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**THE MYTH OF MENTAL ILLNESS
USERS' VIEWS
USERS' ACTION**

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

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Front Cover Picture: '1967' David Feingold

Back Cover Picture: 'Crawling Out Of My Depression'
David Feingold

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

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EDITORIAL

After three editions devoted to one or another specific issue, this one covers a variety of topics. We are pleased to say that the bulk of it consists of the considered views of various service users or ex-users. (Or 'survivors' - there still doesn't seem to be an agreed word to replace 'patient'...)

And you will see that we now introduce a regular section for Poetry and Creative Writing, co-edited by Clare Shaw and Phil Thomas. If you have any ideas for this, please contact either of them (see contact list on p.2).

Whether poetic, creative or simply heartfelt, *Asylum* magazine cannot survive without contributions from our readers, or material which they discover and let us know about. So, however you wish to say something or have something heard, keep the contributions coming in!

THE DEEPEST CUTS - WORK CAPABILITY ASSESSMENTS & THE DISABILITY LIVING ALLOWANCE

The Government presses ahead with its cuts. Aside from cuts in local provisions, everyone on a Disability Living Allowance (DLA) is to be 're-assessed'. The plan is to remove 360,000 people from DLA by 2013, and officials have begun to review every recipient for 'fitness for work'. The Government hopes to reduce total welfare payments and transfer as many people as possible from DLA onto Jobseeker's Allowance. There is no sign that those with mental health problems will be given any particular assurances or help when faced with their Work Capability Assessment.

(But compare this timid Con-Lib idea with the recent comments on his visit to Europe by veteran critic of psychiatry, Thomas Szasz. When challenged to support those on DLA fighting the cuts, he said that the state should not provide welfare support at all. Szasz's libertarian-right politics were made clear when he set himself against '... politicians who want to change the world, like' - wait for it - 'Hitler or Obama'.)

Meanwhile, in the real world, disabled people and their carers struggle on. Those on DLA are twice as likely to live below the poverty line as the non-disabled. Nearly half of disabled people have 'no savings at all', compared to just 12% of the general population. 72% of carers with substantial caring responsibilities are worse off as a result of caring - more than half are in debt and three-quarters already struggle to pay the basic household bills. Disabled people are also disproportionately deprived of education - 23% have no qualifications, compared to 9% of non-disabled. And only half of disabled people of working age are in work, compared to 80% of non-disabled. Most affected are those with mental health problems - only 20% are in paid employment. (See website for The Hardest Hit, a campaign run by a consortium of more than fifty major charities: <http://thehardesthit.wordpress.com>).

Every decade or so, whichever Government is in power has another go at cracking the populist nut of 'the costs of benefits to the taxpayer'. And every past initiative dribbled out into failure, often costing far more than the benefits saved. Of course, the Government's rationale is to save a few billion, catch benefit cheats and discover those who really could work and help them get back into work. Yeah, right, when the official UK unemployment figure has hit three million ...

It was always possible to go after cheats without introducing an intimidating review for everyone on DLA. You would imagine that most of the cheats would be wily enough to escape this dragnet, anyway. But meanwhile all the most vulnerable members of the community are going to be made much more anxious, and no doubt a considerable number will be driven deeper into poverty.

We're all in this together? Yeah, right. It looks more like business as usual for the upper echelons of banking and the big corporations - higher salaries and bonuses, tax breaks, tax havens and other perks ...

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MAD CUTS

IAN PARKER

In the recent wave of protests against the education and welfare cutbacks launched by the Conservative and Liberal Democrat coalition government in the UK, one popular discourse is that of 'madness'. This discourse is often used by the left to mobilise against the cuts, as it was in the past to describe the irrationality of an economic system devoted to the extraction of surplus value. There are many layers of this 'madness' and the left has too often unthinkingly played into some of the most reactionary ideological motifs to combat capitalism.

The market does indeed operate as a bizarre combination of the most rigorous rationality and explosive irrationality. On the one hand there is rationality. Human values are subjected to economic calculation, something conjured up time and again during the recent election that brought the 'ConDems' to power, when commentators asked us to 'wait and see what the markets say'. This supposed rationality then spins into its reverse, and watching what the markets say becomes rather like gazing into the entrails of a slaughtered animal to discover what they portend. On the other hand, then, there is the irrationality as convulsions on the stock market spell the end of this or that state welfare service. In this manner the economic system is modelled by metaphors of individual reason and unreason: every time capitalism is described as being 'mad', that reinforces the idea that individuals, upon whom the model is based, really are either 'sane' or 'crazy'. An economic description based on a practice of dividing – the mad from those who are supposed to be normal – strengthens the false and divisive message that there are some of us who are intrinsically mad.

Once we go down this route there is nothing to stop us from using the metaphor all the time, making it even stronger, applying it even to the left opposition to the crazy economic system and its crazy Conservative Government. For example, the

'Coalition of Resistance' organised a large conference in London at the end of November 2010, and it has gained a presence and weight in the anti-cuts movement. The conference, like the other rallies organised by the 'sectarians' (as we like to say) was itself dominated by star speakers – leftist Labour politicians such as Tony Benn were on the platform along with hip-hop artist Lowkey and film director Ken Loach. One favourite phrase at the conference was that the ConDem cuts were part of 'the economics of the madhouse'. So, still business as usual on the left, it would seem.

But one good sign among others of something different happening now is that the Coalition of Resistance website has links to the other rival campaigns. (It should be pointed out that this is not a favour returned.) A better sign is that there is a link to Mad Pride, and an even better sign is that Mad Pride has been energised to mobilise against the cuts. Mad Pride was one of the more radical of the 'anti-psychiatry' or 'democratic psychiatry' organisations in the last two decades. (And you can choose which term to use, bearing in mind that the radical mental health movement is as sectarian as anyone else around these parts.)

Mad Pride protest meetings have been held in London, and there are calls to 'stop the suicides' of those labelled 'mentally ill'. The loosely connected cells in this movement are explicit in their opposition to the Government's welfare policies, and here is an opportunity to link the anti-psychiatry movement to the anti-capitalist struggle.

But, when they link up with the left, part of the Mad Pride struggle will also be to challenge the discourse of 'madness'. This is a dead end for those building an authentic radical alternative to capitalism and the ideological agenda being forced through to protect it.



THE MYTH OF MENTAL ILLNESS

PHIL VIRDEN

This year is the fiftieth anniversary of the publication of two great American books – Joseph Heller’s *Catch-22* and Thomas Szasz’s *The Myth of Mental Illness*. Both are as fresh and biting today as they were in 1961.

Heller’s novel is famous for its humorous debunking of authority. ‘Catch-22’ has entered the language as meaning any unsolvable logical dilemma, especially one visited materially by the powerful on the weak. Heller’s is a tale of the numerous and sinister absurdities which beset the lives of the men in an American bomber squadron tasked to fly interminable and dangerous missions over Italy during World War 2.

An airman cannot be mad if he requests relief from combat duty on the grounds that the fear of it is driving him crazy. This is due to a particular sub-section of airforce regulations, ‘Catch-22’. This states that anyone requesting medical evaluation of his mental fitness must be sane in order to make the request, and if he is sane he must continue to fly; at the same time, if a flier does not ask for such an evaluation he will not get one, and hence he cannot be found insane; therefore, no one will ever be grounded for being mad, even if he is.

Of course, a kind of ‘Catch-22’ looms over every transaction between a patient and a psychiatrist or psychiatric worker, especially when the patient wishes to have any meaningful input into decisions about his care and treatment: due to his irrationality, he attracted the diagnosis of a mental illness; because he is irrational, why listen to him?

That ‘mental illness is a myth’ is probably not as well-known as ‘Catch-22’, but it must be far and away the best-known idea in anti-psychiatry. Although they resisted it – because the establishment already hated the idea – in 1960 Dr Thomas Szasz managed to get the editors of the journal *American Psychologist* to publish his article, ‘The Myth of Mental Illness’. His argument appeared in meticulous detail in his best-selling book the following year. What a brilliant title! It neatly encapsulates the argument against the so-called medical model of mental illness, the bad idea underpinning almost the whole of modern psychiatry.

The Myth of Mental Illness caused a sensation in mental health circles and, along with *Catch-22*, was required reading for the 60s and 70s counter-culture. It is doubtful that many people actually read Szasz’s book right through (it is rather dry and long) but most psychiatric workers trained in those days would be more or less aware of the general idea: whilst it is undeniable that individuals can suffer from a terrible personal crisis involving overwhelming distress or irrationality, this not the same thing as being ill; in point of logical and scientific fact, there is no such thing as a condition that may legitimately be conceived of, and

Thomas Szasz



treated medically, as a mental illness.

Szasz is now an Emeritus Professor, and ninety-one years old. Although he rejects the term, he was the original anti-psychiatrist. Ever since his first publication (in a journal in 1956) Szasz has written title after title championing the absolute liberty of the individual to live his own life (so long as it does no harm to others), to believe whatever he wishes, and to behave (or misbehave) however he wants. He argues that, in justice, a person may be prosecuted for actually breaking the law but not be restrained, incarcerated or medically invaded against his will, simply for upsetting people, for offending morality or sensitivities.

The argument

Szasz argues from definitions of health and illness. A person may behave in a bizarre or deviant manner due to a discernible brain illness. In which case he really is ill and he may properly be offered a neurological specialist who is able to recognise the organic problem and may well be able to remedy it medically.

In fact, however, most worryingly irrational behaviour has no discernible organic cause (and not for want of researchers trying to discover one). Strictly speaking, and as opposed to those aberrant ideas and behaviours for which there is a clear organic cause, that kind of irrationality should only be termed ‘functional mental disorder’. However, it is now almost universally known as ‘mental illness’.

But this so-called illness is simply very troubling behaviour where there is no actual illness – no tangible disease. So, on the one hand there certainly are real illnesses which may have unwanted neurological effects, and on the other hand there is a certain kind of mental and behavioural deviance the cause of which, until recent times, sensible people did not pretend to comprehend but which they used simply to call ‘insanity’ or ‘madness’. However, nowadays this kind of behaviour is conceived of and treated as a particular and peculiar kind of illness – ‘a mental illness’. This is to confuse metaphoric illness (troublesome mental or behavioural deviance) with genuine illness (troublesome organic process).

The fundamental difference between a real illness and a so-said mental illness is easy enough to discern: the former is an event visited upon the person but the latter appears in the absence of any signs of a genuine organic illness. And mistaking metaphor for reality – for a real disease ‘in’ the person – has alarming consequences for civil liberties. ‘Mental illness’ is a very dangerous figment of the

collective imagination. The myth of mental illness is a gross misunderstanding of what is going on, and it disastrously skews everybody's response to those emotional and mental crises which are actually triggered by contentious problems of living.

So, whereas a real illness is something done to a person's body, 'mental illness' refers to something disturbing or offensive that a person does even though he is physically well (or at least not neurologically impaired). Whilst a mental state may be disordered, disturbed or disturbing, only brains may legitimately be described as 'diseased' or 'ill'. Hence, whilst there may be discernible organic diseases correlating to some instances of undesirable mental states (and very likely causing them), and while we may loosely but at least usefully talk of 'organic mental illnesses' (i.e., brain diseases), it is only confusing to call the great residue of undesirable mental conditions 'mental illness'. With respect to the functional mental disorders, which make up the majority of the psychiatric caseload, 'illness' is simply not an appropriate appellation. This notion of mental illness is profoundly flawed, subjective, misguided – and politically motivated. And yet 'mental illness' is the false assumption – the myth – which underpins almost the entire project of orthodox psychiatry, which considers and presents itself as self-evidentially scientific, medical, objective and politically neutral.

Szasz argues that the notion of illness is always normative: it depends on the ethical value of healthy organic structural and functional integrity. This is all well and good, but the question of normative evaluation is unanswerable with regard to so-called 'mental health'. Such judgements can only ever be matters of opinion: 'health', 'normality' or 'deviation' may only be asserted about a mental state in terms of some underlying theory of psychology, society, ethics or law. When someone says 'mental illness', this is not actually a medical judgement, a legitimate diagnosis. Rather, it is an attempt, in rhetoric, to remedy psychosocial, ethical or legal deviation – an attempt to persuade a deviant to stop thinking or doing whatever it is that upsets others. And yet this rhetorical device is supposed to justify procedures which are purportedly ethically neutral and nothing other than the appropriate technical operations upon an object (the so-said mental illness).

Yet it is absurd to expect to solve problems with medicine when their very existence is actually ascertained on strictly non-medical grounds. For whilst someone may display moral or cognitive deviation – and most likely he also has preoccupying and apparently intractable problems of living – by definition, whenever he is diagnosed as 'having' this or that 'mental illness', there is no discernible physical illness. Since the concept of mental illness (functional mental disorder, not organic) underpins the legal pressing of the attentions of medical officials upon the great majority of psychiatric patients, very often against their will, diagnosis is in these cases a moral and political evaluation, a covert form of domination with only a false claim to medical disinterest and objectivity. The deceit of pseudo-medical diagnosis and pseudo-medical treatment is an appalling abuse of the civil

rights of psychiatric patients.

For there is simply no evidence to justify psychiatry's assertion that what are known as the mental illnesses are just as real and objective as bodily diseases. That claim

...is actually a kind of psychiatric propaganda; the aim is to create in the popular mind a confident belief that mental illness is some sort of disease entity, like an infection or a malignancy. If this were true, one could catch or get a mental illness, one might have or harbor it, one might transmit it to others, and finally one could get rid of it. Not only is there not a shred of evidence to support this idea, but, on the contrary, all the evidence is the other way and supports the view that what people now call mental illnesses are, for the most part, communications expressing unacceptable ideas, often framed in an unusual idiom.

...[w]hereas the term 'bodily illness' refers to physico-chemical occurrences that are not affected by being made public, the term 'mental illness' refers to psychosocial events that are crucially affected by being made public.¹

It prejudices justice to fail to recognise that the psychiatrist is actually not a detached, neutral observer of an organic event susceptible to medical remedy. Instead, he is always and inevitably a partisan judge of his patients as persons, and he is concerned primarily and essentially with conflicts about goals and values.

In the old days people used to believe in witchcraft and possession by demons. Nowadays there is widespread belief in the myth of mental illness, and people fear and make scapegoats of psychiatric patients.

In the past men created witches; now they create mental patients ... Institutional psychiatry is a continuation of the Inquisition. All that has really changed is the vocabulary and the social style.²

The myth of mental illness is a socially tranquillising, symbolic-magical and ideological construct which most people take for granted as a medical-scientific truth. This myth conveniently deflects attention away from pressing problems of living for which no one wishes to take responsibility.

Where does that leave psychiatry? Its ideology serves the modern state as part of a kind of secular religion. It is 'neither a science nor a healing art'. Its main methods are actually conversation and rhetoric, a religious kind of faith, and chemical or physical coercion (by means of state-sanctioned involuntary commitment or treatment). Whilst posing as medical benefactors, GPs and psychiatrists act as a kind of social police. The existence of mental hospitals or units violates the doctor-patient relationship of trust and makes the doctor a kind of prison warden or probation officer.

Psychiatry embodies a lie: it poses as scientific, and it represents disturbing personal problems as indubitably illnesses – mental illnesses – and its own methods as genuinely medical. By extension, this applies to primary mental health provision. The whole enterprise is fundamentally an assault on the individual dignity and freedom of millions.

