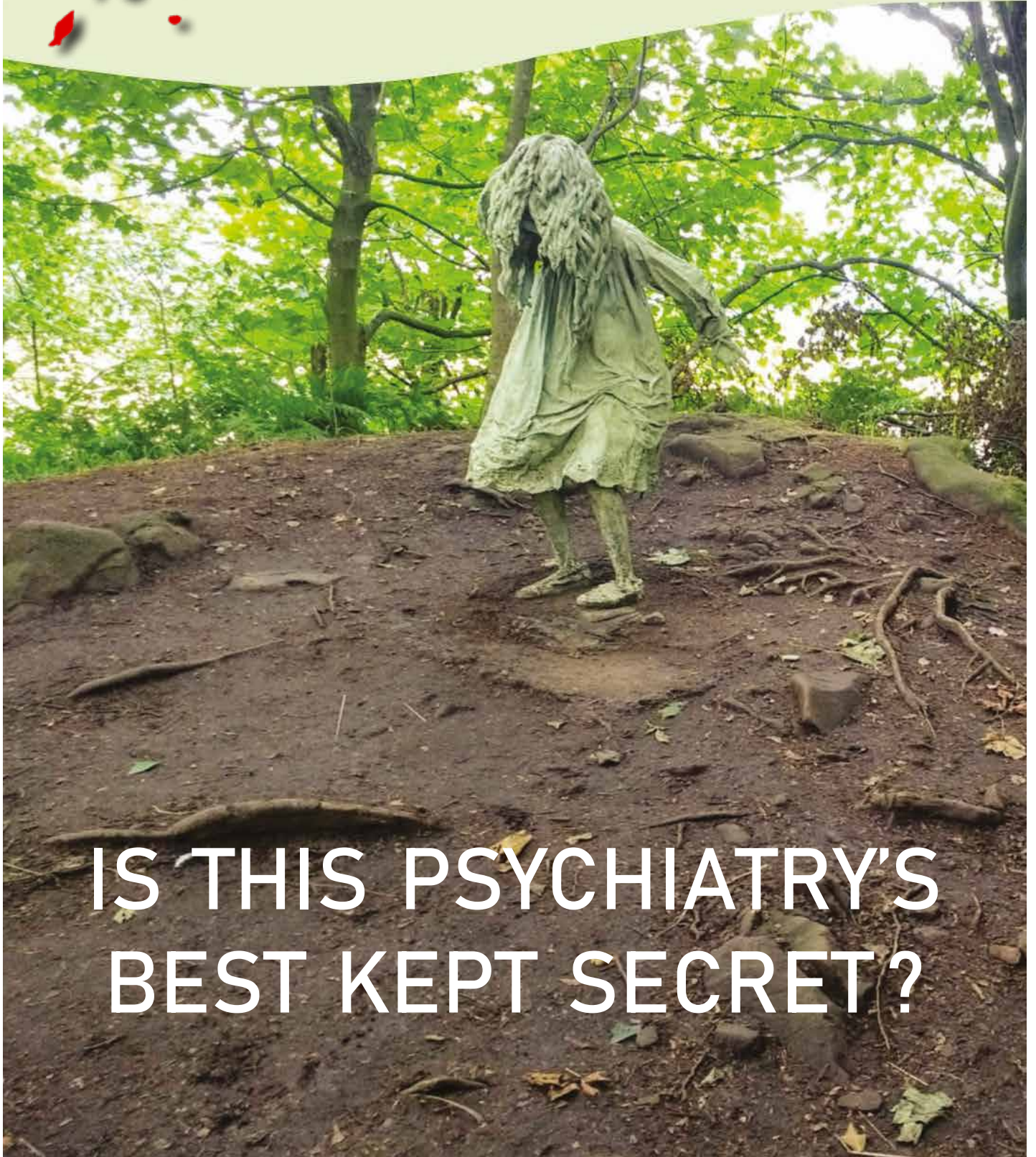


Asylum

the radical mental health magazine

Summer 2019
Volume 26
Number 2
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The radical mental health magazine

Volume 26, Number 2, Summer 2019
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Asylum, formerly the magazine for democratic psychiatry, was established in 1986 as a forum for free debate, open to anyone with an interest in psychiatry and mental health politics, practice and policy. We were inspired by the democratic psychiatry movement in Italy and continue to be influenced by radical mental health movements around the world, including the psychiatric survivor and Mad liberation movements. We welcome contributions from service users, ex-users or survivors; activists, family members 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. We are open to anyone who wants to help produce, develop and distribute the magazine, working in a spirit of equality and democracy. Please contact us if you would like to help.

The views expressed in the magazine are those of the individual contributors and not necessarily those of the editorial group. Articles are accepted in good faith and every effort is made to ensure fairness and veracity.
editors@asylummagazine.org

CONTENTS

Editorial	4
The best kept secret in psychiatry <i>Maria Grazia Turri</i>	5
Survivors History: United Kingdom Advocacy Network (UKAN) <i>Terry Simpson</i>	7
Letter to the magazine <i>Roger Swan</i>	9
A brief experience of multiplicity <i>Sharon Cretsinger</i>	10
A digital future for therapy in the NHS? <i>Richard Hallam</i>	12
A view from inside a medium secure unit <i>Jerome Sewell</i>	14
Creative writing <i>Mica Montana Gray, Mira Nehlawi, Henry Bladon, Shreya Varma & Mark A. Murphy</i>	16
The special education of Dr. Mom <i>Deborah Ross</i>	19
Why I don't believe "schizophrenia" is an illness <i>Tim Dreby</i>	22
BOOK REVIEW: <i>Get Weird</i> by C.J. Casciotta <i>William Park</i>	24
All it takes is a bit of discipline <i>Alastor Nemesis</i>	24
An intellectual emergency in UK mental health services <i>Vincenzo Passante Spaccapietra</i>	25
People mean different things by 'Recovery' <i>Roy Curtis</i>	27
News and findings	28
Empathy and compassion: out of stock <i>Dolly Sen</i>	31

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Editorial

Asylum magazine strives to link the politics of mental health to broader progressive political struggles, social movements and campaigns. For example, *Extinction Rebellion* has been calling attention to the devastating impact of climate change. It has already had significant transformational impact, at least on public consciousness, not dissimilar to that of the *#MeToo* campaign in raising awareness of sexual violence.

Whilst campaigns to raise awareness about mental health and combat stigma have gained widespread media coverage, their messages are often tame and apolitical (for example, 'it's good to talk'). More radical mental health activism has had significantly less media coverage and, it's fair to say, less impact. *Extinction Rebellion* and *#MeToo* have, within a few months, become global bywords, achieving a higher public profile than many years of radical mental health activism.

We invite you to send us your thoughts on the lessons from these new social movements, and from environmental/climate change activism in particular. For example:

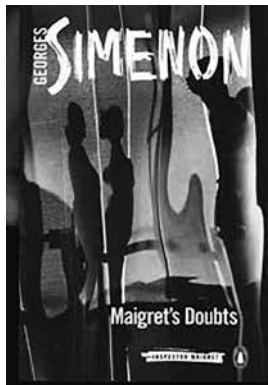
- What lessons can mental health activists learn from the rapid rise and impact of these new movements and campaigns? What can we learn about the role of social media in activism?
- What can mental health activists offer to these new social movements – for example, in relation to the problem of activist burn out and its prevention? Can we share what we understand about how to sustain and look after ourselves and each other, and the outcomes of not doing so?
- We know quite a lot about the connections between sexual violence and mental ill-health, but what about the links between climate change and mental ill health? For example, some people are referring to the idea of 'ecological grief' (intense feelings of grief as people suffer climate-related losses of valued species, ecosystems and landscapes).
- What can mental health activism learn from environmental activism and vice versa? What structures do we need to support such learning?
- What direct role can mental health activists play in climate change activism (and vice versa)?
- Is it relevant that autistic identified activists (such as Greta Thunberg and Chris Packham) are taking the lead in climate change activism? Are people who identify as neurodiverse more sensitive to these issues, and/or more willing to take action?
- How have *Extinction Rebellion* and the *#MeToo* campaigns been impacting on us personally, and on our mental health?
- What are the implications for our work here at *Asylum*?

Please let us know what you think and feel about any of this – through letters, articles, images and creative outputs – and maybe share ideas and resources. If we have enough material, we would like to run a special feature. ■

The best kept secret in psychiatry

MARIA GRAZIA TURRI

In one of Georges Simenon's short novels, *Maigret's Doubts*, Inspector Maigret receives the visit of a man who suspects his wife of wanting to poison him. The man tells of having been off colour recently and accuses his wife on the basis of having found some rat poison in the broom



cupboard. Inspector Maigret is left questioning (hence the doubts of the novel's title) whether his visitor is mentally insane. He consults a number of psychiatric books and he is left with the impression that "by investigating the anomalies of human behaviour, classifying and subdividing them, in the end it was impossible to tell what a man of sound mind might be". As the

investigation leads Maigret to get acquainted with the man's private life and his close relations, he *begins to understand*: "he felt, finally, that he was dealing with people of flesh and blood, men and women with passions and interests".

In 2003, in my first job as a junior doctor in psychiatry, I was asked to interview a middle age woman, I will call her Mrs A. She was an inpatient receiving Electro-Convulsive Therapy (ECT). She had been diagnosed with treatment-resistant psychotic depression for the past two years. She believed that she was being controlled by a little man inside her who made her behave oddly, commanding her to crawl instead of walk and to babble like a new born rather than talk. She was prescribed two antidepressants and an antipsychotic, as well as sleeping tablets and a course of ECT. While I was diligently conducting my semi-structured psychiatric interview, checking how many hours she was sleeping per night, was she waking up early, had she lost her appetite, could she concentrate on watching TV or reading a book – and I will spare you the rest – I noticed a very brief exchange between Mrs A. and her visiting daughter, which made me question whether some family trouble may be contributing to her depression. Questioning family relationships was not part of the semi-structured interview, but it led to a referral for a family therapy meeting, at which I was present. An hour interview with an experienced family therapist unravelled the secret history of this patient, secret because it had never been told outside the domestic walls. That one interview was enough to make us *begin to understand*.

Mrs A. had run the family business and brought up three children all single-handed for many years. Her husband had had several mistresses during their marriage

and had spent lots of the family money on expensive holidays with them. Nevertheless, they stayed together and played the happy couple at family gatherings or for the local community. During all that time Mrs A. had managed without developing a mental illness. But then three years before, her husband had fallen ill with cancer and Mrs A. had become his full time carer. He had no more mistresses now, and even after his recovery, he remained faithful to her and a permanent asset to the domestic environment. He had however taken over control of the family finances and patronised her into following him in expensive holidays that she did not enjoy. That is when she had developed depression. Now I understood why she believed that she had a little man inside her controlling her and making her crawl rather than walk and babble rather than talk. Or at least I thought I understood. There were tears shed in the family meeting. It seemed like the elephant in the room had materialised and was brushing its tail against our eyes, and those of the lady, and her children. Her husband was the only one to remain unmoved and said little.

The family meeting had been an eye-opening experience for a junior psychiatrist.

