Asylum

ASYLUM AND NORMALCY CONFERENCE

Send letters, comments & submissions (incl. articles, art work, poetry, images etc) to: editors@asylumonline.net
© Asylum and Asylum Associates

Executive Editor:
Phil Virden: tigerpapers@btinternet.com
General Editors:
Prof Alec Jenner and Lin Bigwood
Business Manager:
Peter Bullimore
Poetry & Creative Writing:
Clare Shaw: shaw_clare@hotmail.com
Phil Thomas**:** philipfthomas@talktalk.net
Members of Asylum Collective:
Jim Campbell
Clare Crestani
David Harper
Tamasin Knight
China Mills
Ian Parker
William Park
Dina Poursanidou
Helen Spandler
Pauline Whelan (Web Person)

Design:
Old Dog Graphics
Administration & Distribution:
PCCS Books
unit 2 Cropper Row, Alton Rd
Ross-on-Wye
HR9 5LA
Subscriptions (see below for rates):
www.pccs-books.co.uk   email: sales@pccs-books.co.uk
tel: 01989 763 900   fax: 01989 763 901

Front Cover Picture: 'Problem Patient, Against All Odds' by Sarafin
Back Cover Picture: 'Self Portrait in Restraints' by Sarafin

CONTENTS

EDITORIAL

Last September, along with our friends and supporters in the Critical Psychiatry and Hearing Voices Networks, the Asylum Collective held a conference at Manchester Metropolitan University to explore alternatives to the pathological labels of 'mental illness'. This issue of the magazine includes some of the presentations from this event, as well as the usual sections of creative writing, poetry and reviews. We also showcase more artwork by survivor activists: see the exciting new work by the Toronto-based artist and cartoonist Sarafin.

Our conference was held alongside a Critical Disability Studies conference entitled 'Theorising Normalcy and the Mundane' (http://cdsmmu.posterous.com/). 'Normalcy' is a term used by critical disability theorists and activists to question the way society and its institutions define, categorise and understand what is normal. The Normalcy conference aimed to explore how normality is culturally and socially produced, and to address issues such as society's obsession with normality and rationality. So there are obvious connections with the concerns of *Asylum*.

We hoped that both conferences would be a space to think together about the links and interconnections between disability and distress, and about whether critical disability studies could be useful to those of us who want to rethink and challenge psychiatric labels. Holding the two conferences together enabled some crossing over between critical disability studies and critical mental health – both physically, by weaving in and out of each other's conference sessions, and in our thinking. Over lunch, in the corridors, and in the pub afterwards, we were able to chat to people with different experiences of oppression and of different kinds of resistance. We hoped that it would be possible to explore links and possible areas for alliance between the disabled people's movement, and the user/survivor/critical mental health movement.

Perhaps the most interesting connection was made between mental health and the Neuro-diversity movement – disability activists in the field of autism, Asperger's etc. Many people who are neuro-diverse often end up in the mental health system where their reactions to 'neurotypical' (i.e. non-autistic) society can make their difficulties worse, through misunderstandings, misdiagnosis and medication. These connections were strengthened when *Asylum* shared a stall with Disability Action Network (DAN) at the Manchester and Salford Anarchist bookfair, in December.

The two conferences also beamed some sessions over skype, with a number of people presenting from India. Despite being slightly fraught – what with power cuts in India and a bad internet connection in Manchester! – these sessions were a chance to make connections globally, and to hear about experiences and alternatives in countries other than the UK. In this issue of the magazine, Lavanya Seshasayee (from Bangalore, India) presents her experiences of recovery using a feminist standpoint, whilst Sabah, Kimberly and Anup (from Delhi) discuss different meanings of the word 'asylum', by means of an account of their observations at a temple healing-site in India.

Our conference coincided with the celebration of World Hearing Voices Day, and Dean Smith discussed his work exploring how the experience of hearing voices is understood in Kenya. China Mills reflected on the problem of Western bio-psychiatry being exported to other, often poorer countries, such as India. Continuing the international theme, Bob Sapey talked about how coercion might be challenged legally and professionally using the UN Convention on the Rights of Persons with Disabilities.