The response from the psychiatric establishment

No one has ever come forward to properly answer Szasz's argument. This indicates that the profession cannot answer him. But, of course, psychiatrists are not forced to answer Szasz's critique – and who is interested anyway? The whole weight of the law and of public opinion is behind psychiatric professionals getting on with their jobs 'as best they can', in the manner they see fit. Since he appears incapacitated – like a person with a real illness – it seems obvious that critical or chronic mental or behavioural deviance 'must be' an illness, and therefore obvious that he should be treated medically. And against the patient's will, if needs be, since, by definition, if he is mentally disordered he is not able to make appropriate decisions about care or therapy.

The closest any psychiatrists have come to answering Szasz is a few taking the trouble to assert that, whatever the metaphysics involved (which, by the way, they do not discuss), their medical treatments do help. But actually this is one more lie: it is by no means clear that any kind of mental health treatment provides greater benefit than other non-medical interventions, while it is well known that drugging and shock treatment carry great costs. (See *Asylum* 17.2, 2010, concerning psychiatric medication.)

Isn't it true that Szasz has nothing to offer as an alternative?

Psychiatry is still just as much ruled by a kind of 'Catch-22' as it was fifty years ago. Since this 'catch' is most unlucky for some – such as the many psychiatric patients harmed variously by stigmatisation, detention and forced medication – perhaps it could be called 'Catch-13'. Psychiatric Catch-13 runs like this: We psychiatrists have the legal power to do with our patients whatever we wish. You think we have got it wrong? You don't like what we do? We don't have to answer to you, or anyone else. Go take a running jump!

Szasz cannot be faulted on his analysis, but this does not force us to agree with his conclusions concerning the best response to worrying individual irrationality.

Szasz emigrated from Hungary to the USA as a youth, in 1938. By then Europe was largely in the grip of various totalitarian dictatorships. This is surely the key to the passion behind his thinking: he stands against totalitarian state power – as manifested by modern psychiatry. He has always advocated total personal responsibility. He argues that any free help necessarily encourages the person to sink deeply into irresponsible dependency as a patient-who-cannot-help-having-contracted-an-illness. And it is undeniable that this is a possibility too often realised by means of the normal paternalist/authoritarian routines of orthodox psychiatry.

However, forever enigmatic when it comes to such pressing questions as self-harm and suicide – he seems to be saying: "Let them do it" – Szasz is nowadays generally tagged by those who consider themselves compassionate as an irrelevant, dogmatic right-wing civil libertarian more concerned with ideological purity than the suffering of patients and their families.

Although he was amongst the first to eschew pseudo-medical diagnosis, and offers psychotherapy for 'problems of living', it is unfortunate that Szasz often seems barely separated from those who hold a crude 'malingering' theory of emotional distress and mental disorder.

For the idea that everyone should search out, choose and pay for psychotherapeutic help does seem to ignore the constraints of reality. First, there is the individual's overwhelming irrationality at his moment of personal crisis, then the problems of income distribution (i.e., poverty), and then the great vulnerability of most of those who enter a serious emotional or mental crisis. Not only is the individual in crisis very often incapable of many rational choices until he begins to recover, but his suffering is very often exactly a sign of the emotional damage wreaked by social or economic disadvantage and exploitation. Because a person is vulnerable and cannot always help himself by his own individual efforts is precisely why some form of help should be organised for him. And if a person cannot or will not exercise his autonomy in a rational manner, that in itself is a sign of pathological misery which ought to be addressed by some kind of humane social organisation.

None of this means that the communal response to such personal crises has to be psychiatry's patronising and paternalistic ersatz-medicine. Neither should we throw out the baby of what is still the most astute critique of psychiatry with the bath-water of Szasz's apparent lack of a credible alternative. Rather, it means that Szasz's analysis is still correct, and – fifty years on – it really is high time for a root and branch reorganisation of the manner in which this particular welfare project is understood and arranged.

1. T.S. Szasz: 'The Myth of Mental Illness', *American Psychologist*, 15, 1960, in P. Brown, pp. 17 and 18.
2. Introduction to *The Manufacture of Madness*.

Short selection of Thomas Szasz's writings

- 'The Myth of Mental Illness', *American Psychologist*, 15, 113–118, (1960). Reprinted in P. Brown: *Radical Psychology*, Tavistock, 1973.
- The Myth of Mental Illness: Foundations of a theory of personal conduct*, Hoeber-Harper, 1961.
- Law, Liberty, and Psychiatry: An Inquiry Into the Social Uses of Mental Health Practices*, Macmillan, 1963.
- The Manufacture of Madness: A comparative study of the Inquisition and the mental health movement*, Syracuse University Press, 1970.
- Ideology and Insanity: essays on the psychiatric dehumanisation of man*, Calder & Boyars, 1973.
- Schizophrenia – The Sacred Symbol of Psychiatry*, Basic Books, NY, 1977.
- The Therapeutic State: Psychiatry in the mirror of current events*, Prometheus Books, 1984.

INCREASE IN PSYCHIATRIC COMPULSION IN THE UK

George Fowler

Community Treatment Orders (CTOs) were first suggested in the late 1980s, and the Blair Government did intend to implement them. In 2003 Health Department ministers talked about introducing indefinite preventative detention for an unspecified number of mental health patients currently 'in the community' but who might be deemed a potential danger to the public. Ministers were not sure how many people would be detained – perhaps 400, but perhaps six times that number. Special new facilities would have to be built. Those opposing it pointed out that this would constitute internment without trial – like the arbitrary system which so alienated a large section of the public when it was introduced in Northern Ireland during 'The Troubles'.

And yet Section 3 of the 1983 Mental Health Act already enables psychiatrists and their staff to administer treatment forcibly, and a Health Service directive already interprets the Act such that a patient may be 'sectioned' if he stops taking prescribed medication and his psychiatrist considers that he is in danger of relapse due to non-compliance. This did not prevent many psychiatrists from finding that form of authorisation too cumbersome.

In the event, The Mental Health Act of 2007 mainly only amended the 1983 Act in fairly minor ways. CTOs were not introduced as originally envisaged. Instead there is now the Supervised Community Treatment (SCT) Order.¹ This is 'intended for patients following a period of detention in hospital, and it is expected to allow a small number of patients with a mental disorder to live in the community whilst subject to certain conditions under the 1983 Act, to ensure that they continue with the medical treatment that they need.'²

Essentially, an SCT Order permits a psychiatrist or team to bring a patient back into a facility if he fails to comply with his treatment. The thinking is that 'currently some patients leave hospital and do not continue with their treatment, their health deteriorates and they require detention again – the so-called 'revolving door'.³ It seems strange to try to counteract this 'revolving door' by forcibly bringing former inpatients back into facilities, i.e., by a new revolving door. Especially since, in effect, this was already fully permitted under the 1983 MH Act and by subsequent Department of Health regulations.

It is now becoming clear how widely SCTs will be implemented, although for a time only 'preparatory research' will be carried out. There is no legal limit on their use. Legislators expected 350–450 Treatment Orders to be issued in England and Wales during the first year. In fact, 2,134 were issued in England alone during the six months between November 2008 and March 2009. And between 2008 and 2010 more than 6,200 CTOs were served. This is ten times the number predicted. More than this, Mind estimates that 30% of all CTOs are imposed on patients with no history of not co-operating with treatment. In effect, CTOs are a looming threat of readmission hanging over the heads of many people trying to rebuild an independent life.

Besides this development, in the UK in the year from 2008–9 to 2009–10 the number of people being compulsorily consigned to a psychiatric unit ('sectioned') rose 17.5%, to over 38,000. This constitutes nearly 40% of all inpatients. This means that after years of cutting the numbers of beds, wards are filling up with those with the most serious mental disorders



– those seen as a real danger to themselves or others.

Also, increasing numbers are coming in from prisons or the courts – half as many again in the year to 2010 as in the year before. 830 women took that route during 2010, a rise of more than 85% in one year. At the same time, the number of such men rose by 48%, to just under 3,000.

Today, at least 40% of patients in NHS psychiatric units are there under legal duress. The chances of a locked ward providing much safety and respite for the disturbed-but-harmless are fast diminishing. Aside from supervised medication for 'the management of symptoms', psychiatric units are losing any therapeutic use. Instead, they are becoming increasingly unpleasant and dangerous – dominated by their use as holding-pens for those detained compulsorily, including a growing numbers of criminals who threaten or actually carry out violence, and who calculate the exploitation of other patients.

Meanwhile, of the 486 locked NHS wards in England and Wales, nearly one-third report an occupancy rate of over 100%. This means that, so as to accommodate new arrivals, patients have to be sent home before they really appear ready for it.

All this conspires to detract from any therapeutic benefit. It seems that, in practice, and under the pressure of 'freeing-up beds', SCT Orders are used mainly for the premature release of patients who, of course, often have to be quickly recalled due to relapse: 'the revolving door'.

At the same time, many patients complain that it takes far too long to have a CTO removed, and this forces them to take medication they believe they no longer need.⁴

As many feared, CTOs (SCT Orders) do seem to have become 'the long leash' to compel certain patients to submit to treatment (i.e., medication) after discharge from compulsory psychiatric detention. This is not only a serious civil rights issue. There are great dangers of serious organic damage from psychiatric medication, and the longer the medication the higher the risk. SCT Orders seem to have little therapeutic use yet they are likely to consign many patients to a life of permanent and worsening pain and disablement.

All in all, this is not a pretty picture of 21st century psychiatric progress but rather a sorry story of increased compulsion and declining conditions on the wards.

1. Confusingly, mental health professionals and commentators continue to say 'CTO' when referring to SCT Orders.

2. Dept of Health: *Mental Health Act 2007, Overview*, www.dh.gov.uk, 7 Dec. 2009.

3. NIMHE website, May 2008.

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THE CONSEQUENCES OF PSYCHIATRIC MISUNDERSTANDINGS

The author is in a medium secure unit, and wishes to remain anonymous

AN INSIDE STORY

Some patients experiences with mental health professionals, over the course of their time in hospitals, can be negative. This article reports a couple of examples. And to follow on, there are some conclusions from a report commissioned by the USA's Central Intelligence Agency (CIA). This echoes the experience of these mindsets.

A consultant once said to me that he wanted to increase my medication. I asked him to state his reasons: was it to iron out or flatten highs and lows in my thoughts, because I could get quite manic? The doctor said that was not the case, and that was paranoia on my part.

I replied that the reason I had said that was not because I knew it to be true, but that I was just speculating, to see if the doctor would agree or disagree, or offer another reason. In effect, it was playing with words or indulging in a mild form of trickery, so as to harmlessly get some information.

It was interesting to see how quickly the doctor jumped to the wrong conclusion, due to the psychiatrists' mindset towards their patients. As will be explained shortly, the CIA agrees that this happens.

I then explained what I was doing by asking him that, and the doctor laughed, especially when I pointed out that he may be the one suffering from paranoia. Of course I was joking.

How many patients are misdiagnosed and on the wrong amounts of medication because of misunderstandings between them and their doctors? Many, I would suggest. And how many are labelled paranoid when they can't express themselves as I did? Once again, many.

Another time the same doctor asked what interests I had. I said I was doing research into a book I was thinking of writing. It was to be partly occult, partly fact and partly fiction. Because he did not understand exactly what I meant, some days later staff approached me and suggested I agree to my medication being raised. The doctor said they were thinking of doing it anyway, but our brief conversation about the book had tipped the balance. I felt forced to talk in detail about what the book would be about. They then said that they understood, and decided to leave the level of my medication as it was. To me, it seemed ridiculous to jump to conclusions like that about vulnerable people.

This does not mean that every doctor is so free and easy about misdiagnosing and mistreating patients. There's no way of telling how much that goes on. Like everyone else, doctors are only human and can make mistakes. Unless the patient tells him, and unless he listens, a doctor cannot possibly

know what is going on in a patient's head. On their part, patients often do not communicate clearly. But that does not mean that they should necessarily be given increased medication.

PERCEPTION & PREJUDGEMENT

Perception is as much an active as a passive process. we construct rather than record reality. The tendency for people is to perceive what they EXPECT. This may be more important than perceiving what they want.

If a professional is used to looking for patterns based on how he conceives his past experiences, subconsciously this is what he looks for, this is what he attaches importance to. This determines how people INTERPRET what they experience. Because a job creates its own expectations, these patterns form a mindset, making the worker think in certain ways.

This is akin to perceiving the world through a screen or a lens. Mindsets may be either accurate or inaccurate, but they are unavoidable. They tend to be quick to form but resistant to change.

Once someone develops a mindset or an expectation of a phenomenon, this conditions his future expectations about it.

Another fact is that a perception about another person can persist in someone's eyes even after new or more up-to-date information comes in.

Lastly, it seems that the amount of information necessary to invalidate a hypothesis is considerably greater than the amount of information required to make the initial interpretation.



The previous issue of the magazine (18.3) showcased the Spiritual Crisis Network. The piece below is an independent contribution. The author also sent us couple of letters. Here's a bit of what he wrote in the last one:

...The main thing, for me, is that I had the opportunity to write these things, from the heart. To be honest, despite the years of treatment, really, I had very little 'therapy'. And others in my life likewise never took the trouble to quiz me on what had actually happened. So it all stayed inside, festering, or stewing, until I had the sense to let it out for some fresh air. Pretty dumb, actually. But it takes what it takes. I was always one for keeping things to myself unless asked.

Well, I haven't picked up my copies of your magazine in a while but I think back fondly on them. I do think it's great that you've all been able to pull it together and make a go of it. I only hope you have a decent circulation. If it was a DC comic it would sell by the shedload! ...

CHRISTIANITY AND PSYCHIATRY: A PERSONAL PERSPECTIVE

Alan Jennings

Pity as Christ

I discovered this anagram way back in my tenure as a psychiatric patient. Have you got it yet? Easy enough, really. Psychiatry!

Quite revealing I thought. In fact, almost a joke. If there's one thing you're least likely to receive as an NHS mental health patient, it is pity. Quite out of favour, it seems. And amongst the general population too, I should add. That's in my experience, of course. Maybe I was singled out for particularly harsh treatment. Perhaps God in His infinite wisdom really needed to have me punished. Disciplined is a better way of putting it. In line with the traditional Fatherly role.

Yes, pity. It was pity that got me into the mess that has been my life for fifteen years or more. Could it be that pity is what will get me out again? Is pity a form of love, like charity? Am I even allowed to talk about such things these days?

I had only one hint from a psychiatric doctor that religion was tolerated. In a moment of quiet honesty I had finally 'come clean' and told him that I believed I was the Messiah come to save the world. I think he was genuinely shocked. But he had the wits to respond by giving me the name of an author who he said explored the link between religion and mental ill health.

I was never able to follow it up but in the meantime I've made my own discoveries. I think it's perfectly fine for a man to have a thought that he was Christ. Really, to my mind, that's the whole point of the Christian message – that the spirit of Christ dwells within us. It's a bit bonkers, yes, but then so are a lot of things. The eternal questions of how we came to be, and



what it's all about, etc. If you're not Christian, then perhaps it's just so much psychosis. That would seem to be the medical line on it, and no doubt Mr. Dawkins would applaud very loudly – *The God Delusion*, and so forth. But faith is integral to us. It may be very rationalised, or it might be more poetic and imaginative. The thing is that it's there to serve a purpose.