A few years afterwards when I was working as a Specialty Registrar, I teamed up with a general adult psychiatrist to set up what we called 'the systemic assessment clinic' (SAC). Both of us had had extensive experience of systemic family therapy and had come across repeated instances of epiphanies in 'heartsink' cases similar to those of Mrs A. The SAC was a weekly clinic where we assessed patients who were referred to his general adult psychiatry team with a different model from the one used as a standard in general psychiatry. We asked referred patients to bring along anyone they felt was significant to their lives. Patients brought their partner, their parents, their adult children, siblings or, sometimes, a close friend. In the spirit of family therapy we shifted the focus from assessing the symptoms in the individual to investigating the 'problem' in the system. We felt that at the end of these assessments we could almost always say: "*we begin to understand*". We asked patients and carers to rate their satisfaction with the process and scores were high.

Nevertheless, our many attempts to get support or endorsement of the SAC from our local NHS Trust failed. We were told it was not 'evidence-based' and were encouraged to apply for a NIHR grant – 56 pages long, it took a year to write, it pulled together a team of 8 experts and was rejected.

Trying to provide some evidence for the SAC's benefits, I carried out a service evaluation. I compared outcomes for 22 patients seen in the SAC from 2013 onwards and 22 comparable patients who were assessed in standard psychiatric assessment during the same period of time. All patients were new to psychiatric services. Outcomes were measured as: time spent in psychiatric services after assessment, type of services used, and number of times patients were referred back to psychiatric care after discharge. Follow up was between 2 and 3 years after assessment. The results were very interesting and some of them impressive. In both groups, the immediate post-assessment use of psychiatric services was comparable: a small fraction was discharged back to their GP immediately, the majority were referred for an intervention lasting between 6 and 12 months, and a small minority were referred to tertiary services. Rates of referral to psychology and psychotherapy were comparable across the two groups, although – perhaps surprisingly – somewhat higher in the standard assessment group. In both groups the mean time from assessment to discharge from psychiatric services was comparable, although the number of patients discharged within 6 months was 11 for the SAC and only 6 for the standard assessment group. The great surprise came when we counted the number of times patients were re-referred to psychiatric services once discharged. For the standard assessment group 9 of the 22 patients were re-referred within the 3 years period, and of these, 5 were re-referred twice (for a total of 14 re-referrals). But for the SAC group, only 1 patient out of 22 was re-referred once within the next 3 years. You may conclude that the SAC scared people off from coming back to psychiatric services... Our impression was that, by engaging people in meaningful conversations from the start, it allowed for the development of a purposeful care-plan which was recovery-oriented, while standard assessment tended to make them chronically ill.

The interesting part of the story comes now.

Conscious of the fact that such a small study could not gain attention in the main clinical press, in February 2016 I sent a paper summarising its results to the *Bulletin*, a journal published by the Royal College of Psychiatrists and which specialises in the publication of audits and opinions. It has an insignificant impact factor but it has the advantage of being circulated to all psychiatrists in the UK as an addendum to the prestigious British Journal of Psychiatry, with the potential to reach a sizeable audience. After submitting, I was surprised to hear from the Editor that he was not going to send my paper out for peer-review. I wrote back, politely but passionately asking him to reconsider. The Editor sent the paper to

a member of the editorial board for a second opinion, and they enthusiastically replied that the paper should be sent for peer-review. The Editor obliged. I therefore resubmitted to the *Bulletin* in April 2016 and received a positive opinion from the reviewers, who suggested some revisions, which I dutifully carried out. In June 2016 the revised copy was resubmitted to the *Bulletin*. In September 2016 I received confirmation that the resubmission satisfied the requested changes and could therefore, according to the reviewers, be published. However the Editor stepped in and declared that he was still “unable to accept this paper for publication” and nothing could be done to alter his opinion. He justified himself by saying that he did not believe the validity of the data. I was gutted but in November 2016 I had the moral strength to bring the matter to the attention of the then President of the Royal College of Psychiatrists. I expressed my concern that following a lengthy review process the Editor had decided single-handedly to go against the recommendations of the peer-reviewers and to stop the publication of the paper. In January 2017 the President replied that the Editor's opinion should be upheld and I was advised not to “waste any more time and energy on this submission”.



This experience has made me think, and I am still thinking about it.

Psychiatric interventions (particularly biological ones) are tested on a large scale on the basis of a diagnostic system which is founded on the standard psychiatric interview. Or shall we say, that the standard psychiatric interview is founded on the official diagnostic system? It's a chicken-and-egg situation. On this chicken-and-egg is grounded all the evidence that determines whether therapeutic interventions are efficacious or not. And yet there is absolutely no evidence-base for the diagnostic system (and many have written about this), and there is no evidence-base either – and this is the best kept secret in psychiatry – for the standard psychiatric interview. Most evidence-base in psychiatric research has been built on quicksand.

The antipathy for my paper is much more telling and significant than if the paper had been accepted. My paper was the tail of an elephant, brushing against the eyes of the psychiatric establishment: like Mrs A's husband, they would rather be left blind. ■

Maria is now a lecturer at Queen Mary University of London.

Survivors History: United Kingdom Advocacy Network (UKAN)

TERRY SIMPSON reflects on the rise and fall of the United Kingdom Advocacy Network.

The Gist

There was a moment in the mid 1980s when the need for change from within the UK mental health system coincided with a growing radical survivor's movement. The *UK Advocacy Network* (UKAN) was formed out of this coalition. However, it declined when government priorities shifted from implementing "community care", to policing psychiatric patients in the community.

Early days

UKAN grew from the work of *Nottingham Advocacy Group* (NAG), and other pioneering advocacy groups. It was conceived at NAG's 5th birthday conference in 1990, when NAG workers proposed a national network that would take on the work of spreading the word about survivor led advocacy (which a small number of individuals were doing up until then, in addition to running local groups).

From the start, there was a lot of solidarity between the different strands of the Survivors Movement. One of the first financial donations was from *Survivors Speak Out* (SSO). It wasn't uncommon for people to be in SSO and *Mindlink*, the survivor wing of national MIND, as well as belonging to advocacy groups affiliated to UKAN. In 1993 an office was opened in Sheffield with a grant from the Department of Health (Section 64 Fund).

A Bottom Up Approach

UKAN was set up with the intention of being a genuinely democratic organisation.

Even where the office was going to be situated in the UK was put to the vote. (Sheffield won out against Leeds and Nottingham.) The constitution and structure of UKAN were debated at great length by member groups before being adopted.

Our definition of advocacy was broad and included any activity that was empowering to survivors/people in the system. The list of 240 groups in the 1998/9 annual report lists *Performing Minds* from Bradford, and *Leeds Survivors Poetry Group*, who were both performance based; campaigning groups like *Women and Medical Practice* and *ECT Anonymous*; self-help groups relating to specific conditions like *HASFAD* (Help & Support for Anxiety and Depression), and the *Depression Alliance*, as well as user forums, patient's councils and advocacy groups of many descriptions.

UKAN was constituted as a charitable company in such a way that the decision-making body was the Annual General Meeting, where only survivor led organisations had a vote. (Other "affiliated" member groups could speak to a motion, but not vote.) At the AGM the programme of action for the year was decided, and policy decisions made. The early AGMs were lively affairs, with genuine debates on points of principle. They were certainly not stage-managed affairs, and every attempt was made to get reps to Sheffield from as many of our groups as possible. We spent a lot of money each year getting over 100 people from affiliated groups to take part.

The intention was that the AGM would elect a Board which would make sure the decisions and policies decided by the membership were carried out through the year. Workers (eventually 5 of us) were employed to do the practicalities under the guidance of the trustee board.

We passed a policy about the control of advocacy – that all mental health advocacy organisations should have as a long-term goal to give control to service users/survivors.

Achievements

- Producing the first training pack for user/survivor led advocacy, as well as an "advocacy reader", *A Clear Voice*, *A Clear Vision*, and mental health advocacy standards.
- Gathering and distributing information for people to set up patient's councils, advocacy groups, user forums with policies about good practice, equal opportunities, recruitment etc to hundreds of groups nationwide.
- Putting thousands of people in touch with their nearest advocacy project, and how to get legal help.
- Training & development workers worked closely and intensively alongside local groups throughout the UK.
- Surveys of our member groups on ECT, Community Treatment Orders, advocacy, depression etc.
- Supporting advocacy and patients' councils in the three high secure 'special' hospitals, Broadmoor, Rampton & Ashworth.
- A regular bi-monthly journal "The Advocate" distributed to member groups, with information about

many campaigning issues that affected people in the mental health system, as well as advocacy.

- Members of our board and workers were involved in the Mental Health Task Force 1992–94, which created the first mental health advocacy Code of Practice, as well as a training pack for user involvement, and a Charter of Rights.
- Working with other organisations – there were places for *Survivors Speak Out* and *Mindlink* on the Board. We worked with the Royal College of Psychiatrists to develop their “Patient Advocacy” policy and resisted their attempt to redefine the term “advocacy”. For some years we funded a meeting for national survivor led groups like SSO, Mindlink and the Hearing Voices Network.

Snapshot: AGM 13th/14th July 1999

113 people attended from groups all over the UK. The network at this point consisted of 246 groups.

We held workshops on Advocacy & Homelessness; The MH Act Review; a BME Forum; Advocacy in Forensic settings; An LGBT Forum & a meeting of reps from National User Groups, (reps from *Reclaim Bedlam*, *Mad Pride*, *US Network* (Wales), *ECT Anonymous*, *Mindlink*, and *National Voices* attended the latter).

Proposals were debated on the MH Act Review, ECT (2 motions), a campaign for survivor led advocacy; Advanced Directives, and the problem of drugs on wards.

Our limitations

Our Management Structure consisted of 2 reps from each of 10 regions of the UK, including Northern Ireland, Scotland and Wales, annually elected by member groups, along with reps from SSO, Mindlink and Black and minority ethnic communities. This meant the bi-monthly management meetings were big and expensive. On the positive side they were also great networking events, and a lot of relationships and plans were hatched in a hotel the night before. It was the chance to share information and opinions about what was happening around the country, but the size of the committee also made it hard to reach decisions.

Making policy at member level was democratic and meant that positions arrived at had a tremendous strength. However, such a set up meant that we weren't always flexible enough to react to unfolding events. As the culture of mental health organisations increasingly moved to a more CEO (Chief Executive Officer) style format, our structure was seen as a weakness by potential funders.

In some ways we were politically naive. The government wanted to bring in Community Treatment Orders against advice from workers in the field and survivors. The planners saw the potential of advocacy as a sweetener for that, and therefore moved to control

it. A review of advocacy was set up to develop a set of ‘national standards’. For reasons that were never explained, UKAN was excluded from tendering to do this work, which went to a team from Durham University. When they set up a working party, no-one from UKAN was invited to be on it.

In retrospect this was a key struggle, and we should have fought a tougher battle for survivor led advocacy at national level, but we were busy doing the job of supporting our network, distracted by our own internal struggles, and unaware how significant it was going to be.