The conference also saw the launch of the Campaign against Psychiatric Labels, which Sami Timimi presents for us in this issue. Also in this issue, Will Parks talks about how he took his diagnosis into his own hands and made it something he felt comfortable with. Brenda Le Francois talks about how the practice of psychiatric diagnosis is continually performed and repeated as if the underlying 'illness' actually exists as a separate entity independent from the person's social context: this reproduces an imaginary stark opposition between the 'mentally well' and the 'mentally ill'. This is something also discussed in Nicky Forsyth's article, Shades of Madness.

The fact that these events were held at a university (and supported by academics) may lend some credibility to the suggestion by Mick McKeown & Fiona Jones that, despite the dire state of higher education, universities might still be able to act as centres for radicalism. Despite the academic setting of our conference, we tried to make our presentations as accessible as possible. We may (or not) have achieved this – so please let us know!

We still want to hear about other things that are going on – in, around, against, or in defence of the mental health system. We might not always agree with what you have to say. But *Asylum* magazine exists as a space for controversial ideas, challenges and new ways of thinking. And holding the two conferences alongside each other last September was an attempt to create another such space.

Helen Spandler, China Mills and Dave Harper

NO MORE PSYCHIATRIC LABELS

Launch of a new Campaign to Abolish Psychiatric Diagnosis at the Asylum conference 2011

Sami Timimi

The new Diagnostic & Statistical Manual (DSM-5) is soon due to be published. DSM is the modern 'bible' for diagnosis in psychiatry. Yet there is little or no evidence to support the idea that the categories used in DSM are either based on sound science or clinically helpful. So I decided earlier this year that it was time to start a campaign. I've called it: 'No More Psychiatric Labels'.

My arguments are mainly empirical, based on a review of the evidence. I thought it was important to demonstrate that it is the science that tells us that the system of psychiatric diagnosis is a bad idea.

In summary, my review found that:
• Psychiatric diagnoses are neither reliable nor valid.
• Using psychiatric diagnosis does not aid treatment decisions.
• Long-term prognosis for mental health problems has got worse over the years.
• The use of psychiatric diagnosis increases stigma.
• Psychiatric diagnosis imposes Western beliefs about mental distress on other cultures.
• Alternative evidence-based models for organising effective mental health care are available.

Psychiatric diagnoses are not reliable

Validity refers to whether a particular diagnosis has a meaningful correspondence with something that exists objectively in the real, 'natural' world. For example, that the term 'depression' applies to a psychological and/or physiological process that can actually be identified, and that a similar process occurs in people all over the world afflicted with the condition.

The failure of scientific research to reveal any specific biological abnormality to identify a psychiatric diagnosis – or for that matter any physiological or psychological marker -–is well recognised. unlike the rest of medicine, which has developed diagnostic systems based on testable theories about the causes of illness, psychiatric diagnoses have established themselves simply through the voting rights of boards of psychiatrists who decide amongst themselves when a new diagnostic category is to be created.

In psychiatry, diagnoses are descriptions of sets of behaviours that often go together. By itself, a psychiatric diagnosis cannot tell you about the cause, the meaning, or the best treatment.

Even the descriptions of behaviours that make up the criteria for psychiatric diagnoses have large crossovers between them. For example, 'distractibility' can be found in diagnoses such as ADHD, anxiety, depression, and autism, as can aggression, difficulties with making peer relationships, and agitation. This problem flows from the fact that the basis for the categories are only symptoms (behaviours) and not signs (real, measurable organic differences).

If, as seems likely, our diagnoses do not reflect real differences in our biology, then there is always the potential for harm if we use them as if they tell us something about causes.