We need to know that we're doing OK. That's normal. When there are problems we somehow have to find a way to solve them. If things get really bad, then some of us will turn to God. My best description of God, taken from the pages of the Bible itself, is that God is love. In fact, to get it right, God *is* love. The emphasis is worth remembering. It is in the 'is' that we exist. The remedy for delusion is to be recalled to the here and now, surely. And love? That has enough coverage in the world's arts and media already.

Don't get me wrong – it's a tricky old business being Christian. I can only manage it some of the time. But whereas the contemporary psychiatric profession does all it can to nullify and reduce any symptoms of mental or emotional imbalance – out of fear, I may add – the religious are often much more free to let things take their course. Dreams and visions, demonic possession and exorcism (ouch!), revelation, fanciful imagery, grandiose designs – the whole thing is replete with the stuff of reality.

Perhaps I overstep the mark a little by saying that. Who can say what is real? The famous quote from Pontius Pilate: "What is truth?" (John 18:38, pardon my pedantry). However, the point is that there is goodness to be gained from religious understanding just as there is validity in science. They need not be wholly incompatible although it can be a devil of a task sifting the wheat from the tares. But that's life.

For me, being ill is all about getting better. Call it simplistic if you like but that's how I felt the moment I fell into difficulties. Heaven knows, reading the Holy Scriptures is a bitter pill. There are many stories of defeat and condemnation, not quite what you might be wanting to hear. And yet, overall, it presents a positive message of hope, of redemption and rescue.

Just what the doctor should have ordered, if you ask my humble opinion. Just what the doctor failed to provide, I'm sorry to report. We must do better.

Hearing Voices and Social Contexts

Peter Donnelly

Recently I read a couple of websites on the internet, with supposedly new research on 'hearing voices'. They stated a small fragment of what had previously occurred to me: that hearing voices was caused by social isolation, by deprivation from actual social communication.

The websites said that if a person was socially isolated, this would cause over-activity inside the mind or brain. Also, that there was a lack of integration between the thinking part of the person's brain – the part which creates thoughts – and that part which receives and interprets actual social verbal communications.

But this doesn't explain why, on one level, some voice-hearer's such as myself are aware that the voices are their own thoughts. They are aware of both the thinking and the actual social communication as parts of their mind, and of the ways in which they are connected, both inside their minds and in actual reality, in society.

This latest theory or model, and the so-called new research, also seems to assume that actually present social communication is satisfactory for most people – that it involves free and creative relationships – and that the so-called sane don't need or don't have a strong wish or desire to communicate with psychiatrically diagnosed people or voice-hearers.

Obviously, so-called sane people are often in denial and can be defensive about communicating with people with a psychiatric diagnosis, but the wish and desire to communicate is also very strong. This is both in terms of learning about things, and in terms of needing or wanting a certain kind of sounding-board or muse. This tension, and these inner and social conflicts, can also contribute to a mental health problem, as a secondary cause or influence.

Many mental health professionals and psychiatrically

diagnosed people – especially those who regard themselves as psychiatric survivors – put a lot of emphasis on individuals being responsible for their own thoughts, emotions, and actions. In this context, what should be emphasised but is not mentioned is the way that society often likes to believe that the psychiatrically diagnosed (as well as other minorities and oppressed groups) are fully responsible for their own thoughts, emotions and actions, so that they can then be blamed and punished for having their different thoughts, feelings and behaviour.

I once did a mysticism course, and then a sociology course, at college, and I sometimes have both mystical and sociological experiences and knowledge, as well as psychological ones. The mystical experiences that I have are sort of inexplicable, but in time I find I can articulate or explain what I see and experience, and work out what is truth and what is delusion. This applies to the sociological and psychological insights that I have, too. What I do very much believe in is sharing my insights and knowledge with others. But often I need some time to articulate, explain and work things out.

I think it's important to understand hearing voices as, in a way, itself a part of the social context which exists both inside the voice hearer's head, and in society. The conventional psychiatric or mental health view is that this 'social context in the voice-hearer's head' does not at all represent or correspond to actual material and social reality. But this may not be true. For one thing that social isolation can seem to do is to create in the individual an intensified or supersensitive awareness of others – of their verbal and non-verbal communications (body language) and behaviours.

In a way, I think it is very important to experience hearing voices, to understand different aspects of reality, and different worlds, universes, and realities. But it is true that it is also important to take responsibility for one's own thoughts, and to agree or at least try to go along with that consensus of reality which is widely accepted by most people.

LIBERTY & WELL-BEING

Dean Smith

Many of us go in to hospital for treatment and help due to emotional distress. We trust those society deems professional, those we feel are the experts.

But how would you feel if I was to tell you that as soon as you go on to a ward, either voluntarily or because of a Mental Health Act section, you would lose all your rights – even more so than someone in prison?!

We live in a world of pseudo-science which practises treatments that seem outdated and barbaric to me. Yet this is done in the name of 'well-being'. These treatments take away people's identities and emotions – which is certainly not what the people wanted when they asked for help.

It seems to me that psychiatric treatments are now far beyond the limits of decency and humanity in their violation

of human rights. But for some reason this is overlooked, and patients are told: "we are doing this to help you."

I have had my own personal experience in this field, as a patient. And I maintain that this oversight and these treatments only hinder someone's progress towards recovery. I feel this is a valuable and serious question which should be addressed. I see no progress in psychiatry over the years. Psychiatrists are stuck in their own deluded paradigm which, I feel, is only to give them a sense of some control over patients' lives. Mental health or psychiatric treatment only seems to make the patient feel detached from all the reasons they went to seek help in the first place.

Meanwhile, throughout the West we are being bombarded with new Mental Health legislation, which includes more threats of peoples' rights being taken away from them, such as the Community Treatment Orders. The health authorities and the so-called radicals don't seem bothered about this.

I have always said that if you are going to rock the boat

to get attention, you may as well sink it. Maybe then people will realise that these are very important issues which not only get in the way of a person's well-being but also cause deaths – all in the name of treatment.

All the same, I do feel that as a patient you are responsible for your own actions and should speak out. It is no use complaining about the mental health system and yet not doing anything about it yourself. You can either have one or the other, but if you want both, more fool you. Don't complain about the side effects if you still keep taking the drugs. Don't complain about treatment on the ward or by your doctor if you're still going to see him without speaking out. Yes, I agree, speaking out is a battle. But it seems to me that one of the first signs of recovery and moving on is to question things. You may not be liked for it, but to have your own free will and to say how you feel is at least a start.

A CLIENT'S VIEW OF CAPITALIST PSYCHIATRY

Philip Hutchinson

In Britain there is the Socialist Party (as distinct from the Socialist Worker Party and The Socialist Labour Party). I'm not a member, but I understand that the Socialist Party is part of a global movement seeking a democratic mandate to abolish capitalism, to abolish money. Taking away private ownership and the concept of money trading creates the space to organise work and the distribution of wealth in different ways.

Socialism might create a society where more of us felt that we were just as important as anyone else in what we were doing – in our 'work'. It would probably mean that more people, more of the time, had the chance of decent housing, clean water, health and education. The possibilities would therefore be created to improve life in general, without the inbuilt barriers that private capitalism places at every step, in every breath we take.

If we take it – as R.D. Laing posited in his *Asylum* interview 25 years ago² – that psychiatry and the mental health services serve the ideological bent of the State, then with socialism there would be the possibility of mental health services becoming first and foremost what it says on the tin – mental health.

Maybe then we would be able to start from, and keep to, the premise that first of all we have to value a person's ability to achieve and manage their own mental, psychological and emotional state, with benign, caring support as and when necessary. Unhitched from 'market demands', employment would then be part of an individual's own agenda for health and well-being. If there were signs that someone might become a danger to others, there should certainly be the availability of 'asylum'. It should be available to anyone who needs 'time out'.

The present capitalist system operates with its pressure on

However, too many people would rather be maintained as patients. I feel that there is a new breed of service users coming up – those who say they are radicals but kind of want to hold on to both the NHS and the 'recovery' networks. As I look at the so-called 'recovery network', I see most of these people as 'maintenance monkeys'. That's all they are, and I fear it is all that they ever will be.

As I said at the beginning, people are suffering and actually dying in the name of mental health treatment. Without standing firm and making this open and clear for others to see, you are only being complicit with the process and making it hard for others.

In the words of Emma Goldman: 'The ultimate end of all revolutionary social change is to establish the sanity of human life, the dignity of man, the right of every human being to liberty and well-being.'



standupforamerica.wordpress.com/2011/04/21/capitalism-v-communism/
the health services to deliver people to the market as units of labour. Anyone working in the mental health system must ask themselves what they are in it for, what they are about. Is it to patch-up people as quickly as possible, to 'process' them, get them to an assessment of their 'work capacity', and onto 'Job Seeker's Allowance'? Or is it to foster their longer term well-being, to allow space for them to find their own ways, to develop their own abilities and apply them to work in whatever capacity and form that they can, as a valued part of our society? Put yourself in the role of the client.

These are the critical questions. And if you are a mental health worker and aren't asking them every day, then there isn't much hope for any of us.

As someone in the client role, I find the idea of finding help within the current statutory services as pointless as voting. The state serves capitalist values and is steeped in the culture of capitalist marketing. And capitalist ideology warps beyond all recognition the concept of people helping each other. I do not believe that the state is able to produce services which help us to help each other to help ourselves. We are all of us simply put in to the role of getting as much as we can from each other without caring.

1. www.thesocialistparty.org.uk
2. RD Laing interview by Lin Bigwood, free download: www.asylumonline.net/archive/1986_1_1/Asylum_1986_1_1RDLaing.pdf

The press often reports stories about seizing drugs, drug-related crime statistics, celebrity drug problems and overdoses. But what about the root of these problems? where does the addiction start? Does anybody care?

The triggers for drug addiction are multi-factorial.¹ From casual cannabis smoking to heroin use at the extreme end of addiction, each drug is capable of swallowing up the addict and leading to a downward spiral into misery. Liverpool has the highest number of people in drug treatment in the UK and, unsurprisingly, is also home to some of the poorest boroughs in the country.²

There is little written about the social backgrounds of addicts and which factors led them to develop an addiction. I recently reviewed the current literature and compared it with my own findings in a standardised questionnaire to four Merseyside heroin addicts at various stages of treatment at the Lighthouse Project and Independence Initiative. I was working under the guidance of a doctor who is an addiction expert in the Merseyside area. In my small study the main factors were: disrupted parent-child relationship, peer pressure, family history of addiction, homelessness, early school-leaving, poor self-esteem, and previous drug use. This appears unsurprising yet, interestingly, I found no UK studies, only some American and Danish literature.³

All too often it seems that we ignore the causes and only focus on the negative outcomes – they make for a good headline or a good debate. However, the evidence is that the foundations for addiction are laid in childhood and adolescence.

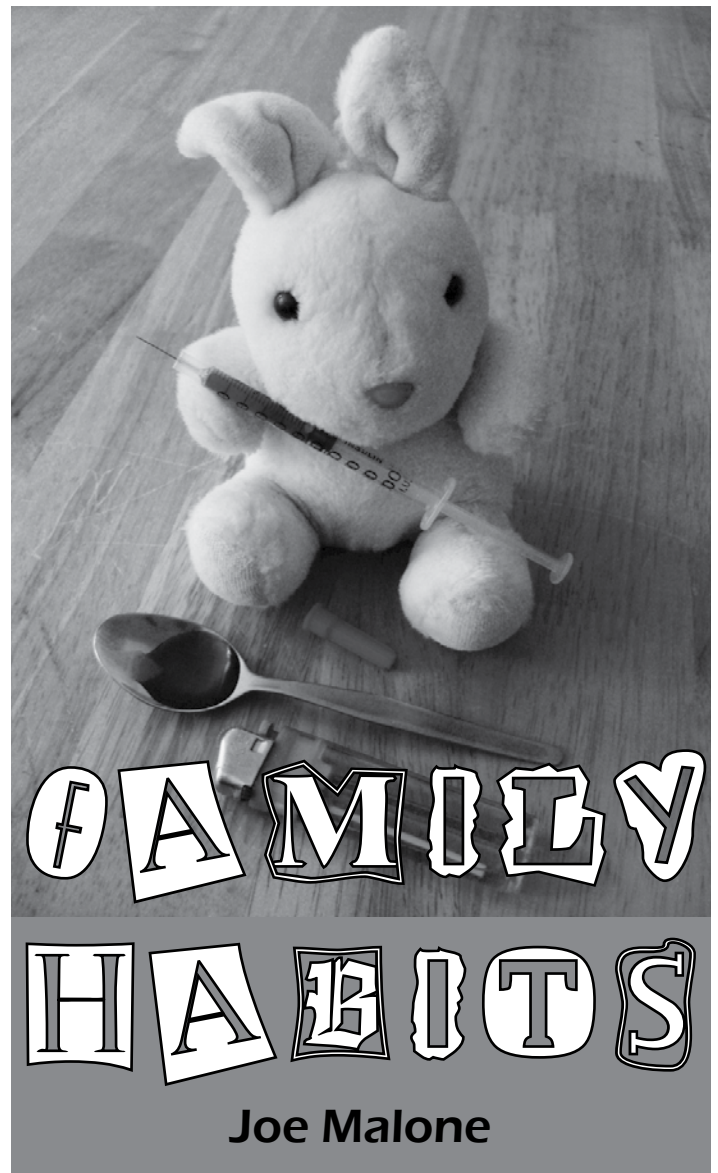
And we would remove those risk factors if we provided more effectively for disrupted households, helped the homeless become independent again, and worked to boost the self-esteem of those who are struggling. But if the risk factors are not addressed, in the same way that obesity, drinking and smoking increase the chance of cancers and heart disease, we allow the potential for addictions to flourish.

In the UK, one-in-three members of the public have tried a drug at least once, so there will always be experimentation regardless. The question is, whether we choose to allow this to progress beyond an individual's control.² It would cost a lot less money to deal with the risk factors rather than the chronic addictions.

Shockingly, whilst I was conducting my study, a forty-year-old charity working to help addicts of all substance types, The Lighthouse Project, went bankrupt.⁴ There was no rescue for this organisation, and around 300 jobs were lost. To quote a Lighthouse client, the key workers at the Project were '... the only people in my life I can trust'.

This seems an all too familiar scenario of ignorance and prejudice against a struggling group. Liverpool has lost a key resource in the management of addictions since the thin contingency program replacing it lacks the years of experience and good client rapport that the Lighthouse had built up over decades.

Let's hope in the recession that this tragedy is not echoed elsewhere.



When he wrote this, Joe Malone was a 3rd year medical student at the university of Liverpool.

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1. Malone J, 'A Case study: What are the main social background risk factors for drug addiction in Liverpool', University of Liverpool, 2009; *various physicians: Drugs Dilemmas and choices*, London, Gaskell, 2000.

2. *National Statistics on Drug Misuse*, HMSO, 2007.

3. See Malone, above.

4. 'Drugs charity in administration', www.news.bbc.co.uk/1/hi/england/merseyside/8241880.stm

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STRUGGLING AGAINST PSYCHIATRY'S VIOLATIONS OF HUMAN RIGHTS

Don Weitz

Don Weitz is an anti-psychiatry activist, insulin shock survivor, co-founder of the Coalition Against Psychiatric Assault and co-editor of *Shrink Resistant: The Struggle Against Psychiatry in Canada*.

The Hippocratic Oath: "First, do no harm."

