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the magazine for democratic psychiatry



**SZASZ: THE THERAPEUTIC STATE
ROMME: HEARING VOICES
THE POLITICS OF PSYCHIATRIC MEDICATION
and more ...**



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Incorporating the Newsletter of Psychology Politics Resistance

the magazine for democratic psychiatry
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EDITORIAL

This is the third issue since the relaunch last March. The first two issues focussed on particular topics – paranoia and medication, respectively. These were packed with information and were well-received by those who saw them. And if you didn't see them, order them now!

In contrast, this issue touches a variety of bases. We lead with an article given by the venerable Dr Thomas Szasz, who might be well-known to our older readers as the original anti-psychiatrist. His book, *The Myth of Mental Illness*, was a sensation when it was published almost fifty years ago. Since the basic assumptions of the psychiatric and mental health project have changed very little during the intervening years, what he has to say is just as pertinent now as it was then.

Can I remind readers that we also welcome contrib-

utions – we need fresh ones so as to keep going! But even more vital at the moment is the need for people to subscribe, and better still to help distribute the magazine by buying in bulk (at reduced rates) and expending just a little energy, four times a year, promoting the magazine amongst friends and colleagues or by visiting likely local outlets (e.g., MH organisations, nurse training libraries, trade union reps, etc.). Asylum magazine will not survive unless we make it known that it is out there – and boost sales! We are not asking for very much: bulk buying starts at £25 for 10 copies. So apart from enlarging your social life and spreading the word you could even make money!

You know it makes sense – join the movement for decent mental health care!
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THE ROLE OF PSYCHIATRY IN THE THERAPEUTIC STATE

Thomas Szasz

Psychiatry: The Shame of Medicine

The practice of medicine rests on cooperation and the ethical-legal premise that treatment is justified by the patient's consent, not his illness. In contrast, the practice of psychiatry rests on coercion and the ethical-legal premise that treatment is justified by the mental illness attributed to the patient and must be "provided" regardless of whether the patient consents or not.

How do physicians, medical ethicists, and the legal system reconcile the routine use of involuntary psychiatric interventions with the basic moral rule of medicine: "First, do no harm"? The answer is: by the medicalization of conflict as disease, and coercion as treatment.

Carl Wernicke (1848–1905), one of founders of modern neuropathology, observed, "The medical treatment of mental patients began with the infringement of their personal freedom." Today, it is psychiatric heresy to note, much less emphasize, that psychiatry-as-coercion is an arm of the punitive apparatus of the state. Absent the coercive promise and power of mental health laws, psychiatry as we know it would disappear.

Ever since its beginnings, about 300 years ago, psychiatry's basic function has been the restraint and punishment of troublesome individuals – justified as hospitalization and medical care. For two centuries, all psychiatry was involuntary. A little more than 100 years ago individuals began to seek psychiatric help for their own problems. As a result, the psychiatrist became a full-fledged double-agent, and psychiatry a trap.

The film *Changeling* (written by J. Michael Straczynski and directed by Clint Eastwood) is a recent example of the public's profound ignorance about these matters. Set in Los Angeles in 1928, this is said to be "the true story" of Christine Collins (played by Angelina Jolie), whose son, Walter, was kidnapped. The police are corrupt, and make little effort to find Walter. Months pass. To repair its damaged image,

the police decide to stage "a reunion" between the mother and an abandoned youngster who pretends to be Walter. Unsurprisingly, she realizes that the fake Walter is not her son. After confronting the police and city authorities, she is vilified as an unfit mother, branded delusional, and incarcerated in "a psychopathic ward", where she is subjected to the brutalities of sadistic psychiatrists and nurses, and watches fellow victims being punished by electric shock treatment – ten years before its invention. So much for the truth.

Clueless about the true nature of the psychiatric terrorization to which the mother might have been subjected, film critic Kirk Honeycutt praises Clint Eastwood who "... again brilliantly portrays the struggle of the outsider against a fraudulent system – *Changeling* brushes away the romantic notion of a more innocent time to reveal a Los Angeles circa 1928 awash in corruption and steeped in a culture that treats women as hysterical and unreliable beings when they challenge male wisdom."

But the Jolie character does not simply "challenge male wisdom". Instead, her actions illustrate the insight of the Hungarian proverb, "It is dangerous to be wrong but fatal to be right." The psychiatrist as brutal agent of the state enters the story only after the mother proves – by securing the testimony of her son's teacher and a dentist – that "Walter" is an impostor. The psychiatrically incarcerated individual's greatest crime – for which the psychiatrists cannot forgive her – is that she is innocent of lawbreaking and objects to being deprived of her liberty.

Psychiatric Coercion is Medicalized Terrorism

So-called critics of psychiatry – who often fail or refuse to distinguish coerced from contractual psychiatry – are unable or unwilling to acknowledge the disturbing truth. As a result, the more things change in psychiatry, the more they remain the same, as the following conveniently forgotten example illustrates.

On May 21, 1839, Elizabeth Parsons Ware (1816–1897) married the Reverend Theophilus Packard. The couple and their six children resided in Kankakee County, Illinois. After years of marriage, Mrs. Packard began to question her husband's religious and pro-slavery beliefs, and expressed opinions to the contrary. In 1860 Mr. Packard decided that his wife was insane and proceeded to have her committed. She learned of this decision on June 18, 1860, when the county

sheriff arrived at the Packard home to take her into custody. At the time, the law stated that married women “may be entered or detained in the hospital [the Jacksonville State Insane Asylum] at the request of the husband of the woman or the guardian ... without the evidence of insanity required in other cases.”

Mrs. Packard spent the next three years in the Asylum. In 1863, due largely to pressure from her children who wished her released, the doctors declared her incurable, and released her. Mrs. Packard stayed close to her children, retained their support, founded the Anti-Insane Asylum Society, and published several books. These include *Marital Power Exemplified, or Three Years Imprisonment for Religious Belief* (1864) and *The Prisoners' Hidden Life, or Insane Asylums Unveiled* (1868).

The Psychiatric Inquisition

Little did Mrs. Packard realize that she lived at the very beginning of the Psychiatric Inquisition, not the end of it. Today, “inquiry” into the minds of unwanted others is a well-established pseudo-scientific racket supported by the full force of the therapeutic state. Millions of school children, old people in nursing homes and prisoners are persecuted with psychiatric diagnoses and punished with psychiatric treatments. And that is not the end of it. Untold numbers of Americans are now psychiatric parolees, sentenced to submit to psychiatric treatment as so-called ‘outpatients’, or face incarceration and forced treatment as inpatients – the judges play at being doctors.

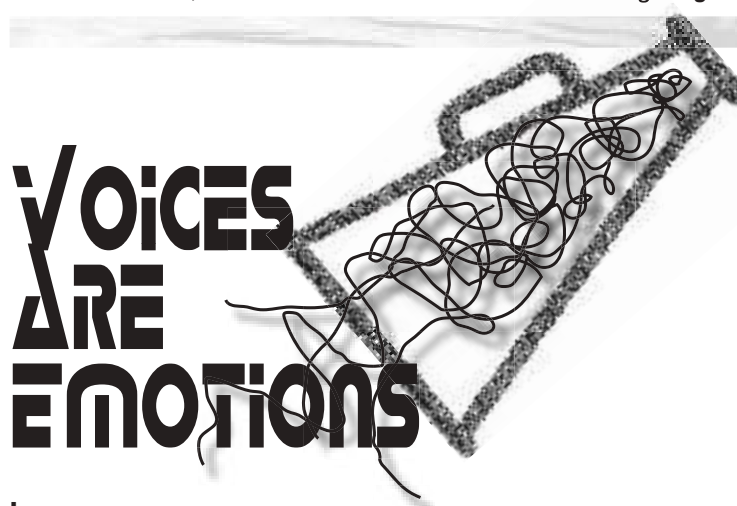
Meanwhile, the subtext of films such as *Changeling*

is subtle propaganda which encourages people to believe that “psychiatric abuse” is only a thing of the past. Yet the truth is that every new psychiatric policy or practice labelled “an advance” is actually a step toward making psychiatric deception and brutalization more legal and more difficult for the victim to resist.

As I write this, I learn from an “antipsychiatry” website that a man named Ray Sandford is being subjected to court-ordered outpatient electroshock treatment. “Each and every Wednesday, early in the morning, staff show up at Ray’s sheltered living home ... in Columbia Heights, Minnesota, adjacent to Minneapolis. Staff escort Ray the 15 miles to Mercy Hospital. There, Ray is given another of his weekly electroconvulsive therapy (ECT) treatments, also known as electroshock. All against his will. On an outpatient basis. And it’s been going on for months.”

As the forced psychiatric treatment of competent adults living in their own homes becomes “the standard of medical practice”, the failure to provide such betrayal and brutality actually becomes seen as “medical malpractice”. In a democracy people are said to get the kind of government they deserve. In a pharmacracy they get the kind of psychiatry they deserve.

Thomas Szasz is Professor of Psychiatry Emeritus at SUNY Upstate Medical University, Syracuse, USA. His latest books are *The Medicalization of Everyday Life: Selected Essays* and *Psychiatry: The Science of Lies* (both Syracuse University Press). Contact: tszasz@aol.com. This article is reproduced by kind permission of Dr Szasz from: *The Freeman*, 59: 12–13 (March), 2009.



by
Marius Romme

We all know that emotions are of the greatest importance in our lives. They define our wellbeing, our happiness and the perils of life. Without them, life would not be worth living.

But in our society expressing emotions is not very highly valued. The typical English response to devastating news, such as a death, is “Have a cup of tea”. And we always seem to hear more about the less welcome emotions – such as anxiety, guilty feelings, feeling insecure and aggression – than about positive emotions – happiness, or feeling good, excited or satisfied.

Many people are afraid of emotions. True, they can be quite overwhelming, and patients who hear voices are often overwhelmed by their emotions. One of the greatest challenges is not to avoid one’s unpleasant emotions but to try to explore them, to validate their real danger and perhaps to discover that

they are not as dangerous as they might at first seem. Learning to express emotions in an understandable manner is liberating. Trying to hide them only increases the sense of their danger.

As a profession, psychiatry should know about how to help people to cope with their emotions. However, mainstream psychiatry seems to have lost that ability and instead relies on medication. This is to stop the feeling of emotion, and by doing so it estranges everybody from the central importance of the emotions in our lives.

This is a very sad development since, most of all, mental health problems express patterns of emotional reaction. A psychosis is an episode during an emotional crisis. To the degree that the voice hearer becomes a psychiatric patient, this is also the case with ‘hearing voices’. The voices express the conflicting emotions involved with the person’s overwhelmingly negative experiences. This is rarely recognized by mental health professionals.

Obviously, negative emotions related to negative experiences are threatening and perceived as upsetting or dangerous. However, voices can also be the expression of positive emotions, and then they may be perceived as inspirational.

Voices and Trauma

In the troubling or negative sense, the characteristics of one’s voices relate to the emotions which the person experienced in a traumatic situation. In that case, it is difficult to cope with the accompanying emotion, and this makes the person feel powerless. So it is understandable that, not being able to cope with them, the person tries to get rid of the emotions.

The phrase “voices are emotions” was suggested by a Dutch voice hearer, Frans de Graaf, who also managed to work

in IT for twenty years. He is one of the 50 voice hearers from whom were elicited their own stories. These voice hearers had all recovered from much distress due to their voices, and had taken their lives into their own hands. As Ron Coleman put it, they "live their own lives, not the lives of their voices anymore".

In their recoveries, many of these voice-hearers gave clear examples of recognizing their emotions from what their voices told them. We can learn a lot more from a voice-hearer who has recovered than from those who are still overwhelmed by hearing voices. The latter are so handicapped by their anxieties that they cannot think clearly about what is happening to them.

For the majority of voice hearers, quite powerful and often long-lasting traumatic experiences lay at the root of the voice-hearing experience. Those traumatic experiences disrupt a person's emotional stability, and this is certainly the case when they happen during childhood, when emotional stability has not yet been formed. Such experiences lead to prolonged anxieties and sensitivities.

Traumatic experiences provoke anxiety and a sense of powerlessness. Voice hearers talk about both emotions, as reactions to their voices. In that sense, the voices mirror the traumatic situation. Imagine the feelings of anxiety and powerlessness engendered by a rape or by being assaulted by a much stronger person, or by being scolded at school every day. Imagine living in a situation where suchlike overwhelming threats might recur at any moment, and it is impossible to avoid them.

Voices also consistently promote low self-esteem and talk about the person being worthless, bad or guilty. Those emotions are also often implanted in the mind of the person when being traumatized. Can you imagine, when being raped, being told that you are the one that has led the rapist on. Or being told that you are being assaulted and raped because you are not worthy of being treated with respect. Or being belittled because nobody will believe that those things happened to you. All this was experienced by Helen, who was abused by her father, a well-respected surgeon.

Voice hearers are often afraid to talk about their voices. This is another idea implanted by perpetrators, who forbid their victims from ever telling anyone what has happened, and threaten to kill them if they tell about it.

And last, but not least, the feeling of shame is another powerful emotion and reason making it difficult to tell anyone else about the experience of hearing voices.

These already troublesome emotions are often complicated by the reactions of other people. The traumatized person is likely to meet a lot of denial and aggression. It is clear that the police and the juridical systems often make the suffering worse by trying to disprove the traumatic experience, by calling it a fantasy, or even worse, by saying it was provoked by the abused person. Or by a simple denial, by refusing to listen. According to the accounts we heard, psychiatry is often the worst denier, helping to destroy a traumatized person's battered self-esteem even more.

Jacqui Dillon describes how psychiatry sometimes tries to destroy the person over again:

I knew that what had happened to me as a child was the root cause of my distress. To my astonishment the psychiatrists that I tried to tell either denied my experience or told me that I would never, ever recover from what had happened. They told me that I had an illness. That I was mentally ill. I was expected to be the passive recipient of

treatment for a disorder I had, and medication was the only option to me, but that actually, I would never really get better anyway. No one ever asked me what I thought might help. The fact that I listened to my voices was evidence of my illness.

In many stories we also observed the effect of emotional neglect. By this we mean that a person was harmed in his emotional development by not having learned to cope with emotions because in childhood it was forbidden to express them, or the youngster was always criticized, could never do anything right, or had never been stimulated and was only ever ridiculed. For example, Frank's mother died when he was two, and his memories of his stepmother were that "she treated me like a serf and expected absolute obedience. I never did anything right. I was guilty of everything. She used me to get rid of her aggression." This resulted in an intense anxiety about failing. For four years he studied psychology at university, but he didn't take his final exams because he was too scared that he would fail. And his voices criticize everything he does. They also repeatedly say the word "die", and that drove him to try to take his own life.

Over and again we saw that, as with Frank, "the old situation just lives on in the person".

How Do Voices Express Emotions?

The identity and character traits of the different voices refer to the persons involved in the original trauma. For example, Lisette reported that a voice called himself "Stefan". Later this revealed itself as a metaphor for the stepfather who had sexually abused her and still provoked memories and anxieties. Many of those who hear voices and had been abused are able to recognize the abuser from the characteristics of the voices. Jo said: "I remember my first voice so clearly because it took on the identity of the person who had abused me." Those who hear voices and had been badly bullied during childhood recognize their bullies, who they still carry with them as their voices.

The content of the different voices expresses what they were told at the time of the trauma, or the emotions experienced at the time. For example, "You are worthless". Or, as with Jolanda, "Remember what happened, and cry". The triggers for the voices reflect the situation in which trauma occurred. For example, Karin had been bullied, and her voices grew in strength in crowded places. The influence of the voices reflects the influence of the trauma situation. Like the bullies did, Karin's voices still strip her of her dignity and self-respect.

