the finest neuroscientific and psychopharmacological brains will be stimulated to carry out research into the disorder, and that this research will result in the development of a new class of drugs and physical treatments aimed at rectifying the neurochemical imbalance that is almost certain to underlie the condition. Studies show that in rats, aggressive and domineering behaviour is mediated through circuits in the brain controlled by noradrenaline and serotonin. In addition, these circuits are thought to be determined by genetic mechanisms associated with the Y chromosome. Indeed, some authorities consider WDD to be a sex-linked recessive disorder. The case history I have presented supports this hypothesis. If so, at some future point it may be possible to genetically engineer sperms by removing the deviant segment of DNA and replacing it with a harmless variety. In this way this dangerous and lethal condition may eventually be brought under control.

Or will it? Of course, experience indicates that such a course of action is extremely unlikely to take place. Setting satire and hyperbole aside, there are disturbing resonances between the language that is popularly used by journalists to talk about progress in both medicine and warfare. Doctors are engaged in 'a battle' against mental illness. Drugs are described as 'magic bullets' that 'target' specific types of brain receptors in much the same way a ground-to-air missile targets an enemy aircraft. The expressions 'smart drugs' and 'smart bombs' are both used to convey sanitised notions of precision and accuracy, of the capability of precisely striking the targeted enemy, whether through focused effects on specific receptor sites in the brain, or through the use of guided bombs that specifically 'take out' suspects, supposedly with minimum 'side effects' or 'collateral damage'.

This kind of language carries the implication that a battle against disease or an enemy cannot be pursued without cost, and in consequence we must disguise the true nature of this, especially its moral dimensions, behind an anodyne expression. 'Collateral damage' is so much easier on the ears than 'civilians slaughtered during the military engagement'. The expression 'side effect' sits more comfortably on our consciences than 'medically induced neuroleptic malignant syndrome'.

However, let us assume for the sake of argument that there really is such a thing as WDD – that it really does exist as a neurochemical imbalance alongside all the other chimerical neurochemical imbalances such as Major Depressive Disorder, Social Avoidance Disorder, and Premenstrual Dysphoric Disorder. All these 'mental disorders' have been the subject of major areas of research by clinical neuroscientists and psychiatrists, largely sponsored by the pharmaceutical industry. Can we believe that WDD would be investigated with the same fervour? Of course not, because the interests of the pharmaceutical industry are inextricably bound to the political interests of our governments.

### In conclusion

I want to end by returning to the problem of this subject's madness. Many of those diagnosed mentally ill have strange experiences involving 'God'. Some act on these experiences because they believe that they are acting on God's will or are under instruction from God. The overwhelming majority of such people pose little or no risk to themselves or to other people, but nevertheless many find their freedom constrained. They are diagnosed with 'schizophrenia', made into patients, compulsorily removed to hospitals and forced to take medication against their wishes. The World Health Organisation has drawn attention to what it describes as the global economic burden of schizophrenia. Five years ago, in the USA alone, this was estimated at a yearly \$148 billion (WHO, 2002).

On the other hand, President George W. Bush had experiences that to all intents and purposes appeared indistinguishable from those experienced by many who receive a diagnosis of schizophrenia. When he acted on his experiences Bush declared 'a War on Terror' and 'a crusade'. He then invaded two sovereign countries, resulting in very many military and civilian deaths and maimings. Three years after the invasion, the direct and indirect economic cost of the War in Iraq was already estimated at \$1 trillion (Bilmes & Stiglitz, 2006).

One cannot help remembering something RD Laing wrote. At the height of the Vietnam War, he made the following point:

*People called brain surgeons have stuck knives into the brains of hundreds and thousands of people in the last twenty years: people who may never have used a knife against anyone themselves. They may have broken a few windows and sometimes screamed, but they have killed fewer people than the rest of the population – many, many fewer if we count the mass exterminations of wars, declared and undeclared, waged by the legalized, 'sane' members of our society. (Laing, 1968: 19)*

Laing directs our attention to the values attached to psychosis in democratic societies. Psychopathology and biological science turn the spiritual experiences of ordinary men and women into the symptoms of schizophrenia. In doing so, Laing also reminds us that the advent of science and technology and the cool detached rationality with which we are supposed to view the world means that we no longer are capable of grasping the essential moral dimension of madness. What is madness? Are we mad if we hear the

voice of Christ or the Devil? Or are we mad if we believe we have a divine mission to conquer Evil, and therefore to order the invasion of another country and rain death and destruction on so many thousands of innocent civilians – men, women and children?