INSULIN SHOCK TREATMENT

Once, more than sixty years ago, I was tortured for six weeks. This was during mid-winter, 1951/52. I was twenty-one. At that time I was locked up for a total of fifteen months. During the torture I was forcibly subjected to a series of 110 sub-coma insulin shocks. This was prescribed by psychiatrist Douglass Sharpe, as treatment for my "schizophrenia". Although Dr. Sharpe and other shrinks labeled me schizophrenic, I never believed it. I still don't believe it – or that I was even "mentally ill". At the time I told them so.

Like many other critics and anti-psychiatry activists, I deny the medical validity of the diagnosis "schizophrenia", and all the other psychiatric labels, because they don't refer to real diseases. These terms are fraudulent. As the psychiatrist and critic Thomas Szasz explained, in psychiatry the diagnostic labels are metaphors for dissident or non-conformist conduct, pseudo-medical terms which discredit and permanently stigmatize people.

In the early 1950s I was a very confused college student struggling to find himself – like many others, I had an identity crisis. I was never violent and was never charged with a criminal offence. Nevertheless, I lost my freedom, locked up as an involuntary patient, a psychiatric prisoner at McLean Hospital. This is a teaching-research facility affiliated with Harvard Medical School and Massachusetts General Hospital. It should be called McLean Psycho-prison.

As is frequently the case, my parents colluded with the psychiatrists. They had me committed.

Within six or seven weeks of admission to McLean, psychiatrist Sharpe prescribed a series of insulin shock treatments because I was openly angry and defiant toward my parents and the world in general. That's the real reason, but you won't find it written in my medical records. There I am labeled "schizophrenic". My discharge diagnosis reads: "schizophrenia – acute undifferentiated reaction, improved". That fraudulent diagnosis has never been changed or erased from my medical record.

Here's a telling excerpt, written by Dr. Sharpe into my

medical record:

The patient was finally placed on sub-coma insulin and after a month of sub-coma insulin three times a day he showed tremendous improvement. There was no longer the outbursts of anger ... He spends most of his time trying to figure out what the effect of insulin has on him ... (Burstow & Weitz, 1988; Weitz, 2004)

It took me almost twenty years to understand, in political terms, my forced psychiatric incarceration and treatment. That long to realize that I was not simply "a mental patient" but a political prisoner of psychiatry, locked up against my will, with no rights to appeal commitment or treatment, subjected to torture by sub-coma insulin shocks. It was obvious to me that insulin shock was not treatment but a form of torture and social control. This is also true for electroshock, psychiatric drugs, and all the forced psychiatric procedures of today. If a medical or psychiatric procedure is forced or administered without consent, that amounts to assault or torture, not treatment. It took me twenty years to understand that "the mental health system" is actually an oppressive system of social control.

Insulin shock was a serious violation of my human rights but it was also radicalizing. It permanently sensitized me to the many human rights violations which psychiatrists have committed and are still committing against hundreds of thousands of people alleged to be "mentally ill". Of course, this is always under the guise of "safe and effective treatment", "medication", "ECT", "research", or "mental health reform". In the 1950s, many of us psychiatric survivors had no rights at all, not even on paper – such as the rights not to be treated against our will or without our informed consent, not to be abused, mistreated or tortured, and not to be harmed.

Nevertheless, these violations of rights are happening today in almost every psychiatric ward, in every "mental health center" or psycho-prison in North America and Europe. This is in spite of all the supposedly progressive mental health legislation, and despite the fact that some of these rights are enshrined in the United Nations Universal Declaration of Human Rights. This Declaration was adopted by the UN General Assembly in December 1948 and signed by forty-seven nations, including the "free and democratic" nations of Canada and the USA. More recently, rights were enshrined in the UN Convention against Torture. Everybody, including every physician, should read those documents. Unfortunately, there is no guarantee that psychiatrists and other doctors will respect their own ethical guidelines or our human rights.

THE RIGHT NOT TO BE TORTURED

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

UN Universal Declaration of Human Rights, Article 5
Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

Canadian Charter of Rights and Freedoms, Section 12

Yet psychiatric prisoners typically are forced to submit to

treatment, or to accept treatment without informed consent. This is often experienced as cruel and inhumane punishment or torture.

Psychiatrists rarely inform their prisoners about the many serious effects (so-called side effects) or risks of their treatments, or about alternatives, especially non-medical community alternatives such as self-help groups, advocacy groups, crisis centers, and drop-ins run by psychiatric survivors. This is despite the fact that “informed consent” is spelled out in Ontario’s Health Care and Consent Act and in the historic 1947 Nuremberg Code.

For example, whenever psychiatrists or other doctors prescribe so-called antipsychotic medication without the patient’s consent or against his will (powerful brain-disabling neuroleptics such as haloperidol, chlorpromazine, clozapine, fluphenazine, risperidone and olanzapine, as well as antidepressants such as Paxil and Prozac), they assault and punish him. This violates the Nuremberg Code, the UN’s Universal Declaration of Human Rights, the Canadian Charter of Rights and Freedoms, The Convention against Torture, the patient’s human rights. Forced drugging, together with its many traumatic, health- and life-threatening effects, is a global epidemic, an international disgrace, a crime against humanity.

PSYCHIATRIC DRUGS – CHEMICAL LOBOTOMIES

The terms “antipsychotics” and “antidepressants” are seriously misleading. “Antipsychotics” do not combat or cure psychosis or “mental illness”, and “antidepressants” do not combat or cure depression or that fraudulent diagnosis, “bipolar mood disorder”. Psychiatric drugs chemically control and disable people – sometimes permanently. Neuroleptics is a more accurate term for “antipsychotics”: it means “nerve-seizing”. These psychiatric drugs – particularly the neuroleptics – are much more powerful, debilitating and brain-disabling than the “tranquilizers” (benzodiazepines) which, by the way, are very addictive. Even at moderate or low doses, the neuroleptics and antidepressants frequently make people look and act apathetic or zombie-like, as if they’ve been lobotomized. These allegedly safe and effective medications always produce painful and serious “side effects”. Some are health-threatening and brain-damaging, others life-threatening.

Consider these common effects: muscle cramps, dizziness, blurred vision, seizures, tardive dyskinesia (a permanent neurological disorder characterized by involuntary movements caused by most neuroleptics), tardive dementia, akathisia (restless pacing), nightmares, psychosis, parkinsonism, neuroleptic malignant syndrome (a neurological disorder with a prevalence rate of 2%–3%, and a mortality rate of 20%–25%), and sudden death. Tardive dyskinesia (TD), tardive dementia, neuroleptic malignant syndrome (NMS) and parkinsonism are all signs of brain damage.

Although TD was discovered and reported in medical journals by the mid-1960s, psychiatrists covered this up or failed to warn patients about this horrific neurological “side

effect” until the 1980s. After a few weeks or months on such “medication”, most patients look and act like a zombie – apathetic, indifferent to their surroundings. Dr Peter Breggin, Dr Lars Martensson and other professionals have documented these horrendous effects. Many psychiatric survivor-activists and other critics prefer the label “chemical lobotomy” since it succinctly describes their zombie experience. In a psychoprison or psychiatric ward, virtually everyone gets drugged – “put on meds”. Or threatened: “Take your meds, or else ...”

Enforced drugging compounds the abuse. “Informed consent” is a cruel sham since psychiatrists rarely if ever warn either incarcerated voluntary or involuntary patients about the common risks to health, or tell them about the non-medical alternatives to drugging. More often than not, psychiatrists coerce, threaten, or intimidate patients into consenting to “medication”. Powerful personal testimonies against the antidepressants and neuroleptics, including frequent violations of the right to informed consent, were frequently voiced by about twenty-five Canadian survivors during public hearings sponsored by the Coalition Against Psychiatric Assault (CAPA), at Toronto City Hall in April 2005. (Burstow et al, 2005; Breggin & Cohen, 1999; Lehmann, 1998; Martensson, 1998; Whitaker, 2002).

ELECTROSHOCK – ELECTROCONVULSIVE BRAINWASHING

Electroshock is officially called electroconvulsive therapy, or ECT. This is another high-risk, controversial, degrading and inhumane psychiatric treatment, chiefly prescribed for “severe depression”, “bipolar mood disorder” and sometimes “schizophrenia”. Since its main targets are women and the elderly, in its administration the procedure is clearly sexist and ageist. According to [Canadian] Government statistics, including those of Ontario’s Ministry of Health, two to three times more women than men (at least 70%) are prescribed ECT.

Despite denials by the Canadian Psychiatric Association and those promoting it, the scientific fact is that ECT always causes some brain damage, including permanent memory loss and other intellectual disabilities. The immediate effects of electroshock are also alarming. They include epileptic or grand mal seizure, coma, physical weakness, confusion, disorientation, nausea, and a migraine-type headache which can last all day, or longer. According to many critics and dissident professionals in the USA, such as psychiatrist Peter Breggin and neurologist John Friedberg, electroshock is actually an “electrically-induced closed head injury”. According to these and other critics, the “improvement” or “high” that some shock survivors experience after several shocks is actually the common sign of a head injury, euphoria.

One doesn’t have to be a doctor, scientist or engineer to understand how the damage is done. The average amount of electrical energy delivered to the brain for half a second or longer, two or three times a week during a course of ECT, is 150–200 volts. It is this – not depression or any “mental disorder” – which causes the permanent brain damage.

Nevertheless, shock promoters continue to claim that “the electroshock seizure is therapeutic”. Try telling that to people with epilepsy, or to a genuine neurologist! More nonsense, more psychobabble.

Women shock survivors and feminist critics claim that electroshock is “psychiatric rape”. This is appropriate since electroshock is frequently prescribed or administered in the face of the woman’s refusal or without her informed consent. Violations of informed consent, and the real trauma experienced by shock survivors, are systemic. This alarming fact was exposed by almost all those survivors who courageously testified during the public hearings at Toronto in 2005.

Dr. Bonnie Burstow is a widely respected feminist, author, anti-psychiatry activist, and chair of the Coalition Against Psychiatric Assault. In a public lecture three years ago, at the Ontario Institute for Studies in Education, she maintained that electroshock is a feminist issue (Burstow, 2006a; Burstow, 2006b). Absolutely. I also agree with the term “electroconvulsive brainwashing” (ECB). This was coined by Leonard Roy Frank, a widely-respected shock survivor, activist, author and editor. In California in the early 1960s he permanently lost two years of university knowledge as a direct result of more than 30 electroshocks and 50 insulin coma shocks. Frank also says that ECT is a crime against humanity that needs to be abolished, as do Drs. Burstow, Breggin and Friedberg, and many other critics, including shock survivors and human rights activists, including myself (Burstow, 2006; Frank, 1978, 2006; Breggin, 1997; Friedberg, 1976; Weitz et al, 2005; Breeding, 2001).

According to the Ontario Government’s Ministry of Health ECT statistics for the years 2000–2002, electroshocking women and old people, particularly elderly women, is no longer in decline but on the increase again in Canada, as it is in the USA. Even with consent, shocking old people (some are 80–90 years old) is abuse. They are bound to be in poor or fragile health, and are much more vulnerable than younger people. Leonard Frank compiled a list of ECT-related deaths. According to him, as reported in English language medical journals, since 1942 electroshock has caused more than 400 deaths. Undoubtedly, many more deaths have been subjected to PR spin, not reported or covered up.

The struggle to abolish this psychiatric atrocity started well over thirty years ago in California, organized by the legendary Coalition to Stop Electroshock. This achieved a partial victory in 1982 when over 60% of the citizens of Berkeley voted in favor of a referendum to ban it. The anti-shock struggle continues in California, Texas, New Zealand, the UK and other European countries.

I am particularly proud that in Canada several of us survivors and activists participated in the anti-shock struggle between 1984 and 1992, when the Toronto-based Ontario Coalition to Stop Electroshock, and its successor Resistance Against Psychiatry (RAP), organized several major protest demonstrations in front of ‘shock mills’ such as the Clarke

Institute of Psychiatry and Queen Street Mental Health Centre (since merged into the Centre for Addiction and Mental Health). Some of us also carried out non-violent civil disobedience in the Health Minister’s office. During visiting hours, a friend and I were once charged with trespass and arrested for trying to hand out copies of anti-shock information to patients on a ward. We launched a court appeal, but lost.

Although there are anti-shock campaigns in various cities, unfortunately there is no national or international movement to ban it. I confidently predict there will be. (see Frank, 2006). In fact, five anti-shock protests were recently held in Toronto, Ottawa, Montreal and Cork, Ireland, on Mother’s Day in 2007 and 2008. The theme and slogan in all these protests was “Stop shocking our mothers and grandmothers”. The May 2007 protest in Toronto, organized by the Coalition Against Psychiatric Assault, attracted 140 people. It featured women shock survivors and other women speakers (see capacanada.wordpress.com).

PHYSICAL RESTRAINTS

On psychiatric wards, the use of 2-point, 4-point and sometimes 5-point restraints and solitary confinement (“seclusion”) is particularly alarming and dangerous. The many psychiatric prisoners and survivors I’ve talked with describe these restraints as cruel punishment or torture. Restraints consist of thick leather cuffs or straps tied around the prisoner’s ankles and wrists and anchored to the sides of the bed. As result, the prisoner can hardly move while being forced to lie flat on his or her back for hours at a time – sometimes days – with only brief restraint-free periods.

Since physically-restrained prisoners are also chemically restrained by the powerful neuroleptics or antidepressants, they are in fact doubly-restrained. A common reason staff give for restraint is so as to “control” or “manage” allegedly uncontrollable or disruptive prisoner behaviour. Or they cite staff shortages. Frequently, tying-up or caging psychiatric prisoners is for the convenience of the staff. Whatever the reason, the prisoner experiences restraint as severe punishment or torture.

To the best of my knowledge, there have been no significant restrictions in the use of physical restraints in Ontario’s psychiatric hospitals and wards. Back in the early 1990s, lawyer and former Ontario patient-advocate Duff Waring published a journal article criticizing the over-use of restraints in Ontario’s ten provincial psychiatric hospitals. There was no media or public concern about this article, or similar ones written by a few nurses – no public outrage. There should have been (Waring, 1991).

I still have a vivid memory of witnessing with horror my close friend Mel trying to raise himself up while being subjected to 4-point physical restraints, in the notorious Queen Street Mental Health Centre. (This is currently merged into the Centre for Addiction and Mental Health in Toronto.) The nurses and attendants alleged that he was

“uncontrollable”, and tied-up his wrists and legs. About the same time, they also threw him into “seclusion” (i.e., solitary confinement) for “head-banging behaviour”. That behaviour was actually agitation caused by one or more antidepressant. Staff on that ward kept Mel in restraints or in seclusion for several weeks. They finally released him in 1995, two years after several of us survivors and other activists protested outside that notorious psycho-prison.

Physical restraints have also caused deaths. A few years ago, in a series of articles published in *The Hartford Courant*, investigative reporters exposed hundreds of such deaths (Weiss, 1998). In Ontario, there has never been media or Government investigation into the use of physical restraints and “seclusion”.