UKAN's Demise

The role of the statutory sector

In the late 1990s the human rights agenda that had opened the way for this phase of the Survivor Movement was under siege from a tabloid campaign to lock up “dangerous mental patients” let loose through Community Care, and the then Labour government's response to change the law to allow Community Treatment Orders (CTO's). UKAN campaigned against these, and so found itself criticising the body, the government, that was funding it, through the Department of Health.

In order to bring in CTOs, the statutory right to an advocate was proposed for people affected. However, in order to do this, advocacy had to be defined very tightly: as time-limited, case-based, one to one, professional work. This was the starting point for the Durham University “research” described above. Advocacy that involved campaigning for systemic change, and unpaid advocacy by system survivors was ruled out, as were user forums, patient's councils, and any kind of creative activism. UKAN's inclusive, group-oriented, campaigning view of advocacy was outmoded overnight.

Once the Mental Health Act was amended and Trusts had a statutory duty to provide advocacy for detained patients and people on CTOs, it was clear most of the funding for advocacy would go in that direction. The groups that had created UKAN and formed its backbone began to struggle for funding and disappear. The UKAN vision of a national network of mental health advocacy groups moving towards survivor control gave way to a version of advocacy that could not challenge the status quo, run by large voluntary sector organisations, centrally controlled and strictly defined to only deal with certain types of patients.

The role of the voluntary sector

Individuals within the voluntary sector were always supportive of UKAN, and particularly in the early days, the *Sainsbury Centre for Mental Health* and the *Mental Health Foundation* supported UKAN with grants. However, in many other ways the sector was not welcoming to UKAN, or the message that survivors could and should

be empowered to run their own organisations. If they had taken this on, after all, they would have had to change their own organisations, or cease to exist in their present form.

National MIND continued to run advocacy training in competition with UKAN's training programme and ignored our campaign for survivors/users to control advocacy. MIND at a national level, as well as local, professionally controlled MIND groups also made funding bids in competition with UKAN and UKAN groups.

The *National Schizophrenia Fellowship* (NSF, renamed *Rethink* in 2002) pursued a policy of tendering for advocacy contracts across the country, whether or not they had any local contacts. Where they were successful, sometimes beating locally based survivor led projects, they had to co-opt people on the ground to help run the contract they had won. Since the NSF was a centralised organisation, policies were set at national level and local people could not influence or control them, so this frustrated involvement and empowerment.

However, the media and the voluntary sector increasingly needed a single organisation they could relate to for an off the peg "user's voice". Jan Wallcraft, a survivor movement heroine of the mid 1980s wrote a piece in June 2004 entitled "What is the address of the User Movement?" which began "This is a question Matt Muijen, former head of the *Sainsbury Centre for Mental Health*, was in the habit of asking. He was expressing the frustration people feel when they find there is no one-stop shop to go to when a user movement opinion is needed". On Our Own Terms, a report commissioned and published by the *Sainsbury Centre for Mental Health* and written by Jan Wallcraft, with Jim Read and Angela Sweeney, recommended "the movement should be supported to develop a national platform." The third sector created for itself this "one stop shop" with the

National Survivors and Users Network (NSUN). This effectively replaced UKAN.

A complex, would-be democratic organisation, like UKAN was actually the perfect basis for the "network of networks" proposed in *On Our Own Terms*, but it did not fit the simplistic bill for the role required by the voluntary sector. Instead, with funding from Comic Relief, a NSUN was formed by workers from large mental health charities like the *Mental Health Foundation* and *Together*. In contrast to UKAN's start, in the melting pot of big survivor conferences, NSUN was designed with a minimum of consultation or involvement, and rolled out fully formed, with an advisory panel, rather than a trustee board with power. Once it existed, with the large-scale funding it had, it thrived among the very groups and individuals that had been the life blood of UKAN.

Conclusion

The main political and economic change in the UK mental health system between 1983 and the millennium was the shift of power and resources from the statutory to the voluntary/commercial sector – Community Care. The "user's voice" was, for a while, a strong voice for change, but I think it was co-opted in the struggle to release resources from the statutory sector to the voluntary.

Outflanked in its mission to promote user led advocacy and campaign for radical changes, both by the government's plans for CTO's, and the voluntary sector's ambitions, UKAN by the late 2000s had lost all major funding support. Despite backing from member groups it was unable to maintain its office base, or any paid workers. It survived for some years run by volunteers, but was dissolved as a charitable company in 2013. ■

This article is based on a talk Terry Simpson gave to the Survivors History Group in October 2018

Letter to the magazine

Dear Asylum

In your otherwise wonderful publication I have noticed what I believe to be an unhealthy and unexamined belief that mental medicine is deficient when compared to that of physical medicine. In one issue I noticed five instances where psychiatric medicine was compared unfavourably to physical medicine. In a neo-liberal world what passes for science is suspect. When dissidents of psychiatric orthodoxy ignore and disrespect the dissidents of physical medicine orthodoxy, this can only serve to divide forces that should be united against all fraudulent medical practice.

We should all be in this together and recognize and honour those frontline dissidents from both communities who have had their lives and careers compromised, even ruined, by the power of the respective orthodox elites.

Only in solidarity can the equally mistreated, either by mental or physical "science", ever hope to find any sort of resolution.

Best wishes, Roger Swan.

A Brief Experience of Multiplicity

SHARON CRETSINGER reflects on her experience of coming out as persons of plural identities

“Coming out” is defined pretty narrowly. I have been coming out my whole life. For many years, I thought of my activism in queer politics and AIDS as my first time coming out—as a bisexual femme. In reality, I came out as a survivor of horrible, pre-verbal sexual abuse as soon as I learned to speak. I grew up on the shores of Willow Creek, deep in Iowa, “The Heart of Corn Country”, the heart of misogynist country, rape central, at the corner of “Shut your fucking mouth, Bitch,” and “Get the fuck down on your knees, Cunt.” I wasn’t allowed to talk about anything.

Sometimes, now, others harshly question my credibility. I don’t much care. My credibility has been in question since I could speak. Maybe there were too many comings out. It feels like there needed to be more of me who were not-exactly-me to hold all of them.

When I came out as a labeled individual and survivor of psychiatric atrocities, around 2007, I did it very foolishly, assuming I had enough experience at being marginalized to handle it. I assumed, because I had read

a bibliography of Mad literature, I would find a community to welcome and protect me. I assumed too much.

It has been only a couple of years since I began to speak openly about my other parts. This is my language of multiplicity. There is infinite other language for it. Clinical people (and others, I suppose) might say “Dissociative Identity Disorder”, or, colloquially, “Multiple Personality Disorder”, or even, with concentration camp-like simplicity, “300.14” (the DSM’s numerical shorthand for Dissociative Identity Disorder).

Clinicians debate whether we exist or not, with a large number of the believers only believing because they want their own “therapy” to contain more importance and drama. I was similar, suffering for a number of years from Clinician Identity Disorder (CID). Many “patients” develop CID as a way to escape diagnostic labels they don’t want, or systems of “treatment” that are abusing, or even torturing them. CID is most commonly expressed by pursuing a degree in Social Work, but some forms of the disorder can also produce licensed psychologists, psychiatric nurses, or, in rare cases, full-blown psychiatrists. I got the Social Work degree, and my primary concern was “helping people like me”. I thought it was a unique and altruistic way to deal with my selves. CID is really very common. Sometimes, when my CID was at its worst, I doubted my own existences.

But I am here. We are here. And here are some reflections:

1. Many people refer to the dynamic of the “split” personality, or “splitting”. It was much more of a dynamic of shattering for me. There are pieces of me I know very well. They are easy to pick up. I can see part of one of my eyes reflected in them. Other bits have slid under the refrigerator. I saw them travel there but was not moved to retrieve them. They remain with the bottle caps and dust bunnies, partially forgotten. Then, there are shards too small to see, miniscule fragments between the cracks in the kitchen floor. There are almost certainly a few bigger shards underneath the refrigerator. I’m going to get a cup water and, suddenly, one of them is stuck in the bottom of my foot.

2. I don’t know all my parts. I accept that there are parts I will never know. The shattering metaphor is very applicable in the context of someone like me who



struggles with the (seemingly simple) demands of **just being** on a day to day basis. I don't really do relationships and tend to abandon them as soon as they are difficult. I'm not motivated to clean up messes of broken things very well.

3. The unknown fragments and shards are exactly as stealthy and sharp as their names suggest. Accidentally stepping on one in the dark cuts. One may get stuck inside of an especially tender area of flesh and fester. The larger shards, if discovered in an unaware place, can facilitate a spur of the moment artery slashing escape attempt.

4. I don't know all my parts. I don't want to. Finding a "new part" is one of the most (re) traumatizing experiences possible.



5. I don't like all of my parts. Not all of them like me. My relationships with them are very much like my relationships with other people who are (I believe) separate. It's complicated, as the popular Facebook relationship status says. Some of them like me or depend on me. Some of them like me well enough, but still talk a lot of shit about me when I'm not around.

6. Some parts are much more functional than I, and some much less. All of them are necessary, holding their own skill sets and traumas from a particular time. One part doesn't hate my mother but is indifferent. Obviously, this is useful when I have to deal with her.

Another one is fifteen, still able to have massive, multiple, trauma-bound orgasms with dusty old pedophiles even though our physical body has retreated into nuclear menopause.

7. The concept of "self-acceptance" is beyond laughable when living in shatters. Although, for me, a gradual easing of boundaries between my parts has come with the turning of the planet over years. But it is nothing close to the "integration" that the clinical community would have me seek. Most of us will die before this happens. Some might just fall over one day, exhausted from the sheer effort required by this impossible expectation. More will be killed by the system, given extreme cocktails of toxic drugs or prescribed "last resort treatments" like brain electrocution that leave us forgetting our relationships and professional educations (but still remembering the atrocities). For me, now, there is less urgency to "keep my parts in their places" and present a unified face to the world.

8. Mainstream models of "recovery" don't apply to us. It does not matter which model. Consider, for example, Dialectical Behavior Therapy. Which part is being mindful? Which part knows what skill? Similar questions are equally applicable to so-called "alternative" models of "recovery".

9. Some shattered individuals change their names and other things about themselves to allow one of their parts to become their primary identity. There may be any number of reasons for doing this. It's not something I have done, though I have contemplated it, and sometimes I do allow a part to be primary in a de facto sense because that part can function better in the required environment, or simply because I wish to avoid a certain situation.

10. This is completely different from "dissociating". When I dissociate, I go away to a place where my brain does not generate the experience of being (any) human in the real world, this dimension or any other. I don't materially exist in reality and neither do any of my other parts. I am staring at the biggest theatre screen in the known universe. The usher has safely locked the double doors behind me, and I'm waiting for the movie not to begin. In dissociation, I am not another part of me. I am not myself. I non-exist.

11. There are clear distinctions between my parts. Parts who are minors or elders need care, just the same as anyone else of those ages. It is often difficult to reconcile such a wide range of wants and needs. When the most pressing desires of the parts are ignored, very bad things begin to happen in my life.

I am fifty years old. This coming out is the most terrifying one yet. ■

A digital future for therapy in the **NHS** ?