How Do We Know that Voices are Emotions?

Many recovered voice-hearers gave us examples. Eleanor affirmed that "The contempt and loathing that he [the voice] expresses is actually to do with me, in that it reflects how I feel about myself. He is like a very external form of my own insecurities, my own self-doubt, and that is the part that is relevant and needs attending to."

Sue said that:

Working together with other voice hearers I learnt a lot about my voice-hearing experience. The more we explore our voices the more we discover and start to understand. I explored what had happened in my life that might have a relationship with my voices. I accepted those emotions I did not like and could not easily master.

The voice was of a woman yet the feelings were of the child I was when the abuse took place."

Debra stated:

I thought of the role the voices played in my life and discovered they fulfilled a role in my life, a need to feel connected, a need for a friend, a need to belong. The voices kept me so busy I had no time for any other relationships. They also spared me the pain I had experienced by numerous rejections by people in the past. At least [the voices] did not desert me. I decided I needed to take the risk of inviting real people into my world. Developing relationships and being exposed to people who showed they could be kind, freed me from the need for voices.

Why are the Voices Still There Yet the Trauma Happened So Long Ago?

People who imagine they are rational think it strange that voices and the emotions connected to them still live on while the traumatic situation usually happened so long before. I believe there are three reasons for this.

1. Memories of very intrusive events and the emotions involved never just disappear spontaneously. They remain because there was a real threat to the safety of the person. We might consider it an instinct: that the warning signs stay vivid to protect the person from possible danger. This happens not only with serious traumas but also with smaller ones. For example, after a burglary a person might keep waking up early, at the time of the event. Voices are part of a survival strategy. Similarly, a person might dissociate in order to avoid the overwhelming emotion connected to what happened.

Whatever we call it – survival strategy, defense mechanism, or coping strategy – the main issue is that the person's safety is at stake, and the safeguards have remained switched-on. They function automatically. What many voice-hearers can't understand is that one has to go back to the original emotions so as to at least understand those safeguards. Then the person may be able to discover how best to cope with them or counteract them. No one gets into an emotional crisis or psychosis simply because they hear voices. That only happens because the voices don't defend the person sufficiently against the overwhelming emotions that are triggered.

2. People still hear voices and have troubles with them, and especially with the emotions involved, because the voices never solve the conflicts within the mind. For example, Daan had been physically abused, regularly beaten and locked into a dark shed at night. He was then taken into a very nice foster family. But he hears the voices of relatives who swear at him. The conflict in his mind is about the aggression he feels due to being abused. It is hard for him not to act out that aggression on others, for example his brother. He doesn't want to be like his abusing parents but he certainly feels aggressive and only slowly learns that this is a natural reaction to what happened to him. He does not want to be like his abusive stepfather, so it is difficult for him to express aggression, even when there may be a genuine reason for it.

It is very difficult to accept some realities and one of the most difficult for some of those who hear voices is that they really were harmed by those who should have protected them. If voice hearers are to work this discrepancy through,

they have to give in to the sadness involved. They also have to learn that they must take on the responsibility for how much longer they will remain a victim.

3. The voices and the emotional problems involved remain so potent because the person who hears voices does not recognize that what is being expressed by the voices are the hearer's own emotions.

For example, Jeanette had to learn that the girl who lay there, traumatized, was herself. The pain of the girl was her own pain. The death agony of that girl was her own death agony. She had to learn to accept those terrible feelings because it was natural for her to have had them. She had to realize and accept those emotions, and to learn that she had only lost them by dissociating from them. Only then could she genuinely feel herself, without missing out a large part of her real self.

Conclusion

I hope it is clear that voices are emotions and not the signs or symptoms of a psychosis. Rather, they are a kind of protector against overwhelming emotions, and yet at the same time they express those conflicting emotions. Therefore, on any road to recovery, a person has to discover that those emotions are actually his or her own. To hear a voice is to experience an emotion which is not easy to cope with or accept.

Marius Romme, MD, PhD, was Professor of Social Psychiatry at the Medical Faculty of the University of Maastricht (Netherlands) from 1974–1999. His most recent book is *Living with Voices: 50 stories of recovery*, co-edited with Sandra Escher, Jacqui Dillon, Dirk Corstens & Mervyn Morris, published by PCCS Books, 2009.

PSYCHIATRIC DIAGNOSIS AND VALUE-BASED PRACTICE IN MENTAL HEALTH NURSING

by a Nurse

Depending on the underlying beliefs and values of whoever makes the observation or judgement, a person's situation may be understood in a wide variety of different ways. I want to explore how personal and professional values and beliefs influence psychiatric diagnosis and how this affects people who use the mental health services.

Let's start by defining certain terms. The Oxford dictionary has 'diagnosis' as 'the identification of the nature of an illness or other problem by examination of the symptoms'. A 'belief' is defined as 'a feeling that something exists or is true, especially one without proof', or 'a firmly held opinion'. An 'attitude' is 'a settled way of thinking or feeling'.

Meanwhile, The National Institute for Mental Health in England (NIMHE) Framework for Values-Based Practice understands 'values' as 'judgements of good/bad, of any kind ... in so far as these serve (directly or indirectly) to shape attitudes and to guide actions' (nimhe.csip.org.uk). Dickenson and Fulford (2000) regard psychiatric diagnosis as a 'value judgment', that is, 'an assessment of something

as good or bad in terms of one's standards or priorities'.

Reich (1999) argues that, when we want to do unto others as we would not have them do unto ourselves, we find some way of turning them into 'others'. We label them, exclude them from our own group and dehumanize them; we define their status as less than ours and therefore them as less human. Terms such as 'crazy', 'mad', 'mental', 'psycho' or 'schizo' often serve as informal exclusionary labels, used in everyday speech to identify others who are annoying, discomfiting and different.

When applied formally by psychiatrists, diagnosis can make a person seem like he or she is essentially disordered and dangerous, making them out to be something other than their fellow human beings. This legitimates confining people against their will in psychiatric wards, which can be unpleasant places, and coercively subjecting people to techniques such as physical restraint, drugs and electric shock. Any of those 'treatments' may be experienced by a patient as highly noxious, of questionable benefit, and cause a certain degree of harm.

Belief in medical diagnosis endorses a kind of absolute separation between those who are 'ill' and those who are 'not ill'. Rather than violators of human dignity and freedom, this notion permits psychiatric professionals to see themselves as helping to transform a psychiatric case back into a human being – back into someone more like themselves.

*

On one acute ward I met an elderly woman who presented with 'treatment resistant depression and anxiety'. As her 'symptoms' had not responded to pharmacological intervention, the consultant decided that she 'had a personality disorder'. When I first met her, the ward staff saw her primarily as a 'management problem'. They only spoke about the problems she had caused them on the ward due to her constant pacing, her refusal to stay seated at meal times, and her criticism of staff and the care she was receiving. A senior staff member told me: "There's nothing wrong with her. She's not ill, she's just behavioural and purposefully uncooperative."

For several weeks this lady waited on the ward for placement in a home. Then it was decided by the consultant, a specialist in electro-convulsive therapy (ECT), that this treatment might help her. Since she was adamant she did not want it, she was simply re-diagnosed with 'depression', sectioned, and then given the ECT. At this point, the same staff team began talking about her as being 'very unwell' and 'having the right to be treated against her will'.

A separation of 'them' and 'us' was rife. It was deeply embedded in the culture of some of my clinical placements. Frequently, staff loitered in the staff room, separated from the rest of the ward by a glass screen, socializing with each other and becoming territorial and defensive if non-staff tried to enter this space. The staff had toilets, kitchen areas, mugs and even teabags separate from the patients. Along with other new members of staff on the ward, when I made a tray of hot drinks for all the members of staff it felt rude and embarrassing not to offer a cup of tea or coffee to patients or carers. And yet doing so would invariably be met with disapproval from those members of staff who had worked there the longest. Some openly admitted that they simply did not want to share cups with patients. But the other most common explanation was that 'they' (meaning the patients) should be doing things such as making tea for themselves, so that 'they' don't become dependent on 'us'

(the staff). I found this very strange, especially considering that a number of 'them' were on the ward against their will to begin with, and wished for nothing more than to be at home, away from 'us'.

When they tried to understand a patient's motives, needs and feelings, some members of staff would routinely overlook the possibility that these might be similar to their own. Instead, they concocted elaborate 'pathological' explanations for behaviour. One example left me astounded at the level of paranoia developed amongst the staff. A discharged patient telephoned the office to request that a message be passed on to a patient who was still on the ward. Whilst in hospital, the two men had been having daily prayer meetings. The message was to say that the discharged patient would be attending a certain church service on Sunday if the other one wanted to join him. The staff member who took the phone call did not give this information to his friend because she and some other members of staff were convinced there was a secret message hidden in it. They thought it was a code about buying and selling illicit drugs. When I suggested to this group of staff that perhaps the discharged patient simply wanted to invite his friend to a church service, the response I received was: "They're dual diagnosis, they don't think like you and me. Trust me."

The process of diagnosis removes all of the person's experience from its social, cultural and historical context (May, 2007). A man from Nigeria was viewed as a wise shaman in his culture. When he told his consultant in the UK that he heard voices he was diagnosed schizophrenic and offered medication. He told me that he found it bizarre, unhelpful, disrespectful and inappropriate to medicalise his 'gift of voice hearing'. Boyle (2007) writes that there is strong evidence that emotional distress and behavioural problems, even the most bizarre, are understandable responses to adverse circumstances and relationships, or ways of actively trying to manage them. However, in 'the medical model of mental illness', adverse environments and relationships are understood as the consequences of 'having a disorder', not as the causes of distress and disturbing behaviour. One lady I met on the ward appeared to feel trapped in a difficult marriage. However, interpersonal problems between her and her husband were simply blamed on her 'recurrent depression', for which she was being 'treated' with ECT and medication. By diagnosing 'an illness', the psychosocial problem (marital problems) was converted into an individual problem (her depression).

*

Campbell (2007) reports that individuals who are given a psychiatric diagnosis often feel trapped within a negative framework. From the professionals' point of view, significant (albeit unusual) aspects of patients' experiences may be dismissed as irrelevant, and (from the public's perspective) this seems to support stigmatizing and discriminatory psychiatric responses. The effect of having a medical interpretation imposed on a person's experience is illustrated well by May (2007). Now a psychologist working for the NHS, he writes about the devastating experience, at the age of eighteen, when told that he had 'treatment-resistant schizophrenia' and would need to be on medication for the rest of his life. He says that if a person is given a diagnosis of schizophrenia, they and the people around them can acquire a learned helplessness. Likewise, a person with 'bipolar disorder' can resign himself or herself to a period

of depression after a period of being high, whilst someone with a 'personality disorder' can be expected (and expect himself) never to change, and every spiritual experience can be written off by clinicians as 'delusion'.

Rufer (2007) argues that the diagnostic procedures of the system of psychiatric classification – which focus on certain objectively identifiable symptoms – omit the subjective experience of the individual and his or her sense of needing help. On the ward, I met several people who believed they were having some kind of spiritual experience, and who described a sense of oneness and connection with all beings in the universe, or with God. Their problem was not their belief in, or direct experience of, 'something greater' but their inability to 'ground' this understanding and integrate it into their daily lives – which is something spiritual and religious teachers the world over routinely help spiritual seekers to do. However, those who believe in psychiatry, with its materialistic foundations in Western Science, would tend not to view such experiences as potentially valuable personal learning opportunities. Instead of helping people to find some meaning in their madness, to understand and grow from these experiences, the focus is on medicating people in such states until the intensity of their experience is sufficiently dampened down and they began to behave more 'normally'.

Hence, nursing notes for one man on the ward frequently read: "remains silent and unresponsive, sitting cross-legged and unmoving on the floor in his room with a towel over his head". This man claimed he was deeply absorbed in meditation, but his diagnosis was 'catatonic schizophrenic'. From a psychiatric perspective, those patients who spend hours every day watching television in the lounge, or chain-smoking together, might be seen as 'more well' than this 'isolative' man who preferred instead to engage in a quiet and concentrated inquiry into the nature of reality – something that in many religious circles is considered a noble and worthy pursuit.

*

With regard to people 'in a psychotic state', I often heard the argument that "they need stabilizing on medication before they are able to engage in any kind of psychological therapy". This would usually result in very disturbed people not only being traumatized further by the coercive treatment they were receiving, but also not having anyone to talk to about their problems until they had come around to the psychiatric professionals' 'rational' way of thinking – i.e. until they seemed 'compliant' with their medication regime, were 'cooperating' with the people holding them in the hospital, and had developed some 'insight' into the fact that they were 'ill'. Attitudes towards people who were 'persistently uncooperative' tended to be either paternalistic or simply judgemental and dismissive. An 'uncooperative patient' was one who did not agree with the diagnosis; this was otherwise known as 'lack of insight' and was taken as 'further proof' of the seriousness of the person's 'illness', and hence his inability to make any reasonable decisions. But some were eventually deemed not to be 'ill'. They were then said to have 'a personality disorder', and were considered 'attention-seeking', 'manipulative', 'untreatable' and 'probably best ignored'.

*

In summary, it seems clear enough that psychiatric diagnosis is not a value-free practice, and that locking a person's mental and emotional experiences into a medical belief

system often has deleterious consequences for the person involved. As well as stripping away diagnosed people's human rights to freedom, dignity and respect, believing that they are 'mentally ill' or 'disordered' leads to a separation between staff and patients which justifies a range of very questionable treatments. People's real problems are taken out of their wider context and instead are understood as rising only out of the 'disordered' individual. The person's own interpretation of events is devalued and dismissed, while the subjective feelings and opinions of professional 'experts', who erroneously consider theirs an objective, 'scientific' stance, are taken as the only 'truth' of the matter.

Through researching and considering these issues, I have realised how markedly my own personal belief system and underlying values clash with those of individuals who subscribe to the 'medical model' of mental and emotional difference and distress. This investigation has helped me to clarify my own beliefs and values. These are strongly aligned with the core beliefs and values of the service-user movement, especially the Hearing Voices Network, and the work of a number of inspiring professionals, carers and survivors of psychiatry.

For example, May (2007) believes in working within the person's reality, respecting a variety of explanations for someone's experiences, and creating therapeutic and social spaces where different beliefs about the nature of reality are accepted. He maintains that helping people describe their experiences in their own terms – e.g. feelings of dread, hearing voices, dissociation, panic, despair – is more respectful than trying to fit a person's experiences into a diagnostic category.

Likewise, I believe that people should be allowed to understand, describe and explain their personal experiences in their own way, and be supported to 'tell their own story'. Every individual is the best expert and the highest authority on himself, and his treatment and care should be provided according to his own individual agenda, in line with his particular values and beliefs.