There was also no media criticism or public outrage in Ontario over the brutal death of 26-year-old Zdravko Pukec, on September 26, 1995 in Whitby Psychiatric Hospital. Pukec was an immigrant, recently arrived from Croatia. At the time of death he was restrained by neuroleptics and cuffs. With the approval of administrator Ron Ballantyne, a head nurse called for help from the Durham branch of the Ontario Provincial Police (OPP). The police stormed the ward, pepper-sprayed Pukec and forced him to lie face-down such that he could barely breathe. Within thirty minutes he was dead. The coroner’s inquest was a sham. “Positional asphyxia” – not pepper spray or police assault – was listed as the major cause of death. No Whitby psychiatric staff and no OP police officers were seriously criticized, and no one has ever been charged. A good example of psychiatric justice in Ontario.

COMMUNITY TREATMENT ORDERS – THE LEASH LAW

Under Ontario’s neoliberal-conservative Government, a law was passed to permit the enforced drugging of psychiatric outpatients – otherwise known as “Community Treatment Orders” (CTOs). ‘Brian’s Law’ was named for an Ottawa sportscaster killed by someone with a psychiatric history. It was proclaimed by an amendment to the Mental Health Act in December 2000. CTOs are also law in Saskatchewan and British Columbia, and will probably become law in Manitoba and Alberta.

In the USA, these leash laws are called “Involuntary Outpatient Committal” (IOC). By 2008, more than 41 states had passed this draconian decree, targeting for outpatient treatment many thousands of psychiatric prisoners and survivors. This usually takes the form of forced drugging in a clinic, a doctor’s office or even at the patient’s home. In Ontario, under a CTO, you can be forced to take psychiatric drugs or electroshock for up to six months – but actually sometimes for years since CTOs can legally be renewed indefinitely. If you refuse an ordered “medication”, or fail to keep a doctor’s appointment in the community, an Assertive Community Treatment Team (ACTT, typically consisting of a psychiatrist, a psychologist, a nurse and a social worker) can forcibly drug you or force you back into a psycho-prison,

without benefit of a hearing or trial, and for a longer period of incarceration.

Between 1998 and 2000, several public protests against CTOs were organized by the survivor-led political action group People Against Psychiatric Treatment (PACT, now defunct). And despite continuing criticism of them, CTOs have not yet been challenged in any court, as a violation of the Canadian Charter of Rights and Freedoms. It’s time CTO and IOC laws were challenged as serious human or civil rights violations. So should Ontario’s Consent and Capacity Board be challenged. This is a quasi-appeal court which rubber-stamps virtually all psychiatrist-ordered treatments and involuntary committals. Appeals to this Board are almost a complete waste of time since this psychiatrically biased and Government-appointed tribunal rejects more than 90% of all patient appeals.

But it could be argued that CTOs violate several sections of the Canadian Charter of Rights and Freedoms – particularly section 7 which guarantees all citizens “the right to life, liberty and security of the person”; s9 which guarantees “the right not to be arbitrarily detained or imprisoned”; s12 which guarantees “the right not to be subjected to any cruel and unusual treatment or punishment”; and s15(2), the equality clause, which prohibits “discrimination based on mental or physical disability”, along with several other grounds including age, sex, colour, religion, and national or ethnic origin (Fabris, 2006; Weitz, 2000).

A CALL TO ACTION!

In the next few years we can expect more psychiatric imperialism – more invasions of our persons and communities, more CTOs and IOCs, more abuses, more forced drugging, more electroshock, more use of physical restraints, more patient deaths and cover-ups, more stigmatizing, more stereotyping, more biased reporting, more medical model myths and psychiatric lies promoted as “medical science” and parroted in the corporate-controlled media.

Violations of the human rights of psychiatric prisoners and other vulnerable populations will continue unless or until many more psychiatric survivors, anti-psychiatry activists, other social justice activists, human rights activists, dissident health professionals, and other concerned citizens start speaking out, fighting back, demanding action and real accountability and transparency from governments. At the provincial, state and federal levels of government, we need independent, public investigations of psychiatry’s numerous human rights violations. In practical terms, this means much more grassroots organizing, lobbying, networking, direct action and public protests in our own communities, cities, provinces, states, and countries.

10th December is International Human Rights Day, the day in 1948 when the UN General Assembly adopted the Universal Declaration of Human Rights. Forty-seven nations signed that historic UN Declaration and since then more than one hundred other countries have ratified

it. We should observe this important day by remembering and celebrating the lives of the many courageous psychiatric survivors, political prisoners, colleagues and friends, mothers and fathers, brothers and sisters, sons and daughters, who suffered and died while struggling for their rights in the psycho-prisons and in the community.

Let us re-dedicate ourselves to the fight against psychiatric oppression, and for human rights for everyone everywhere. We owe this to ourselves, to all psychiatric survivors, to all political prisoners, and to everyone struggling to be free of psychiatric and state oppression, struggling to speak truth to power, struggling to be human. Our human rights are worth fighting for, even dying for. Every day should be Human Rights Day.

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PSYCHIATRY & OPPRESSION

A personal account of compulsory admission and medical treatment

Dr B Gray is an academic and a researcher in the field of mental health. He was also diagnosed with schizophrenia in 2003, spending a total of twelve months in a mental hospital.

So as to make a polemical and admittedly one-sided case against traditional psychiatry and compulsory medical treatment, he now tells of his personal experiences. They suggest to him that we need a modern kind of anti-psychiatry. Dr Gray concludes that there needs to be more attention paid to voice-hearers' stories and accounts of mental illness.

Hearing voices: A personal story

My negative conception of traditional psychiatry and compulsory treatment is certainly coloured by the twelve months I spent in an acute psychiatric unit. Although physical force was never used against me, I was kept in the unit under Section 3 of the UK's Mental Health Act. I was obliged to stay in hospital and take anti-psychotic medication against my wishes.

Perhaps quite rightly, my strange religious beliefs were classified as delusions and discounted by my family, my psychiatrist and the nurses. But this left me with the impression that my experiences, however negative and painful, were also simply discounted. I felt that, in any humane manner, no-one was listening so as to understand me. Szasz's famous line often came into my mind: "If you talk to God, you are praying; if God talks to you, you have schizophrenia."

*

Among the people I met during my time in hospital was Rosemary. She was an unassuming, quietly spoken woman, unremarkable apart from an air of sadness. Rosemary had told me - and many of the nurses - that rather than hearing any more of the terrible voices that kept her from sleeping, she would be better off dead. "Better up there with my mother in

heaven," she told me, "than down in the hell of the psychiatric ward with my voices."

Within a few days of being discharged, Rosemary was "up there with her mother". The nurses called a meeting in the communal lounge. There had been an accident. Rosemary had thrown herself in front of a train. The girl next to me burst into tears ...

*

Night after sleepless night, and through the long, seemingly endless days on the ward, where smoking and television stood instead of any attempts to engage in therapy, my fellow patients and I experienced similar feelings to those of Rosemary – feelings of loss, isolation, pain, sorrow, self-pity, confusion and helplessness.

"You're alone," an insidious voice whispered to me. "You're going to get what's coming to you."

"You're going down there!" it shouted. "You wait until you see what I'm going to do to you!"

My voices would often shout at me, and when I heard them it surprised me to see that no-one around me moved or looked startled. It was just me hearing the voices. I tried not to answer them: Better to ignore them, repress them and soldier on, I thought. I had seen others screaming back at their voices, and it had left me with mixed feelings of consternation, pity and fear. I didn't want to look mad, like them. Any symptoms of hearing voices would go on the medical casenotes, to be brought up at my case reviews, as evidence of insanity. And that would keep me locked up in the hell of the ward, away from family and friends, and from what seemed like a far distant normal life.

I learned several important lessons, as well. Never admit you hear voices. Certainly never answer them. Do exactly as you are told by staff or concerned family, or they will view you as ill. Never question your diagnosis or disagree with your psychiatrist. Be compliant and admit your mental illness, or you'll never be discharged.

All the time the voices got worse.

"Hot fire in your eyes!", shouted a voice to me, in the hell of the ward. "That's where you're going! Into the fire of the sun!"

*

Both as a patient and as researcher and academic, I have spoken with hundreds of people diagnosed with a mental illness. Many of them tell me that they have had to suppress and hide their voices so as to be considered stable and well. In this way, symptoms are suppressed, but so is individuality the very person. This is why one might argue that traditional psychiatry is little more than an instrument of oppression and social control, and a system of so-called scientific beliefs that – albeit perhaps unintentionally – crushes people's subjectivity, choices and human rights.

Of those people I have spoken with who were diagnosed as schizophrenic or mentally ill, the majority find meeting their consultant psychiatrist threatening since any unusual thoughts or behaviour are so easily taken out of context and construed as psychotic. From my own personal experience in a psychiatric acute unit, I have to agree. Many people with mental health problems are genuinely afraid of meeting their psychiatrist, or with other members of the mental health team.

Before his weekly case review with his psychiatrist, I remember seeing a teenage boy on the ward wringing his hands and literally shaking with fear. This very much concerned me, the nurses, the boy's mother, and his mental health advocate.

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So it is that many people with mental health problems hide

their symptoms, their aberrant beliefs and their voices, in order to stay out of hospital. But this means that they are ostracised in their lives, and that there is a lack of any real dialogue between mental health professionals and those with mental health problems. Of course, this also means that there may be a lack of disclosure, of what is really going on in people's lives and of what voices they may be hearing.

Due to fear of the psychiatric encounter, and of punitive intervention or compulsory treatment, psychiatrists and mental health professionals are simply not getting the full picture. So how can they make rational decisions about care plans and treatment? This is also true of family carers, who are increasingly being called upon to provide round-the-clock support, 'in the community', for people with mental health problems. Family carers are often little more than the unpaid work horses of community care, but they lack the skill and information necessary to provide adequate support to the relative who may hear voices.

*

The most worrying result of the failure to genuinely listen to patients is that violence is sometimes used so as to get the non-compliant to take their medication (usually via depot injection). This violence is always conceived of as right, just and in the patient's best interest. Certainly, many nurses I have spoken to have said that they do not like administering forcible injections. But they also say they have "a duty of care". 'Violence as care' is an oxymoron which hides the institutionalised abuse of people with mental health problems. I have witnessed eight occasions where patients have had to be violently restrained by staff, but only two assaults by patients on staff. My experience is in line with the general evidence that people with mental health problems are much more likely themselves to experience violence, rather commit violence on others.

*

Psychiatry generally takes the bio-medical approach, with prescriptions of powerful anti-psychotic medications, including drugs such as olanzapine, risperidone and clozaril. I have been prescribed each of those. But these powerful drugs have serious and debilitating side effects – they are toxic and over the long term often have harmful effects. The anti-psychotics have often been termed 'the chemical cosh' since they leave people passive, debilitated and zombie-like. This suggests that they lead to the tranquilisation of people's personal beliefs (however irrational) and their thoughts, subjectivity and feelings. Such an approach could certainly be argued to crush diversity and discount the diversity of people's experiences of life, all in the name of normalisation and keeping a stable social order.

To put it crudely, popping a pill is far less of a burden on the NHS, with its limited resources, lack of money, severe pressures on beds and general lack of inpatient provision. Meanwhile, Care in the Community is limited in scope and often means: no care in the community. This leaves those with mental health problems feeling that they are ostracised, abandoned or invisible, and, at best, having to depend on family carers who lack the knowledge and expertise to deal with their distress or mental health problems.

*

All of this means that there is little attention paid to what a schizophrenic's voices say to him. Yet such attention would make people's experiences more valid and meaningful, besides lending itself to a more humane account of mental illness. At the moment, the experience of hearing voices is silenced. That can only augment ignorance and fear, both within society and the mental healthcare system. Far too

little attention is given to what people with mental health problems think and feel, and what treatments they would prefer. Psychiatry is over-reliant on powerful anti-psychotic medications, and the waiting lists for less invasive treatments, such as counselling and cognitive behavioural therapy, are too long.

*

To complicate and make matters worse, when the voices are raging inside you and shouting you down it is almost impossible to talk with other people, and relate the pain that they inflict. It is even harder to face the voices and achieve what psychiatrists and mental health professionals call 'insight'. My voices, in particular, often sounded telepathic – as though people were speaking to me through their minds. My voices would often be racist or abusive about mental health staff and other patients. It is perhaps not surprising that voices like these, if dismissed as bizarre delusions and not discussed as at least subjectively 'real', may sometimes lead to violent behaviour toward staff, other patients or (as I have witnessed) the smashing of hospital furniture, equipment and the television from which the voices seem to emanate.

*

To reiterate, the main point is that these voices are silenced and dismissed as delusions, and that they are managed mostly by medical treatment. Hence, they are not addressed in those humane and sympathetic terms which might begin to tackle the root cause of the problem, and which, in turn, might help people cope with their voices through greater insight.

The over-reliance on medication is perhaps not surprising, given that people who hear voices may be perceived as aggressive, irrational and violent. My voices often took on a demonic or hellish quality: "You think you've been exploited and abused?" a demonic voice often shouted at me. "You wait until you see what I'm going to do to you! You wait until you see what I look like!"

But this is partly the point: other people cannot hear the schizophrenic's voice. There needs to be a dialogue so as to treat as valid and meaningful the voice-hearer's experience (Foucault, 1992; Laing, 1967). Democratic psychiatry listens to people with mental health problems and is open to their experiences and voices. The voice-hearer is then not stigmatised which, in turn, may lead to a more holistic, democratic and sensitive delivery of mental health care.

Discussion: The rise of democratic psychiatry and the hearing voices movement

What I have learnt as an academic and researcher, as well as a mental health patient labelled with schizophrenia, is that what people with mental health problems want is to be treated as equal citizens with equal human and medical rights. People with mental health problems who hear voices or hallucinate want to be valued – as we all do – not feared and ostracised. They want their views and opinions taken into account, especially as regards their care plans and what sorts of treatment they will have. They want the right to accept or refuse medication, and not have it forced on them supposedly for their own good. At the very least, people with mental health problems want their narratives and voices to be valued and taken into consideration.

Such an approach would take into consideration people's diversity – their diverse experiences and beliefs – and not label them as mad or bad, but value them as human beings, with all the faults and strengths that this entails. Such an approach would give rise to a more democratic and person-centred psychiatry. Rather than discounted as delusions, it would respect mental health patients' experiences as a form

of expertise to be shared with the professionals.

what is required is a balance of perspectives between traditional psychiatry and the diverse experiences of people with mental health problems. This would aim to achieve a consensus on pathways of treatment, and innovative or alternative methods of mental health practice (Stastny and Lehmann, 2007). Hearing Voices groups and voice-hearers' internet discussion forums are just two contemporary examples, as is the use of Advance Agreements and Directives.

Central to this process is the rise of the movement for democratic psychiatry, led by organisations such as Asylum, Intervoice, MindFreedom and the Hearing Voices Network (see web-links, below). Instead of ostracising and silencing people who hear voices, democratic psychiatry and the Hearing Voices movement creates space for their voices, personal thoughts, experiences and narratives. This will lead to more humane and holistic approaches to understanding and treating schizophrenia or other kinds of mental illness in the future. Rather than doing things 'to' or 'for' people, psychiatry must begin to work 'with' them.

According to Romme and Morris:

The term 'schizophrenia' is not just stigmatising, but also fundamentally flawed. It is a label without scientific validity. Diagnosis ignores connections between life experiences and core illness experiences. We urge mental health professionals to listen to what their patients are telling them and help them understand their experiences. (Romme and Morris, 2007, p.7).

A call for the personal stories of voice hearers

Intervoice and Dr Gray are in the process of putting together a book on the experiences and stories of hearing voices, entitled *Hearing Voices: The Personal Stories of Voice Hearers*.