The frequency with which patients are given more than one diagnosis illustrates the lack of clarity around what a diagnosis means or represents. Widespread co-morbidity (i.e. giving a person more than one diagnosis simultaneously) indicates basic deficiencies in the understanding of the 'natural boundaries' of even the most severe forms of mental distress. The main diagnosis an individual receives often changes, and this happens by means of a subjective judgement rather than a scientific test. That is to say, the change occurs due to a different belief on behalf of the doctor doing the diagnosing rather than as a result of a new test, for example.
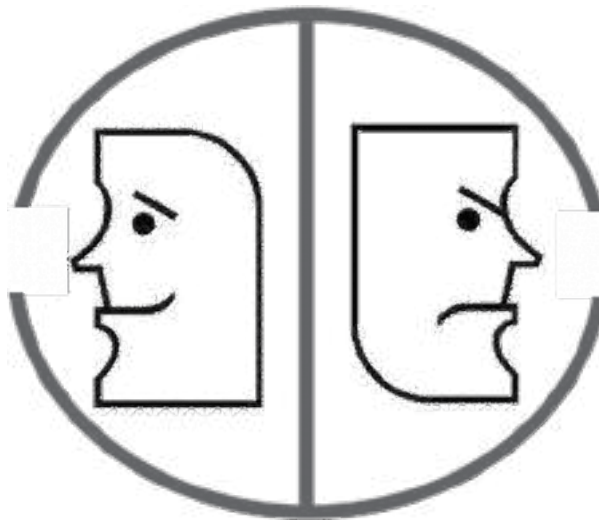
And so, when a clinician claims that a patient is clinically depressed, or has ADHD, or has bipolar disorder, or whatever, not only is he trying to turn something based on subjective opinion into something that appears scientific, but he are also reifying the event – turning something subjective into something 'concrete'. This causes a kind of 'tunnel vision' where the psychiatric diagnostic version of events becomes the dominant story and alternative ways of viewing the situation are pushed to one side. Hence, if someone believes ADHD is a 'real' disorder that exists in the brain and is potentially lifelong, that person – and those who know them – may come to act according to this belief. This is to create a pessimistic self-fulfilling prophecy.

'Reliability' refers to the extent to which clinicians can agree on the same diagnoses when independently assessing a series of patients. Research concerning the reliability of major diagnostic categories gives results ranging from pure chance to perfect agreement, but studies in clinical settings show particularly poor reliability. In itself, this indicates that psychiatric diagnoses are not valid, since one needs to be able consistently to agree on who should be included as a 'case' in any particular category before one can start to examine whether the description has validity.

There is also a poor correspondence between levels of impairment and having the required number of symptoms for many psychiatric diagnoses. Thus, many people below the threshold for a diagnosis actually have higher levels of impairment than those above. Conversely, many people who reach the cut-off for a positive diagnosis may actually have relatively low levels of impairment.

Using psychiatric diagnosis does not aid treatment decisions

Matching diagnosis with a specific treatment has no statistically significant effect (whether for a specific drug or a specific psychotherapy). A positive outcome for treatment of psychiatric disorders is most strongly related to factors other than treatment, such as social circumstances. For example, when a person receives treatment, the strongest association for improvement is with 'developing a good therapeutic relationship with the clinician'.

Many psychiatric drug treatments (as with psychological treatments) rely more on these 'non-specific factors', such as the quality of the relationship between the professional and the service user, than disease-specific therapeutic effects. For example, it is generally assumed that drugs marketed as antidepressants 'correct a chemical imbalance'. However, the placebo effect is much more important than any pharmacological effects. (The placebo effect occurs when a person reports a positive effect even though they have been given a simulated treatment, e.g. a sugar pill rather than an active one.)

Several reviews comparing the results of different trials have concluded that most of the benefits from 'antidepressants' can be explained by the placebo effect, with only a small effect attributed to the drug – a small amount, moreover, that is unlikely to be clinically significant for the great majority of patients. Studies investigating the degree to which non-technical factors (such as the therapeutic relationship) affect outcome have found that, whether with psychoactive drug treatment or not, these factors are far more influential than the treatment model used.

The long-term prognosis for mental health problems has got worse

Over the past half century, and unlike the rest of medicine, no overall improvement in long-term mental health outcomes has been achieved by the richer, industrialised countries. However, some studies do suggest that mental health in the West is getting worse. Compared to a few decades ago, more people are being given diagnoses such as chronic schizophrenia. This is particularly so for young people, more of whom are nowadays labelled with a long-term disability because of a mental condition than ever before. Rates of psychiatric drug prescriptions for young people have been rising year-on-year without any accompanying evidence that their long-term mental health outcomes are improving.

The use of psychiatric diagnosis increases stigma

Surveys of public attitudes toward mental illness have found an increase in Western countries in the number of people who believe that mental illnesses are 'an illness like any other' which is caused by biological abnormalities in the brain. However, a large number of studies have found that attributing mental health problems to biology is associated with negative public attitudes such as a belief that patients are unpredictable and dangerous, and an associated fear of them and a wish to keep them at a distance. It seems that the 'medical model' diagnostic approach has a significantly negative impact which causes an increase in stigma rather than a reduction.