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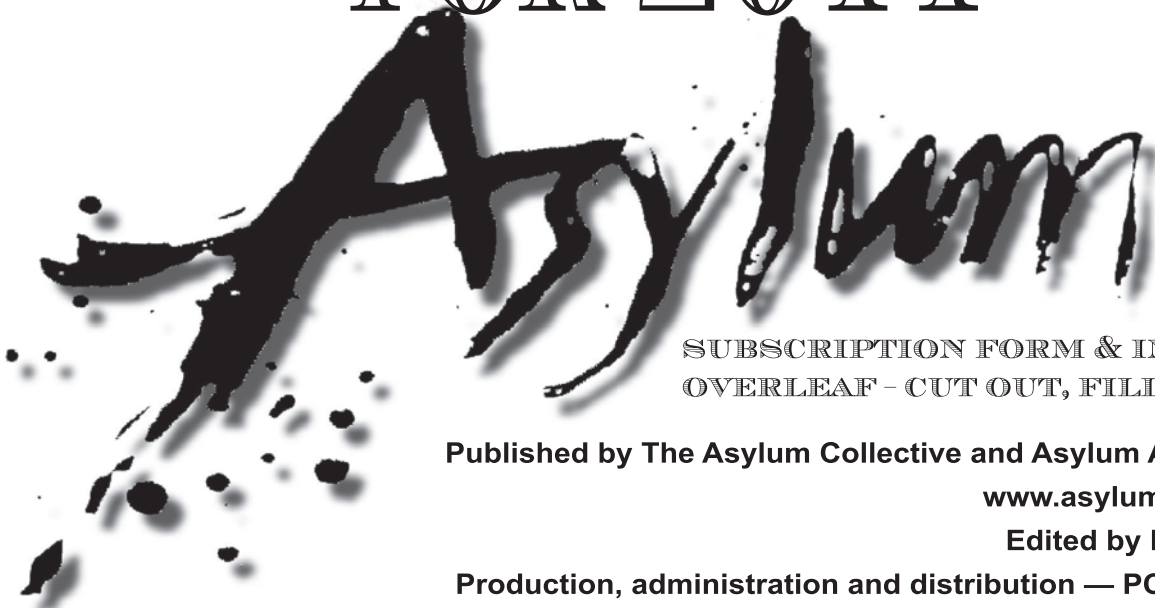
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SOLDIERS IN DOUBLE JEOPARDY

by

Fred A Baughman, Jr, MD

Neurology and Child Neurology Fellow, American Academy of Neurology. Author of *The ADHD Fraud*.

A Letter to US Senator Cardin,

Herein, I refer to the story 'Senator: Study prescriptions-suicide link' by Rick Maze of *Air Force Times*, July 23, 2009.

Our troops at home (especially those in Warrior Transition Units) and abroad are taking more than just antidepressants and sleeping pills. They are taking every category of psychiatric drug including the most potent of all – antipsychotics, such as Seroquel, Zyprexa, Risperdal. Moreover there is ample reason to believe that many such deaths are sudden cardiac deaths, not suicides at all, and on this point Surgeon-General of the Army Eric B Schoomaker is not forthcoming.

Long ago, on February 7, 2008, General Schoomaker, said there had been “a sequence of deaths in Warrior Training Units ... often as a consequence of the use of multiple prescription and nonprescription medicines and alcohol.” He continued, “we all saw the unfortunate death of Heath Ledger, the ‘Brokeback Mountain’ star, who died from an accidental overdose.” But Mr. Ledger was not on any cardio/heart-toxic antipsychotic (Ray, et al, *New England Journal of Medicine*, January 15, 2009).¹ When found, Ledger’s pulse and respirations were intact. This was not a sudden cardiac death at all.

However, when found, none of the veterans were breathing or had pulse. Theirs, most likely, were sudden cardiac deaths! Sudden cardiac death (SCD) is an unexpected death due to cardiac causes occurring in a short time period (within one hour or less) in a person with known or unknown cardiac disease in whom no previously diagnosed fatal condition is apparent.

As of April 16, 2009, veteran’s wife, Diane Vande Burgt, had Googled 19 (most from WTUs) “dead in bed,” 36 “dead in barracks,” or “... room,” and 19 “under investigation” Removing reported “suicides” shortened our original list by 15 names, leaving a total of 74 probable sudden cardiac deaths – most of them soldiers or veterans in their 20s. Additionally, an article from the *Associated Press*, out of *San Antonio*, 17 April 2009, reported “The deaths of two soldiers are being investigated ... both men apparently died in sleep.”

It was reported in June, 2008, that 89% of veterans with PTSD [post-traumatic stress disorder] are given antidepressants and 34% antipsychotics (Mohamed & Rosenheck, June 2008). A third, then, are exposed to the additive potential of both, to cause sudden cardiac death. (Sicouri & Antzelevitch, 2008).

The cause of death of every such soldier or veteran is the first thing that must be established, and the Big Pharma-beholden psychiatrists of the National Institute of Mental Health are not the ones for the job. If, as I suspect, this is

already known, Surgeon General Schoomaker should say so and should make all of the pertinent facts and records known to the public and to the families. In the cases to which I refer there can be no presumption that these were deaths by “suicide”.

Diane Vande Burgt (wife of veteran Tom Vande Burgt), Stan White (father of Andrew White – dead, in my estimation, due to antipsychotic-induced SCD) – and myself stand willing to appear before any House or Senate committee to testify on this issue.

Sincerely yours,

Fred A Baughman, Jr, MD

Meanwhile, in August 2009 the ABC network news reported that a recent study showed 5 out of 6 people now have “a favorable opinion” of psychiatric pills. There is nothing so powerful as The Big Lie!

It’s difficult to realize how a combination of greed, marketing, intellectual and psychiatric dishonesty can commit such a ‘biological’ fraud about ‘mental abnormalities’ and ‘diseases’. Of course, this lie is aided by a ‘free’ press in dereliction of its duty and, by no means least, the wishful thinking of the broad public, at every level of income and education.

Perhaps the public can be faulted for its scientific illiteracy but no one could be expected to second-guess physicians hell-bent on deceiving everyone. This is where the Hippocratic Oath and trust in one’s physician has its uses. Outside the profession, who could imagine that ‘chemical imbalance/disease’ is a total lie? The tragedy today is that the ‘chemical imbalance’ strategy has been sold by the Psych/Big Pharma cartel to every other kind of physician (neurology, pediatrics, family practice). And so each year it takes a bigger bite out of the healthcare dollar while real medical care – especially in Medicaid and Medicare – is rationed and cut-back. Healthcare reform simply cannot accommodate the ever-increasing number of invented psychiatric diseases (374 in DSM-IV), and still afford to cope with all of the real diseases affecting the members of our society.

Hold on! There’s a new book out: *Scientific Illiteracy*. It looks terrific – except that the authors absolutely accept the scientific validity of so-called biological psychiatry. This makes them either scientifically illiterate or complicit liars.

Endnotes

1. For full reference details, contact the author. Go to his website: www.adhdfraud.org



Catherine Clarke is a mental health carer. In the last issue (17.2) she wrote about psychopharmacogenetics and the possibility of testing for metabolism so as to prevent the terrible 'side-effects' of psychiatric medication.

SIDE EFFECTS AND PSYCHOPHARMACOGENETICS: POLICYMAKERS KEEP DODGING THE ISSUE

Catherine Clarke

Introduction: Department of Health evasions and the failure really to include users and carers

What is behind officials blocking the truth about the side effects of psychiatric drugging and the refusal to employ pharmacogenetic testing, which would be so helpful in preventing those ill effects? Where does the information come from which makes up the 'Clinical Excellence' National Guidelines for the NHS?

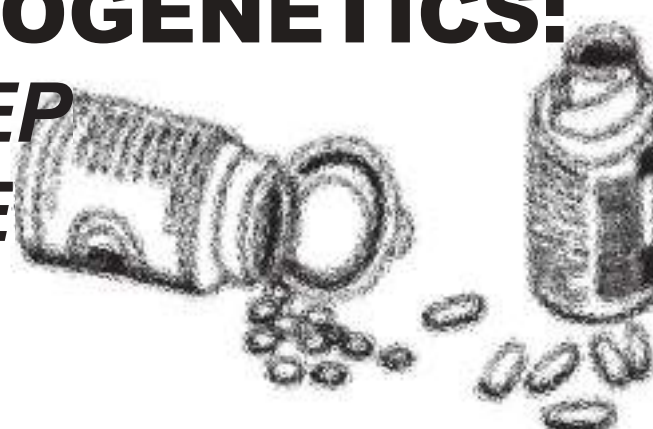
As a carer, I have been involved with a number of government initiatives supposed to improve mental health services and care. I have repeatedly met with excuses, claims that pharmacogenetics did not fall within the committees' mandates, and delaying tactics calling for yet more government initiatives to embark on extensive research into the cost-effectiveness of psychopharmacogenetic testing. My increased awareness is that such initiatives base their work predominantly on information provided by the pharmaceutical companies. And I don't know of any organisation or initiative which can be trusted to address the fundamental problems of psychiatric medication, or bring them into professionals' and public awareness.

Pharmacogenetic Research

In the last issue of *Asylum* magazine I referred to pharmacogenetic research undertaken by the National Institute for Health Research Coordinating Centre for Health Technology Assessment (NCCHTA). This is now renamed as the Evaluation, Trials and Studies Coordinating Centre (NETSCC). NETSCC research into the suitability for the genotyping test prior to neuroleptic prescribing now indicates the need "to either demonstrate or refute the ability of pharmacogenetic testing to assist in the development of individualized patient care in the area of schizophrenia".¹

In line with this aim, NETSCC suggested further research needs to include: explicit information about patient selection; a large number of patients who are Poor Metabolisers; investigating all currently used anti-psychotics; "environmental factors such as smoking, concomitant medicines, medicine adherence"; ethnicity. Economic-validity studies would include "improved evidence ... sought on the link between improved schizophrenia care and life expectancy", and "data that identifies the pattern of adherence, length of time in relapse and cost of care (including cost of care provided in the community)". A final decision has yet to be made about whether this research will take place.

NETSCC's pharmacogenetic research for general



medication is only slightly ahead of this position. Nevertheless, a number of pharmacogenetic tests are routinely carried out in general practice prior to treatment for various diseases. And doctors have not waited for the research outcomes. It seems that ground-floor experience in general medicine already shows the necessity for such tests before prescribing. Bearing in mind the length of time needed for further research, I think that psychotropic prescribers could emulate their colleagues' practice for the genotyping test prior to treatment. However, the cost quoted by NETSCC for the psychopharmacogenetic test was £300. This compares with the current cost of £30 for a test for Azathioprine (used in organ transplantation and autoimmune disease). I believe this £300 quote is over-inflated and could well dissuade the Government from further research.

The DH's New Ways of Working: The Mental Health Pharmacy Group

In 2006 I became a carer member of the Department of Health's New Ways of Working (NWW) Mental Health Pharmacy Group. It quickly became clear that pharmacogenetics was simply not on the agenda.

I spoke up about the differences between people's capacities to metabolise – to process medication (or not) – and how much this affects outcomes. There was a deathly silence. The Chair said she didn't know what I was talking about. Eventually, one acclaimed 'expert' pharmacist said that pharmacogenetics was an important issue and would be raised at the next meeting. But this did not happen.

Two meetings later, when I again raised the question of pharmacogenetics, I was informed the issue had been addressed at "a top level meeting" at the National Institute of Clinical Excellence (NICE), but NICE had decided that pharmacogenetics was not in the remit of the NWW Mental Health Pharmacy Group. The issue was simply not mentioned in the Final Report.

Such high-handedness is hard to credit. What does 'New Ways of Working' indicate if not real change or progress? Yet in this case it seemed that NWW would only consider delivering an improved pharmacy service based on the existing questionable 'medical-model' treatments. This was the first of many Department of Health (DH) documents I have seen which deliberately omit reference to pharmacogenetics.

Because I insisted, a further DH meeting about pharmacogenetics took place in 2008. The idea was to raise the concerns about pharmacogenetics being voiced by a group of us, including a nursing lecturer, carers and service-users. This was to see how the issue might be progressed nationally. Proceedings began with an hour-long slide presentation about pharmacogenetics. This was given by an Honorary Consultant Psychiatrist and member of the Executive Committee for Psychopharmacology Special Interest Group (PSIG) at the Royal College of Psychiatrists (RCP). Their presentation left little time for carers or service users to present all the issues which concerned them. And discussion proved difficult, due to the apparent 'emotional sensitivity' of one particular psychiatrist. Eventually it was decided that a letter would be sent to the President of the Royal College of Psychiatrists (RCP), asking for support for the role of the PSIG, so as to give psychopharmacology a higher priority, and maybe get extra funding.

Then it was discovered that the RCP's PSIG is only concerned with research into pharmacogenomics, not pharmacogenetics, which is quite different. The one concerns the genetic bases to diseases, the other is about genetic differences between individuals with respect to the possibility (or not) of their 'taking-up' and processing medications – or being poisoned by them. Our interest was not in pharmacogenomics: after all, despite years of research there is no evidence that schizophrenia has a genetic cause. So the agreed letter was not sent.

The position of NICE, the Government's policy-maker

Two weeks later the full group received the minutes. Included was another report: Pharmacogenomics Briefing Update. This was based on discussions with Dr Tim Kendall. Dr Kendall holds a number of key positions nationally, e.g., at NICE, at the Royal College of Psychiatrists and at The National Collaborating Centre for Mental Health, as well as powerful positions at the Sheffield Care Trust. The Update was dated three months prior to our DH meeting and comprised the following points:

1. There is no evidence that psychopharmacogenetic screening should take place at this time.
2. Screening for all would not be cost effective.
3. However, pharmaceutical companies may support it as it would provide a useful stream of income.
4. There may be a place in the future for selective screening for people with different phenotypes.
5. Recognising that there are different rates of metabolising, current schizophrenia guidelines recommend always starting with low dosage of drugs, and that this should be carefully monitored.
6. If side-effects are observed at low dosage levels, this is potentially a group that should be screened; additionally, those on high doses, who have not responded, would be another group to consider for screening.
7. There is a review of NICE's Schizophrenia Guidelines currently underway.
8. Dr Kam Bhui and the Schizophrenia [SCZ] Guidance Development Group are currently considering how to address inequalities in SCZ, especially those around Black, Minority, Ethnic (BME) groups... and in particular, access and engagement with services.
9. They may also scope the feasibility of looking at the evidence around treatment differences and pharmaco-

phenotypes in different groups. However, this will depend on the volume of work and the timescale for revision of the SCZ guideline.

10. It is likely that pharmacogenomics will be considered in future guidelines, wherever there is evidence. This would always include addressing cost-effectiveness.
11. This will not, however, obviate or replace the need for the careful use of medication, in which initial doses should be low and then titrated according to response and the emergence of side effects.

Issues raised by the NICE statement

1. In the Update, NICE recognises that "there are different rates of metabolising". However this Update is accessible neither to professionals nor to the general public. In comparison, everyone does have full access to the *NICE Guidelines for Schizophrenia and Depression*. Yet not once does either refer to the problems of metabolisation. How can ground-floor prescribers understand the need for low doses of neuroleptics in association with the variable metabolising rates when they have never heard of pharmacogenetics?
2. The Update frequently mentions cost-effectiveness. This seems to be used as a reason to keep the scientific information from a wider audience, and certainly out of the wider public domain. This subsequently limits the number of prescribers and individuals who would be able to access and try out genotyping tests for themselves. In my view, cost-effectiveness should be treated as an issue separate from that of the availability of information.
3. When considering the cost-effectiveness of pharmacogenetic testing, NICE really ought to consider the total long-term costs to the Government – the costs of life-long care for each patient as against a few pounds for carrying out an up-front genotyping test. Besides, if testing were routine, increased volumes of production would be bound to pull costs down.
4. It would be tantamount to racism to give the test only to Black Minority Ethnic (BME) patients. For, although 40–50% of BMEs are Poor Metabolisers (PM) for the CYP2D6 pathway, so are 10% of Caucasians, and 35% Caucasians are Intermediate Metabolisers.
5. The Update referred to "the emergence of side effects". Unbelievably, one leading psychiatrist at this DH meeting remarked that if neuroleptic side effects were problematic, patients could stop the medication, as with general medicine. He seemed to fail to appreciate that 'sectioned' patients cannot choose to stop their medication. Besides, due to drug dependency, stopping a neuroleptic would cause many patients to experience a 'cold turkey' psychotic reaction.