This innovative book will be about all sorts of voices and voice-hearers, and all sorts of points of view, experiences and personal journeys. For example: what did the voices say? How did they make voice hearers feel? what were the reactions of family, friends and mental health professionals?

If we are going to change and improve the lives of people with mental health problems, then personal stories and journeys to recovery and insight are arguably the first place to start.

For more information or to contribute, please email: voices2009@hotmail.co.uk

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Web Links

- Asylum Magazine: www.asylumonline.net
- Hearing Voices Network: www.hearing-voices.org
- Intervoice: www.intervoiceonline.org
- MindFreedom: www.mindfreedom.org
- Rethink: www.rethink.org

Building a global network of activists organizing against Psychiatry

Co-chairs: Shaindl Diamond and Bonnie Burstow

May 7th and 8th 2010 saw a groundbreaking conference in Toronto. According to its mandate, the aim was: "To provide a forum for scholars, activists, radical professionals, artists, psychiatric survivors and mad people from around the world to come together and share experiences of organizing against psychiatry. Dialogue about these experiences was intended to foster networking and coalition-building across disciplines, social justice movements, and geographical locations; to clarify some key goals in the struggle against psychiatric oppression; to develop some longer-term strategies to help us achieve these goals; and to help us critically examine how we use specific tools for social change, such as the law, science, theory, media, art, and theatre."¹

The conference was initiated by the Coalition Against Psychiatric Assault (CAPA) and sponsored by the Ontario Institute for Studies in Education at the University of Toronto (Department of Adult Education and Counselling Psychology at OISE/UT). It was supported generously by a wide range of academic and community groups² and individual donors. Volunteers included students and community activists who worked long hours behind the scenes to make the conference a success.

About two hundred people attended from across the globe – from Canada, USA, Germany, England, India, Ireland and Australia. Presentations included keynotes, papers and workshops. The keynotes were David Oaks from MindFreedom International (USA); Peter Lehmann from In Any Case (Berlin); Bonnie Burstow from OISE/UT and CAPA (Canada); and Dan Taylor from MindFreedom Ghana (Ghana).

David Oaks opened the conference with an exciting, futuristic-feeling keynote: 'Planet Earth Gets Mad Pride!' His delivery was a gripping performance of a conversation between his future, present and past selves. This imparted wisdom gleaned from years of activism, and imagined possibilities for the future of our movement. Peter Lehmann's keynote, also on the first day, was shorter: 'Resisting Psychiatric Assault – a European initiative to introduce a Suicide Register'. This demonstrated the critical need to track those suicides resulting from psychiatric interventions. The longest presentation was Bonnie Burstow's keynote, on Day Two: 'The withering Away of Psychiatry: An Attrition Model for Anti-psychiatry'. Beginning with an impassioned plea for different parts of the community to pull together, she forwarded the case that the abolition of psychiatry can only be achieved over time. She outlined guidelines for assessing choices and actions. The last of the keynote speakers, Dan Taylor, was prevented from coming to the conference when denied a travel visa. We learnt that this is a systemic problem for African visitors, and we have been organizing against it ever since. His presentation, 'Community Awareness Vis-à-vis Psychiatric Abuses in Ghana', was read by Eugenia Tsao. It outlined some of the problems faced by mad people in that country, and the initiatives of MindFreedom, Ghana.

Thirty-eight papers were presented, and there were seven panels and eight workshops. Topics were as diverse as Resistance from the Vantage Point of a Nurse, to The Auto-ethnography of a Mad Woman, to Suing the Drug Companies. Highlights included:

- A theatre workshop facilitated by Christine Mayor and Naomi Tessler.
- Scholars and mad people uniting across differences to defend the conference from an attack by a national newspaper. This

led to some brilliant letters to the editor, four of which were subsequently published.

- The plenary, during which the 200 participants passed a resolution against electroshock. This was subsequently read out in the House of Commons.
- On May 9th at Queen's Park, after the conference, a Mother's Day demonstration against electroshock.

This conference was important for many reasons. First and foremost, it is the first conference solely focused on resistance to psychiatry. The fact that it was so eagerly attended is encouraging. What adds to this is that it was held when other conferences are losing their radical edge due to pressures from the psy-industry. Witness Alternatives 2010 (in California), where attempts were made to remove from the agenda the outspoken journalist Robert Whitaker (who examines the dangers of psychiatric drugs) and a workshop about coming off psychiatric drugs. These were only reinstated after an outcry from many psychiatric survivors, mad people and their allies.

What was also timely and important was the conscious and whole-hearted attempt to bring the different streams of this community together. Significantly, while the organization that initiated this conference is anti-psychiatric, the organizers ensured that three of the four keynotes were from other elements. Presentations with a myriad of different perspectives were accepted, and there was an emphasis throughout on people in the movement accepting differences and pulling together. Likewise, there was a conscientious attempt to look at the intersections between psychiatric oppression and other forms of oppression. Accordingly, presentations addressed issues within psychiatry such as sexism, racism, ableism, classism, heterosexism and transphobia. The organizers also tried to create an accessible conference. They were very grateful to Students for Barrier-Free Access, an organization at the University of Toronto, which helped us find ASL interpreters for Deaf participants, provided advice for challenging ableist policies in the university, and shared helpful guidelines for creating an accessible event.

Another feature of the conference was the fact that about three-quarters of the presenters were psychiatric survivors or mad people. Correspondingly, depending on how it is measured, either three-out-of-four or all of the keynote presenters were psychiatric survivors. Related to this, given that the vast majority of the participants were also scholars in their own right, this conference questioned the conventional differentiation between mad people, scholars and professionals. It was made abundantly clear that people can fit one, two or all three categories.

There is always opposition to conferences like this. But what was unique about this one was that resistance to that opposition became part of the conference itself. There was a panel which looked precisely at the problems that academia presents to people who advance a critique of psychiatry and mount such a conference. Participants studied and then responded to a front-page 'exposé' in the major Canadian daily, *The National Post*, which ran into three pages. Reporter Joseph Breen described the conference as 'a totally slanted meeting of ideological zealots that has no proper place at a university'. He characterized participants as 'paranoid, fringe, delusional, nutty, crackpots, extremists, conspiracy theorists, and donkeys'.³ Those participants who criticised his article were able to show that our conference was scholarly, inclusive and profound.

The final contribution to the conference was made by participant Lauren Tenney, who announced that organizers in New York would host PsychOUT 2011: A Conference for Mobilizing Resistance Against Psychiatry. This was billed for

June 20th and 21st, at the Graduate Center at City University of New York. And it would immediately follow a demonstration and vigil to mark three years since the murder of psychiatric inmate Esmine Green at Kings County Hospital Center, Brooklyn.

There are many lessons emerging from this groundbreaking conference. Here are some of the more important:

- We can unite across differences.
- Every fight that you take up inevitably leads you to new fights that likewise need to be taken up.
- Even a small grassroots group with no money can initiate a major and successful global conference.

We welcome organizers from other places around the globe to continue the PsychOUT tradition and create venues to share our creativity, knowledge, skills, strategies, and explore how to build stronger networks committed to mobilizing against psychiatric oppression.

1. PsychOUT Committee: 'Conference Mandate', PsychOUT Conference Website, <http://ocs.library.utoronto.ca/index.php/psychout/>, 12.10. 2010.

2. The following organizations generously supported the conference: Office of the Associate Dean, Research, OISE/UT; Women and Gender Studies Institute at the University of Toronto; Sociology and Equity Studies at OISE/UT; Centre for Women Studies in Education at OISE/UT; Tooker Gombert Greenspiration Fund; Transformative Learning Centre at OISE/UT; Nova Scotia Cerebral Palsy Association; DisAbled Women's Network Ontario; the Opal Project; Nationwide Call to Action: Stop Forced "Mental Health Treatment"; No Involuntary Outpatient Commitment Campaign; Mindfreedom International; Students on Seven at OISE/UT; Toronto Women of Colour Collective; Resistance Against Psychiatry; Students for Barrier Free Access at U of T.

3. J. Brean: 'Delusional movement to depose psychiatry emerges from the shadows.' The National Post, 8 May, 2010.

WE DO NOT BELIEVE IN SILENCE

Clare Shaw introduces the new, regular creative writing section she will co-edit with Phil Thomas.

I do not believe in silence

Because, tonight –
however I try – I cannot get downstairs
without waking my daughter
I do not believe in silence.

Because of the Warboys enquiry,
because of the two hundred-plus women he raped –
because of the policeman defending the findings
unable to utter the word –
“this (herrrrm) crime, this (ahem)
assault, this category (cough)
of offence” –
I do not believe in silence

Because of the stairs and the banister's crack;
the sound of the lock
and my hand on the door – the fifty-tone creak –
the magnificent echo of light-switch and click –
I do not believe in silence.

Because of Neda – and everyone's sister –
and the man who said 'Don't be afraid';
for the sake of my daughter, because of the burkha,
because of the patter of rain;
because of two hundred-thousand years of human history,
thirty-seven of them my own –
I do not believe in silence

for the sake of my arms, the wrists especially.

With respect to my legs
and my belly and chest
and the comfort long due to my throat

because of nightclubs at one a.m.
and shouts in the street and feet in pursuit
and shops that don't shut;
because of sirens and the dealers downstairs;
because of Levi and Akhmatova;
because of the blue-lipped prisoner;
the itch and the scratch of my pen;

I believe in the word.
I believe in the scrabble of claws
on uncarpeted floors.
I believe in my daughter's complaints.
I believe in the violin, the E-string,
the see-sawing bow; the cello
straining its throat.

I believe in the heart and its beat
and its beep and the dance of the trace
on the screen, I believe in the volume
of colour turned up, and my blood
which was always too loud.

Because of nights, and the sweats,
and the same rowdy thoughts;
because that one afternoon
when I nailed my own voice to the air
and because there was nobody listening
and through it all
birdsong
and the sound of cars passing –

I do not believe in silence.

Because, as the poem says, in this noisy, colourful, never-still, packed-full world of ours there never could be anything that could rightly be described as true silence. And even if there was, I wouldn't want it in my life, not for long.

Why? Because alongside the inner silence of spiritual practice, we have the experience of being silenced. Alongside 'silence is golden', 'breaking the silence' – the imperative to speak out about domestic violence, sexual abuse and, of course, psychiatry. I do not believe in silence. Not just because of the existence of wrong. But also because I love life and all of its movement and mess and noise.

Asylum magazine is based on the necessity of speaking out. On the premise that the more voices we listen to, the better. No one has privileged access to The Truth – whether it's the truth of the meaning of life, the cause of distress, or the way honey looks in a jar. Yet many of us will have been subject to the lie that someone 'in authority' knows better than us – that the diagnosis we have been accorded speaks the truth of our life more accurately than any of the stories we tell.

I was told that the diagnosis 'Borderline Personality Disorder' spoke some essential truth about me and my life. For this and other reasons it's become vitally important to me to tell the truth of my own existence, in my way.

And still more of us will have been told that our voices, our ways of expressing ourselves, are not up to scratch. Even at the point that my first collection was being published to critical acclaim, my cognitive behavioural therapist informed me that my problem was that I was unable to express myself. There are none so deaf as those who will not hear.

Asylum magazine will regularly devote a page or so where voices will be heard.

Creative writing – stories, poems, pictures, prose, plays, whatever you choose to do with words – offers us an almighty opportunity. As both Phil and I can attest. Like the chance to look at the world afresh. To break all the rules and to invent some. To invent whole worlds and have them shared by others. To acknowledge that there are an infinite number of truths. To speak yourself, to make yourself, and to set the rules of your own conversation. And for those of us whose experiences, ways

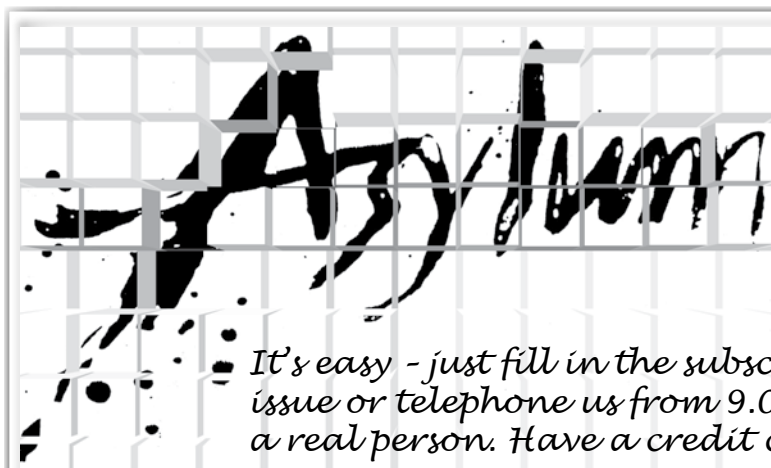
of seeing the world and methods of expressing ourselves set us outside what's expected – well, we have a head start.

There will be a space for all languages on these pages – but especially language used creatively. Language that breaks the rules. Language which uses the rules for its own astonishing ends. Language which gives a home to all those experiences which have no home in the commonplace. We all have something to say of worth. We all have stories to tell, songs to sing, pictures to paint. Here's the space where we get to do that. In our way.

Each edition will feature the work an established writer, along with a short interview. Expect to see writers you will certainly have heard of, alongside others you'll be glad to be introduced to. We'll feature writers with their own experiences of psychiatry or distress. And we want to hear from you. Send us your work: poems of up to 500 words, and short stories or excerpts from longer pieces of work, up to 250 words. We're particularly interested in work which explores issues relevant to the issues covered by *Asylum*.

Clare Shaw is a key figure in the UK self-harm survivor movement. She's also 'one of Britain's most dynamic and powerful young poets' (the Arvon Foundation). Her first poetry collection, *Straight Ahead*, was published by Bloodaxe in 2006, and attracted a Forward Prize Commendation. Her second collection will be published by Bloodaxe in 2012.

Philip Thomas trained as a psychiatrist in Edinburgh, and worked as a full-time consultant psychiatrist in the NHS for more than twenty years. He left clinical practice in 2004 to focus on writing. He is well-known internationally for his academic work in philosophy and its relevance to madness, diversity and identity in psychiatry and society. He has worked closely with survivors of psychiatry, service-users and community groups, nationally and internationally. Until recently he was chair of Sharing Voices Bradford, a community development project working with Black and Minority Ethnic communities. He is a founder member and co-chair of the Critical Psychiatry Network. His first book, *Dialectics of Schizophrenia* was published by Free Association books, and he has co-authored two other books, most recently *Postpsychiatry*, with Pat Bracken (Oxford University Press, 2005). He is currently writing a book about critical psychiatry, and another on culture and madness.



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ASYLUM at Manchester's OKasional Café

Supporters of *ASYLUM* magazine ran a workshop at the The OKasional Café in Manchester in October – Should anti-capitalists be anti-psychiatry? The OKasional Café is a temporary space – a volunteer-run, squatted social centre.

It has a daily cafe, regular vegan meals and functions as a radical space for meetings, organising actions, workshops and events. For example, activists are organising opposition to the ban on squatting. At the time of writing, anti-capitalist protesters are peacefully camping outside St Paul's Cathedral in London. Discussion continues amongst the media and politicians whether they should be forcibly removed, echoing the recent violent eviction of Traveller communities at Dale Farm.