I have one final suggestion for the DSM-V Prelude page. Recall that Category 5 of their category of categories referred to deletions of existing disorders from the DSM. Here is my suggestion. SCRAP THE LOT! After all, in December 1973 the American Psychiatric Association voted to remove homosexuality from the DSM because it could no longer be considered a mental disorder.

So, let them delete ALL the categories and let's see if we can make a fresh start by seeing madness as the expression of a wide range of human differences, similar to the different ways in which we express our sexuality or spirituality. Instead, let us demand an end to the true madness of this world – intolerance, hatred, exploitation, oppression and injustice.

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## Carol Batton

### WEEDKILLER

I can't find it in these Instructions –  
(I know it's not for Trees).

I've looked everywhere for Reasons,  
And comforted the seeds.

I can't see why it's needed,  
For the murdering of these.

Dear God, who created them,  
Which flowers are the Weeds?

Dear God, who created us,  
Which of us are weeds?

• • • •

### SCHIZOPHRENIA'S PALLIATIVES

They gave me medication to stop me  
Burning out at forty.

And so burnt me out at twenty.

• • • •

### ADVOCACY

Welcome to Madness and the side effects of  
medication.

1. You'll need an advocate.
2. You'll need an advocate to express the anger you are no longer allowed.
3. You'll need an advocate to socialise with.
4. You'll need help to explain yourself if your speech is badly damaged by years of your 'medicine'.
5. You'll need a PAID advocate to find you work.
6. You'll need someone else to persuade your advocate to do things now beyond your power.
7. You'll need an advocate to explain to your neighbours: 'She's actually human'.
8. The advocate will go with you to your psychiatrist. (But tell you that you must go?)
9. Mine won't do Welfare Rights, etc.
10. You'll need an advocate for fifty years.
11. I feel demeaned by the very concept of needing advocacy.

Carol Batton's *Page Fright* is available at [www.amazon.co.uk](http://www.amazon.co.uk), for £6.95.

# You'd have to be Mad not to protest

Posted on October 27, 2010 by Dotmasters

So the Mad Pride tribe came together for the day of action in Hyde park at speakers corner yesterday. As i arrived the effigy sporting a double faced head (made during an effigy making workshop at Core arts the week before) hung from a tree. As the chill wind blew, it spun to reveal the lying eyes of both cameron and osborne. The demonstrators sporting their new Mad pride tee shirts and holding the placards of earlier posts, listened to rallying cries of defiance and sad tales of psychiatric miss adventure. These cuts shouldn't hurt our societies most vulnerable but it seems that those whose voices are the weakest will be the ones who pay the dearest. After poetry, call to arms and a two minute scream, the effigy was beaten with some gusto, its entrails (sausages) finally being cooked on an open fire made of its body and devoured by the crowd. The event was important in generating a sense of unity among the displaced and medicated, in these troubled and stressful times there may not be much that separates the sane from the mad, there but for the grace of god go i.



Pictures courtesy of  
Dotmasters.co.uk

Coming soon - Special issue of *ASYLUM* on Mad Pride  
So get your subscription for 2011

# Special Feature on Survivors History

## 1: A poet's view of the Survivors History Group by Júlia Sorribes and Phil Ruthen

### Survivors of the UK's mental health system rewrite their history

Since April 2005, a group of mental health system service-users/survivors and historians have been putting together an archive of documents and artworks of all kinds to reflect the shared experiences of people involved in the wider mental health political movements in UK history.



From left to right: Frank Bangay, Mandy Chainey, Peter Campbell and Phil Ruthen at the signing of Phil's contract, in March 2008.

Poet and former mental health service-user Philip Ruthen was employed in 2008 to assist the development of the project. In an interview with journalist Júlia Sorribes, he explained that the Survivors History Group aims to 'recall the real lives of people who have lived in a mental health setting from their own point of view, not that more often presented by the staff or academics'.

This initiative stemmed from a meeting at the end of November 2004, called by mental health experts Thurstine Basset and Peter Lindley at London's Sainsbury Centre for Mental Health (now The Centre for Mental Health). The group was formed on Thursday 21 April 2005 at what was then the Mental After-Care Association (MACA) in Lincoln's Inn (now Together Working for Wellbeing, in Old Street, London). MACA had appointed survivor activist Ann Beales 'to support service-user involvement nationally', and she arranged that Together would provide a base for the group, without interfering in any way with its independence. To launch the group, Survivor historian Peter Campbell outlined five significant events in the history of the movement, and people viewed an impromptu museum put together by participants, each bringing a couple of items from their own collections.