When I raised this issue at a NWW Mental Health Pharmacy meeting, a leading pharmacist simply denied neuroleptic dependency. Perceiving a confrontation, the Chairperson called a halt to any discussion of the matter, leaving the pharmacist and I stonily glaring at each other. It seems that the Department of Health is also in denial of the issue of neuroleptic dependency.

Had we all received that Update prior to the meeting, we would have been able to request that these issues should go on agenda.

Additionally, in effect, the belated Update made a

mockery of that meeting. For it appeared that the 'expert' outcome had already been decided without consulting all of the committee. In the eventuality, our sub-group managed to get the minutes amended, together with extra material that covered the issues which had not been properly addressed.

All the amended minutes and extra material we had researched for this DH initiative was then placed in the DH archives. In other words, it was 'shelved'.

Medicines Management: Everybody's Business: A guide for service users, carers and health and social care practitioners

By this time the DH had embarked on another initiative, *New Ways of Working: Medicines Management: Everybody's Business – A guide for service users, carers and health and social care practitioners*.² I raised the issue of pharmacogenetics at the first meeting. The Director of the National Institute Mental Health England National Workforce agreed that information about the Genotyping Test would be included.

However, the draft process involved the opinions of 'experts' (psychiatrists and pharmacists) who 'toned down' side effects and deleted material they thought would put service users off taking psychotropic medication. And before the next meeting a 'behind the scene' decision was taken at the DH to omit the genotyping test. This meant yet another DH document which failed to mention pharmacogenetics. Following the DH's 'expert' censorship of the guide, it seems that the pamphlet was no longer of any interest to professionals, and boxes of the pamphlet were simply destroyed.

Over the years I have found that many mental health practitioners say: "I don't prescribe medications", or "It is not my responsibility/role to know about medications", or simply (and incredibly!) "I don't know anything about medications". It seems these officials are not aware of that particular DH pamphlet, which does at least specify that knowing about psychotropic medication is the responsibility of all mental health professionals, not just those making out prescriptions.

I have contacted other mental health organisations about research into pharmacogenetics and the side effects of non-pharmaceutical antidepressants, specifically the European Medicines Agency (EMA) and the UK's Mental Health Research Agency (MHRA). EMA is responsible for authorising the European marketing of medications. But it only circulates the information within its own agency, emphasising the need to constantly monitor medicines by receiving safety reports from the European Union. As well as other problems with medication, the EMA completely ignores pharmacogenetics. This is irresponsible.

MHRA has a mandate to provide the latest information and clinical advice on the safe use of medicines. I am still waiting for a full response to my requests. And when I approached the Chief Executive of NICE, requesting a response to my raising the same issues about pharmacogenetics and antidepressant, this was ignored.

The DH initiative: Improving Access to Psychological Therapies

I also introduced the issues of pharmacogenetics and the side effects of antidepressant medication into the agenda at another DH initiative: *Improving Access to Psychological*

Therapies (IAPT). IAPT is supposed to provide psychological therapies for common mental health disorders. At first, one aim was to reduce the prescription of antidepressants, but as part of the 'stepped-up programme', SSRIs will now be prescribed. SSRIs are NICE's 'antidepressants of choice' for nearly all the common mental health disorders – not just for depression. Despite IAPT workers needing to "demonstrate knowledge of and competence in supporting people with medication, in particular antidepressant medication, to help them optimise their use of pharmacological treatment and minimise any adverse effect",³ all the IAPT experts I met repeatedly asserted that medication was "NOT in their remit".

Besides this blatant contradiction, surely it is important that all practitioners involved in the IAPT programme should know about the relevance of SSRI medication pharmacogenetics? Otherwise, how would they know whether a patient's deteriorating psychological condition – e.g., psychosis, mania, or suicide threat – was due to a deep seated psychological trauma or simply to being PM or IM, and thereby overdosed by SSRI medication? Apart from those few IAPT professionals who read the documents that I submitted, hundreds of practitioners will not know that antidepressants leave "60–80% of formerly medicated patients experiencing a rapid return of depressive symptoms", and how antidepressant medications are interfering with the potentially lasting results from psychological therapies.⁴

IAPT arranged a 'Depression Workshop' about antidepressant medications and psychological treatments. An American expert in pharmacological and psychological interventions was invited to lead the proceedings. All I heard was aggressive marketing for antidepressant drugs, together with mainly inadequate and dishonest information about the side effects. I was disgusted and squirmed uneasily in my chair. When I asked, the expert affirmed that drug companies had funded the antidepressant and psychological trials. The Chairperson tried to stop me, but I spoke out about the correct information about pharmacogenetics, and about the side effects, i.e. suicide, mania, brain damage and tardive dyskinesia. Afterwards, a psychologist argued with me for half an hour that "antidepressant toxicities are no worse than breathing in the toxicities of the atmosphere". I wonder how much these 'experts' really know and yet, when it suits them, they are quite prepared to deceive patients.

Whilst still maintaining that medication is not really part of their remit, IAPT decided to formulate a document, *Medication Guidance for Prescribers*. I have been informed by IAPT this will not include "individual differences, genotyping and drug responses". So you can guarantee that this Guidance will not be honest about metabolism, let alone about the known side effects of medication, both long- and short-term, as described above. This is one more DH initiative that fails to address the issue of pharmacogenetics.

Policy-making is Confined to a Club of Like-minded 'Experts' – Many Professionals Who Sit on DH National Policy Steering Groups Crop Up Regularly at Other DH Initiatives

The NICE Guidelines are developed together with the National Collaborating Centre for Mental Health (NCCMH). I am a carer living in Sheffield, and I take a special interest in what goes on locally as well as nationally. In 2002 the NICE Guideline Development Group (GDG) for Schizophrenia was

chaired by the Medical Director of the Community Health Sheffield NHS Trust, Dr Tim Kendall. At that time Dr Kendall was also Co-Director for The National Collaborating Centre for Mental Health (NCCMH), Deputy-Director for the Royal College of Psychiatrists Research Unit, and a consultant psychiatrist in the Sheffield Trust. The Chief Pharmacist from Dr Kendall's trust was also on the GDG panel.

By 2009 the Chief Pharmacist from the Sheffield Care Trust (SCT) was again on the panel of the NICE Guidelines for Schizophrenia Guideline Development Group; he was also a member of the New Ways of Working Mental Health Pharmacy Group. In the meantime, Dr Kendall was Director of the Sheffield Trust and had become Facilitator to the GDG (rather than Chair). He continued his position as Joint-Director for NCCMH (which works closely with the GDG). Besides this, Dr Kendall was on the Topic Selection Consideration Panel for NICE and DH, whilst for Royal College of Psychiatry he was on the Medical Director's Executive, The Special Committee on Professional Governance and Ethics, the College Education and Training Centre Advisory Board, and the CR 117 Pharmaceutical Industry Sponsorship Group. For the DH, he is a Member on the Long-term Conditions Board. But only five of at least a dozen of the important positions he has recently held are mentioned when Dr Kendall is listed on the NICE Guidelines for 2009. This reduces the visibility of his real power and influence.

This is only one example of how a relatively small number of senior NHS officials take control of the NHS's policy-making committees, and how committee memberships tend to interlock and pass from one to another amongst what seems to be a select group of senior Mental Health officials. This dominance of key committees by so few people does not create trust in their impartiality.

In fact, relationships between committee members often appear incestuous. It is obvious that there is collaboration between senior officials before the committees even meet. And if the committees are largely made up of officials who tend to be close colleagues, they are bound to support each other's ideas about treatment – which is to say, they will support the dominant 'medical model'. Their domination of the committees easily overrides any progressive ideas suggested by a few other GDG members.

And neither is this power and influence necessarily based on demonstrably superior expertise. For instance, before acquiring the status of Foundation Trust, in an Acute Inpatient Mental Health Service Review conducted by the Health Care Commission, Dr Kendall's SCT scored fourth from the bottom out of 63 Trusts. The SCT only achieved Foundation status after a number of attempts. Currently, it is under scrutiny by the Care Quality Commission (CQC – the Health Care Commission under a new name). Who is it that decides who is ideally suited to be a key member of a national Mental Health Guideline committee? Meanwhile, when a professional holds such an influential position this is likely to protect him or her from public scrutiny.

What we do know is that all the decisions about who else should be on the panel were taken by the Chairperson of 2009 NICE Guidelines for Schizophrenia GDG, along with the Co-Director, Dr Tim Kendall. We know that they chose a carers' representative who was very unlikely to question 'the experts'. And of the two service user reps, one was already known nationally and seems to support the medical model. Holding so many influential positions, Dr Tim Kendall seems

provided with almost unlimited power to select the other members of the GDG. This seems to guarantee that nobody could seriously question 'the medical model'.

Conflicts of Interest in the DH Mental Health Regime

All of the New Ways of Working Mental Health Pharmacy experts were members of the United Kingdom Psychiatric Pharmacy Group (UKPPG). Some had been members of the UKPPG Committee. One held the influential position of Vice-President of the UKPPG College of Mental Health Pharmacists. Possible conflicts of interests are supposed to be declared and open to inspection in the UKPPG, i.e., consultancy work or funding from a pharmaceutical company. However, an exception is made for the public scrutiny of any interests of its Vice President!

But we do know that the UKPPG has been sponsored by many pharmaceutical companies: AstraZeneca, BMS, Otsuka Pharmaceuticals, Janssen-Cilag-Shire, Lundbeck, Novartis, Pfizer and Sanofi-Synthelabo. Money is provided to fund its conferences, as well as for "unrestricted educational grants (accommodation etc.)". The conflicting interests of the UKPPG are vast. In 2010 the UKPPG and College of Mental Health Pharmacists merged to form the College of Mental Health Pharmacy. The new UKPPG website for visitors does not declare any pharmacists' conflicts of interest. UKPPG Corporate Partnership is with Lundbeck, a research-based company engaged in research to find new drugs for mental health treatment.

Meanwhile, the UK's Mental Health Research Agency is funded completely by the pharmaceutical companies. The Chairperson and its controller of Licensing were both high-level employees of GSK. MHRA has very serious conflicts of interest. In my opinion, this is not conducive to the safe medication of patients.

NICE is largely funded by the DH. But members of Guideline panels can still have a conflict of interest. Some members of the panel for the 2009 NICE Guidelines for Schizophrenia received money from drug giants: Janssen-Cilag, AstraZeneca, Eli Lilly, Bristol-Myers Squibb, Otsuka, Janssen and Merck. One psychiatrist had undertaken consultancy/advisory work in relation to psychotropic medication with Bristol-Myers Squibb, Johnson and Johnson and Servier. Some members received grants from the Wellcome Trust for Cognitive Behavioural Therapy. Although the Wellcome Trust claims financial independence from drug companies, it has helped to sponsor a new £37m Bioscience Campus in Stevenage.

And the term 'consultancy' covers a multitude of sins. It is easily used to cover payments from pharmaceutical companies. The excuse that work for a pharmaceutical company is done outside of NHS hours is irrelevant: the person has a divided loyalty – and it is not the patients who can pull the plug on his income.

The influence of the pharmaceutical companies

The manner in which NICE derives its knowledge about the side effects of medications means that it might as well be funded by drug companies. NICE gets its information from the British National Formulary, which comes from the British Medical Association, which accesses the Summaries of Product Characteristics (SPC). And who writes the SPC? The pharmaceutical companies.

Actually, the pharmacokinetic section of SPC does name

the medication-metabolizing pathways. But by excluding facts pertaining to Poor and Intermediate Metabolisation, prescribers and mental health workers may be misled into believing that every patient has fully functioning pathways. The severe side-effects experienced by PM patients are omitted due to the designs of drug trials.⁵ Consequently, NICE certainly does not receive the whole truth about the side effects of medication.

Meanwhile, DH initiatives are “required to work within the confines of NICE Guidelines, which define and dictate Government policy.” In effect, then, all DH initiatives are bound to adhere to the controlled and limited information that the drug companies wish the ignorant public and practitioners to hear.

NICE appears to repeat information from a narrow selection of sources. Independent reviews of literature, scientific research, the practices of other countries, and common sense all seem to be lacking. At one DH meeting a NICE professional made the excuse: “NICE can’t know everything”. NICE never will if it confines itself to drug company information. It needs to look to other, non-drug company research if it wishes live up to its name: ‘Clinical Excellence’.

Grace Jackson’s book, *Drug-Induced Dementia – A perfect crime*,⁶ is a non-pharmaceutical source of psychotropic information. This gives research information about long-term psychotropic medications, about which the UK’s ‘experts’ seem quite ignorant. I presented a copy to the President of the Royal College of Psychiatry. His interest seemed minimal – the book was put into the library within a week. No one could read that book thoroughly so quickly. In other words the President shelved the book – literally.

In my opinion, NICE, DH initiatives, the Royal College of Psychiatrists and other such ‘authorities’ cannot be trusted to provide health workers and patients with the whole truth about the side effects of mental health medication. I suggested to NICE that it should admit deficits in its information about side effects by putting a disclaimer on the front page of all its Guidance documents. Some hope.

Senior officers of the Department of Health are in a position of trust. We all pay for the DH ‘Initiatives’. We have a right to expect honest information about the safety of medications. The DH’s suppression of the issue of pharmacogenetics and ‘side effects’ is tantamount to deception. Nobody – practitioners, patients or the public – is given a fully informed choice, so as to be able to give any kind of meaningful consent to psychotropic treatment. It is vital that knowledge about side-effects and pharmacogenetics is shared with prescribers as well as with every social care and mental health practitioner. Otherwise we are all kept in ignorance about patients’ physical or psychological deterioration.

I have witnessed the lack of genuine responsibility and accountability for patients’ physical and emotional safety. If it continues to plough the same furrow, the DH will become a national laughing stock.

Tim Kendall once asked “How do you know what you don’t know?”