Diagnosis imposes Western beliefs about mental distress on other cultures

Countries around the world are being encouraged to adopt Western beliefs and to recognise diagnoses like ADHD, depression and schizophrenia. This is called 'psychiatric literacy'. However, as already indicated, outcomes – particularly for the more severe mental health problems – have been consistently better in developing countries than developed ones. In the process of encouraging the adoption of Western psychiatric models, we not only imply that those cultures that are slow to take up these ideas are 'backward' but we may also undermine effective local practices and distract attention from factors that do make a difference to mental health, such as economic ones. For example, several international studies conclude that the greater the disparity between rich and poor in any society, the poorer the mental health.

Psychiatric manuals and their categories have been popularised over the last fifty years, and diagnoses are regularly discussed in the media. As a result, it is widely argued that a significant proportion of the population suffers from mental illness, that this is a global issue, that this amounts to a significant economic burden, and that there is a strong case for investing in improved mechanisms of detection and treatment. However, there is little evidence to support the idea that popularising mental health diagnoses and convincing policy makers of the need to diagnose and treat more people does actually benefit mental health.

There have been a variety of campaigns in order to increase rates of diagnosis and treatment. For example, in the early 1990s the uK's Royal College of Psychiatrists and Royal College of General Practitioners launched their campaign 'Defeat Depression'. This was intended to raise public awareness of depression, reduce stigma, train general practitioners in recognition and treatment, and make specialist advice and support more readily available. unfortunately, evaluations following the campaign failed to detect any significant improvements in clinical outcomes. However, the campaign did result in a rapid increase in the prescription of antidepressants and an accompanying increase in the medicalisation of unhappiness and distress.

unlike other areas of public health, mental health in those societies with the most developed services appears to be the poorest. In such societies 'epidemics' of psychiatric diagnoses – for example, ADHD, autism, depression, bipolar disorder – have only emerged and become popularised in recent years. Whilst there are complex political, social and cultural reasons for these 'epidemics', they are encouraged by the emergence and popularisation of new diagnostic categories which then change our ideas about the nature of distress and what it is to be a person.

Alternative evidence-based models for organising effective mental health care are available

We already know about many of the factors associated with a greater likelihood of developing a mental health problem. These include emotional or psychological trauma (particularly early childhood trauma), adversity, poverty, lifestyle, and family functioning.

In addition, rating levels of impairment and distress would provide a much more accurate and less stigmatising way of categorising mental health problems than using psychiatric labels.

The message from research into treatment outcomes is that mental health services can improve them, but not by using diagnostic categories so as to choose treatment models. Rather, it is important to concentrate instead on developing meaningful relationships with service users, ones that fully include them in decision making.

Furthermore, we know that the biggest impact on outcomes derives from factors external to treatment, such as a person's social circumstances and levels of support. This means that services need to learn how to work with the lived reality that people experience, not simply with 'the space between the ears'.

Developing the knowledge base and services in these ways would give mental health services and practitioners a better chance of improving the lives of those they work with. It would also help to break long-standing barriers between mental health services and the rest of medicine by allowing the development of paradigms that are evidence-based and which properly incorporate an understanding of how physical and mental well-being are closely related to each other. Such non-diagnostic-based paradigms could then help patients, whether they present with physically unexplained symptoms, serious distress or psychosis, without needing to label them 'mentally ill'.

The full article can be found on the International Critical Psychiatry Network website: www.criticalpsychiatry.net at: http://www.criticalpsychiatry.net/?p=527

And you can sign up in support of the campaign on: http://www.causes.com/ causes/615071-no-more-psychiatric-labels

Sami Timimi is a consultant child and adolescent psychiatrist and Director of Medical Education at Lincolnshire Partnership Foundation Trust. He writes from a critical psychiatry perspective and has published many articles and books including *a straight t alking introduction to Children's Mental Health problems* and most recently *the Myth of autism: Medicalising Men's and Boys' social and emotional Competence*. He is a founder member of the International Critical Psychiatry Network.

AND WE ARE STILL BEING PSYCHIATRISED

Brenda LeFrancois

Sometimes I am mad. But I am always, always angry. I am angry about the way that psychiatrised people in society get pathologised and labeled as 'mentally ill'. I am angry about the way that this pathologisation and labeling leads to oppressive psychiatric treatment. I am angry about the experience of 'sanism' (Perlin, 2003) – that is the systemic discrimination, the individualised prejudice, the structural barriers, as well as the fear, hatred, and distrust directed toward psychiatrised people. Sanism impacts negatively on their entire world – socially, politically, economically, physically, personally, intellectually and emotionally. Generally, the impact of sanism is far-reaching and devastating, more devastating than the experiences that bring us into contact with psychiatry in the first place.