In January 2006 the Survivors History Group published its official manifesto. In this document, the group asserts

that they seek to 'record, preserve, collate and make widely available the diversity and creativity of service-users/survivors through personal accounts, writings, poetry, art, music, drama, photography ... and all other expressions'.

Phil Ruthen explained that in 2008 the group's intention was to obtain sufficient funding, including seeking donations, and to maintain and develop its online archive at [www.studymore.org.uk/mpu.htm](http://www.studymore.org.uk/mpu.htm). Within this website, people from the service-user community can interact and will be increasingly able to provide a wide range of material – from DVDs to photographs, poems or pamphlets – as the practicalities of physical archive facilities are explored.

He also explained that the Survivors History Group is a nationwide initiative and stressed that service users not only from London but also from places like Manchester, Scotland or Birmingham, for example, have a lot more to say about the survivors' movement, being at times 'overlooked in the UK drift towards increased centralisation of policies and facilities'. People around the country are being encouraged to find and list items and documents they already possess, with a view to these eventually being added to the archive.

One of Phil's suggestions was an Internet forum that would allow people in all parts of the country (or, indeed, the world) to discuss survivor history and the issues related to it in an open, democratic and de-centralised way. This was established at <http://groups.google.com/group/survivor-history>. The forum now has about 70 members and active discussions most days.

### Mental patients in story, poetry and song

The poet, who has been a mental health campaigner for more than a decade, points out that the social and political side of the group is important: 'What we want is to preserve materials that may be lost to history, make them available for future research and give a wider perspective.'

While supporting the group, Philip Ruthen continues fulfilling the role of a trustee in Survivors' Poetry, a national organisation set up in November 1991 to promote poetry and the literary arts 'by and for survivors of mental distress' (according to its current Chief Executive Officer, the distinguished poet and critic, Simon Jenner). Survivors' Poetry, and the quarterly magazine *Poetry Express*, can be reached at [www.survivorspoetry.com](http://www.survivorspoetry.com).

Much of the inspiration for Survivors' Poetry came from a decade of music and poetry gigs organised by Frank Bangay in aid of the organisations: Preservation of the Rights of Patients in Therapy (PROMPT) and the Campaign Against Psychiatric Oppression (CAPO). Frank, a historian of the working-class roots of the Survivor movement, once said, 'Our poetry and other forms of creativity are our only voice, and the only way we really have of communicating our experiences.'

This interest in creativity at the core of survivor history was reflected in the 'Pageant of Survivor History – Mental Patients in Poetry, Story and Song from the 18th to 21st Century', which the history group organised together with the Friends of East End Lunatics (FEEL) in the historic Kingsley Hall, in March, 2010. Much of this performance, including

some of the music, is preserved at <http://studymore.org.uk/pageant.htm>.

Although it proved impossible to secure funding for a paid employee, the Survivors History Group has found that it can work effectively with the unpaid energies of its members and the funding it has secured. Phil Ruthen remains a member of the group but has now moved on to earn his living in other Survivor initiatives.

## 2. *Asylum to Action* by Helen Spandler: A review by Mark Cresswell



Helen Spandler

### Survivors' history and the symbols of a movement

Subtitled: *Paddington Day Hospital, Therapeutic Communities and Beyond*, this book is a superb addition to a small but significant genre – the study of political activism within the mental health system. The exemplary text of this genre remains Peter Sedgwick's *Psychopolitics* (from 1982), and it is to Spandler's credit that her book deserves mentioning in the same breath. I should also mention the following: Kathryn Church's *Forbidden Narratives* (1995), Nick Crossley's *Contesting Psychiatry* (2006), and Linda J. Morrison's *Talking Back to Psychiatry* (2005).