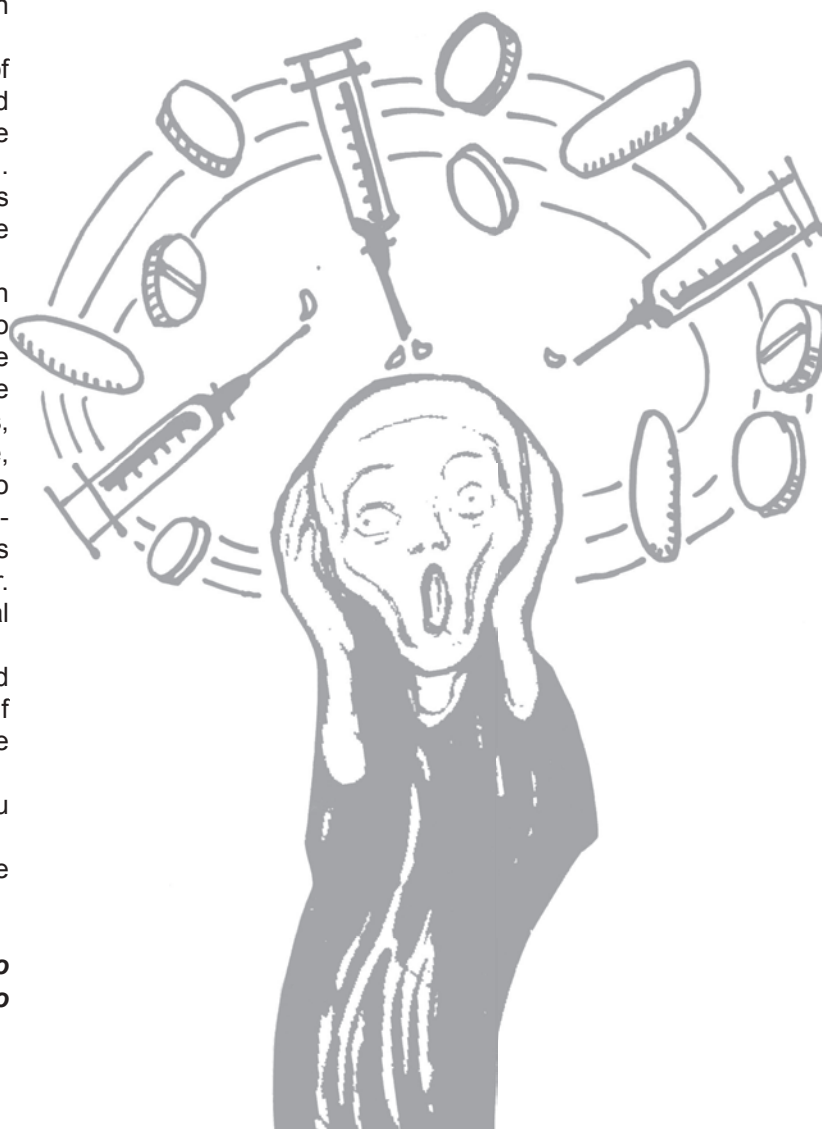
I would reply “By honestly circumnavigating the pharmaceutical companies.”

Tim Kendall (of NICE, etc.) was invited to respond to Catherine Clarke’s two articles and promises to do so in a future issue of the magazine.

Endnotes

1. ‘The clinical effectiveness and cost-effectiveness of testing for cytochrome P450 polymorphisms in patients with schizophrenia treated with antipsychotics: A systematic review and economic evaluation.’ *Health Technol Assess* 2010;14(3):1–182.
2. *Medicines Management: Everybody’s Business – A guide for service users, carers and health and social care practitioners*, Department of Health, 2008.
3. *Improving Access to Psychological Therapies: Implementation Plan: Curriculum for low intensity therapies workers*. Care Services Improvement Partnership, National Mental Health Institute for England. Department of Health, 2008.
4. G. Jackson: *Drug Induced Dementia – A perfect crime*. AuthorHouse, 2009. This book discusses the long-term effects of psychiatric drugs.
5. Apart from other tricks, such as rejecting ‘unsuitable’ test subjects, drug company trials usually last less than two months, so they only ever find very immediate ‘side effects’. Grace Jackson: *Rethinking Psychiatric Drugs – A Guide for Informed Consent*, Authorhouse, 2005, provides much more information about the shorter-term side effects, e.g., up to one year.
6. See Note 4 above.

Link to various highly recommended You-Tube videos:
www.neuroleptic-awareness.co.uk/?You_Tube_Education_Series





A psychiatric salad – Salmagundi

by Nigelloh

This is a simple and delicious salad that any society can knock together at the last minute. It's ideal for serving up to those awkward guests who turn up hearing voices when you've nothing else in the cupboard to offer them. My husband can't get enough of it. He says it's the tastiest thing since witchcraft! Although the ingredients are quite expensive (especially the psychiatrist) the results are guaranteed, and it goes well with Intolerant Stew (see page 53), or Drug Company Soufflé (see page 65). This salad is just the thing to come home to in the middle of an economic recession!

Ingredients

1 human being
1 psychiatrist (half baked)
2 – 3 police officers (tough skinned variety preferable, skins intact)
1 social worker (heart removed)
2 – 3 psychiatric nurses (brains removed)
Medication to taste
Preparation time: Several years to a lifetime

Method

Carefully select a human being. This recipe used to work well with the working class, but the fashion now is for 'fusion' recipes using Black or Asian humans. Whatever your choice, the best results are to be obtained with those who've experienced physical and sexual abuse, oppression and racism.

Place the human in a police station.

Beat well with police for several hours.

Move into a cell and allow the human being to marinade with the psychiatrist and social worker for half an hour or so.

When the human reaches boiling point, transfer to a psychiatric ward and allow to simmer for several days, under a low light.

If the human being remains tough, beat well with psychiatric nurses for several weeks until nice and pliable.

Then add a dash of psychologist, until the human is well addled.

Transfer to a secure unit, season well with medication, and bake for three years, or until human is voiceless.

Label, and lock away in a safe place.

Note: this schizophrenic will keep for ages in a cool place away from society.

Joan Hughes died at the end of 2008, at the age of eighty. Characteristically, she asked that she would like people to use her wake to meet old friends and make new ones. Joan was a research chemist, and in 1975, as a co-author, she lent that authority to the controversial pamphlet *Directory of the Side Effects of Psychiatric Drugs*. For many years, she was Minutes Secretary to Hackney Action on Learning Disability, and she produced its colourful newsletters. She was also active in physical disability groups, the peace movement, animal rights, the Catholic Church, and much more. The last organisation that she gave time to was the Survivor History Group. She was one of the first to join. And one of the last photographs of her was of Helen Spandler pointing out an article in *Asylum* magazine that Joan had forgotten she had written!

By kind permission, the following is taken from the Summer 2009 edition of *Time Together*, the magazine of Together for Wellbeing.

The story of Joan Hughes (1928 - 2008)

Joan Hughes was a scientist and peace campaigner who helped build unions of mental patients and became one of the first historians of the survivors' movement. Social historian Andrew Roberts has used her writings to describe her as she saw herself, and as he remembers her.

The Joan you saw depended on whose eyes you used. She was ordinary - she was flaky - warm and friendly - an embarrassment - reliable - a mental patient - a pioneer of women in science - a peacemaker - a radical - a cat-lady - a Catholic - the list could go on. But Joan

knew who she was. Here is a short fantasy obituary that Joan wrote about herself in 1989, and which the priest read out at Joan's funeral.

"Born in 1928 in a warm working class street where all the children played together. Did well at school. Remained

child-like all her life, because that was fun, but had an adult side. She did some original work in chemistry. Had great fun in doing laboratory work... after a breakdown, became concerned about other people with breakdowns in a house for homeless people from mental hospitals... The policies worked out in these houses later became Government policy, and people who had breakdowns, when better, were able to have community care and live as equal members of the community... Joan had a lot of friends, who were of all different types. Almost everyone came to the funeral... The cat was also brought to the funeral, and scratched for joy on the grave."

Science

As a little girl Joan developed a passion for measurement. Her delight was using the family thermometer on the open coal fire - snatching it away before the red alcohol line hit the top. At eight years of age she "did this once too often, and the thermometer was broken". Tears followed, but her father said it indicated her interest in science and bought her a Pears Cyclopaedia to study.

But not everyone was so encouraging. Joan had to fight to be a woman scientist. When she became a Government Chemist, even the aunt she lived with complained "that is a man's job!" Many older Catholics Joan knew "wholly distrusted science", but "1959 was a time of change" and Joan was asked to speak in the parish hall on the positive relationship she saw between religion and science. There were also conflicts within science when Joan fought for ethical research which

Joan in the 1950s, when she was working as a Government Chemist



safeguarded consumers.

Joan became a graduate member of The Royal Institute of Chemistry in 1962 and her work as a government chemist led to her research at Birmingham University on Trace Methods for Sulphate and Nitrate, for which she was awarded her M.Sc. in 1966.

Just before, and after, her research, Joan was detained in several old-style mental hospitals. She was both a scientist and a mental patient and, sometimes, people found it convenient to dismiss her claims for scientific ethics as the ravings of a lunatic.

Breakdown

In the early summer of 1965, Joan's doctor decided to send her "to Horton Hospital for a rest". "They tell me that I'm unlikely to be here for more than three or four weeks," she said to a fellow patient. "They told me that, when I first came," he answered, "but I've been here for 23 years." Joan, however, went through the "revolving door" of repeated admissions and discharges.

One of Joan's breakdowns was of special significance for her as a chemist, because the most severe part of it was brought about by a psychiatric drug her G.P. gave her for depression. The first dose was an injection. On the way home, Joan went to see a film, during which she became "incredibly depressed". "The world was slipping away". Everything "appeared to be taking place in another world". Psychiatric medication continued as tablets, which she took "automatically" for the next two years. These were two years when she "did not initiate any activities for myself". She lived in "a shadowy world" where she "could observe what people were doing, but not act for myself, except in a desperate way". She eventually arrived in Goodmayes Hospital, where the doctor stopped the tablets she was on. Six weeks later, on November 29th 1971, Joan wrote in her diary "suddenly my periods returned. With the first flush of escaping blood my depression was cured, and I resumed normal life."

Joan had been prescribed an alternative drug, but she was always convinced that her recovery was the result of stopping the first one. Like other patients who later formed the Mental Patients Union, she had taken

medication uncritically and only learnt from stopping it what a "side effect" is.



Joan's painting of her room in the Mental Patients Union House. The multi-coloured bedspread was knitted by Joan. The picture is consciously modelled on one by Van Gogh.

The Mental Patients Union

In her Short History of The Mental Patients Union (1986), Joan describes how "groups of psychiatric patients and sympathetic mental health staff began to make political comments on their situation in society". In August 1973 she read a small advertisement in a socialist newspaper that said: "The Mental Patients Union are meeting once a week in Prince of Wales Terrace." On October 12th 1973 she moved all her possessions into the house that the union had established in Mayola Road, Hackney. In May 1974 she wrote "during the last six months, I have painted and wallpapered my room, given a lecture, published an article in Science for the People, painted pictures, written letters for the union, cooked my own meals and gone to socials and a film. I never did any of these things on drugs. Why do doctors make these mistakes?"

I met Joan at Mayola Road and we worked together on the Directory of the Side Effects of Psychiatric Drugs, a ten page pamphlet published in October 1975 that shocked people because it was so carefully based on pharmacological sources. It was almost certainly our most important publication. Burnt by his earlier experience of the union, the Director of Mind prohibited it being mentioned in the association's magazine and it was confiscated from our members in Rampton secure hospital, but it was reported on the front pages of medical journals and received enthusiastically by patients who could read, for the first time, an objective account of which of their symptoms could be the result of their medical treatment. Joan kept the

Directory in print for several years, revising it in 1977, drawing a picture for the cover, and printing it by hand on a community duplicator. She continued to work with other patients for the rest of her life.

Cosy corners

On one side of Joan's bed was her own painting of her room in the Mental Patients Union House. On the other side she had a chart describing the scientific discovery of the elements from which matter is made. Joan was the thinker and the home maker.

Joan called her autobiography *Cosy corners in war and depression - The story of one person's nests*. She was someone who made safe, comfortable homes in the midst of turmoil and distress, a streak of sanity in our lives. When the rest of us were fruitlessly agitated about one of our members being taken into a mental hospital, Joan was sorting out clean underwear to take to her.

Joan and Andrew Roberts worked together in the Survivors History Group, which often meets at Together. Parts of Joan's autobiography can be read at <http://studymore.org.uk/arcjoan.htm>



Joan Hughes, Tony O'Donnell (the founder) and David Kessel prepare to leave the Old Fire Station, Stoke Newington, for a Hackney Union of Mental Patients expedition to Walthamstow Marshes. The Hackney Union of Mental Patients was formed in 1987 to "devise useful and gainful ways of work" and an active life for patients.

Judy Chamberlin (1944 - 2010)

PSYCHIATRIC SURVIVOR ACTIVIST

Recollections on her impact by Louise Pembroke, Jan Wallcraft and Andrew Roberts, who met Judi on her visits to the UK. All three are members of the Survivors History Group.

No mental patient since Clifford Beers has attracted such worldwide attention as Judi Chamberlin, who died on January 16, 2010.

Clifford had nurtured the mental health movement of the first half of the 20th century. His work culminated in 1948, with the founding of the World Federation for Mental Health. But he had already died in an asylum in 1943.

Judi Chamberlin was born the next year. Clifford was open about his experiences of mental distress but he was quiet about the network of fellow-patients who had supported him and kept him in touch with issues. The times had not been propitious for collective action.

Judi inherited the new world that the courage of Clifford and his secret friends had helped to create. Her life and work was to nurture not the worldwide mental health movement, but the worldwide movement of mental health users, victims and survivors.

Although she became an icon, Judi knew that she was just one of us. This article is not about the icon, but about the friend who shared her life with some of us in the UK.

What drove Judi into taking a leading role in the movement to guarantee basic human rights to psychiatric patients was her experience of involuntary confinement in a mental hospital in the 1960s and subsequent unhappy experiences with the normal system. As an American mental patient visiting Europe, Judi followed in the footsteps of her friend Anne Boldt. Anne introduced Judi to the English network of ex-Mental Patients Union members and, like Anne, she used the successor to the MPU house as her base for touring Europe during the first half of the 1980s. Anne reported in *Lawletter* (UK) and *Madness Network News* (USA) on groups such as PROMPT and the Matthew O'Hara Committee in the UK, as well as on groups in Denmark, the Netherlands, and elsewhere.

Judi first arrived in the UK in July 1982, and promptly fell ill. Her new MPU friends actually thought she might die, but a doctor revived her by prescribing a small sip of aspirin!

My trip to London seems almost dreamlike. I was there such a short time, and the day of sickness was such a drag. But I really was there, I really did ride on the double-decker buses, and see the Tower of London.

In August a postcard arrived from Iceland, where she had arrived after further illness in Holland. Judi's enormous energy and achievement came from her soul, not her body.

Judi has left us her book, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (1978). She told us that she had wanted to write the story of the movement, but the publishers would only allow her to write about alternatives. Nevertheless, she had squeezed in as much as she could about the movement.

As people might know, in 1985 Mind decided to invite



people from Holland, Denmark and the USA to represent the mental patients' movement at the World Congress in Brighton. They thought that the English, were "not together enough".

Judi accepted her invitation to be a guest speaker because it paid her fare to Europe and gave her the opportunity to renew her links with the English movement. Meeting with old MPU friends in London, she discussed the irony that she would be speaking to an audience from which the English users were excluded.

We did not know then that Frank Bangay, Eric Irwin and Barry Blazeby from CAPO were planning to gatecrash the conference. They put up a resistance stall outside the Congress, and survivors from other countries negotiated them into the main hall. A revolution had started. European survivors (including Scottish and English) and the American (Judi) took over the part of the Congress that they thought they should own.

"I got quite involved in Brighton, working out a declaration on 'self and citizen advocacy' ... Most of it is liberal but I think our section (Part 2) is pretty radical", Judi wrote back to London.

That autumn, Mind's annual conference was devoted to the English users' movement. No longer "not together enough", they ran the conference. Frank Bangay even provided the off-site entertainment.

Survivors Speak Out started in January 1986, with Peter Campbell as its secretary and, in December 1987, Jan Wallcraft was employed by Mind to start what became MindLink. Here, Jan first heard about Judi, because Anny Brackx, the dynamic founder and editor of OpenMind, was gearing-up to publish *On Our Own* as a Mind publication. "I read it and identified with so much," she said, "and I think her ideas continued to influence my thinking and writing

about service-user-led crisis services, my PhD, and all my work thenceforth.”

Louise Pembroke, Education Officer of Survivors Speak Out, met Judi at the start of her own activism. Louise recalls “a landmark conference” in Brighton, entitled Common Concerns, in September 1988.