RICHARD HALLAM

Our Health Secretary, Matt Hancock, is keen on seeking a digital transformation in the NHS. This objective would certainly conform to cultural trends - a reliance on the Internet, smartphones, big data, and an ever-increasing number of software applications. Hancock believes that, "AI and genomics and the increasing amount of data about how people live their lives" will transform services. However, seeming to contradict himself, he says mental health "must be less about the medicinal and the pills and more about people as people . . . nothing can replace the doctor-patient relationship." So is there really a digital future for therapy as well?

A Savoy Partnership conference held in December 2018 clearly thinks so. The blurb argues that investment in IAPT (presently mostly face-to-face) has blocked the growth of digital alternatives: "the NICE/IAPT axis has put the brakes on digitizing IAPT." I argue that this is hardly a sensible solution to the current 'mental health crisis', a world in which therapy is self-delivered via smart phone apps or presented in modular chunks to a person sitting with their computer. Somewhere in the background to this scenario sits a mental health professional directing and coaching the service user. I have no objection to face-to-face therapy simulated by video-conferencing, but this is not what the blue-sky dreamers have in mind. There would be few financial savings through adopting it.

I also accept that the Internet is a boon for bringing people together for traditional sources of self-help, and it makes health-related information readily available at little cost (although there is, of course, a downside to the kind of information sometimes found on the Net). The digital age simply extends what self-help books have been doing for decades. There is nothing new in people working out solutions to their own problems. Gurus have been dispensing advice on how to live well going back for thousands of years. What differs now is a widely held belief that we are 'in a crisis' because there are an overwhelming number of people with 'mental disorders'. Self-help seems insufficient. It is supposed that cheap solutions will have to be found because there are not enough mental health professionals to go around.

To a large extent, the present 'crisis' is a result of psychiatry manuals creating an increasing number of 'disorders'. Thresholds for diagnosis have also been lowered. One journal article claimed that 29.8% of the population suffers from an 'anxiety disorder' and hastened to mention 'sub-clinical cases' as well. It could well be true that half of us are stressed out for various reasons, but to see this as a 'health' crisis is absurd. It is also true that people are seeking help - around 40% of GP attendances involve a so-called mental health problem. This high figure might reflect the fact that there is nowhere else



to turn. The GP might get you off work for a few weeks as well. Seeing a GP is not necessarily grounded in a conviction that the answer lies in medication or referral to an expert in mental health.

The answer to the crisis seems obvious to public health planners. E-therapy solves the numbers game! For instance, the cost of three times a week psychoanalysis for one person over two years would fund the delivery of e-therapy to, say, several hundred or more people. It's known that e-therapy is not terribly effective but even if only one or two people out of six are satisfied with the result, the gain in 'numbers treated' is huge. Dozens of people are said to be 'cured' for the same outlay as one person treated by psychoanalysis. E-therapy is cheap because it typically consists of remotely delivered learning modules and exercises. The e-therapist does not relate directly with the service user but provides feedback digitally, the total time amounting to little more than minutes per week. The opportunity for dialogue, exploring issues that arise, is not part of the deal. E-therapy is task-focused and is usually based on protocols that have been derived from face-to-face CBT.

What is the evidence that e-therapy 'works'? Research evaluations have been no less thorough than for other 'treatments'. In randomised control trials, e-therapy is compared with alternative 'active' techniques or with the effect of being placed on a waiting list. For instance, one excellent recent study compared e-therapy with e-bibliotherapy (being prompted to read a relevant book!), with e-mindfulness based on an App, and with a waiting list control condition. There was no difference in outcome between any of the active 'treatments' but all were somewhat more successful than simply being placed on a waiting list.

In all the studies I have examined, the degree of 'success' is never more than small to moderate. A majority of the participants don't benefit to a significant extent or may not finish the course. It would not surprise me if these 'failures' felt let down. If e-therapy were to be made widely available on the NHS, what would happen to those people who didn't want to use it or failed to benefit? On current policies they would be 'stepped-up' to a more intensive form of therapy involving face-to-face contact. It is therefore possible that e-therapy would kindle an interest in exploring a problem in greater depth, more people would be added to the 'mentally disordered' population, and the 'crisis' due to a lack of mental health resources would grow.

A major weakness of evaluations of e-therapy is that nearly all studies advertise for their participants (i.e. through websites, newspapers, etc.). They are not usually selected from people who seek help through the NHS, who may not be confident in using a computer (let alone afford one). The participants are already tuned-in 'psychologically' and probably have a good idea of what they want to work on. Another major weakness is

that e-therapy has been designed around categories of psychiatric disorder (anxiety, depression, etc.). People who don't quite know what their problem is, or how to formulate it in a way that makes sense to them (a majority in my experience) are either forced into a diagnostic box or have to be excluded from e-therapy studies.

A further concern is confidentiality. A therapist regulated by the HCPC could be struck off or severely sanctioned for revealing confidential information. People in one-to-one therapy often divulge secrets that they have kept from their closest intimates. They may wish to speak of behaviour that could potentially carry a criminal conviction (for self or others). The information could adversely affect employment or cause a breakdown in family relationships. Is a service user likely to reveal details of this nature to an anonymous e-therapist, where the data is accessible to other unknown professionals, or could be hacked? In any case, important details of a client's situation are unlikely to be requested.

E-therapy rigidly fits people into diagnostic boxes, fails to appreciate the context of a problem and misunderstands the complexity of causation. So-called anxiety and depressive disorders consist of symptoms with unknown causes. It is a misnomer to describe a 'cure' as a reduction of symptoms on a questionnaire. Without an analysis of causes, therapy can be wasteful and pointless. A cure, ideally, is the removal of a cause. Analysing the personal, social, and societal causes of a problem takes more time in the short term but is likely to pay off dividends in the long run. For instance, it hardly takes a genius to realise that legal changes to rules about online gambling might save a lot of mental distress.

In sum, the logic of digital advocates is impeccable but flawed. If half the population is mentally disordered, and it is too costly (and impractical) to employ expert therapists to cure them, any 'treatment' that is cheap and widely available is preferred. As one journal article argued, there is: "clinician shortage, long wait times, appointment scheduling conflicts, social stigma, high treatment costs, and accessibility barriers such as transportation and childcare." Consequently, "there is a critical need for alternative treatment options... to enable people to receive adequate mental health services."

The identification of 'mental disorders' glosses over real causes that need real answers. Digital technology can add to the tradition of self-help but self-help often has little to do with curing disorders. In any case, the promise of e-therapy is built on extremely shaky foundations. Instead of e-therapy, greater financial support could be given to groups of people who wish to self-organise and take control of their own problems. Voluntary sector and self-organised alternatives to State services seem to have been almost entirely ignored. ■

A View From Inside a Medium Secure Unit

Jerome Sewell offers some advice for clinicians and fellow patients

I would like to begin with a brief introduction to my journey with the mental health services and how I got where I am.

I was sentenced to prison for committing GBH (grievous bodily harm) and sentenced to 5 years in prison for a stabbing. About a year and a half into my sentence on the month of August I was visited by a doctor and then moved to the medical unit in the prison. I was formally assessed by the doctor and shortly after (without any conversations whatsoever) moved over to the Royal Bethlem hospital and detained under section 47/49 of the Mental Health Act.

After a while I had settled into the hospital. Although there were some initial growing pains, I started to communicate with the psychologist, social worker, ward doctor and especially the Occupational Therapist (OT) and took up some sessions baking and doing art. After some initial improvement in my mental health I was moved to Effra ward where I functioned on a higher level with more engagement with the OT. I discussed with her my previous ventures that I had partaken in out in the community and developed plans that I could actively work on in hospital to rebuild my contacts. I engaged extensively in activities: I went to a games group (run by another member of the occupational therapy team), photography, video editing, art and I got a job on the ward doing litter picking and I also got a job in the library.

Due to my extensive engagement in OT I was told I was doing quite well. I was also granted escorted leave (which is a service that offers access to the local community outside of the hospital) and that gradually increased to an hour to the community for 3 times a week. Eventually I was granted unescorted leave and that gradually increased. I started engaging in more community-based activities: I started doing mindfulness, Reiki, drama therapy and play reading. My activities continued and my leave gradually increased and eventually I was granted 3 hours in the library, twice a week, meaning that I was using 5 hours of leave for 2 days out of the week (as the 3 hours was granted on top of my 2 hours that I have daily). At my last care programme meeting it was said that I was showing a

steady improvement. At this point I am now waiting for a bed in a low secure unit.

This place does not set life aspirations very high. It limits people and acts as though their mental illness will debilitate any opportunity to progress their life further. It limits people as though their mental illness will debilitate any opportunity for them to progress. What gave me this experience was talking to the occupational therapist. When planning for my future it was constantly assumed that I was going to be on benefits (as though I had no prospect of work). My ambitions were a lot higher. It is different if people are not able to work but I do not feel everyone with a mental illness should be treated this way. It limited my opportunities and lowered my self-esteem. But I felt more determined to prove those people wrong in the long term.

To be fair to the occupational therapist when I did discuss my previous work in the community she encouraged me to keep it up and gave me ideas of how I could make my ambitions a practical reality. She always referred to me as a high functioning individual but for some reason this did not stop her from apparently anticipating that I was destined for a life on benefits. There is a ceiling where the abilities of an individual are not measured accurately and ambitions for the future are looked at as unrealistic. This was a big problem I had.

Being creative I was involved in a number of initiatives and ventures. I was also entrepreneurial and therefore had ideas about what I wanted to do. However, doctors would look at it as unrealistic because some of these projects were not in my chosen field. They never actually looked at the fact that I had backing from a charity beforehand with my initiatives. The doctors seemed to have a very closed-minded opinion (looking at life as though people cannot have alternative interests).

My message is that if you have an idea and other people believe in you, stick at it. No one can tell you what your potential is and what an idea might lead to. No one has the right to limit the abilities of an individual without an accurate measurement of what one has achieved in the past. The doctors here make no effort to positively encourage patients: they constantly look at the negative rather than the positive.



Image:
'Pancras Road'
by Patrick Wood

observations. Clinical oversight is biased and is based on immovable opinions, rather than a flexible oversight. It seeks to control one's life with assertions and opinions and sets the trajectory of someone's life course.

Despite doctors and psychologists readily admitting that their tests and assessments are subject to varying factors (such as the information they have available at the time), there is still a tendency to rigidly stick to assertions and not accept when they are adequately challenged. They would rather believe they are correct in their assertions than consider other explanations. This can make communication seem like a pointless exercise and damages the patient-doctor relationship. This can lead to clinical inaccuracies.

This was a major problem for me when in hospital. The doctors would often show anxiety and worry if you highlighted progress you made and when sighting reports they would highlight the negative rather than the positive. This was also a view expressed by other patients when I hosted a 'News and Views' group on the ward (where patients get to voice their opinions about the ward).

There is nothing worse to a person and their recovery than facing constant negativity. In order for any person to get the best out of themselves they need to focus on their strengths and what is being achieved in order to build on a good foundation. When a doctor constantly focuses on the negative it can evoke a sense of worthlessness and stop somebody's ambition. For myself, I had to stay motivated and see every criticism as a positive challenge in order to better myself.