Briefly, Helen tells the following story. During the decade spanning the mid-1960s to mid-1970s – until its closure and the dismissal of its Medical Director, Julian Goodburn – The Therapeutic Community (TC) at the Paddington Day Hospital in London was amongst the most radical of its kind. Its closure followed an official inquiry in 1979. For that decade or so Goodburn implemented an innovative group psychoanalytic approach within the TC. This stressed patient autonomy and the need to combine non-medical recognition of human distress alongside a confrontation with the social and political reality 'beyond'. In addition to its well-attested radicalism as a TC, Paddington was also noteworthy for helping to facilitate the development of the 'User/Survivor' movement in Britain, especially the Mental Patients' Union (MPU). The MPU was formed in 1973, specifically originating in protests, during 1971/72, against

closing down the Paddington TC. *Asylum to Action* surveys the history of that TC, from inception to closure, including 'the victorious protest' and the formation of the MPU.

In a sense, *Asylum to Action* works in 'major' and 'minor' keys: if the history of Paddington as a TC is the major axis, the formation of the MPU is the minor axis, although Spandler welds together both stories by treating the physical space of Paddington as a 'paradoxical space' through which radical mental health movements (TCs and 'Survivor' movements) appeared together for the first time.

At first sight, Spandler develops the narrative of Paddington in a straightforward and linear way. However, she has a deeper purpose concerning the historical status of a previous and, as it turns out, rival account of Paddington as a TC – that located in Claire Baron's well-known and contrastingly titled *Asylum to Anarchy* (1987). It is important to appreciate the sense in which Spandler invokes the rival concept of 'action' against Baron's concept of 'anarchy'.



There are two points to make about this contrast. First, and most obviously, Spandler's account displays the wider historical compass insofar as, compared to Baron's work, it incorporates the *entire* history of Paddington, that is from 1962 to 1979. Her analysis extends to include the symbolic and disputed function it enjoys to the present day. On the other hand, Baron's book is limited by its narrative of 'decline and fall', which is to say, to the controversy surrounding its practice in the post-MPU period (1973–79). It was then that Medical Director Goodburn was accused and pronounced guilty of unprofessional conduct, and the Paddington TC closed down.

Baron suggests a *One Flew Over the Cuckoo's Nest* scenario in which institutional power, masquerading as 'therapy', systematically denies the 'lived experience' of the mental patient – to the latter's detriment. Spandler recognises that Baron's sociologically determined narrative in *Asylum to Anarchy* is very compelling. So too is Ken Kesey's *Cuckoo's Nest* novel (1962) and Milos Forman's film (1975), which was released to popular and critical acclaim during the period surveyed by Baron. After all, 'decline and fall' is an aesthetically satisfying 'tale'.

But is it *over*-compelling? And, as much to the point, is the narrative *true*? It is a mark of Spandler's subtlety that she is at least as concerned with the first question as with the second. She argues that Baron's account functions as nothing less than a 'consumable pill of history'. By this, she means that the narrative of 'decline and fall' cannot be separated from its historical context. This was the resurgence of an ideology of the New Right, obsessed with 'order' and abhorring 'radicalism'. Baron's simplistic condemnation of 'anarchy' – expressed in her title – chimed harmoniously with the Reaganite/Thatcherite mantra that

'society was becoming ungovernable', to the degree that left-wing radicalism needed 'a summary purge'.

Spandler is persuasive that 'the truth about Paddington' is far more complex and disputed than Baron allows, and it is certainly possible to oppose the fatalistic narrative of 'decline and fall' with a more progressive narrative which preserves Paddington's radicalism as that 'political action' which her own book's title invokes. She sums up this counter-narrative in the following way:

*[A] struggle for greater democracy neither surrenders itself to its illusions nor aspires to a permanent substitute. This means developing spaces that enable greater democratic dialogue .... While it remains important to develop specific therapeutic communities ... it is perhaps more important to ... cultivate the radical spirit necessary to enable the creation of wider critical communities ... both within and beyond TCs.*