Mind supported this three-day event with international survivor speakers from the USA and Canada, such as Judi, ‘Howie the Harp’ and David Reville. Practically everyone who was active in the 80s either attended or knew what happened by word of mouth. Judi was inspirational to me as there were few women leaders in the British survivor movement at that time, and here was a world leader talking about user-run services, which for some of us was a dream we thought not possible.

Valerie Argent, of the MPU, last met Judi in June 1990 when they lunched with Rae Unzicker (Co-ordinator of the National Association of Psychiatric Survivors) in London. The next time Judi, Rae and (this time) her husband came to London, in April 1992, Rae was saying that she wanted an obituary like Valerie’s. Rae died some years ago. We hope she got her wish.

Jan Wallcraft first met Judi when she and Rae came to Mind.

One of my best ever memories was when Pam Jenkinson, then of National Schizophrenia Fellowship, invited Judi, Rae and me to a restaurant in Park Lane for a truly posh afternoon tea. Judi asked the waiter if she could have decaffeinated cappuccino. He said she could, listing many further options she could have, and she said, in that emphatic American accent: ‘You. Are. WONDERFUL! I think I will take you home with me.’ The waiter looked so charmed and pleased.

Judi and Rae then made sure that Jan was the next person Mind sent to the USA.

Mind’s then Director, Ros Hepplewhite, had attended the conference of the National Association for Rights Protection and Advocacy (NARPA) the previous year. Judi and Rae suggested to Ros that it would not look right for her to go two years running and that she should send Jan, as MindLink co-ordinator the next time.

So I had this life-changing trip, my first long distance flight, staying a week with Judi in Boston and then travelling with her to the NARPA event in Austin, Texas, where I met icons of mine such as Leonard Roy Frank, the anti-ECT campaigner, and all the other leading names of the US survivor movement such as Sylvia Caras, Darby Penney, Celia Brown and many more. It left me with a conviction that the international survivor movement had enormous power and right behind it, and that we should believe in ourselves more, as the US survivors clearly did. That conviction has never left me.

Louise says that whenever Judi visited, she would take her and Peter Campbell out for a meal, “and we treasured our

time with her and valued what we learnt and shared with her.” Judi would have treasured the obituary that Louise Pembroke wrote for her. It is called *Memories of Judi Chamberlin: Dignified activism.*

What was so striking to me about Judi was her total lack of ego and ‘stardom’. Frankly, even if she had been, I certainly would have forgiven it because she had the intellect, hard work and unconditional compassion to back everything she did, and at a time when there were not the financial rewards there can be now. Judi wasn’t interested in kudos and personal status, all she was interested in was furthering the greater good of survivors, for us all to be met with love, compassion and with patient-controlled alternatives to psychiatry.

Face to face, one to one, she was no different, she was interested to share experiences with us, would give us her full attention and was kind and generous. She always made you feel like whatever you had to say mattered. Judi was always dignified. I never saw her raise her voice or rant at anyone, yet she could calmly and effectively argue the most seasoned opponents under the table. She was also a fine academic but a good one in that she could make a well-read argument accessible to anyone.

The year after, I spoke alongside Judi in Montreal, at a conference for Canadian survivors. We also shared a hotel room and unsurprisingly Judi was a gracious room-mate. To sit beside someone who was a living legend to me was very special indeed. Even when I know she disagreed with her peers she would do so quietly and with respect, never putting down another’s thinking. She made people think not only by the sheer strength of her words, but also how she imparted them, measured, powerful. She was deadly serious in her work, driven and dedicated. Judi was a role model to me because she embodied how I felt activism should be, how we could best conduct ourselves as activists.

She was also aware of how difficult it could be too, and how survivors were also capable of cannibalising each other, and to my mind she led by example, by keeping her focus on the work in hand. To understand what Judi gave us all over thirty years of her life, listen to her speak at the 2007 World Psychiatric Association conference on ‘Coercive Treatment in Psychiatry’. Even if you never knew her or her work, listen to this 30 minute talk. It is a bright shining beacon to survivors across the world. Her last sentence will live in my heart forever: ‘Nothing about us without us!’

Judi Chamberlin: *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (Hawthorne, 1978) is reprinted and available from the National Empowerment Center.

To hear Judi go to: <http://video.google.com/videoplay?docid=3396224219182374265>

THE AVENGING ANGEL OF THE NORTH

George Fowler

A Summer of Shootings

We all know there is a depressingly steady rate of murders and physical and sexual assaults, year on year, and that most are committed by males between the ages of eighteen and forty. What made Raoul Moat so special? How could a murderer become anyone's hero? And what was the Prime Minister's intervention all about? Not least, are there any implications for psychiatry, mental health care and the social services, or for wider social policy?

A month or so before Moat's lethal outing, and in the course of a morning, a Cumbrian taxi-driver also drove around shooting people, beginning with a few obvious targets but then apparently at random. Twenty-three people were shot and thirteen died. Nobody said he was evil – or a hero.

The events sparked by Moat were so very exceptional due to the extent and the type of publicity it generated – far more and different from the reaction to the Cumbrian killer. Moat seemed to symbolise something. For the press, the politicians, and who knows how many of the voiceless public, he didn't just represent Evil, he was Evil. Yet for others he was a misunderstood victim and a hero.

The Moat in Our Eyes

What was it that made Raoul Moat so interesting, whilst a killer who cut a much wider swathe through so many more lives not very interesting at all? Media coverage must be a major factor. In Cumbria the shootings were all over by the time the reporters and TV crews had arrived. And when they did get there they couldn't find anyone who could (or would) say very much about the killer. This contrasted with the seven days of drama which unfolded in the North East, allowing reporters to saturate the area and provide 24-hour, on-the-spot coverage.

More than this, though, it seemed that the Cumbrian taxi-driver was only a boring middle-aged bloke who had an entirely 'normal' upbringing and home life, and had worked steadily all his life. Except in financial terms, his excessive response was unaccountable: the idea seemed to be that he was under the pressure of an average-sized debt and had simply 'cracked' when he found out he had been cut out of a will which might have paid it off.

Somehow, Moat was much more interesting. There was speculation that his psychopathic behaviour was exacerbated by addiction to steroids – often a focus of media interest. Steroids are used for a number of medical conditions, but there doesn't seem to be much research on the psychological effects, and what is known is mostly anecdotal. All the same, "significant psychiatric symptoms including aggression and violence, mania, and less frequently psychosis and suicide have been associated with steroid abuse."

In the popular imagination, the steroids factor might also have added a 'scientific' hint that Moat was a kind of Frankenstein's monster – a misunderstood, put-together being who couldn't help himself but, really, who loved little children and had feelings just like everybody else. Muscle-bulking steroid abuse was only part of the fascination, but perhaps a significant one.

Certainly, for most of the media and some politicians, Moat seemed to represent a dreaded type: the rampaging Monster from the Great Unwashed.

Not a Happy Life

The immediate information was that Moat was a hulking 37-year-old bodybuilder with failed relationships. He had been banned from being a club doorman and his attempts at business had failed. He was just released from a short jail sentence for harming a minor, and his 'girlfriend' had dumped him. And – obviously – he was paranoid.

Some locals expressed surprise about the shootings since Moat was such a regular guy – always pleasant and helpful. These were mostly young (or youngish) men. They included the Geordie celebrity Paul 'Gazza' Gascoigne, once the most talented English footballer of his generation but now famous for his 'unpredictability', for being confused and sometimes crazy, for his boyo drinking, and for episodes of violent misogyny. Gazza turned up with a bottle when Moat was finally cornered by the police, wanting to talk to him "because they were mates". (Moat and Gazza seem to have shared much the same attitudes, and certainly had a similar open-faced, slightly surprised look. Both experienced emotional traumas during childhood.)

Others who knew Moat well – especially two former partners – said he was essentially a bully – misogynistic, puffed-up, selfish, whining and violent.

More information emerged after the drama reached its seemingly inevitable conclusion. Raoul Moat was born in 1973. His mother had been a "60s flowerchild". She admitted that the father was different from that of her first son, born three years before, but always refused to identify either. This single-mother lived in her own mother's house, but was "often away", and in effect the boys were raised by Grannie Moat. The two boys yearned to find out about their fathers. In the end, the older brother did find out, but Raoul never did.

Meanwhile, their mother "suffers from bi-polar disorder" and "has been in and out of hospital ... There was a lack of maternal affection ..." which "... caused Raoul a lot of problems. That much is evident from what he said during his last moments on the riverbank. He was talking about having no dad".

The family seems to have lived on a council estate, and since the mother was "often away", and there is no mention of a grandfather, probably they lived mainly on benefits. As a boy, Raoul suffered from asthma and was "puny with ginger hair". At school he was "average". He got some GCSEs and then took a few practical courses. The mother did marry when Raoul was thirteen, but "he clashed" with this step-father who was "apparently something of a disciplinarian". (The older brother would have been sixteen. He was academically successful and went on to university and moderate success in a professional career. By this time, presumably, Gavin Moat was less involved with life at the family home.)

In his late teens Raoul "bulked up on steroids". By the time he was twenty he had developed his 'Popeye' arms and torso, and was employed as a doorman. In 1996 Grannie Moat died and the two brothers "drifted apart". Raoul began associating with types his brother didn't approve of: "Men of his huge dimensions are much in demand in the underworld". Moat had been accused but not convicted of various serious offences, including attempted murder. Because of his violence, his doorman licence was revoked. He began to work as a tree

surgeon but the police prevented him from dealing in second-hand cars and then confiscated his van because he carried scrap metal without a licence.

Moat is reputed to have had six children by various women. His first partner "said he was monster who would beat [her] to a pulp." The next, who lived with him for nine years and had two children by him, "said much the same, and described how he routinely raped her." Both claimed that "Moat forced them to be tattooed with his name, so they would forever be his trophies."

Moat met his last partner (the one he shot) at a nightclub when he was thirty-one and she was "barely sixteen". They set up home with their infant daughter and two of his other children. Moat and this young woman were together for six years. Apparently he was faithful but "violently jealous". Because he had custody of two of his other children, he was allocated a council house. But there were a number of run-ins with social services officials, apparently due to their concerns about the welfare of his children. Moat responded by threatening the officials. Then a social worker discovered that one child was badly bruised, and the children were removed. Moat was convicted of harming the child and sentenced to eighteen weeks in Durham prison. Being deprived of the custody of his children meant he would lose his house. While he was in prison his partner phoned to dump him. Apparently she also goaded him with a number of other phone calls, and so as to frighten him off, she lied to him that her new boyfriend was a policeman.

While he was on the run, the papers reported Moat's mother as saying that it would be better if he was dead. Moat's brother believes that he will have heard this, and that this information ensured that he would not give himself up alive.

The Public Response

We can't know what the general public thought, but the popular media consensus was that Moat was an Evil Monster.

Yet, like the public's impromptu shrine to Princess Diana (but in much more modest numbers), floral tributes immediately began to gather at the site of Moat's death. And before it was rapidly removed, 35,000 had left messages of condolence or registered their approval on a Facebook page: RIP Raoul Moat You Legend!

The press expressed its outrage at this turn of events, and Prime Minister Dave intervened, announcing that he "could not understand why anyone would sympathise with a callous murderer". Another Tory minister declared that Moat was evil.

Since we all know that murders happen every day, what is to be made of either of these opposing kinds of reaction?

First of all, why would the Prime Minister feel he must

speak out? Shouldn't he display an ability to keep a cool head and take a wider view? What is to be made of his apparently 'knee-jerk' reaction? Was it simply a cynical attempt at populist politicking – the Government trying to ingratiate itself with what it saw as 'the public mood'?

Or does it show that Cameron's vision is obscured by his class affiliation? Perhaps he would now like to apologise for the Tory party's support, during and beyond the Thatcher years, for the immeasurably more effective torturers and mass-murderers in the apartheid governments of South Africa and in Pinochet's Chile?

Perhaps the official response was both genuinely bemused and conveniently populist. For it is unlikely that Cameron and company would have much idea about the strength of the feelings of disaffection amongst a certain class, nor the reasons for it. Fed from silver spoons, how would they understand?

For others – members of that other class – the publicity glamourised Moat and made him into a kind of nihilistic anti-hero. After he had avenged himself on his jilting partner and her new lover – and who wouldn't wish to avenge themselves on a jilting partner and the new lover? – this was especially due to the publication of Moat's declaration that his vendetta was only with the police, and that members of the public were safe from him. This information, along with his week-long evasion of the massed and apparently panicked forces of the police, guaranteed Moat's elevation to the status of folk hero for that disaffected part of the population.

RIP Raoul Moat You Legend! The Fan-base

Any world-weary officer on the beat, or social worker, or psychiatric worker would recognise the bare facts of Moat's life history as typical of the usual suspects: 'the socially disadvantaged' are always with us, always wanting something for nothing, and at any moment likely to cause mayhem.

Moat's constituency consists of many of those who feel abandoned by our society: those who, mainly due to their lack of qualifications and social skills, and to the locality into which they were born, find themselves either unemployed, unemployable or barely employable – and so, at best, on a minimum wage and with no prospects of anything better. That is to say: members of the unskilled or lumpen working class. They would have had direct experience of the same kinds of constant disappointments and failures experienced by Moat in his life at home, at school, in his 'relationships', at work, and in the wider community. This class tends to share a confused awareness of its dislocation, frustration and despair. And its members tend to kick impotently against 'respectable' or official society, which they only ever experience as condescending, disapproving, monitoring, harassing and hemming them in.

It is the social reservoir from which the BNP and EDL fish, that gave us Kerry Katona and Jade Goody. They are the dangerous class which keeps politicians awake at night, repulse the arbiters of good taste, and earn the ire of ever-so-superior middle class media hacks... Moat had been abandoned by society and left to rot like so many others, and for a moment he was the lightning rod for lumpen anger and defiance. He is their Taxi Driver, the man who couldn't take it any more.³

The young (and youngish) members of this class are particularly evident in every town and city. Their disaffection is



signalled by a certain look of wariness-cum-bravado, as well as more obviously by extravagant tattoos and body piercings. As well as asserting a defiant 'outlaw' identity, these masochistic bodily signs announce: 'I am hard. I can take pain.' Amongst males, combat readiness is further expressed by displays of steroid-induced muscles and an extreme haircut (e.g., the bullet-head or the 'Mohican'). A vicious-looking dog doubles as fashion accessory and undeniable threat.

This class tends to be concentrated in areas – such as the back streets and council estates of many towns and cities in the North – which a generation ago lost all those old labour-intensive manufacturing industries which used to sustain a viable community spirit, and wherein was very often bred class consciousness, solidarity and the optimism of union and political activity which was literate, democratic, socialist and internationalist.

The official unemployment figures are a joke, and have been for a generation. For every one who is registered there is at least one more who doesn't sign on, or who retires early or is on the long-term sick. Nowadays, in our post-industrial wastelands – in the ghettos, 'sink estates', and 'pockets of rural poverty' – such is the competition for the few available jobs that the chance of actually getting work – of ever making a satisfactory living, let alone of 'making a contribution to society' or feeling as if one does so – is close to zero. Besides, quite reasonably, any sight of a menial job is weighed against the usually higher returns of a kind of life of freedom and leisure 'on the welfare'. And the most successful people in the locality (the 'role models') are likely to operate, to some degree or other, on the wrong side of the law.