Over the past couple of years I have started to change my use of language in this regard. When I talk about psychiatrised people, I am making a political statement. 'Psychiatrised' is an adjective denoting that something has been done to the person: a diagnostic label has been put on them in order to pathologise their experiences. I have stopped using terms like 'mental health', 'mental health problems' and 'mental health issues'. 'Mental health issues'? I am not even sure what that means, but I do know that it is a sloppy attempt to hide the oppressive nature of psychiatry, to make it seem more palatable, even to make it seem friendly.

Let's not be fooled. I now reject any term that includes 'mental health' because it underscores the binary opposition health/illness. It underscores the idea that we have to understand our experiences only in terms of what psychiatry deems as 'normal' and 'abnormal'. Actually, I refused to buy into this dichotomy a couple of decades ago. However, I am coming to realise how my own use of language has reinforced biomedical psychiatry and the health/illness opposition. So I have made the decision to stop using such terms. When we use the language of psychiatry we bolster it up, whether or not this is in the context of criticism.

Instead, I talk about the experience of being psychiatrised. This is a sociopolitical experience that entails pathologising a range of human experiences which are seen to be outside the norm, and labeling them as illness. These experiences may include feelings of distress, euphoria, confusion, unusual or visionary thinking, reliving painful memories, and alternative experiences of reality. Many of these experiences are distressing for the person involved, but some are not. And yet psychiatry insists on purging them all away. This is not attempted gently or respectfully but instead by drugging people, locking them up, using traumatising electroshock machines, and creating a space in society for sanism to be rife. This is psychiatric violence.

Recently, I have been working at theorising about psychiatrisation by using the lens of 'queer theory'.

Before explaining what that lens looks like, I want to first address two major problems with so-called queer theory. The first is its class bias. This is evident in the inaccessible language it uses. Being working class, this issue touches me directly. If I were to say, at a family dinner party, something like: "Disrupting the inherent (hetero)normativity within psychiatry by engaging in localised acts of subversion demonstrates the agentic queerness of psychiatrised people" they would most likely either question whether I was at that very moment experiencing some alternative experience of reality (from the way my family jointly constructs reality) or they might feel intimidated by the string of long words that don't seem to mean much at all.

So how do we get around the language barrier? It doesn't matter how useful or instructive a theory may be, if no one can understand what you are talking about except for a small handful of academics. It won't make any changes. Instead, I am turning my energies to using the concepts without the inaccessible jargon, however poetic and seductive 'queer discourse' may be to me. Seduced even more by the emotional intelligence and accessibility of story-telling, Ivan Coyote (2011) compels me not only to make myself visible in my writing but also to address the way academia at best condescends to, and at worst excludes, working class people. And so I acknowledge my own queerness and use it as a prop in this creation of alternative meaning making.

The second major problem with queer theory is its exclusive whiteness: it ignores the existence of – or makes invisible and absent – people who have been racialised as 'other than white'. Also, Andrea Smith (2010) has pointed out the invisibility of indigenous people and indigenous experiences within queer theorising. And so, in an attempt to redress my own complicity with this white bias, when I am theorising I ask myself not so much who am I theorising about but who am I missing?

It is also important to consider that one of the aims of queer theory has been to transcend identity politics – though it has not been wholly successful at doing so. I am not suggesting that we attempt to wholly transcend identity politics and that we understand and treat all oppressed people as the same. Instead, I suggest that mad politics has a lot to learn from race politics, lesbian/gay/bisexual/transgendered studies, queer politics, anti-poverty organising, critical disability studies, and from native studies. If we were truly united, oppressed people – those deemed outside of the norm (for a myriad of reasons, such as not being white, not being 'sane', not being an adult, not being male, not being able-bodied, not being straight, etc.) – would outnumber by far that small group of white middle-class able-bodied men who rule over us, who rule over us by defining what is normal.

Although I cannot completely divorce myself from my anti-psychiatry roots, I am no longer thinking about anarchy, about dismantling psychiatry in one sweep. Instead I am looking at particular contexts, where the realities of individuals in those particular contexts are known. I consider engaging in localised subversive acts, by setting off small explosions, trying to see how, within specific services, life can be made more livable for psychiatrised people. Let's

chip away at the problem that is psychiatry, bit by bit, not to try to transform it or tinker with it but to erode it over time. I guess the end goal is still anarchy, but over a long period of time, because the actions are local rather than global.