### Questions of history (1)

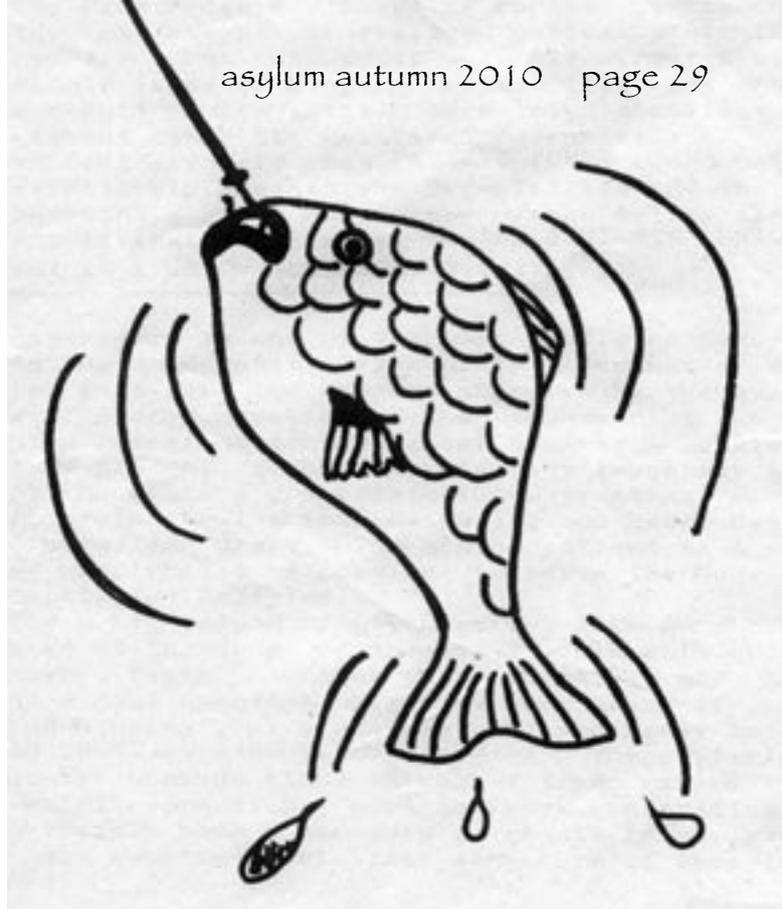
Yet the questions raised by the book are tricky. Spandler recognises the extent to which *all* history is connected to a narrative genre which somehow 'fixes' its meaning. This does not mean that 'the facts' do not matter but it does mean that we have to relinquish any idea that the task of historical writing is simply to 'pile up the facts' in such a way as to produce an *indisputable* account of the past. The historian EH Carr once suggested that facts are not like 'fish on the fishmonger's slab' – a 'fishy' symbolisation to which I'll return – and 'postmodernism' tends to push this idea of 'history-as-interpretation' towards *relativism*. Why 'relativism'? The risk here is that in opposing one narrative to another, in opposing a narrative about 'the flourishing of democracy' against a narrative of 'decline and fall' – i.e., of 'action' against 'anarchy' – we lose sight of that reputed criterion, 'the indisputable facts', which may permit us to adjudicate between the two.

This is precisely the sort of 'risk' I want to address. I aim to pursue this not just in terms of the Baron/Spandler encounter, but in terms of a wider set of questions provoked, not only by *Asylum to Action*, but also by recent reflections on the history of the 'survivor' movement undertaken by the Survivors History Group and by other academic work on political activism within psychiatry. Taken together these sources provoke a relay race of relevant questions.

For instance, when we ask about 'the truth' of events – by which I refer to 'the indisputable facts' – what are we actually asking? Are we suggesting that there is *one* such truth (Spandler's or Baron's), and that it is true for all time? Or that there may be a plurality of truths (Spandler's *and* Baron's *and* anyone else's) each of which is either: (i) equally true, or else; (ii) may be treated as such, there being no adequate criterion for adjudication (i.e., precisely the risk of relativism, noted above)?

### 'The Fish-on-a-hook'

I address these questions by analysing what is often taken as the founding symbol of The Survivor Movement: the 'fish-caught-on-a-hook'. This symbol was the cover image of the 1972/1973 manifesto of a group of people linked to Paddington Day Hospital called *The Need for a Mental*



*Patients' Union.*

That symbol – and its significance – has been much discussed. The indisputable historical 'facts', though, seem to be these. When it employed the symbol of 'the fish-on-a-hook', the manifesto cited the psychiatrist and psychoanalyst, Karl Menninger. His 1930 book, *The Human Mind* opened with this analogy:

*When a trout rising to a fly gets hooked on a line and finds himself unable to swim about freely, he begins a fight which results in struggles and splashes and sometimes escapes. Often, of course, the situation is too tough for him.*

*In the same way, the human being struggles with his environment and with the hooks that catch him. Sometimes he masters his difficulties; sometimes they are too much for him. His struggles are all the world sees and it usually misunderstands them. It is hard for a free fish to understand what is happening to a hooked one.*

The sense of this symbolisation is simple enough: what is called 'mental illness' is an attempt to cope with a hostile environment – a coping mechanism which is susceptible to misunderstanding and pathologising by those with power.