In the meantime, society has an ambivalent attitude towards violence: most people still seem to love a good war (at least before 'our boys' start getting killed), and violence is an absolute staple of the news and entertainments industries. Is this a fearful fascination? Or could we suppose that a lot of people feel aggressive a lot of the time, and like to get their kicks vicariously? Certainly, at some time or another we will all have fantasised the annihilation of our enemies. From the 'harmless fun' of the ever-popular mixture of sexual promiscuity, snobbery and violence that makes up a James Bond film to the seriously blood-splattered movies and video games that seem especially alluring to young males, a major theme in the general culture is Vengeance – preferably wreaked out of the blue by a solitary, self-contained, super-hard man.

Obviously, a part of the population readily identifies with Moat the Avenger and Moat the Evader of Authority – and they feel justified in doing so. The distance between Moat's fans and most 'normal' and upstanding citizens is mainly a matter of the degree to which they feel hard done by and justifiably vengeful. Moat is their hero because, from 'the purest of motives' – such a powerful love for his 'girlfriend' and his children (he said) – he acted out their own fantasies of vengeance on all the jilting lovers and unfairly oppressive and denigrating authority-figures in their lives.

A Terminally Frustrated Man's Motivation and Mindset

It is well-known that testosterone levels increase rapidly with the onset of adolescence, and reach eight or ten times the levels measured in boys during the latency period – and that levels stay high until they begin to drop after about the age of forty. So it shouldn't be a matter of surprise that young men are particularly prone to sexual activity – and to aggression when frustrated.

Everybody fears abandonment and rejection, because everybody experiences the terror of it, to some degree, during their earliest years. Besides this, we now know that baby boys are more prone to separation anxiety than girls, as well as to becoming more emotionally 'shut down' when they feel abandoned. An unresponsive mother during a baby's first two years is also known to inhibit the very development of the brain, and again, especially with boys. At the same time, baby boys are more likely to receive harsher punishments than girls. As infants, boys are much more likely to develop restless or aggressive behaviour during pre-school childcare, and then tend to carry a reputation for trouble or worthlessness with them into their schooldays. The absence of a positive adult male role model during childhood also correlates with

the development of behavioural problems. One might guess that Moat lived with frustrations and psychological terrors common to many males, but for him (and his victims) they finally proved overwhelming.

Yet, so far as the tabloids and some Tory politicians were concerned, apart from



his extreme anger, there were no questions about Moat's mental state: he was simply evil. But this kind of demonisation only avoids the issue. Unless there is some evidence for congenital mental difficulty, extreme behaviour can only sensibly be interpreted as a reflex to acute psychological problems.

What else is there in Moat's case? Steroids are used so as to look like a he-man without putting in all the effort. Along with the haircut and the tattoos, using steroids is a deliberate attempt to appear, as one commentator put it, 'boneheadedly vicious'. How else interpret someone adopting a combative look, except as a sign of his low self-esteem and his generally 'feeling cornered'?

Men who feel more for themselves than for their women and children often get their names tattooed on their arms. This says: "look how committed to you I am, and to what extent I am prepared to suffer for you." However, this display of attachment is sentimental: it is often not accompanied by much real commitment – the hard work and the give and take of mutual emotional and economic support.

Moat was obviously driven by extreme narcissism. In his rambling letters he apparently expressed much anger but no grief when his partner left him for someone else: the 'girlfriend' seems only to have existed as a kind of trophy to bolster his own embattled ego. However, he asserted that such was the strength of his love for her and his children that it drove him to violence. Frustrated narcissism demands vengeance.

This begs the question: why did Moat express little genuine feeling other than self-pity and narcissistic rage?

Moat rationalised his behaviour in his letters. He saw himself as a victim: all his failures were due to being unfairly picked on. This view allowed him to express sentimental self-justifications: the extremity of his behaviour ought to be persuasive of an extremely deep love for his (shot) partner and his children (one of whom he had badly hurt). Sentimentality is a form of emotional exhibitionism which substitutes for a lack of genuinely loving feelings.

The appeal to sentimentality and the excuse of the victimhood of his class is again evident when Moat justified shooting the hapless policeman in the patrol car. He fantasised that he himself was somehow a defender of vulnerable mothers and children, writing that it was likely that the policeman was “waiting to bully a single mum who probably couldn’t afford her car tax”. Obviously he saw himself as a latter day Robin Hood, or a Clyde wrongly deprived of his Bonnie.

Misogyny is not unknown amongst males raised by a grandmother: a fundamental fear of abandonment and hatred for the abandoning mother is carried over into a deep distrust of all young women, and hatred for them. But perhaps Moat was not so much misogynistic as vengeful towards anyone who got in his way. He was not able to live with a lifetime of disappointment, “discipline”, denigration and failure, and would lash out when he felt cornered. For those who suffer a lifetime deficit of unconditional love, if it is not aggression exteriorised, it is aggression interiorised: if not a paranoid propensity to harm whomever they perceive as affronting them, it is a propensity to paranoid psychosis, self-harm or suicide. And often each tendency alternates.

However, it turns out that Moat was not entirely evil, nor wholly psychotic. Before the escalation of setbacks which led up to the shootings, he was so worried about his violent temper that he asked to see to a psychiatrist. He was offered an appointment but apparently failed to keep it.

Defining Madness, and a Mental Health System that Tends to Turn Up Too Late

From the beginning to the end of the Moat event, the police seemed intent on playing at Keystone Cops. Apart from the puzzling endgame, many questions are raised. Why did the police not respond immediately when the prison authorities warned them about the state of Moat’s mind at the time of his release? Why invite the media in, and turn the week into a kind of soap opera? What were they thinking when they gave the press juicy extracts from Moat’s rambling letters? Did the media influence Moat’s subsequent actions? Such questions must be left to an Inquiry, which will doubtless recommend slapping a few officers on the wrist.

For our interest, however, the events of the summer yet again call into question the definition of sanity and insanity. Why was there talk of Moat being Evil, whereas the Cumbrian killer’s behaviour was simply incomprehensible – and so, presumably, only momentary madness?

And had it not been rational of Moat to ask to see a psychiatrist when he was, one must imagine, very worried about his own volatility? Why would anyone ask for that kind of help if they did not feel fairly desperate at that moment? However, he was asked to come back later. Such is the sanity of our mental health policy that if you are sane enough to ask for psychiatric help you must be sane enough to go away and struggle on without it. Catch 22: Have your breakdown (or

violent outburst) and then we’ll immediately come and help you (or rather, ‘treat’ you, or imprison you and ‘treat’ you).

Later, after Moat was released from jail, there is a sense in which he clearly knew what he was doing when he got himself a gun (apparently with the aid of men who must be hardly less psychopathic) and went looking for his victims. Until recently French law was lenient towards ‘crimes of passion’. Had Moat lived in France before 1970, and only shot his ex-partner and her new man, passion would have been a powerfully mitigating factor. His crimes could have been viewed an understandable rage, almost reasonable under the circumstances.

But does it make sense to call Moat’s actions ‘evil’, which is to say, somehow rational or sane, i.e., not mad? For example, until quite recently attempted suicide was counted as a crime, that is, presumably, as not due to mental disorder; nowadays it is defined as a problem of the person’s mental health. It seems clear enough that Moat’s actions were not only deliberately homicidal but also, almost inevitably, suicidal. His whining about victimhood might seem pathetic, but surely that doesn’t mean he wasn’t also a victim – and fairly mad – as perpetrators always are?

Desperate Measures Rise Out of Desperate Circumstances

The dangerously self-absorbed, psychopathic lumpen proletarian hard man is not a new phenomenon. Given the biologically determined high testosterone levels of young males and a relentlessly competitive social structure in which there are always bound to be very many more insecure and emotionally damaged losers than winners, he has been with us since the year dot. Certainly he was around in the 19th century, as is memorably depicted by Charles Dickens in *Oliver Twist*, with the character of the murderous petty criminal Bill Sykes (who had a vicious dog).

Sympathy for Moat but not for those he shot is certainly perverse, but it is not puzzling that it is readily voiced by members of that unsuccessful but defiant section of the poor who are able immediately to identify with him. Their lives are similarly frustrating and they feel his impotent rage. Due to too much failure and rejection and not enough unconditional love, they also tend to rationalise their feelings, and to idealise their images of themselves, by means of easy and sentimental rather than realistic and difficult declarations of love and respect and concern. And they, too, wish for vengeance. But the larger perversion is that, at this late date in our civilisation, the poor are perhaps as despised and kept from a fair life and happy prospects as they were in the time of Dickens.

Notes

1. See ‘Anabolic Steroids’, Wikipedia.
2. The following biographical details and quotes are from reporter David Jones’ interviews, mainly with Gavin Moat: ‘A Tale of Two Brothers’, *Daily Mail*, 17 July, 2010.
3. Blog: A Very Public Sociologist, July 15, 2010.
4. Steve Biddulph: *Raising Boys – Why boys are different, and how to help them become happy and well-balanced men*, Thorsons, 1997.
5. With someone from Moat’s background, it would be surprising if there weren’t also other problems of drug abuse, apart from addiction to steroids.



THE USE OF ELECTRO-SHOCK TODAY

Cheryl Prax

Citing the Freedom of Information Act, I recently wrote to the Central & North West London NHS Foundation Trust asking for information about their use of Electroshock (ECT). Here are the questions and replies (presumably correct for the year 2009):

I notice that out of the four clinics practicing ECT in the Central & Northwest London MH Trust, only one has been accredited by the Electroconvulsive Therapy Accreditation Service (ECTAS) – that is the Riverside Clinic. The others: South Kensington and Chelsea Mental Health Centre, Northwick Park Hospital and St Charles Hospital are not members.

1. Are you intending to apply for accreditation for these three? **Yes**
2. How many patients per year receive ECT? **89**
3. How many patients per year receive ECT whilst under a mental health section? **30**
4. a) What proportion of ECT patients are women? **68.55%**
b) What proportion are men? **31.45%**
5. What proportion of ECT patients are of ethnic minority? **Less than 10%**
6. What proportion of ECT patients are:

a) Under 16 years?	0%
b) Between 16 and 60?	41.55%
c) Over 60 years?	58.45%
- 7 How often are your ECT machines serviced? **Annually**
- 8 Do sectioned patients have a right to refuse ECT? **Yes, if they are deemed to have the capacity to refuse treatment.**
- 9 Does the trust have any plans to cease the practice of ECT in the near future? **No**
- 10 I would also like to ask what conditions are treated with ECT in your Health Trust, and in what proportions?
ECT-treated conditions are:

Severe Depression: 70 patients	78.65%
Psychotic Depression: 8 patients	9.00%
Bipolar Disorder: 7 patients	7.90%
Catatonia: 2 patients	2.25%
Treatment Resistant Psychosis: 1 patient	1.10%
Schizoaffective Disorder: 1 patient	1.10%

Cheryl comments:

I would guess that the percentage of patients who receive electroshock is high as I have seen the positive-sounding leaflet they give to patients. And this leaflet is soon to be rewritten by the local ECT Service Manager, who was recently given an award for promoting his Department. Also St Charles Hospital in the Trust admitted to me that they put an 'ECT Sheet' in EVERY inpatient's notes, even those just in for observation!

ECTAS is the 'ECT Accreditation Service'. Basically this was set up by psychiatrists worried that ECT might be outlawed due to its incorrect application. So they tried to get a set of criteria for clinics to adhere to. Some clinics are not 'up to standard' and some have not even tried to get 'up to standard'. St Charles Hospital is one of those not accredited.

Accredited or not, ECT still causes brain damage and it should be banned. When sectioned, you cannot refuse it if they feel you are seriously deteriorating or are likely to die – even when you have given an advance directive against having it. If you cannot give consent because you are too ill they can give it to you without consent. Outside of psychiatry, if you put an electric current on any part of a human's body it is called torture.

Dr Peter Breggin, in the USA, is the only medical expert who has won a damages case for a patient given ECT against their will. Why aren't more people suing? My lawyer lost a case for a man in Manchester who did not want any more ECT. He was forced to have it because his psychiatrist said it was good for him, and the judge was swayed by the psychiatrist's expert opinion.

I hope to achieve two aims:

1. To make all authorities declare the negative effects of ECT in their leaflets and consent forms.
2. To campaign for the abolition of ECT, a barbaric practice – an electrical form of lobotomy. Would you put an electric current across the hard-drive of your computer? Why are computers fitted with surge-guards? To protect them.



MODERNISING THE FARM

Dr Jessica Hogsbristle, Chief Archivist,
Silo NHS Foundation Trust

The political task is to 'resist the irrational momentum of anonymous, impersonal and inhuman power – the power of ideologies, systems, apparatus, bureaucracy, artificial languages and political slogans.' (Vaclav Havel)

Once, in the nearly forgotten past, there was a family farm. Some say it was a friendly place full of chickens, pigs, cows and sheep. These folk say that the animals were cared for and that they cared a lot about each other and the public, who came to visit the farm to buy high quality milk, eggs and cheese, and to show their children the animals. Others say the old farm was riddled with problems, that the public often had to queue for ages to get any produce, and the farmer wasn't great at balancing the books. Who can now tell how it was, since the accounts given by the few remaining denizens of the old farm, who have moved on, are generally agreed by today's farmers to be wholly biased and untrustworthy?

What is clear from the remaining historical accounts is that one day the farmer decided that he had done such a good job of the farm that he should make it more accessible to more humans. But he realised that, in order to do this, he needed a much more efficient farm with faster, sleeker animals. So from a neighbouring farm he recruited a new pot-bellied pig, called Pal Pot, and put it in charge of modernising his farm.

At their very first meeting, Pal Pot told the other animals that he was certainly their pal and that together they would work to make this the best farm on the planet. They'd know it was the best farm because all the visitors to the farm would leave the farm feeling full of energy from the dairy produce, enabling them to be much busier than they currently were. Pal Pot explained that when every one of the visitors was gainfully employed, the farmer would give all the animals a special reward, delivered in person by a rare breed of pig, called Flying Pig (FP). The other pigs had not heard of this breed, but Pal Pot, who had travelled extensively and attended very many important conferences, assured them that this was a magnificent pig beyond compare.

Pal Pot worked tirelessly, explaining to the animals how things would get better when they pulled themselves out of the Dark Ages. For instance, the animals tended to spend all the afternoon with children who visited. The children stroked the pigs' backs, rode on Sally the Sheep (in the days before the Sheep-Riding regulations were issued), and followed the chickens about their business. Pal Pot said this could not continue. He argued that it wasn't fair that only a few children should spend time with the animals as this deprived all the other children in the country from seeing them. He also calculated that for every moo the cows made to a delighted child, that cow could have produced 100 ml of highly saleable milk.

The new 'More Sow for your Money' (MSM) initiative was an ambitious undertaking, and Pal Pot appointed other pigs from the farm to help him drive it through. He called these recruits the 'Pal Pigs to Model Uniformity of Purpose' (PPMUP). Sally the Sheep noticed that the uniformity drive was so successful that all the Pal pigs also seemed to talk

the same way – very fast and with the most up-to-date turns of phrase. As the frequency of a grunt was more easily measurable on the farm's new audio equipment than the frequency of a moo or a bleat, grunting became the favoured means of expression.

Sally the Sheep found it hard to grunt when it seemed so natural for her to bleat, but one of her old pig colleagues explained that he had come to realise how backward the old bleating and mooing had been, and that even if they lost a few of the 'un-cooperatives' along the way, the new plan was worth a shot. He laughed that the pigs and sheep that had deserted the farm were a bit funny anyway. Some of them had decided to go off to the pasture beyond the farm and practise a very old-fashioned and silly game of allowing the public to lie down in the field and think about things while the sheep and pigs just bleated and grunted at them.