These are some ideas I am now considering, although they are not wholly developed. I might change my mind, too. I am just trying to make some sense about what the best course of action may be to try to liberate us from the continuing grip of psychiatry.

Because very little has changed over the twenty years that I have been playing this game of criticising psychiatry. December 2011 marked a decade since David Brandon died. He had spent forty years of his life criticising the system and organising psychiatric survivors in England. If he were alive right now, would he say that much has changed over the past fifty years? I think he might say probably not.

I am not saying that nothing is happening. We continue to organise, in the uK and around the world. In Canada and the uSA we have started yearly PsychOuT conferences, and there is mad activism and radical activist scholarship taking place that is forming the field of 'mad studies'. These are exciting developments BuT psychiatry still remains in its position of dominance, as it has done for a very long time.

So now I want to describe some of the actual theorising that I have been doing, along with Shaindl Diamond. Queer theory makes us pause and question the ways in which we come to know and understand what is normal and what is abnormal. In this process we learn how those in positions of power benefit socially, politically and financially from calling certain people 'abnormal'. In queer theory, the term 'queer' does not refer only to those who are considered abnormal because of their sexuality and gender identity: it may include anyone considered abnormal for any number of reasons – race, class, age, disability, etc. – and as such is then treated as abject, sick and inferior. I see this as a tool to foster a deeper understanding of how and why psychiatry pathologises, punishes and erases human diversity. For it is this very diversity which threatens those in positions of power. Psychiatry is about social control. It is about naming 'abnormal' those who are in some way threatening to the powerful in society, in order to keep them in an inferior place where they can be controlled and where they can be made to conform. Psychiatry is about controlling those who either are unable to control themselves or refuse to do so.

One of several useful concepts from queer theory is the idea of performance (adapted from Austin, 1962; Derrida, 1982; and Butler, 1997). This idea may be used to demonstrate how false diagnostic categories can take on what seems to be an objective reality by being voiced repeatedly by psychiatric professionals and by being enacted by those who have been psychiatrised. When this happens, psychiatric diagnoses are accepted as valid and are understood to be the result of a person's genetics and bio-chemistry, when in fact there are no real psychiatric illnesses, in the same way that there is no real 'state of mental health'. Psychiatry acts as an authority – that is, psychiatry is given credence by us – in the naming of sanity and insanity. This is then repeated by others in

'the helping professions', and this serves to sustain those theoretical claims as 'actual facts'. The general public then takes up these theoretical-claims-proffered-as-facts, repeats them as established factual knowledge, and thereby plays its part in 'solidifying' psychiatric knowledge as 'the truth'.

More than this, people within the general population even casually diagnose themselves, their family and their friends. As such, we have all become the handmaidens of psychiatry, monitoring ourselves and each other for symptoms of mental illness, forgetting that actually there is little evidence to support the system of psychiatric diagnosis. In addition, this production of (white) psychiatric knowledge undermines various indigenous, cultural and/or spiritual understandings of trauma and distress, and it de-legitimises alternative healing practices. Although some of these healing practices may be as dehumanising as orthodox psychiatric ones, others take on a more holistic, embodied and, respectful approach to understanding the impact of lived experiences on emotional well-being. And the current official mission to impose biomedical psychiatry across the world may well eradicate these alternative healing practices.

Psychiatrised people tend to learn – sometimes quickly, sometimes over a protracted period of time – how to perform the various roles expected of a mental patient. Amongst other things, this includes knowing what performance is required in order to receive certain minor privileges, what is required to avoid sedation and electroshock, as well as what is required in order to be discharged, demonstrating a desire to continue to consume a cocktail of drugs, and a desire to conform to expectations of well-controlled behaviour.

We must continue to challenge and subvert the disciplinary norms that frame the dominant biomedical version of our experiences. I believe we must do so by continuing to engage in mad activism and radical scholarship. As well as this we should engage with and learn from the intersecting experiences of others also deemed outside the norm due to their identification with marginalised groups whose organised existence also threatens current forms of social dominance.

References

Austin, J.L. (1962). *How to do things with Words*, The William James Lectures, delivered at Harvard university in 1955. Oxford: Clarendon.