Clinicians should take note that they should positively encourage their patients and make balanced

I would suggest (as a psychologist once told me) that you are your own expert and therefore when you know something is inconsistent you must keep a strong mind and not change your opinion to suit what your doctors say because you will end up losing your identity (which is an easy thing to do when you are confronted by what experts are telling you). Always aim to not compromise your principles or what you know about yourself.

I suggest taking a long hard look at who you are and measure what the experts say in a balanced way. Sometimes being in denial can be a natural response to hearing things you don't want to hear or sometimes your perception may not facilitate your understanding of a situation. That's why I'm cautious in my final criticism because sometimes it is good to take advice. But when you know you have the capacity to understand what you are talking about, I think it is important to hold onto your opinion. ■

Creative Writing

anger

i get so angry
when i think about
how many souls
have gone through this
awakening
and have been stripped
of the possibility
of emerging into their truths
and instead have been forced to live
in the cul de sac
of dead diagnostic endings

speak love

be kind to the voices in your head,
please don't frustrate yourself
by shouting and fighting
when you can speak softly,
firmly,
kindly.

you might find
that they speak kindly to you too.

high on life

now I realize
there is no drug
no substance
no synthetic thing
that can take me to the same heights
as surrendering.

to create peace

learn not to react
to the behaviour of others,
but instead seek out
that which is love
within them
and speak
to the higher being
that sits behind
the external that you are seeing.

living

i have learnt there is no glory
in resting in the negatives
or in over intellectualizing everything
I have learnt instead to focus
on earths cushion underneath my toes
on how it feels to have the sun
reach behind my skin and make love to my bones
how it feels within my soul
when i make my body God's home

Poems by Mica Montana Gray, taken from When Daisies Talk, a self-published collection exploring her experiences with psychosis and depression. They explore racism in the mental health system, culture, spirituality, faith, womanhood, healing, self-care, love and identity. Mica is now an assistant psychologist working in mental health services.

Let It Be

When someone leaves, when someone does us wrong, we automatically blame it on ourselves, the “why am i not good enough?” “What have i done that drew them away?”. And we shouldn’t. Some people choose to start away a chapter with different characters not because we’re out of plots or because ours wasn’t adequate enough to satisfy their story but because they’re looking for a different series of events which requires characters with different qualifications, and just ‘cause it’s different doesn’t mean ours is any less or any better.

Let them be. Remember the series of events you went through your whole life and how the characters kept changing, how some had the main role at a time and now they have none. It’s not a fight or a certain event it’s just how life flows around my dear.

But you know something ... what hit us is not the fact that we’re out of the story but the way we’re pushed away, the way they yelled FIRED. It lingers to our memory and takes more space than we’re willing to give. You keep rewinding it unconsciously. You forget all that logic of “it’s just because they chose a different path” and focus on the “they pushed me away”. It’s really not something they intended to make you feel, something they never thought of at all maybe, they just went with the flow and left you walking in the circles of self doubt. It might be the new WhatsApp group you’re not a member in, or the text saying “my airplane’s tomorrow at 7”, or how they just switched classes to be with someone else, the parties and outings they forgot to invite you to, the birthday they forgot to wish you, the broken calls to check on you. It’s the way they choose to slip you away is what stings. And if you’re convinced you’ve done no one wrong, then let them be.

Mira Nehlawi

Mira Nehlawi is a 20-year-old medical student from Damascus Syria. She suffers from anxiety and had an experience with depression. She writes for Teen Ink online mag.

The Psychiatrist's Office

Soothing tones in the room.

A clock, a picture, a book on a desk.

The voice asks: How do you feel?

I want to answer: Well, how would you feel if you were to be me?

Henry Bladon

Henry Bladon writes short fiction and poetry and runs writing groups providing support for people with mental health issues.



IMAGE: Eigen shuld (Own fault) by Marcel Herms (marcelherms.nl)

Splinter

Twigs and thorns
Bite in places you know not
It hides under your skin
A little laceration

Your raised skin, an abscess
A foreign body
Not visible to the naked eye

Now scab your skin
Make many incisions
Dig deeper
Only bones you'll find

Just look at your hollow carcasses
This brown ugly rotten excess
It's growing
And filling up your skin

It was just a thorn
Hiding under your skin
Now oozing out the pus
That you couldn't keep within

Shreya Varma



Shreya Varma is a clinical psychologist by profession and her poems have previously been published in 'The International Library of Poetry' and 'Poetry and Psyche.'

Law of the Past

This poem is the only artefact that's left
after all the years
of my loving you in secret. Even now
we hope to hide our identities
from the world. You are still *L*, and I, *M*.

This is how it must be, with all the resolve
of heaven and Earth.
Perhaps this will be the last thing
I ever write about us.
Remember when you played guitar for me?

Now you are married with a family
and wish to forget.
Only the past has a way of catching up,
catching us off guard, forcing us
to account for our strange, conflicted selves.

Mark A. Murphy

*Mark A. Murphy is editor of online journal
POETICA REVIEW.*

The Special Education of Dr. Mom

As a parent, DEBORAH ROSS reflects on the impact of psychiatric diagnosis on her family

We all know what nerves look like: webs of octopus arms with glimmering, pulsating connection points meant to suggest the throbbing pain of fibromyalgia or shingles or diabetic neuropathy. They're usually Pepto-bismol pink – though, in an ad for a memory-enhancing supplement, they're a luminous blue, to imply (falsely) that it is sourced from lovely cartoon jellyfish. This one's twinkles are intermittent, to illustrate the “misfiring” that is supposed to occur in the brain when people forget things. One thing the advertisers apparently count on our forgetting is that “misfiring” itself is not a literal description of neurological activity but a metaphor: a verbal cartoon. Still, this word and picture will likely come to mind the day a mom hears from a kindergarten teacher that her child has a problem. And then Mom may wonder what product she can buy to sort those jangled nerves into some orderly pattern.

How do I know this? I'm only a Ph.D. not a *real* doctor, as my five-year-old son was always telling people. Still, I am, as the old commercials for Robitussin would have it, “Dr. Mom.” That means that, like a lot of women, I presided over my kids' health in the early part of their life, just as daughters and wives, even in this age of gender equality, often preside over the final illnesses of parents and husbands. We do this with no official recognition and with little information beyond the simplified words and pictures provided by doctors and purveyors of pharmaceuticals. It's an awkward position that makes it hard to know if we're ever making the right decisions, especially since the cartoons seem to be directing us toward simple, chemical solutions to complex human problems, such as ADHD and Asperger's.

This is the story about how a whole army of well-meaning people, tasked with making children into productive citizens, tried over many years to turn my unique, fascinating, complicated son into a cartoon. It's about how School, backed up by special ed. teachers, counselors, social workers, psychologists, paediatricians, psychiatrists, and neurologists – what might be called the medical-educational complex – processed the wondrous mystery of his personality into a riddle for which the solution, or diagnosis, seemed

predetermined. After twenty years, I still wonder if any of us were asking the right questions. And I wonder how many mothers today may be wondering the same thing.

Before School entered Charlie's life, babysitters would brag about how well he took turns, never even moving toward a toy until no one else was using it. Even in the institutional setting of preschool, he caught on easily to the plentiful rules, like the tape on the floor enforcing where one was allowed to do what. But preschool was also where he met his Waterloo: Circle Time. For some reason, he was allergic to sitting in formation with other children and could just about do it if they let him face outward. Given Charlie's habit of avoiding conflict, during free play time he preferred playing indoors with girls and dolls and kitchen toys to outdoors with boys, for whom conflict seemed to be the point. Worried that a public kindergarten would be even more of a Lord of the Flies affair, I scraped up tuition for a “progressive” private school: a secular institution founded on Alfred Adler's theories of self-reliance, but run by a Catholic nun. During my interview with Sister Mary, she pointed out that though it was morning recess and her windows onto the play area were open, there was hardly a sound to be heard. Surely, I concluded, here my unusual little boy would be safe and attended to. That was my first mistake.

Charlie's new kindergarten, it turned out, had thirty children, and it was basically Circle Time all the time. He did everything he could to quietly evade the groupiness. When I looked through the window at the end of the day at the circle of children holding hands, singing the Goodbye Song, I saw that Charlie alone was silent, looking at his feet. He later explained that he thought if he sang *his* song he would get in trouble. That he could sing what everyone else was singing never crossed his mind. The teacher's response to his non-compliance was time-out – not a punishment, it was explained, but merely the “natural consequence” of his choices – from which he would wander off, since there was not enough staff to supervise one “individualist.” Despite the school's advertised libertarian philosophy, this label was not a compliment. Best for all concerned if he just went away.



Since private schools are not obliged to provide special education, his casting out was to be achieved by Science: professional, outside testing to bring his individualism under some official diagnostic category – ADHD for choice, or Asperger’s, which was new at the time. And what was the precise instrument that would reveal what Charlie had, and what mental health benefits he might be entitled to in public school? A brain scan perhaps? At this point, if someone had offered to take an actual picture of my son’s nerves and point out exactly where they were “misfiring,” I would have said, Great, sign us up. But even the dumbed-down online sources I – not a *real* doctor, after all – was able to comprehend seemed to scotch any notion that one can really “map” (another metaphor) the parts of the brain responsible for specific behaviors. So, of course, no one would consider it worthwhile to do anything to my son as expensive and intrusive as an MRI. Instead, he was to be diagnosed by Social Science: a behavioral checklist consisting of eighteen questions, scored on a four-point Likert scale by parent, teacher, and therapist (after an hour of observation). The numbers might make

you think, Wow, social science really is a science after all! But consider: a teacher who has already referred a child for testing because of troublesome behavior, and a psychologist who has been called in to look for this behavior, contribute two-thirds of the data in this analysis. If the third provided by the parent scores problematic behaviors as occurring even “sometimes,” chances are the overall score will be positive. And so it proved in Charlie’s case.

So, yay! Now we were officially eligible for special education and therapy – or as much of it as was on offer in a world of shrinking budgets and pressure to spend whatever money there might be on computers for everyone. The first step was the drawing up of an IEP (Individual Educational Program) – which sounds great, something probably every kid should have, since every kid is an Individual. How lucky, then, to have a qualifying Disability! In practice, however, the IEP mainly meant twelve years of parent-teacher-counselor-principal meetings in which various personnel would debate whether the Learning Outcome “Charlie will put his crayons away 80% of the time” meant all the crayons

put away four out of five days a week, or sixteen of the twenty crayons every day, and how many crayons or how many days would count as E for emerging skill or M for mastery. These were meetings in which I would have to bite my tongue to keep from asking how a scale so numerically precise in one way and so hopelessly vague in others could possibly yield any meaningful assessment data, or what any of this had to do with learning.

I, and a very few others, over these years, could see that there was something in Charlie that the tests weren't measuring: "a beautiful mind," his fourth-grade teacher called it, alluding to the movie about a famous schizophrenic economist. She was trying to be nice. But eventually, I was constantly told, he would have to live in the "real world." Charlie's third-grade teacher said the most important Learning Outcome that year was copying assignments off the board (not reading and arithmetic?). His ninth-grade social studies teacher said the most important Learning Outcome that year was to follow a detailed rubric (not learning about the Constitution and the Bill of Rights?). What was I to do? To me, the meanderings of Charlie's attention away from these trivialities were far more "special" than his "special ed." curriculum. Yet if I downplayed the importance of putting away 80% of one's crayons, thus undermining his teachers' efforts, what chance would he have later on, in college, or in his career? What employer would hire someone with a messy crayon box?