Here we encounter what later became the classically Laingian, anti-psychiatric motif concerning 'the intelligibility of madness'. Fast-forward to the year 2000 and we find 'The Fish Pamphlet' being reproduced by Mad Pride, one of the most significant recent survivor organisations, with the following words:

*This now rare document, also known as The Fish Pamphlet, is said by some to mark the beginning of the organised 'survivor movement' in Britain as it can be recognised today. The document is therefore of great historical and political importance ... Although some of the following material and the language used may appear dated, it is a timely reminder of where it is*

*that the 'survivor movement' has come from, and sets the context for the book Mad Pride: A celebration of mad culture in more ways than one.*

It is certain that these three different appearances of the 'fish-on-a-hook' symbolisation are 'indisputable facts': Menninger was one of the most famous psychiatrists of his day, so it began its life within mainstream psychiatry, but later it was re-articulated by the social movement, where it serves a symbolic function to this day.

One disputed issue, however, concerns the alleged 'Marxist' status of the 'fish-on-a-hook' motif. As seems clear, the framers of the MPU *Fish Pamphlet* were largely Marxist-influenced, if not themselves Marxist, and the text is explicitly so. The symbol of the 'fish-on-a-hook' serves to characterise the fate of mental patients as mainly members of the working class, under a system of capitalist social relations for which psychiatry is a subcontractor for social control. However, this proves itself a prime example of why historians should never confuse the rhetoric of a text – particularly a 'founding statement', and including its symbolisation – with the ideology and practice of the actual movement. The MPU was clearly not a Marxist organisation: it quickly rejected *The Fish Pamphlet* in favour of the more liberal *Declaration of Intent*. And it replaced the 'fish-on-a-hook' symbolisation with that of a human face enmeshed in a spider's web.



The work of the Survivors History Group, and its associated Mental Health History Timeline, is salutary here. Through its digitised primary sources and first-hand eye-witness testimonies, the Timeline shows that not only was the Marxist influence of *The Fish Pamphlet* ephemeral but its 'fish-on-a-hook' symbolisation was not even the only 'fishy' metaphor canvassed by the MPU! For, at meetings in April 1973 which adopted *The Declaration of Intent* and the 'face-in-a-spider's-web' motif noted above, an *alternative* symbol was proposed but rejected – a symbol which some described as 'a very beautiful coloured fish'.

And, in a dénouement to this history, which displays a fine ironical sense, that 'beautiful symbol' – rejected for the sake of a sinister 'face-in-a-spider'sweb' – has, as Júlia Sorribes and Phil Ruthen describe, been adopted as the *contemporary* symbolisation of the Survivors History Group:

## Questions of History (2)

In light of this brief history of a movement's symbolisation – and keeping in view Spandler's *Asylum to Action* – let's finish by addressing that relay race of questions noted above, apropos 'the truth' of a movement.

In a sense, what the Baron/Spandler encounter and the history of the fish symbolisation demonstrate is that 'the indisputable facts' are a moveable feast. History 'moves' because we do indeed discover *more* 'facts'. Spandler substantially *adds to* Baron's account in the same way that the Survivors History Group *adds to* already existing academic accounts of the MPU. In one sense, then, 'the truth of the movement' is progressive because it's cumulative.

Yet there is a right way and a wrong way to establish this point. The wrong way is to present this history of the movement as a positivistic 'story of progress': to believe the risk of relativism is removed simply by due diligence to 'the indisputable facts'.

It is not. And the reason is that the history of democratic societies – those which pursue, as 'Survivors' do, what Claude Lefort calls the 'adventure of rights' – is every bit as much 'symbolic' as it is 'real'. By this I mean that (with respect to Baron and Spandler) what I have called the 'narrative' dimension, and (with respect to the 'fish' motif) what I have called the 'symbolic' dimension, are as much a part of the movement's history as any 'indisputable fact'.

Actually, they are more *politically* salient insofar as disputes over the 'symbolic' dimension – as to whether Paddington *is or is not* a narrative of 'decline and fall', or whether the 'fish' symbol *is or is not* a Marxist motif – provide movements with what Lefort calls their 'theatre of contestation', within which political 'action' is defined and formed. Spandler calls this 'theatre of contestation' a 'paradoxical space'. It is paradoxical precisely because it presents us with alternatives for political action all of which cannot be 'true' but *between* which we do have to choose. In this sense, 'relativism' is not so much a problem for historical writing as it is the precondition for a political choice: as Spandler says, a precondition for 'action'.