Pal Pot explained that while the farmer was absolutely in favour of difference, in terms of having different animal breeds, which was anyway required by the 'Many Breeds Together Make a Happy Colourful Farm' (MBTMHCF) policy, other kinds of differences – like differences of opinion, for example – were very unhelpful.

Some of the chickens and cows complained that they had not been renamed and chosen to stand by Pal Pot's side. The cows had a big barn with powerful bulls guarding it that nobody wanted to upset. So the Pal pigs tried to be nice to the noisiest cows and gave them twice as much feed as the other animals. They also gave a few of them titles, such as Absolute Head Bovine Director (AHBP) and Deputy Absolute Head Bovine Director (DepAHBD), which they liked very much. The chickens, on the other hand, lived in a modest shed and still spent far too long with the visiting children without producing enough eggs. The Pal pigs also decided that the chickens did not walk quite right, and that this was a Special Worrisome Incident (SWI) which needed to be tackled immediately.

Pal Pot believed in "listening to his animals". So he called a Very Special Meeting (VSM) in which he showed the animals the correct way to walk – on four legs, wiggling the tail in all directions as you go. Only pigs had all the attributes of an ideal tail and so only they could be ambassadors for the farm, although some other animals with tails were adequate for more basic tasks. The chickens argued that they just couldn't walk as demonstrated, and why should they anyway, as you could get around perfectly well on two legs and without a piggy tail? Pal Pot responded by introducing a dog colleague from the highly prestigious National Association for the Strategic Termination of Individuality (NASTI). The dog from NASTI pointed to the latest research which showed unequivocally, for the time being, that it was A Fact that only four-legged animals were popular with the public.

The chickens were furious, but the angrier they became, the sicker they seemed to get, and before long many of them contracted a dangerous virus known as MRSA (More Resistant Sadder Animal). In only a few weeks, nearly all the chickens had died or been taken off to the vet, never to be seen again. In the past, on the few occasions that an animal would visit

the vet or go to another farm, there was a ceremony in which all the animals would gather together and express how much the departing animal meant to them. However, there were now so many departing chickens that the animals simply couldn't attend all the ceremonies. None of the Pal Pigs came to these ceremonies as there was a suspicion that Relating, Reflecting about the present, and Reminiscing about the past (the 'Three Retrograde Rs') took place at those dubious gatherings. Worse still, sentimentality was reputedly observed. This was an unhelpful activity that could not be logged on the modern computer systems. And although it therefore did not exist, technically, it created procedural difficulties that slowed down the smooth functioning of the system.

One day, when Sally the Sheep was walking to work, she heard a strange noise in the barn. She poked her head around the door and saw the Pal Pigs taking down the rickety sign that had stood high in the barn for many years. It read: 'Pigs Before Pork'. Now it was being replaced with a new brass plaque that read: 'Function Before Field'. Even though, admittedly, the old sign had not really referred to sheep and cows, and therefore did not meet the requirements of the new Equality and Diversity for All Animals (EDAA) policy, Sally found it easier to say 'P' than 'F' when she was munching.

Sally slept badly that night. In the morning, another VSM was called. This time, short-haired dogs wearing dark glasses circulated in the barn, chanting and giving out leaflets about 'Animal-Led Empowerment' (ALE). When Pal Pot arrived, the new plaque, 'Function Before Field', was unveiled to the sound of bursting corks – champagne provided by the farmer.

Sally was confused, and bravely asked what the sign meant. Pal Pot helpfully and patiently explained that it meant that fields were an anachronism and were to be abolished. At this point, the dog from NASTI jumped onto the podium and spelled it out: "An – ack – ran – ism", spitting out each syllable and getting all the animals to shout the dreaded word back to him. "There are no such things as relationships," Pal Pot continued, getting into his stride. "The three retrograde Rs must stop," he declared. "The time for Activity is upon us, quadrupeds, and through Activity alone, we will understand our function. This is ..." he paused, and then, to avoid any possible public error, gave the answer "... to produce!"

As the animals dispersed, the short-haired dogs ushered them along to a new-look barn, which they called the Compact Enhanced Space (CES). A speaker announced that "more of the public can visit you here more quickly." Except for the Pals and some of the bigger cows, all the animals would now live in the CES.

It looked at first as if there simply wasn't enough space for all the animals, but fortunately this had all been carefully thought through by the cleverest of the Pal Pigs. As a certain amount of attrition was expected in the ranks of the weakest animals, new space would be fairly continuously created for the strongest and most committed. By splitting-up all the animals and placing them in different parts of the barn, they were also less likely to be able to speak to each other, so they would be more likely to be productive. Since animal development and animal-human relations were anachronistic topics, there was no need for any private space to discuss these things anymore. Furthermore, they had thoughtfully put up a large picture of Pal Pot high up in the barn, and every time the animals stopped producing for more than three seconds, the image of the great, smiling pig appeared, as if to offer friendly encouragement.

The CES was an awesome hive of activity. This new project was incredibly successful with crowds of visitors to the farm and an almost endless demand of produce. Unfortunately, some animals quickly became worn-out and rather ineffective. Some were reputed to have asked for transfers to other farms, and there was a vicious rumour circulating that a few even wanted to escape under the electric fences that now encircled the entire compound. Others were disappearing to the vet at an alarming rate, and not returning. Fortunately, the march of progress was unimpeded by these statistical blips, who were easily replaced by more cost-effective breeds.

Another plank to the modernisation was the now famous 'Six Second Rule' (6SR). A system was developed in which each member of the public was given six seconds with an animal, and after that the human had to sign a NASTI-approved form which proved that humans were very happy when they saw pigs, cows and sheep (but not, of course, chickens). In addition, the animals wore cute little devices which measured how many interactions they had produced each day. Pal Pot had made a beautiful chart in the barn underneath his picture, outlining the daily output of each animal.

When some animals did not reach the quotas set by the farmer, The Interaction Plus (IP6SR) rule was introduced. This stated that each six-second interaction might now be recorded as two interactions since, in six seconds, the animal was likely to have said "Hello", the human was likely to have said something back, and the animal was likely to have replied to that. This might therefore *appear* to be a single six-second interaction but, as we all know, appearances can be deceptive. This system was highly acclaimed by farmers everywhere.

There was really only one slight hitch in the whole proceedings. Despite the evident brilliance of the Interaction Plus rule, in practice, during six seconds the animals really only ever had time to shift their position and say 'Hello' before the whole event was over – therefore not leaving much time to either respond or actually produce anything. And so a black market emerged in Crap Disguised as Tenderness (CDT). CDT was a little pellet of poo that could be sold to the public at a discounted price, and which the animals could produce whilst they were simultaneously saying 'Hello' to the public, and all within the six-second window. CDTs were soon approved by NASTI and became very popular with the public, who could swallow the pellets whole without even chewing, thus saving even more time.

In general, the new system worked so well that it laid the ground for the next step in the farmer's plan. Unconfirmed details of the unpublished report, 'Back to Bacon', have been partially leaked to the pig press and have generated a good deal of concern. Information was leaked by one of the top dogs at the Department of Truth (DoT): pigs are now considered too expensive, and dogs thought able to provide CDT easily, and much more quickly than pigs. Some pundits even dared to suggest that, given their measurable output, pigs eat a huge amount. A highly progressive plan is rumoured to map out the use of the latest technology, with the help of which CDTs could be distributed much more widely. Apparently, holograms of animals have already been developed at Flying Pig HQ (FPHQ). All the public will have to do is come into a nice clean room, sit down in front of the hologram, place a funnel in their mouths, and be fed as many pellets of CDT as they can gobble in six seconds.

Disclaimer: Any apparent resemblances to animals known to the reader are purely coincidental.

THE VALUE OF MAKING ART

A Therapeutic Art Community

The work and development of Studio Upstairs

by Douglas Gill
 Director of Studio Upstairs,
 member of the Philadelphia Association

Introduction

Studio Upstairs is dedicated to exploring complex human experience through the practice of art.

The Studio is a registered charity providing artistic resources and therapeutic support to adults experiencing mental and emotional distress and to those in drug and alcohol recovery. These therapeutic arts communities are places where its membership has the opportunity to experiment in the company of others, free from the constraints of contemporary art fashions, therapeutic interpretations and psychiatric diagnosis. Studio artists are encouraged to develop the confidence to exhibit or perform their work and become part of contemporary art culture. Artistic and therapeutic support is provided in a flexible, unobtrusive but considered way.

From the Studio Upstairs 'Vision' and 'Mission' statements.

Celebrating its 21st year, Studio Upstairs is a firmly established mode of practice that has come of age. Integral with both mental health and education, the organisation is distinctly situated within the creative arts – a set of different idioms seamlessly practiced in the same space. Although the set up is unconventional, the tensions between these positions have generated a huge creative output. These tensions can be very challenging but continue to remain the essence and vitality of studio practice.

Often the work of Studio Upstairs is conveniently identified as 'art therapy'. But whilst the studio managers are all HPC-registered Arts Therapists, their priority is creativity. This is neither a clinic with occupational therapy nor a day-centre providing art as an introspective pastime. Rather, there is a serious commitment to an ongoing engagement with the process of making art. Art is the overarching culture where studio members, volunteer artists and studio managers all produce their own work alongside one another. Art abounds, and with an open-door policy any newcomer has the propensity to produce an admirable work of art.

Participating in the creative arts is a way of seeing oneself – being on show and being seen by others and thereby coming into the relational. People move on and through their art: their art sustains them. In turn, working with the therapeutic approach to individuals' underlying issues through a committed engagement with art, creates a long-term solution. The complexities and depth in the studio members' art are just as potent as those of the social relations within the studio community. There is no differentiation between art and the individual's intellectual or emotional understanding. Personal issues can be explored within the safety of the studio community. Studio Upstairs has an agreed policy that nothing goes outside the studio without permission.

People are encouraged to do what they like. But at the same time not anything goes, art is not seen as just an outpouring of emotions, but is thought about, discussed and taken seriously. Rigorous thinking about the work is encouraged, in the form of everyday conversations between members, volunteer artists and studio managers. This becomes intensified when an artist shows a body of work in a studio review. In preparation for exhibitions, an in-house selection committee is formed (with the addition of an external curator) before translating work into the public gallery.

In a working environment, where personal development is as important as artistic integrity, although it is impossible to disentangle one from the other, neither can come to fruition in the short term. Isolated individuals diagnosed with enduring mental health problems cannot be programmed to become social. Similarly, you cannot force relationships. They evolve quite naturally in their own way and in their own time – as they do in any community. There are no quick-fix solutions. At Studio Upstairs we work in the medium-to-long-term. Individuals may attend for three or four years before they are able to consider participating in the wider community. This is particularly the case with those subjected to the traumas of incest or childhood sexual abuse.

It is very important that there is a place where people can simply be themselves, no matter what their condition.



Performance workshop,
 London StudioUpstairs

There is so much pressure today to be well, as if 'well being' is the solution. Of course, art is well-known for its ability to hold a complexity of human emotions within the same frame. Studio Upstairs constantly challenges notions of mental illness, and the social stigma that surrounds it.

The development of Studio members is a testimony to the value of this mode of practice, which can be measured statistically by:

- Decreased levels of medication
- Decreased hospital admissions
- Reduced stigma
- Increased self esteem
- Increased confidence
- Increased Social inclusion
- Gaining an identity with the artistic community
- Ability to participate in voluntary work
- Ability to engage in further or higher education
- Ability to participate in paid employment

History

Studio Upstairs started as part of the Diorama Arts Centre in London, in 1988. Founders Douglas Gill and Claire Manson were experienced in Community Arts, Art Therapy and psychotherapy and saw this as an excellent environment in which to develop their ideas. The motivation for Studio Upstairs came from their frustrations with their art therapy practices, where art was produced only for its interpretive value and then kept hidden away in a file. They wanted to create a culture where art was not just a recreational pastime but a serious objective in its own right, so that it could appear in the public arena. More importantly, they recognised the need of people moving away from the psychiatric system who were too vulnerable to attend adult education. What was needed was the opportunity to create art away from the clinical setting. When art therapy was working hard to establishing itself as a profession, here was a project that was radically different from anything in the psychiatric services at the time.

Studio Upstairs is a place where people have the liberty to think and speak aesthetically, emotionally and socially or to remain silent if they wish. It is a place where madness is seen as ordinary though the extraordinariness of art.

The Founders: Annual Report, 1994

Bristol's Studio Upstairs was founded in 2000. It soon became a thriving part of the city's arts culture, and there are plans to develop Studio Upstairs in Liverpool in 2011.

Influences

Studio Upstairs developed out of the community arts movement. It was informed by the traditions of Dartington (England) and The Black Mountain Arts Colleges (USA). Their approaches to art in education were much more concerned with experimental collaborations between contemporary artists than studying the history of art in the Western world

The second major inspiration was RD Laing and his colleagues at the Philadelphia Association who, in the 1960s, developed Therapeutic Households as places of asylum alternative to psychiatric institutions. These were places

where the ordinary difficulties of living together could be met and discussed, rather than having people pathologised and medicated out of awareness. The continuing contribution of the PA to bringing social phenomenology to the therapeutic discourse is rarely acknowledged. Amongst health and social care professionals, the PA is still known mostly for its controversial ideas and practices.

Exhibiting

One of the biggest challenges was to take up our place in a public gallery. 'Bats Out the Belfry', in 1990, was the first exhibition, a major show of over 70 pieces at the Diorama Arts Gallery. It is quite natural for artists to be anxious about exhibiting, but this was the first time a body of work of this kind had been shown in a public gallery. Previously such work had only been seen patronizingly, on hospital or library walls. Before the event, an eminent figure in the Art Therapy profession commented that 'It would be seen as a freak show', and people began to lose confidence. However, the exhibition was a huge success with several sales – confirmation of the public interest in this field.

Exhibiting continues to be an integral part of the practice of Studio Upstairs, with regular shows and performances produced each year by both Bristol and London studios.

The work at Studio Upstairs is not 'Outsider Art'. It is seen as integral with contemporary culture. Although Studio artists may be unaware of where they stand within contemporary art culture, this does not prevent them from appearing in the public gallery. Culture is dynamic and informs us of society's complexities. To confine personal experience as mental illness that must be kept in hospital is quite mad. It strikes me that the gallery is not only a much healthier option but more informative.

I have been working as a Consultant Psychiatrist in South Bristol for over ten years and I can confidently say that the support offered by yourselves at Studio Upstairs to a number of people I have seen in recent years has been amongst the most valuable community support available. It is clear that you have developed a way of engaging with individuals whom we have found difficult to engage with other aspects of support in mental health services. I can think of at least two people recently for whom I believe the service you provide has been crucial in promoting their recovery.

Dr Jonathan Evans,
Consultant Senior Lecturer in Psychiatry, Avon and
Wiltshire Mental Health Partnership NHS Trust

Coming up from Studio Upstairs!

Expressions 2010: Exhibition, poetry and music performances. 4–9 October. 11.00–5.00 Paintworks Event Space, Bath Road, Bristol BS4 3EH
info 0117 9300 314

Moving Madness: 5-week project culminating in large scale performance. Sunday 10 October 12.00–4.00. Gillett Square, Dalston, London N16 8JN
info 0207 503 1330

For more information go to: www.studioupstairs.org.uk

Young Mother – Jodi Cooper



Fractured – Hayley Hellings



Pentangling with Isis – Tristan Brain



Blanks – Marc Higgins

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