Besides an "individualized" education, we were also entitled to a string of social workers (six different ones in his first six years of public school). They were all women, and most were soon to leave for less soul-crushing employment, whose main task, ironically, was to teach my son how boys are supposed to act. Take, for example, Miss Ann, a brisk, kindly woman in her sixties, wife of a retired colonel, whose behavioral goals for Charlie seemed mainly to consist of getting him a neat brush cut and teaching him the manners of a Midwestern child of the nineteen-fifties. She would take him to the playground where other boys his age were playing ball and instruct him to walk up to one, look him in the eye, and ask, "May I join you?" (Ineffective, even dangerous advice.) Miss Ann had handled the organizational challenge of raising her own six children mainly, she told me, through color-coding – literally assigning each child a color for all his or her clothes and belongings. Now that Charlie had a baby sister, she was sure that if I adopted a similar strategy, and let her take Charlie to Supercuts, all would be well. (I didn't, and it wasn't.)

Meanwhile, when Charlie was in fourth grade, he found out about a magic pill that would enable him to sit down and keep his place on the page. Science,

and those cartoon nerves, were about to make a comeback. Despite strong misgivings, perhaps with some remnants of an Adlerian idea that even a nine-year-old should be master of his fate, I made an appointment for Charlie with the psychiatrist who, under our health plan, would write a prescription for Ritalin and see him for a few minutes every three months or so while referring him to a family counselor for longer and more frequent therapy. I squirmed under this patriarchal arrangement: the doctor was male, most of the psychologists, like the social workers, female. I was wary of the Freudian tradition of blaming the mother, and with some reason. (The doctor scolded me once, for example, for not telling Charlie to get his feet off the couch, and then at the next appointment scolded me for telling him to put his feet down.) But my son got his medication, which did seem to help him. Although even time-release versions would eventually wear off by the end of the school day, after which he would still find it hard to shift his thoughts away from how birds' feathers lie flat, or how the Old Spice deodorant stick with the slightly concave top, which they gave him when the boys were taken to a separate room to learn about sex, could possibly conform to the contours of the human armpit.

Charlie is now twenty-five. Looking at the challenges he still faces – much darker than anything I could have imagined when he was five – I constantly revisit every decision I made to try to help him deal with School. The one decision he approves is Ritalin. At six foot one he's entitled to scoff at the doomsayers who predicted it would stunt his growth. On the other hand, I can't say it enabled him to realize the promise of his "beautiful mind." And I wish like anything he didn't still believe that his life would be made easy if he could just find the right magic pill. What Charlie complains about – what he sees as my original sin – is ever having allowed him to be labeled as "special." This he will never again submit to, even if doing so would qualify him for social security, or give employers an added tax incentive to hire him. As far as he is concerned, there was never anything wrong with him, apart from being smarter and more interesting than a lot of people. I'd like to believe that if he knows this, I must have done something right. Today, when I think about diagnosing schoolchildren, I imagine what those nerve cartoons would look like with the connecting octopus arms erased: a screen full of sparkling lights, like the ceiling of a planetarium. We could watch as the man in charge draws in the lines to make Orion's Belt, or the Southern Cross. But once we go outside, the pictures we see might be completely different – prompting different questions, and different answers. The possibilities would be as vast as the night sky. ■

Why I Don't Believe "Schizophrenia" is an Illness

BY TIM DREBY

No, I still don't believe schizophrenia is an illness. Many would say I still demonstrate poor insight into my illness for the declaration. That's okay with me.

I was diagnosed with schizophrenia by a man with a pony-tail in cowboy boots. He wouldn't identify his role to me. I did know I was in the state hospital because I had been set up by the police who I had successfully evaded for three days.

I hadn't eaten since noon the day before, and staff denied my request for food before the interview. I was just waking up after arriving at 4:00am the night before. I was miffed because the list of police officers I had collected for my competency hearing was missing out of my pocket.

* * *

Three days earlier I had stopped at a gas station to refill. I prepared to dive under my car in the event of gun shots on my way in. As I approached with a coke, the police were standing by the merchant. Part of me was relieved to see them.

"Oh, did Mommy and Daddy say your brain chemicals are distorted," mocked a state trooper, in a falsetto. He looked like a social-worker colleague of mine back in New Jersey who used to pretend he was a CIA operative.

It was true I had a slight bone to pick with the Seattle PD for leaving law enforcement up to black market forces. Within six months of moving to Seattle, I had been contracted to set up services in a notorious housing project. I had received a significant verbal threat from an old friend from back east who said he had the power to harm me if I ever betrayed him. I was on my way to Canada to seek asylum. I had leaked information about corruption to the press. Now I believed my actions would one day be revealed.

My face turned red. I was angry with my parents for wanting me hospitalized, just as I had intuited on the road, before I decided to head to Canada. Once again, my intuition was proving correct. I could feel myself grimace.

The police were on me and painfully forced me to my knees. To prove their control, they bruised my wrists with handcuffs. For the most part, I remained limp and passive.

I knew how to evade hospitalization. I assured the copper of this on my ride to the hospital in the calmest of voice tones. I kept my eye on the mileage. I practiced what to say to the quack doctor in the ER to get released.

The doctor was a reasonable man. I told him I was having memories of being sexually abused. As soon as he said I could go, I left abruptly out the glass doors. I had my life savings in the inseam of my jeans. The game wasn't over.

Outside the hospital, at dusk, a pack of the local PD floated toward me like rowdy ghosts and the ringleader asked me if I was Tim Dreby.

"Leave me alone!" I shouted. I didn't identify myself. I braced for another attack, but it never came.

A day later, after testing out what I could and could not get away with, I feared retracing my steps to my car or taking a flight from the local airport. I knew I could not risk another hospital incident. Instead, I decided to walk from Helena to Butte Montana in one day. I had hiked fifty miles in a day before. But I hadn't counted on the midnight temperature on the mountain pass. So I surrendered to the ever-present state troopers.

* * *

The diagnosis from the pony-tail man came after I finished this and other parts of my story. I told him I thought my parents were part of the mafia and were pulling the strings behind the scenes.

After I finally got a small portion of cold slop on a plate, I met my roommate.

"I am here to tell you that the Mafia really is after you," said the Native American man who dressed in a hillbilly hat. "I am just a hillbilly, schizophrenic man in the hospital, with 130 IQ," he said during my extensive interview of him. The friend who threatened me knew that I had an IQ of 130. "Did you know Marylyn Monroe died when Jack Kennedy stuffed cyanide up her ass," he also said.

"So, I want to ask you a question, and this is important," said the hillbilly, with a pause: "When did the mafia start following you?"

With a certain Alan Alda vulnerability, I said, "I think I was raised by a mafia family."

The hillbilly looked uncertain. I wondered if I had said the right thing to the pony-tailed man.



The next day the pony-tailed man testified against me at my competency hearing. I was sentenced to a three-month incarceration.

* * *

My soul was deeply wounded in the hospital. Being confined to a day-room for two weeks was very hard. It also hurt to get my back injured again by the cowboy security squad during a misunderstanding. I was known to be entitled because I tried to hold my workers accountable for not doing their job. As a result, no worker would speak with me. My psychiatrist took two months to meet with me. However, the neglect of the chronic unit was the worst. A year of nightmares ensued.

When I got out of the hospital I took a greyhound and started over with \$4,500 in assets. I had only one month of medication. Withdrawing off the medication caused me to lose the job I had managed to attain at a daycare. I pounded the pavement daily for three months for any job, including Walmart and McDonalds. I did manage to get an offer from a foster-care agency, but I was afraid to take it.

My family agreed to intercede if I moved to the Bay Area and I obtained a job at an Italian delicatessen. Perhaps it is ironic that this was the only job I could get. I went through a great deal of harassment, gaslighting, and persecution. Finally, when I returned to taking medication ten months later I was able to come out of the emergency state. I stopped being prejudiced against the teenagers who taunted me at the Deli. I realized that my family was not pulling all the strings.

* * *

Nineteen years later, I make a daily choice to continue medication to prevent the catastrophic loss associated with an emergency state. Maybe I haven't made it clear:

I still object to the word "schizophrenia" and the idea that what I go through daily is an illness. In fact, the latest reports define schizophrenia as more of a syndrome or neurodevelopmental condition than a disease. They even suggest that it is something that affects people across diagnostic divides, something that I have argued for years.

I accept that some of my perceptive abilities are different than others. I accept that they can lead me into an emergency state if I am not careful. However, I believe the word "illness" was behind the treatment I received at the State Hospital. There, I was trained to be controlled by the industry. No one would let me talk about my experiences. I was forced to suppress them even when aspects of them were one hundred percent accurate. I was not encouraged to learn from others. The hospital only prepared me for poverty and to be abused in a local board and care.

I continue to perceive that many people who believe that schizophrenia is an illness internalize treatment that can communicate such negative forecasts.

The outcome of my journey didn't coincide with the "sick" mainstream delusions associated with schizophrenia. I'd read about those delusions in school where twin studies proved the genetic component and there was a noted progressive decline that would get worse and worse and result in brain damage. Turns out twin studies aren't so reliable: abuse results in brain damage, not the syndrome which is more an expression of neuro-diversity.

Furthermore, there are many details, coincidences and evidence that I was being monitored in ways many might not think possible. There are also many extremely oppressed people who share experiences of being monitored to which I relate. Such experiences include voices, disassociation, viewing bizarre television scenes, having an apartment ransacked, secret service badges, receiving job related mail that was broken open, being tailed by police officers, and so much more.

* * *

Eleven years ago, I heard about the hearing voices network in Europe, and started to run professional groups in which I disclosed my lived experience with "schizophrenia." I learned to use my experiences to facilitate storytelling and reflections in group therapy. I have found doing this in a group transforms what was once terrorizing, maddening and unspeakable into something that can provide insight and inspiration to others. Now I am a licensed psychotherapist on an outpatient psychiatric unit.

I may not have all the answers to all the questions I have, but, finally, I know I am not alone. Knowing this is such a relief! ■

Book Review

Get Weird: Discover the Surprising Secret to Making a Difference.

By C. J. Casciotta. (2018) New York: Faith Words

During the final Chapter of *Get Weird*, in the last few paragraphs, I began being tearful: the kind of tears which happen when you know you're about to be gifted a revelation.

I was not disappointed.

At the start of Chapter 1, Casciotta quotes John O'Donohue [poet, priest, and philosopher]: 'It's strange to be here. The mystery never leaves you alone.'