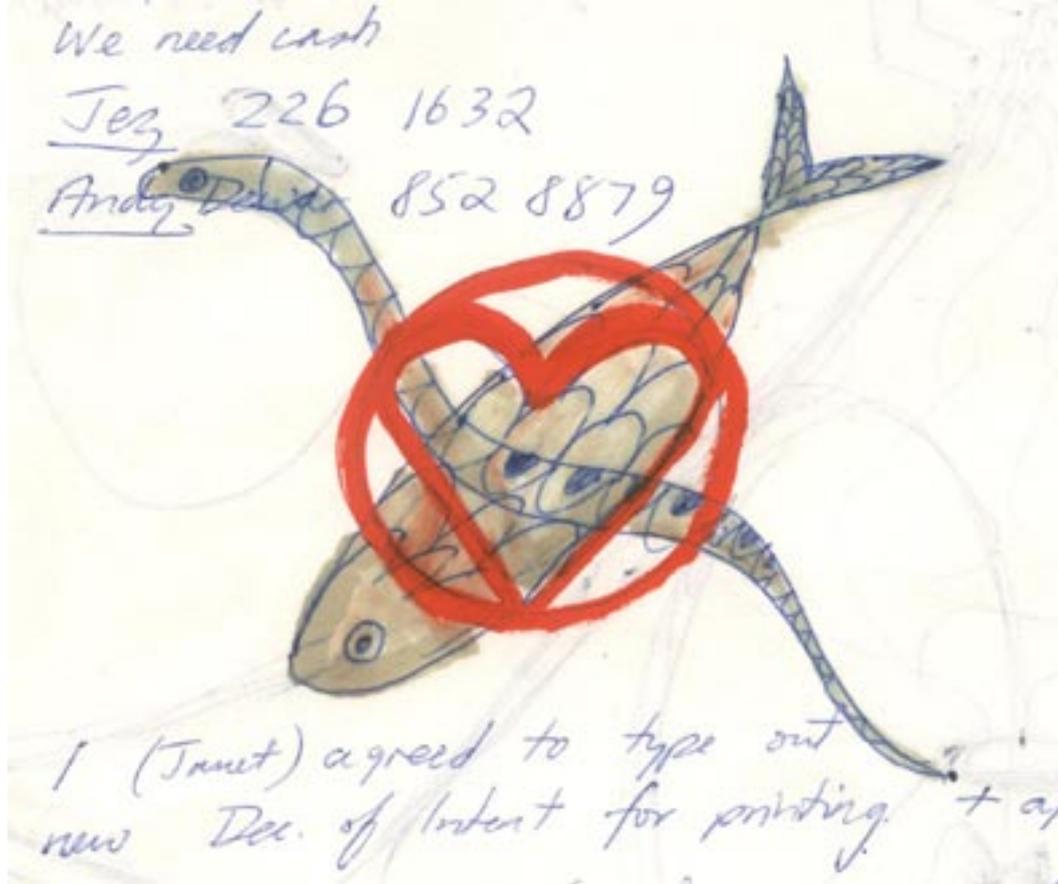
In a 'paradoxical space', it is hard to cope with what Lefort calls 'complications'. The 'simplifications of history' – e.g., notions of 'decline and fall' – are more reassuring. But 'the complication' is this. I do not advocate a simplistic duality between 'the symbolic' and 'the real' – between, say, 'the indisputable facts' and the 'values' that surround them. Rather, I hold that the dimension of 'indisputable facts' is *interpenetrated* by the 'symbolic' dimension – by the dimension of 'narrative' – to the extent that in the 'theatre of contestation' there only really exists, in practice, *disputable* 'facts'. In any case, all such 'facts' (if 'facts' they be), are capable of disputation.

And that, I conclude, is a good thing. Simply because Spandler inhabits a 'theatre of contestation' for which that eternal 'decline and fall' is antithetical; simply because she detects in that narrative another unspoken 'decline', that of the Left and of what might be called the 'great moving right show', she is at pains to dispute it. Simply because the Survivors History Group, through its primary sources, through its eye-witness testimonies, inhabits a 'paradoxical space' for which the symbol of the 'fish-on-a-hook' is opposed by the 'beautiful fish that swims free', they are able to reclaim the 'adventure of rights' which vulgar Marxism would simplify out of existence.