Unfortunately, mental health is a topic that is still rarely touched upon by the radical left. So the workshop and discussion asked – why is mental health an important issue for anti-capitalists and anti-authoritarians?

To kick off the workshop Helen Spandler offered ten reasons why anti-capitalist activists should care about mental health, and why we should see it as a political issue. People added many more reasons during the discussion (too many to list here!). As one example, Dina Poursanidou talked about the impact of the Greek economic crisis on mental health, and especially the alarming increase in rates of suicide and attempted suicide among those directly affected by the crisis. Capitalist values (such as competitiveness, individualism and consumerism) are not only bad for our mental health, but neither do they readily produce qualities (such as compassion and common humanity) that are necessary to support people in crisis. In particular, capitalism doesn't create any real collective care and support for people in crisis e.g. genuine asylum, sanctuary or refuge. Instead it prioritises short-term, quick-fix solutions to maximise productivity and profit and reduce welfare spending.

we discussed why we need 'asylum' as a place of refuge and sanctuary when we are in crisis – a space that cannot be violated. Dina talked about the notion of 'University asylum' in Greek Law which specifies universities as spaces that cannot be entered forcibly by the police, so that people finding refuge within universities are protected. It seems clear that neither psychiatric hospitals nor universities offer people genuine asylum. Other government policies, including the ban on squatting, makes it hard for people to develop their own alternatives to hospitalisation, such as 'crash houses'

for people in crisis – like the Mental Patients Union did in the early 1970s.

We also discussed how, as activists, we might need to challenge our own culture and attitudes towards mental health difficulties and offer solidarity to people labelled 'mentally ill'. we discussed finding ways of offering support to one another – to prefigure the kinds of mental health support that society needs to develop. *ASYLUM* is proud to be part of this exciting initiative and to have helped facilitate a lively debate on mental health and psychiatry – hopefully it will lead to more reflection and further action. we hope that anti-capitalist activists will take radical mental health politics seriously (and vice versa).

Thanks to Steve Graby and Lauren wroe for helping organise this event. Our friends and colleagues from the OKasional Café and *SHIFT* magazine will be helping us put together a special issue of *ASYLUM* on anti-capitalism and mental health in the near future. watch this space!



For more info: The OKasional Café at: <http://okcafe.wordpress.com/>
Shift magazine at <http://shiftmag.co.uk/>

The Observatory for Rights in the Field of Mental Health was founded in 2006. Its purpose is to defend the rights of persons implicated in the mental health service system, and to promote alternative, non-psychiatric ways of managing distress. The Observatory is a network of people involved in the mental health system, that is to say, users of psychosocial services, relatives, mental health professionals and employees. It is based in Thessaloniki, but it accepts demands and complaints at the Greek national level, and it organises relevant actions, usually in collaboration with other organisations. The Observatory is open to anyone who shares its philosophy and aims.

PRINCIPLES

In the last few years legislation has been introduced in Greece with the declared intention of protecting persons with mental health problems from acts of violence and abuse. But this has not been achieved in practice. Mental distress and experiences which deviate from 'the norm' are attributed to a specific form of illness which, unlike other illnesses, is considered beyond the mental control of its bearer. Consequently, the management of this illness is assigned by the state to systems of social control and suppression which are incompatible with the usual notions of illness and treatment. This practice, which is supported by the dominant mentality of mental health professionals and by public ignorance and fear, leads to mental distress being treated as something akin to an offence, for which the sufferer is punished. This is done by discrediting their speech, personality, capacities, wishes, dreams, personal and social rights, and control over their own life.

The main principles underscoring our initiatives are:

- Whether they become at some time users of psychosocial services or not, the concept of the personal and social rights of every citizen is valid over and above supposedly scientific or any other interpretative theories. This cannot be subject to negotiation.
- The violation of these rights constitutes violence against the persons whose rights are violated.
- The existing mental health system is largely structured in a way that produces and reproduces such forms of violence. This is primarily by means of the political and existential discrediting of its users, but also through specific daily practices, both in closed institutions and in the community.
- Albeit in different ways, this context of supporting violence inevitably affects not only the users of services but also their families. When they violate the rights of persons who find themselves in crisis (or are ordered to do so), it also affects the employees of the various mental health agencies. In this sense, society as a whole is also affected, since it maintains institutionalised practices of violence upon its weakest members, excludes them and keeps them in ignorance. We contend that this directly offends the ethics and culture of society as a whole.
- As informed and concerned citizens, who do not wish to remain observers of this situation.

AIMS

- To begin a public discussion concerning the social management of mental distress.
- To change the prevailing view of mental health and the so-called mental disorders.
- To inform the public on matters concerning the rights of users of mental health services and of workers within them.
- To resist the logic of institutionalisation, social exclusion, the exercise of any form of violence, and the violation of human rights in the field of mental health.

HELLENIC OBSERVATORY FOR RIGHTS IN THE FIELD OF MENTAL HEALTH

- To contribute to the development of alternative forms of the social management of mental distress.
- To defend and expand the rights of persons in distress, both in and out of the mental health service system.
- To promote the participation of the users of psychosocial services at all levels of decision-making which concern them.
- To promote the view that, along with any other parties involved, family members of persons in distress are directly concerned with matters of mental distress, and deserve equal attention, support and the inclusion of their views

ACTIONS

Gathering information regarding the violations of rights

This concerns (a) incidences of abuse of in-patients in public and private mental health facilities; (b) cases of violation of the rights of users or ex-users of mental health services, of their relatives, as well as of workers in this field; (c) incidents and questions regarding ethical issues; and (d) gaps in the mental health service system.

On the basis of the demands or complaints it receives, the Observatory acts either collectively, by initiating formal complaint procedures, or individually, by supporting persons concerned with defending their rights. The prerequisite for undertaking action of any kind is the concerned individual's consent, active participation and joint shaping of decisions at every stage of the action taken.

Complaint regarding violations of rights in private psychiatric facilities

In April 2008, on the basis of complaints by interested persons, the Observatory sent a written complaint concerning the violation of human rights in private psychiatric facilities to the Committee for the Protection of Rights of Persons with Mental Disorders, Greek Ministry of Health and Social Solidarity. This complaint demanded the investigation and restitution of the incidences and conditions reported therein. The Committee conducted an investigation and made recommendations to the facilities concerned. However, according to information obtained from persons hospitalised in the facilities concerned, the Observatory has learned that, until now, nothing has changed with regard to the issues that were raised. We continue to apply pressure to the Ministry, and we have initiated a media campaign on this matter.

Supporting individual persons in defending their rights

In cases of persons contacting the Observatory with complaints regarding violations of their rights during their involvement with mental health services, or persons who express an intention to exercise their rights, the Observatory supports the persons concerned (a) by informing them of their rights and the legal ways to defend them; (b) by referring them to legal or other professionals who may initiate actions on their behalf.

Operating a Public Information Office in Thessaloniki's Psychiatric Hospital

Volunteer members of the Observatory work in the Public Information Office run by the Thessaloniki Parents' Association for Mental Health. This is situated in the grounds of the Psychiatric Hospital at Thessaloniki. Hospitalised persons, their families and other concerned persons are informed of their rights and supported in any relevant action that they may wish to undertake.

Promoting the Psychiatric Will

The Psychiatric will is used in many countries as a way of safeguarding a person's self-determination during their admission to psychiatric facilities. This document is signed in the presence of a notary or lawyer. It contains the person's decisions regarding what they wish to allow and what they forbid to be exercised on their body or mind during the course of a prospective psychiatric hospitalisation (whether voluntary or compulsory), in accordance with their constitutional rights to individual freedom and self-determination. The person can also name specific persons as his or her legal representatives. Using all legal means, these representatives take on the responsibility to ensure that the person's expressed will is respected in cases of hospitalisation in a psychiatric unit. The Observatory supports anyone who wishes to compose a psychiatric will (a) by providing relevant information, (b) by providing a template of a psychiatric will on its website, and (c) by referral to legal professionals.

Support network for persons wishing to stop psychotropic medication

Members of the Network can be mental health professionals and persons with psychiatric experience who wish to support others as they gradually reduce psychotropic drugs so as to restore or maintain their mental health without chemical means. The Network does not encourage anyone to discontinue psychotropic medication, but it aims to support those who have already made the decision to do so. This is so that detoxification is achieved whilst minimising the potential dangers to their health from a sudden and un-informed discontinuation.

Hellenic Hearing Voices Network

The Hellenic Hearing Voices Network is part of Intervoice, the international Hearing Voices network. The Hellenic HVN has operated at the national level since 2010. The section that functions in Thessaloniki operates under the auspices of the Observatory. Thessaloniki has a self-help and support group of persons who 'hear voices' or have 'unusual beliefs'. We also organise events and collect and translate materials regarding our specific approach to voices and unusual beliefs. This is available on the Observatory website, and it can be forwarded to interested persons. Finally, so that support can be given to whoever requests it, we are planning training in the individual support of persons who hear voices or have paranoid ideas.

Providing support for setting up and running self help groups

As part of the Hearing Voices Network, and supported by The Observatory, there is already a self-help group for persons who hear voices or have unusual beliefs. The Observatory can support the setting-up and running of self-help groups (a) by providing information regarding self help, and (b) by providing a space and infrastructure for the functioning of the group.

Promoting alternative ways of managing mental distress

With the aim of promoting freedom of choice, which is fundamental to the exercise of the rights of the users of psychiatric services, the Observatory seeks and promotes alternative modes of managing distress (a) by producing and translating relevant information, which is made available via the Observatory website, (b) by organising lectures, seminars and other public events, and (c) by seeking, promoting and publicising existing alternative practices in Greece.

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TROUBLE AT T' DIAGNOSTIC & STATISTICAL MILL

Gary Greenberg, a practising psychotherapist, exposes conflicts over the revision of psychiatry's 'bible', the *Diagnostic and Statistical Manual of Mental Disorders*.

It seems there have been intense disputes between leaders of the psychiatric industry over the upcoming version of the DSM. Al Frances was lead editor to the fourth edition – DSM-IV. In 2010 he was interviewed by Gary Greenberg, who found a troubled psychiatrist. Every so often Frances would say something very surprising, such as: '... there is no definition of a mental disorder. It's bullshit. I mean, you just



can't define it ... These concepts are virtually impossible to define precisely with bright lines at the boundaries.'

Frances came out of retirement to launch a bitter and protracted battle with the people, some of them friends, who are working on the next edition of the DSM. He has

criticized them repeatedly – and not in professional mumbo-jumbo that would keep the fight inside the professional family, but in plain English, in newspapers, magazines and blogs. He accuses his colleagues not just of bad science but of bad faith, hubris and blindness, of making diseases out of everyday suffering and, as a result, benefiting the drug companies. These aren't new accusations to level at psychiatry but Frances used to be their target, not their source.

In its first official response to him, the APA diagnosed Frances with 'pride of authorship', pointing out that his royalty payments would stop when the new edition is published – a fact that 'should be considered when evaluating his critique and its timing'. But Frances claims he doesn't care about the royalties, which only amount to \$10k a year, chicken-feed to a retired senior psychiatrist. He also claims not to mind if the APA cites his faults. He just wishes they'd go after the right faults – the serious errors in DSM-IV, now set to be perpetuated in DSM-5. 'We made mistakes that had terrible consequences', says Frances. Diagnoses of autism, attention-deficit hyperactivity disorder, and bipolar disorder have sky-rocketed, and Frances thinks that DSM-IV inadvertently facilitated these epidemics. And, in general, DSM-IV fostered the ever-increasing tendency to explain away any of life's difficulties as mental illness, and then treat them with psychiatric drugs.

The insurgency against DSM-5 (the APA decided to shed the Roman numerals) has spread far beyond Allen Frances. Many senior psychiatrists and even some contributors to the new edition have expressed grave reservations about it. Dissidents complain that the revision process is in disarray and that the preliminary results (made public for the first time in February 2010) are filled with potential clinical and public-relations nightmares. Although most of the dissenters on the DSM committees are squeamish about making their concerns public – especially due to a very restrictive nondisclosure agreement which all insiders were required to sign – they are becoming increasingly restive. Some are beginning to agree with Frances that public pressure may be the only way to derail a train that he fears will 'take psychiatry off a cliff'.

At stake in the fight between Frances and the APA is more than professional turf, more than careers and reputations, more than the \$6.5m in sales that the DSM averages each year. The DSM is now the basis of psychiatrists' authority to pronounce on all mental health matters, and to command healthcare dollars from insurance companies for treatment, and from government agencies for research. The DSM is as important to psychiatrists as the Constitution is to the US government, or the Bible to Christians. It is also the authoritative text for other mental health workers, psychologists and social workers. It is invoked by lawyers when arguing over the culpability of criminal defendants and by parents seeking school services for their children. Frances warns that the new volume is 'an absolute disaster'. If so, that could cause a seismic shift in the way mental

health care is practised in the USA and across the world. It could cause the psychiatrists to lose their franchise on psychic suffering, on the rights to name and treat emotional pain and mental torment.

This is not the first time that defining mental illness has led to quarrels within the profession. In 1993 feminists denounced Frances for considering the inclusion of 'late luteal phase dysphoric disorder' (formerly known as premenstrual syndrome) as a possible diagnosis for a revision of DSM-IV. In 1980, psychoanalysts objected to the removal of the word neurosis – their bread and butter – from DSM-III. In 1973, after years of protests, gay psychiatrists forced the APA to acknowledge that homosexuality was not an illness after all. Indeed, quarrels have happened since at least 1922, when two prominent psychiatrists warned that a planned change to the diagnostic nomenclature would be tantamount to declaring that 'the whole world is, or has been, insane'.

Any profession is bound to experience internal arguments. But when psychiatrists say (as they have during each of those conflicts) that the success or failure of their efforts could sink the whole profession, they aren't just speaking rhetorically. The authority of any doctor depends on the ability to name a patient's suffering. For a patient to accept a diagnosis, he must believe that doctors really do know that he has a real disease. But the kind of certainty displayed by physicists in relation to physical matter has always eluded psychiatry. And every fight over nomenclature threatens to undermine the legitimacy of the profession by revealing its secret: that for all their confident pronouncements, psychiatrists cannot rigorously differentiate illness ('mental illness') from everyday suffering. This is why, as one psychiatrist wrote after the APA voted homosexuality out of the DSM, 'There is a terrible sense of shame among psychiatrists, always wanting to show that our diagnoses are as good as the scientific ones used in real medicine.'

Since 1980 (DSM-III), psychiatrists have tried to solve this problem by using what is called 'descriptive diagnosis': a checklist approach, whereby illnesses are defined wholly by the symptoms presented. The main virtue of descriptive psychiatry is that it doesn't rely on unprovable notions about the nature and causes of mental illness. Two doctors who observe a patient carefully and consult the DSM's criteria lists won't usually disagree on the diagnosis – something embarrassingly common before 1980. But descriptive psychiatry also has a major problem: its diagnoses are nothing more than groupings of symptoms. If, during a two-week period, someone has five of the nine symptoms of depression listed in the DSM, then he has 'major depression', no matter his circumstances or his own perception of his troubles. 'No one should be proud that we have a descriptive system', says Frances. 'The fact that we do only reveals our limitations.' Instead of curing the profession's own malady, descriptive psychiatry has simply covered it up.