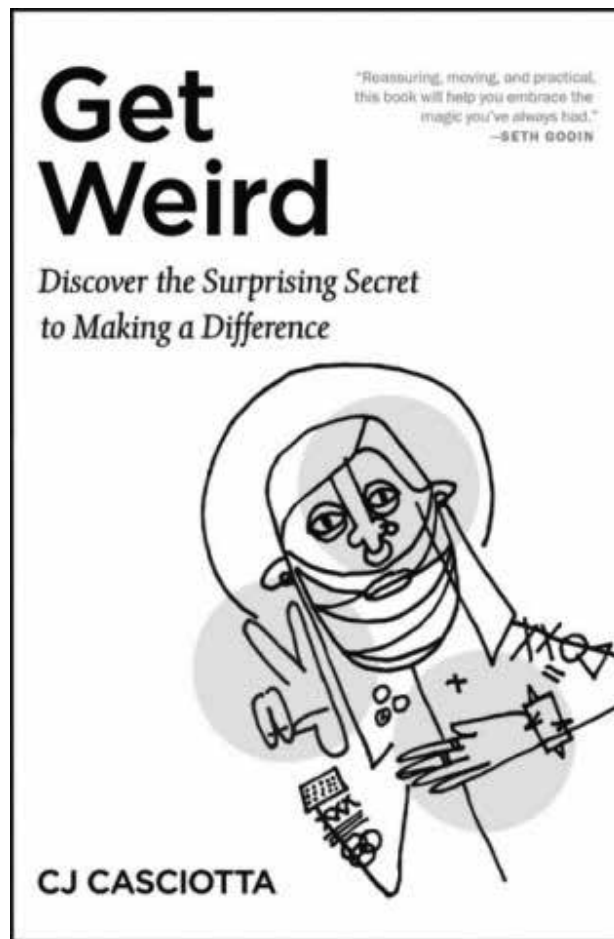
Occasionally, Casciotta lapses into cliché, but, overall, his writing is inspired, weaving in the wisdom originating from his Christian faith without being clumsy or off-putting.

"*Weird* isn't just this inconsequential word to be thrown around in jest or used to belittle someone we don't understand. *Weird* suggests the supernatural. *Weird* is unearthly. *Weird* is sacred". [Chapter 1]

"Your weirdness is your worth. It's the value you bring to this universe simply by breathing air with a set of lungs no one else has ever used before". [Chapter 1]

Quoting Educator Sir Ken Robinson: "If you're not prepared to be wrong, you'll never come up with anything original. ... We stigmatize mistakes ... and the result is that we are educating people out of their creative capacities." [Chapter 3]

"I do not believe your story matters as much as you might have been told ... Your story is not as important as your identity". [Chapter 10, referencing John O'Donohue again]



Casciotta asks "where were you when you got the weird kicked out of you?"

Get Weird celebrates the 'weird', embracing along the way concepts such as the Japanese philosophy of *ba* [a kind of space that creates and shares knowledge]. It moves into how individuals and collectives [or continually evolving *re*-collectives] can and have changed the world.

I suspect I will be returning to this book to refresh my own sense of the value of 'weird' to enhance my courage – perhaps with a little of Jim Henson's 'whim of steel' – for my own ventures, for many years to come. ■

William Park



ALL IT TAKES IS A BIT OF DISCIPLINE

So, with mental health support outsourced to charities, some of which had no previous experience of mental health support, the local Women's Institute got the contract in my local area. I needed the support so went to some sessions. It was run by an old tory who preached that all that was needed for mental health recovery was good old discipline. I was suspicious but desperate to feel better so I tried it...

I am now into S&M.

I still have chronic mental health issues. But now I have a fetish as well.

Alastor Nemesis

AN INTELLECTUAL EMERGENCY IN UK MENTAL HEALTH SERVICES

VINCENZO PASSANTE SPACCAPIETRA came to the UK from Trieste, home of the Italian democratic psychiatry movement. He was surprised by what he found.

Some people do not fit into our society, they are neglected by unfair social structures and become desperate. What should we, as members of society, do about this?

In the UK (and elsewhere) we still assume that psychiatric hospitals are justifiable; alternative ways of thinking about care are not currently on the menu. We avoid working on different premises, even though hospital admissions far too often lead to the very opposite of safety. The procedural efficiency of the system takes priority to the well-being of the people it is supposed to help.

Staff members are provided with risk management templates that temporarily provide the illusion of controlling suffering. We persuade patients that they are thinking about their life in the wrong way and they must change to fit the requirements of the society that failed them. The most scientific way to repress the symptoms of society's failure is defined as "best practice" and any other approach is looked at with suspicion.

Far from gradually moving away from the asylum system, psychiatric hospital care has been on the rise in the UK: there has been a 2.4% increase in detentions in 2017/18 compared to the previous year and a recent research article found that rates of detention have at least trebled since the 1980s and doubled since the 1990s. If you are black you are more than four times more likely to be admitted to hospital and seventeen (!) times more likely to be diagnosed with a severe mental disorder than if you are white. There are disparities for other social groups as well.

This is often seen as having nothing to do with society, politics or psychology, but a medical issue that coincidentally seems to affect the brains of social groups that society dislikes. How can all of this be the result of "best practice"? The science behind the system ends up defending dominant social groups from the suffering of those who get left behind and this oppression is presented as an objective necessity for society. Otherwise we would have to accept that there is no magic box where society can safely dispose of the problems it causes.

This mentality, that the more we repress the expression of madness, the more we can cure it and ensure safety, takes shape in different ways. It goes well beyond the mental health sector: it can affect schools, universities, families and every other human organisation. Citizens face an intrinsic hypocrisy – we live an intellectual

crisis where many of us want to fight stigma, but we re-enforce it in our habits, policies and procedures. In turn, to protect ourselves, we justify the actions we undertake as necessary or even therapeutic. This ensures the perpetuation of prescriptive rituals, where individuality is denied, and emptiness is endemic, an emptiness that gets inevitably filled by tragedies.

Life is more complex than any safeguarding procedure. Mental health professionals have to apply a simplistic and unidimensional idea of "risk" to complex phenomena that society refuses to address holistically. Dangerousness becomes the only important aspect of self-harm, suicidality, aggressiveness, or even hearing voices, that a psychiatric hospital system cares about. However, it is by no means the most relevant, let alone the only, element to consider in the practice of creating safety.

I qualified as a Psychologist in Trieste, an Italian city that led a national revolution in the 1970s which closed all psychiatric hospitals. The implementation of the new legislation was generally poor, and this led to a range of problems which are yet to be addressed. Despite this, in the minority of cases where it was implemented as intended (Trieste being the most prominent example), it proved that a different way forward is possible. There is still a small, open door, general hospital psychiatric ward in Trieste for acute psychiatric emergencies: and its existence is still questioned by some of the reformers. The system is almost exclusively focused where it should be, in the community, with the provision of beds in open door community mental health centres, in a relational context where the person is considered much more important than the disorder.

In 2014, given the chronic lack of career opportunities in Italy, I came to work in Britain (not as a Psychologist, in the UK you need a doctorate for that). I crashed into a care system that in Trieste had been defeated by Franco Basaglia and others many decades ago. I quickly realised that hardly anybody knew anything about this situation (*Asylum magazine is a virtuous exception*). The training I got was the opposite of what I learned in Trieste (a widely internationally recognised setting for training). I realised I would not even have the right to believe, for instance, that doors should be kept open to bring about safety. Years and years of training became suddenly pointless, or even wrong, and I had

One of the buildings of the ex-Provincial Psychiatric Hospital of Trieste:

“La verità è rivoluzionaria”
(The truth is revolutionary)
was one of the mottos of the revolution.



no opportunity to discuss this with managers, because they knew nothing about any of this.

British mental health care is in a state of emergency. Harmful practices are often defined as “best practice” and taught as the only acceptable view. In Trieste I was taught to avoid seeing complex behaviour through the limiting and stigmatising lens of dangerousness. Here I found myself in a position where my level of competence was evaluated against skills like remembering to ask patients: “Do you have any thoughts of hurting other people?” at every contact. This was meant to “ensure safety”. It applied to every patient, regardless of whether there was or was not a concern for their state of mind (this, to be fair, does not happen in every service). Imagine if we applied this mentality to other social groups, if for instance we asked every black person that entered a shop: “Do you have any thought of robbing the shop?” Would that be an acceptable way forward? Would that ensure safety?

This is the type of thinking that in Trieste we call “stigma” and we commonly attribute to poorly informed individuals who are worried about the supposed dangerousness of mad people. Lack of funding has a role in all of this, but these concerns go well beyond the (important) issue of austerity. Call me mad but sometimes I feel we are living through a large scale “Milgram experiment”, a famous social psychology experiment where subjects were persuaded to administer lethal electric shocks to other people for the sole reason that the experimenter had told them to do so. My perception is that workers persist in carrying out questionable procedures without objection, for the sole reason that the establishment tells us that it is necessary to follow the rules.

Action must be taken. Whereas in Trieste I had endless debates with my supervisors about questionable aspects of care, here in the UK I find myself confused, caught in the dilemma of leaving the system or staying in. In a small way, by staying in, I have already seen change happen in places where I worked, despite remaining in an intrinsically contradictory position.

For these reasons, a friend and I recently started to host a podcast: “A place of safety?”, in which critical voices are legitimate. We question whether safety measures, like hospital admissions, can be defined as such if they lead to tragedy, or whether an intervention is really “best practice” if it ignores things that could be done better, differently.

If we could become less dogmatic about our beliefs, we could find healthy spaces for debate. More democracy must be the first step. Without the right to disagree no change is possible. When I came across *Asylum magazine*, I realised we had a similar ethos and history. So they were one of the first places I turned to for help. This quickly is turning into establishing a closer working relationship, where we hope to put our resources together to widen this important debate. Any contribution you want to give, we are here to listen. ■

Our “A place of safety?” podcast is available on the main platforms: iTunes, Stitcher, Spotify...

E-mail: apospodcast@gmail.com

Twitter and Instagram accounts: [@apospodcast](https://twitter.com/apospodcast).

We will keep you updated,

Vincenzo Passante Spaccapietra

People mean different things by 'Recovery'

BY ROY CURTIS



BEFORE



AFTER

My life had no meaning, but since my Super Holistic Industrial Therapy support worker fixed me up as an apprentice human scarecrow and the Chief Executive of the Recovery College forced me to go out bird watching for two hours a week, things have really started looking up.

Antonin Artaud (1896–1948) was a poet, actor and dramatist. By many accounts, he was a deeply unpleasant and troubling character; by all accounts, he suffered greatly. In 1937, following an unexplained incident on a boat from Ireland, Artaud was confined to a series of mental hospitals.

In 1943 he was sent to the Rodez asylum, where he remained until 1946, when he was released to a psychiatric clinic at Ivry-sur-Seine, near Paris, at the instigation of the Committee of Friends of Antonin Artaud, a loose confederation of artists and intellectuals, which served to supply Artaud with the opiates he was addicted to as well as marketing him as an outsider genius.

M. Artaud was not a fan of psychiatry. In *Alienation and Black Magic*, one of his last works, dated January

1948, he writes: "Insane asylums are receptacles of black magic, deliberate and premeditated... It's not only that doctors encourage magic by therapies that are ill-natured and stupid, it's that they practice it. Had there been no doctors, there'd be no patients... There is nothing like an insane asylum to quietly hatch death, and to keep the dead incubated."