*Asylum to Action* comes replete with 'complications'. And that's an indisputable fact.

Helen Spandler: *Asylum to Action: Paddington Day Hospital, Therapeutic Communities and Beyond*, Jessica Kingsley Publishers, 2006.

The Survivors History Group website and timeline can be found at: <http://studymore.org.uk/mpu.htm>. The archive includes copies of articles by Mark Cresswell, including a fuller version of this one.



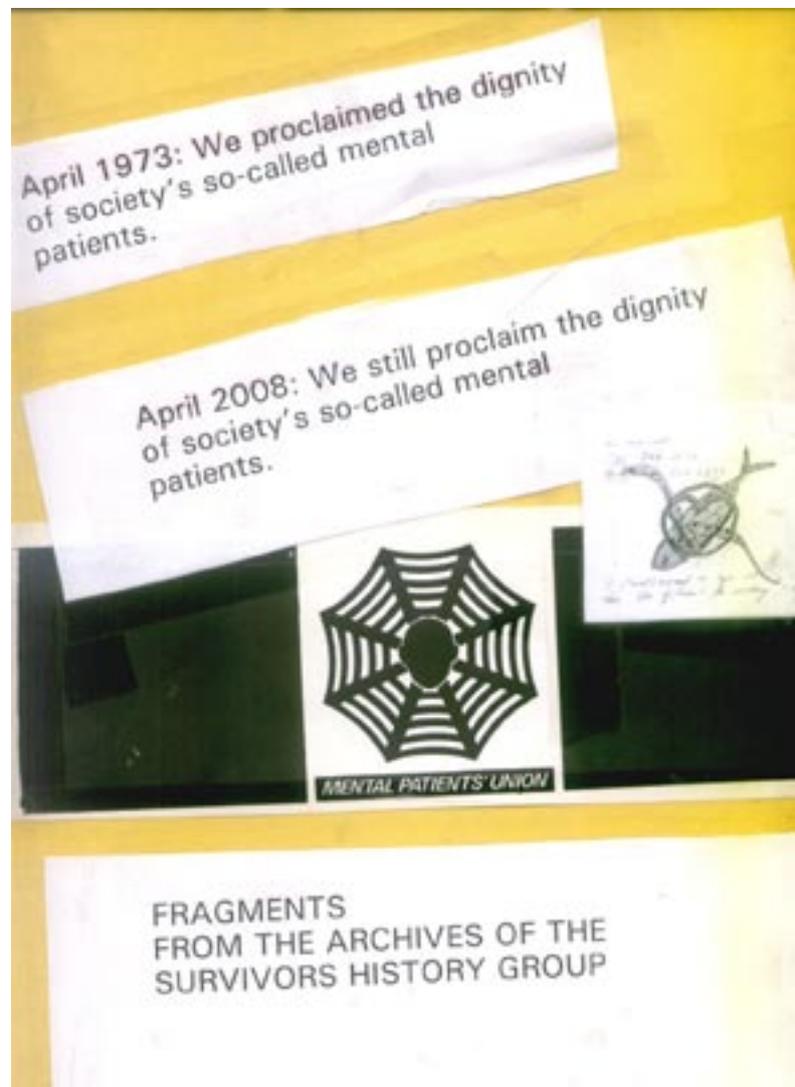
### 3: The symbol for the Survivors History Group

The picture that has become the *logo* of the Survivors History Group was painted by Janet Forge in April 1973. It was intended for the newly formed Mental Patients' Union (MPU), the case for which had been made in a pamphlet decorated with a fish on a hook. What the symbolism means is not recorded, but Andrew Roberts, who was a member of the MPU, has his own theory: 'In it nothing twitches on a hook and nothing struggles to be free of a net. The fish swims free in the water, the snake moves free in the grass and the heart beats free in the breast. We are now free.'

The image was not adopted by the MPU, which instead chose an illustration depicting the face of a patient caught in a spider's web. Janet wrote the minutes of a meeting on her discarded artwork and, in this form, it was preserved in the archives of the MPU. The Survivors History Group has now recovered Janet's artwork to incorporate it into its identity. Andrew calls it 'The Love Fish'.

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<http://studymore.org.uk/mpu.htm>**



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