This conflict over DSM-5 comes when psychiatry's

authority seems increasingly tenuous. In terms of both funding and public attention, molecular biology – neuroscience and genetics – has come to dominate inquiries into what makes us tick. And indeed, a few tantalizing results from these disciplines might cast serious doubts on long-held psychiatric ideas. Take schizophrenia and bipolar disorder: for more than a century, those two illnesses occupied separate branches of the psychiatric taxonomy. But research suggests that the same genetic factors predispose people to both, a discovery that casts doubt on whether that fundamental division exists in nature or only in the minds of psychiatrists. Other results suggest new diagnostic criteria for diseases. For example, depressed patients tend to have cell-loss in the hippocampal regions (areas normally rich in serotonin). And certain mental illnesses appear alleviated by brain therapies, such as transcranial magnetic stimulation, even though the reasons are not entirely understood.

Some researchers are convinced that the DSM might soon be completely revolutionized or even rendered obsolete. In recent years, the US's National Institute of Mental Health has launched an effort to transform psychiatry into what its director, Thomas Insel, calls 'clinical neuroscience'. This project will focus on observable ways that brain circuitry affects the functional aspects of mental illness – symptoms such as anger, anxiety or disordered thinking, that figure in current diagnoses. NIMH says it is 'agnostic' about whether, or how, this process would create new definitions of illnesses, but it seems poised to abandon the reigning DSM approach. Insel says: 'Our resources are more likely to be invested in a program to transform diagnosis by 2020, rather than modifying the current paradigm.' Although the APA agrees a revolution might be on the horizon, it doesn't feel it can wait until 2020, or beyond, to revise DSM-IV. The current categories line-up poorly with the ways people actually suffer, leading to high rates of patients with a multiple diagnosis. Neither does DSM help therapists draw on a body of knowledge, developed largely since the last revision in 1980, about how to match treatments to patients based on the specific features of their disorders. The profession cannot afford to wait for the science to catch up to its needs. This means the stakes are higher, the current crisis deeper, and the potential damage to psychiatry greater than ever.

Allen Frances' revolt against the DSM-5 was spurred by another unlikely revolutionary – Robert Spitzer. He was lead editor of DSM-III, and was believed by many to have saved the profession at that time by spearheading the shift to descriptive psychiatry. As the DSM-5 task force began its work, Spitzer was 'dumbfounded' when Darrel Regier, the APA's director of research and Vice-Chair of the task force, refused his request to see the minutes of its meetings. Soon thereafter, Spitzer was appalled to discover that the APA had required those involved in the revisions to sign a promise that they would never talk about what they were doing, except when necessary for their work. "The intent seemed

to be not to let anyone know what the hell was going on," said Spitzer.

In July 2008, he wrote to *Psychiatric News*, an APA newsletter, complaining that this secrecy was at odds with scientific process, which '... benefits from the very exchange of information that is prohibited by the confidentiality agreement'. He asked Frances to sign onto his letter, but he declined. A decade into his retirement, Frances '... told Spitzer I completely agreed that this was a disastrous way for DSM-5 to start, but I didn't want to get involved ... I wished him luck and went back to the beach'.

But that was before Frances found out about a new mental illness proposed for DSM-5. In May 2009, during a party at the APA's annual convention in San Francisco, he struck up a conversation with psychiatrist Will Carpenter. Carpenter is chair of the Psychotic Disorders DSM-5 work group, one of thirteen panels which have been holding meetings since 2008 to consider revisions. Each panel consists of ten or so psychiatrists and other mental health professionals. They report to the Supervising Task Force, which consists of the work-group Chairs and a dozen other experts. The Task Force is to turn the work groups' proposals into a rough draft to be field-tested, revised, and then ratified – first by the APA's trustees and then by its 39,000 members.

Frances and Carpenter talked about 'Psychosis Risk Syndrome', a diagnosis that Carpenter's group was considering for the new DSM. This would apply mostly to adolescents who occasionally have jumbled thoughts, hear voices, or experience delusions. Since these kids never fully lose contact with reality, they don't qualify for any of the existing psychotic disorders. But, says Carpenter, 'Throughout medicine, there's a presumption that early identification and intervention is better than late.' If adolescents on the brink of psychosis can be treated before a full-blown psychosis develops, 'it could make a huge difference in their life story'.

This proposed disease reminded Frances of one of his keenest regrets about DSM-IV: its role, as he perceives it, in the epidemic of bipolar diagnoses in children over the past decade. Shortly after DSM-IV came out, doctors began to declare children bipolar even if they had never had a manic episode and were too young to have shown the pattern of mood change associated with the disease. Within a dozen years, bipolar diagnoses among children had increased forty-fold. Many of these children were put on antipsychotic drugs, whose effects on the developing brain are poorly understood but which are certainly known to cause obesity and diabetes. In 2007, a series of investigative reports revealed that an influential advocate for diagnosing bipolar disorder in kids, Harvard psychiatrist Joseph Biederman, failed to disclose money that he had received from Johnson & Johnson, makers of the bipolar drug Risperdal (risperidone). (*The New York Times* reported that Biederman told the company his proposed trial in young children 'will support the safety and effectiveness of risperidone in this age

group'.) Frances believes this dangerous 'bipolar fad' would not have occurred had the DSM-IV committee not rejected a move to limit the diagnosis to adults.

In light of research suggesting that only about a quarter of its sufferers would go on to develop full-blown psychoses, Frances found 'psychosis risk syndrome' particularly troubling. He worried that this would not stop the drug companies from seizing on the new diagnosis and sparking a new treatment fad – a danger that Frances thought Carpenter grievously underestimated. Frances also regretted remaining silent as he watched the pharmaceutical industry insinuate itself into the APA's training programs during the 1980s. (Annual drug company contributions to those programs reached \$3 million before the APA decided to phase out industry-supported education, in 2008.) Frances didn't want to become '... a crusader for the world. But the idea of more kids getting un-needed antipsychotics that would make them gain twelve pounds in twelve weeks hit me in the gut. It was uniquely my job and my duty to protect them. If not me to correct it, who?'

Spitzer and Frances carried out their public criticisms throughout 2009. Frances published a broadside on the website of *Psychiatric Times*, an independent industry newsletter. Among the numerous alarms he sounded, Frances warned that the new DSM, with its emphasis on early intervention, would cause 'a wholesale imperial medicalization of normality and a bonanza for the pharmaceutical industry', for which patients would 'pay the high price [of] adverse effects, dollars, and stigma'. The two dissidents also wrote a letter to the APA's trustees, urging them to consider forming an Oversight Committee, and postponing publication so as to avoid 'an embarrassing DSM-5'. Such a committee was convened, and it did recommend a delay, because 'the revision process hadn't begun to coalesce as much as it should have'. In December 2009, the APA announced a one-year postponement, pushing publication back to 2013.

The APA insists that Frances 'did not have an impact' on this rescheduling. APA medical director, James Scully, says that Frances is wrong about everything. He is especially upset about criticism of the confidentiality agreement: it is 'simply an intellectual property agreement about who owns the product'. Scully reckons that, because of the internet, DSM-5 will be the most open and transparent DSM revision ever: by 2010 there had been more than 8,000 online comments on the proposed changes. But Greenberg maintains that a number of professionals working on DSM-5 have expressed their worries about the bad management, lack of direction and 'monumental screw-ups' which will lead to psychiatry appearing 'capricious and silly ... a laughing stock'. But these internal critics fear 'retaliation' or 'reprisals', and are not willing to go public.

However, not every dissenter insists on anonymity. E. Jane Costello, Co-director of the Center for Developmental Epidemiology at Duke Medical School, says she doesn't mind

going on record because she's 'too small a fish' for them to bother with. Costello was one of two psychiatrists who resigned from the Childhood Disorders work group in Spring of 2009. In her resignation letter, subsequently made public, Costello excoriated the DSM committee for refusing to wait for the results of longitudinal studies she was planning, and for failing to underwrite adequate research of its own. The proposed revisions, she wrote, 'seem to have little basis in new scientific findings or organized clinical or epidemiological studies'. In response, the APA cited 'several billions of dollars' already spent over the past forty years on research which the revision is drawing on. But to the critics, the greatest liability of the DSM-5 process is precisely this disconnect between its ambition and the current state of the science.

Of particular concern is a proposal to institute 'dimensional assessment' as part of all diagnostic evaluations. In this approach, clinicians would use standardized diagnostic-specific tests to assign a severity rating to each patient's illness. It is hoped that these ratings, tallied against data about the course and outcome of illnesses, will eventually lead to psychiatry's holy grail: 'statistically valid cutpoints between normal and pathological' (Regier). Able to reliably rate the clinical significance of a disorder, doctors would finally have a scientific way to separate the sick from those who merely suffer. No one, not even Frances, thinks it's a bad idea to augment the current binary approach to diagnosis – in which you either have the requisite symptoms or you don't – with a method for quantifying gradations in illness. Dimensional assessment could provide what Frances calls "a governor" on absurdly high rates of diagnosis: epidemiologists have noted that, according to the current DSM criteria, in any given year a staggering 30% of Americans are mentally ill. Diagnostically, something has to be done.

But Michael First, a Columbia University psychiatrist who headed the DSM-5's Prelude Project to solicit feedback before the revision, believes that implementing dimensional assessment now is a tremendous mistake. He says that the tests are nowhere near ready for use; while some have a long track record, 'it seems that many of them were made up by the work groups' without any real-world validation. Bad tests could be disastrous not just for the profession, which would erect its diagnostic regime on a shaky foundation, but also for patients: if the tests are sanctioned in the DSM, insurance companies could use them to cut off coverage for patients deemed not sick enough. 'If they really want to do dimensional assessment', First says, 'they should wait the five or ten years it would take for the scales to be ready'. APA research director Regier won't say how many of the tests are usable yet. He acknowledges that dimensional assessment is still evolving, and says the DSM-5 field trials (studies in which doctors will test the rough draft of the manual with patients) will help refine the tests. But the field trials, too, are bumping up against formidable deadlines. Although trials were scheduled to begin in May 2010, as

of October 2010 only a pilot study was actually under way. And protocols for the rest of the trials couldn't be finalized until that study was completed. Meanwhile, Regier has pegged May 2013 as the deadline for publication of DSM-5, which means that two sets of field trials and all revisions must be completed by September 2012.

It is interesting that when the rough draft of DSM-5 was released, in February 2010, the diagnosis that had galvanized Frances – psychosis risk syndrome – wasn't included. But another newly proposed illness had taken its place: 'Attenuated Psychotic Symptoms Syndrome'. This has essentially the same symptoms, but with a name that no longer implies that the patient will eventually develop a psychosis. In principle, Carpenter says, this change 'eliminates the false-positive problem'. This is not as cynical as it might sound: a kid having only occasional hallucinations, especially one distressed enough to land in a psychiatrist's office, is probably not entirely well, even if he doesn't end up psychotic. And currently a doctor confronted with such a patient has to resort to a diagnosis that doesn't quite fit, often an 'anxiety' or 'mood' disorder.

But the diagnosis 'Attenuated Psychotic Symptoms Syndrome' still creates a mental illness where previously there wasn't one. And this gives the drug companies a new target for their hard sell, and the doctors another reason to medicate. Even Carpenter worries about this. 'I wouldn't bet a lot of money that clinicians will hold off on antipsychotics until there's evidence of more severe symptoms ... A diagnostic manual shouldn't be organized to try to adjust to society's problems.'

His implication is that the rest of medicine, with all its scientific rigour, doesn't work that way. But in fact, medicine makes adjustments all the time. For instance, as obesity has become more of a social problem, doctors have created a new disease they call 'Metabolic Syndrome', and they're still arguing over the checklist of its definition: for example, the blood pressure required for diagnosis, and whether waist-measurement should be a criterion. As Regier points out, diabetes is defined by a blood-glucose threshold, one that has changed over time. Whether physical or mental, an illness is really a statistical construct, a group of symptoms that afflicts a group of people similarly. We may think our doctors are relentlessly stalking the biochemical culprits of our suffering, but in real medicine they are more likely simply trying to discern the patterns in our distress, and to quantify them.

But the fact that illnesses can be invented (or, with homosexuality, un-invented) and their criteria tweaked in response to social conditions is exactly what worries critics like Frances about some of the disorders proposed for the DSM-5. Not only is there the Attenuated Psychotic Symptoms Syndrome but also Binge Eating Disorder, Temper Dysregulation Disorder, and other 'sub-threshold' diagnoses. To harness the power of medicine in service of children who have hallucinations, or compulsive overeaters, or eight-year-

olds who throw frequent tantrums, is to command attention and resources for undeniable suffering. But it is also to increase psychiatry's intrusion into everyday life, even as it gives us tidy names for our eternally messy problems.

Greenberg recently asked a former president of the APA how he used the DSM in his practice. He said his secretary had just asked him for a diagnosis on a patient he'd been seeing for a couple of months, so that she could bill the insurance company. 'I hadn't really formulated it', he said. So he consulted DSM-IV and concluded that the patient had obsessive-compulsive disorder. He admitted the diagnosis did not affect the way he treated the patient, but the value of the diagnosis was that 'he got paid'.

As scientific understanding of the brain seems to advance, the APA finds itself caught between paradigms, forced to revise a manual that everyone agrees needs to be fixed, but with no obvious way forward. Regier says he's hopeful that 'full understanding of the underlying pathophysiology of mental disorders will someday establish an absolute threshold between normality and psychopathology'. Realistically, though, a new manual based entirely on neuroscience – with biomarkers for every diagnosis – seems decades away, and perhaps impossible ever to achieve. To account for mental suffering entirely through neuroscience is probably tantamount to completely explaining the brain, a task to which our scientific tools may never be matched. As Frances points out, a complete elucidation of the complexities of the brain has so far proven 'an ever-receding target'.

Regier and Scully are willing to acknowledge that psychiatric diagnosis is always uncertain and negotiable. As Scully puts it, 'The DSM will always be provisional; that's the best we can do'. For his part, Regier says, 'The DSM is not biblical. It's not on stone tablets'. The real problem is that insurers, juries, and (often) patients are not ready to accept this fact. Nor are psychiatrists ready to lose the authority they get from seeming to possess scientific certainty about the problems they confront. After all, the DSM didn't rescue the profession, and become a best-seller, by claiming only to be provisional. This bothers Al Frances, and it even makes him wonder about the wisdom of his crusade against the DSM-5. It seems to him that diagnosis 'is part of the magic', part of the power to heal patients – and to convince them to endure the difficulties of treatment. 'You know those medieval maps?' he says. 'In the places where they didn't know what was going on, they wrote "Dragons live here". We have a dragon's world here. But you wouldn't want to be without that map.'

Gary Greenberg (garygreenbergeronline.com) is the author of *Manufacturing Depression: The Secret History of a Modern Disease*. With kind permission, this article is mainly condensed from 'Inside the Battle to Define Mental Illness', *Wired Magazine*, Jan 2011.



'See what Eye See'



'Seeking Asylum'

Many thanks to David Feingold for the pictures on the covers and inside this issue. David has a Masters Degree in Social Work from Loyola University, USA, and a Masters Degree in Visual Design from the Institute of Design, Illinois Institute of Technology. He has been a social worker for fourteen years and is a Doctoral student in Disability Studies at National Louis University, Chicago. His dissertation (in progress) offers a non-medical, humanist approach as an alternative to the traditional psychiatric discourse on treating bipolar disorder. Previous to social work, he was a designer and instructor of Visual Design at Columbia College, Chicago.

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