I firmly believe that our hero would have been similarly unimpressed by the state sanctioned Recovery model that promotes work as the key to an individual's liberation, irrespective of how unrewarding it might be, and regardless of the fact that there aren't enough jobs to go around. I'm convinced he would have opted for a rant and a spot of laudanum. And who can blame him? ■



NEWS & FINDINGS

Manufacturer admits ECT may cause brain damage

The largest manufacturer of ECT machines has just admitted for the first time that a risk of brain damage is associated with ECT. The unprecedented admission by Samatics Inc, the manufacturer of Thymatron, came in the form of a Regulatory Update posted on its website: 'ECT may result in anterograde or retrograde amnesia. Such post-treatment amnesia typically dissipates over time: however, incomplete recovery is possible. In rare cases, patients may experience permanent memory loss or permanent brain damage'.

From Our Voice. *Notre Voix magazine No 68 June 2019*

Police fined over death of man restrained with belt

A police force has been fined £234,500 over the death of Thomas Orchard, a church caretaker with mental health problems who died after a heavy belt was placed across his face while officers restrained him. Devon and Cornwall police were strongly criticised by Orchard's family, the sentencing judge and campaigners, who believe it is a landmark case.

The decision has prompted calls for more national oversight of the way in which police forces use equipment like the American-made belt that is at the centre of this case.

Morris, S. (2019). *The Guardian*, 3 May

Benefits stress impacts mental health services

Nine out of ten NHS mental health trusts bosses in England believe benefit changes have increased the number of people needing help for anxiety, depression and other conditions – according to a survey by NHS Providers. 36 trusts responded to the survey, of which 63% said changes to claimants' payments or the rollout of universal credit had had a "high impact" and was the single biggest driver of demand. Other factors included the historic fall in most people's incomes, increased problems with housing, loneliness, social isolation and long-term health conditions, and cuts to local services. Better public awareness due to mental health campaigns may also have impacted on demand.

Despite PM May promising a major budget boost, in some areas MH services are still being cut by the NHS and local councils: 91% of trusts have too few doctors,

nurses and therapists, and the mental health share of the NHS budget will only increase by 0.5% over the next five years.

Meanwhile, analysis of the Chancellor's Spring statement by Resolution and the Institute for Fiscal Studies finds that while pay for the top 0.1% rose considerably faster than the average over the last year and more, the poor will continue to suffer during the fourth year of the Government's benefits freeze. 10 million families will have lost an average of £420 a year as a result of the freeze; not counting those only affected by the freeze on child benefit, 7 million poorer families will have lost an average of £560. Altogether, changes to income tax, council tax, universal credit, fuel duty and the benefits freeze since the 2015 election boost incomes for 2019–20 by an average of £280 for households in the top fifth of the income distribution, but reduce them by £100 for those in bottom fifth. On average, this policy will leave couples with children in the bottom fifth of the income distribution nearly £900 poorer in 2019–20 than they would otherwise have been, with the poorest single parents down almost £700.

All this as thousands are dying whilst waiting to hear if they will get disability benefits: the DWP admits that in five years 17,070 PIP claimants died, while a further 4,760 claimants died between their case being referred to an 'assessment provider' and coming back to the DWP.

Campbell, D (2019) NHS bosses: Benefit stress driving mental health care demand. *The Guardian* 8 Mar; Benefits freeze hits 10 million poor families, but top 0.1%'s wealth swells (2019) *The Guardian* 14 Mar; Bloom, D (2019) DWP reveals people 17,000 died waiting for disability benefits. *The Mirror* 15 Jan.

Benefits assessments cause psychological harm

Liverpool University Public Health Department has studied 1.03 million claimants from 149 local authorities who were reassessed for employment and support allowance (ESA) from 2010 to 2013. On top of existing mental health morbidity, for every 10,000 claimants there were an extra 2,700 cases of reported mental health problems, 7,020 more antidepressant prescriptions, and six more suicides than expected. Across England as a whole, this suggests 279,000 more reported mental health problems (11% of the total), 725,000 more antidepressant prescriptions (0.5% of the total) and 590 more suicides (5% of the total).

For claimants of both ESA and personal independence payments (PIPs), sources of distress include the quality of reporting by "health professionals". The government's own appraisal stated: "During visits to both Capita and Atos (the health professionals' employers), the review observed that the requirement to gather evidence was not always being fully considered ... In some cases, it was clear that insufficient evidence had been gathered ... Claimants have also expressed a lack of trust in the ability of health professionals to record what has been

said during face-to-face assessments. Some assert that the health professional had misinterpreted or even deliberately misrepresented what was discussed during the assessment".

Bernadt, M (2019) Letter. *The Guardian* 11 Mar.

Air pollution linked to depression and psychosis in teens

Many studies show that air pollution affects physical health, and there is strong evidence that it reduces intelligence, but there is little research on the effect on mental health. A study of 284 children (led by Helen Fischer, published in *Psychiatry Research*) finds that those living in parts of London with the highest air pollution at the age of 12 are much more likely to develop major depression by the age of 18. Taking into account other possible factors – such as a family history of mental illness, level of income, bullying and smoking habits – children living in the top 25% polluted areas at age 12 ran three to four times the risk of depression at 18, compared with those in the 25% clearest areas. Comparison with other studies indicates that air pollution is a greater risk factor than physical abuse, which increases the risk of depression about one-and-a-half times.

These findings are particularly significant because 75% of all mental health problems begin in childhood or adolescence, which is when the brain is still rapidly developing. The study was not designed to investigate the cause of the depression suffered by the adolescents, but the author believes that inflammation due to toxic pollution is most likely, and children and adolescents are very vulnerable: '...The pollutant particles are small enough to cross the blood-brain barrier [and] we know there are big links between inflammation in the brain and the development of depressive symptoms.'

Psychotic experiences are much more common in adolescents than in adults, and those having the symptoms when young are more likely to develop a serious mental disorder later. It is known that there is a strong correlation between living in a city and the chances of having psychotic experiences. Now a study of 2,000 17-year-olds across England and Wales finds that those forced to breathe high levels of nitrogen oxides are 70% more likely to have psychotic experiences, such as hearing voices or intense paranoia. Overall, 30% of all the young people reported at least one psychotic experience – which is normal for teenagers – but psychotic experiences were significantly more common among teens living in the top 25% polluted places.

Published in *Jama Psychiatry*, the research took into account other potential causes of psychotic experiences, such as smoking, use of alcohol or cannabis, family income or psychiatric history, and neighbourhood deprivation. Nitrogen oxides explained about 60% of the association between urban living and psychotic experiences. There was also a link to small particle pollution, with psychotic experiences 45% more common for teens exposed to higher levels.

Deriving mainly from diesel vehicles, nitrogen oxides are at illegal levels in most British towns and cities, and small particle pollution often exceeds WHO guidelines. The government accepts that dirty air shortens lives and harms children, but environmental lawyers say its latest action plan on roadside pollution is 'pitiful', and in the high court it has lost three times over its failure to cut pollution levels.

Young people more likely to have depression at 18 if exposed to dirtier air at age 12. Carrington, D (2019) *The Guardian* 30 Jan. Carrington, D (2019) Air pollution linked to psychotic experiences in young people. *The Guardian* 27 Mar.

Surge in deaths from fake Xanax

Xanax (alprazolam) is a powerful tranquiliser used to treat anxiety and panic attacks. It is widely prescribed in the US, and though not available on the NHS, it can be got on private prescription.

Counterfeits circulate on the black market, and in 2018 the BBC found that children as young as eleven had been given emergency treatment after taking fake Xanax. The BBC now reports that since 2015 at least 204 deaths in the UK have been linked to the misuse of Xanax, usually fake and cut with other stuff. Counterfeit Xanax with a street value of over £1m has been seized at ports and airports since 2016.

Northern Ireland's coroner, Joe McCrisken, says he currently signs off an alprazolam-related death nearly every week. The rise in deaths linked to fake Xanax, is "an escalating crisis... a very tiny tip of a very huge iceberg." In Scotland there were 24 'Xanax'-related deaths in 2016, and 99 in 2017. In 2018, Public Health Wales reported that fake Xanax was among the "most commonly identified" classes of psychoactive substances analysed by the Welsh Emerging Drugs and Identification of Novel Substances Project's (WEDINOS) drug testing service. While the Office for National Statistics shows 30 such deaths for England and Wales between 2015 and 2017, Public Health England says there is "no evidence that there is a very widespread epidemic of its use... [although] its use is increasing".

Izundu, CC (2019) Fake Xanax: Anxiety drug deaths an 'escalating crisis'. *BBC News* 4 Feb. Phillips, N (2019) 'Xanax' linked to more than 200 deaths. *BBC News* 5 Feb.

One in thirteen 18-year-olds have PTSD

A sample of more than 2,000 English and Welsh 18-year-olds indicates that 31% experienced trauma in childhood, and a quarter of these (one-in-13) developed the insomnia, flashbacks and feelings of isolation known as post-traumatic stress disorder. The research was by the King's College London Institute of Psychiatry, Psychology & Neuroscience, and published in *The Lancet Psychiatry*. It found that slightly more than half of those with PTSD symptoms had also had a major depressive episode, and one in five had attempted suicide. But only one in five of those with PTSD had been seen by a mental health professional in the previous year. Senior researcher Prof Andrea Danese said: "Our findings should serve as a wake-up call. Childhood trauma is a

public-health concern – yet trauma-related disorders often go unnoticed. Young people with PTSD are falling through the gaps in care and there is a pressing need for better access to mental health services."

Therrien A (2019) PTSD affects 'one in 13 by age of 18'. *BBC News* 22 Feb.

High suicide risk for gambling addicts

An 11-year Swedish study monitored more than 2,000 people with a gambling disorder. Holding other factors constant, it found they were 15 times more likely than the general population to take their own life, with the rate 19 times higher for men aged 20–49.

Sweden has a similar prevalence of problem gambling to the UK, at around 0.5% on the gambling severity index measurement, rising to around 1.6% when including people at moderate risk. If these results were applied to the UK, there would be about 550 suicides a year in which gambling played a part – more than 10 a week. There is just one specialist problem gambling clinic in the UK, although a second is due to open in Leeds after the government promised greater funding for treatment as part of a 10-year NHS plan.

Davies, R (2019) Problem gamblers at 15 times higher risk of suicide, study finds. *The Guardian* 13 Mar.

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Send creative writing and poetry submissions to: william.park@talk21.com

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Back cover image: Photograph by Jill Anderson, of 'Weeping Girls' by Laura Ford

Empathy and Compassion: Out of Stock

by Dolly Sen

The screenshot shows the Amazon UK website interface. At the top, there's the Amazon logo and navigation links like 'Today's Deals', 'Gift Cards', 'Sell', and 'Help'. Below that is a search bar with 'Shop by Department' and 'Search' buttons. The main navigation bar includes categories like 'Home & Garden', 'Deals & Offers', 'Best Sellers', etc. The product page features a red heart-shaped balloon held by hands. The product title is 'An equal, humane, kind response to distress.' and it has a 5-star rating from 16 reviews. The price is £9.01, marked as a 10% discount from the RRP of £10.00. A 'Temporarily out of stock' message is prominent. The right sidebar shows the shopping basket with a total of £10.00 and options to 'Add to Basket', 'Buy now with 1-Click', and 'Add to Wish List'.

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