Butler, J. (1997). *excitable speech: a politics of the performative*. London: Routledge.

Coyote, I. (2011). *and then What Happened: some thoughts on the power of personal narrative*, performance delivered at the School of Social Work, Memorial university of Newfoundland as part of the St. John's Story-Tellers Festival.

Derrida, J. (1982). *Margins of philosphy*. Chicago: IL: university of Chicago Press.

Perlin, M.L. (2003). "You have discussed lepers and crooks": Sanism in clinical teaching. *Clinical Law review*, 9 (2), 683-729.

Smith, A. (2010). Queer theory and native studies: The heteronormativity of settler colonialism. *GLQ: a Journal of Lesbian and Gay studies*, 16: 1/2, 42-69.
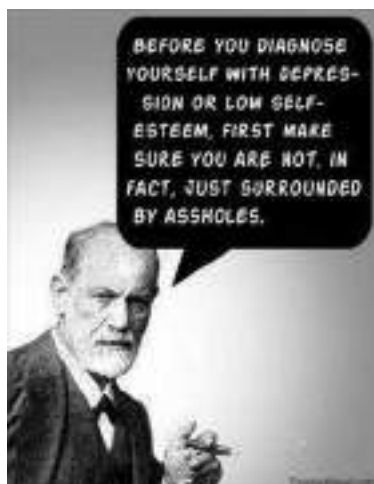
CHALLENGING PSYCHIATRIC COERCION

Bob Sapey

During the 1980s I was an Approved Social Worker, and I cannot quite understand how so much power was invested in me. I now understand how little I knew and how little I needed to know in order to satisfy the authorities that appointed me.

Over the years since I have heard and read several first-hand accounts of the experience of 'being sectioned' and these have reinforced my concerns about coercion. But it was listening to Jacqui Dillon and Peter Bullimore a few years ago that convinced me that it was not only wrong to invest the authority to detain in social workers, but that it was also wrong to invest it in psychiatry.

Jacqui's and Peter's explanations of their experiences, along with so many stories from others in the Hearing Voices Network, simply made much more sense than the ideas constructed by pharmacological psychiatry. So in this article I want to question the professional legitimacy of social workers being involved in the detention and compulsory treatment of people struggling to recover from trauma.

I don't want to question this legitimacy from a strictly anti-psychiatry position. As Bentall puts it, the challenge to psychiatry today is utilitarian compared to Szasz's[1] arguments fifty years ago. It is not simply about not doing wrong, but of being in a position to offer alternative social and psychological forms of help.

Bentall[2] summarises four powerful arguments against coercion:

- Psychiatry has failed to show an adequate understanding of mental disorder, enough to justify its prescribed treatments.
- Pharmaceutical treatments prescribed for psychosis are not only generally ineffective but they have harmful side-effects.
- Coercion can harm a person's psychological capacity to recover and is therefore, in relation to mental health, intrinsically wrong.
- Compulsion is unhelpful in establishing a therapeutic relationship that could be helpful in recovery.

However, while the arguments against coercion may be growing, so too is its use. In England in 2009/10 there was a 30% increase in the number of people being compulsorily detained in hospital.[3] This was almost 10,000 additional people. This is accounted for mostly by psychiatrists and Approved Mental Health Professionals filling beds that had become vacant due to the introduction of Community Treatment Orders.[4]

In England, the 1983 Mental Health Act allows psychiatrists and Approved Mental Health Professionals to detain people and to treat them without their consent if they are 'suffering from a mental disorder' and if detention and treatment are considered to be in the interests of their health or safety, or so as to protect someone else. Yet, at the same time, Article 5 of the European Convention on Human Rights requires states to respect people's 'liberty and security'. However, the Convention does make certain exceptions to the right of liberty, including wherever a person is deemed to be 'of unsound mind'.

In its ruling in the case of Winterwerp v The Netherlands, the European Court of Human Rights said that:

> The Convention does not state what is to be understood by the words "persons of unsound mind". This term is not one that can be given a definitive interpretation ... it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitude to mental illness changes ...[5]

Whilst psychiatry is empowered to assess people and to detain and treat them if they are 'of unsound mind', what is meant by 'unsound mind' is open to argument and challenge.

Szmukler[6] has suggested that the UN Convention on the Rights of Persons with Disabilities challenges detention on the basis of a person having a mental disorder. The argument is that the Mental Health Act is discriminatory since it is aimed at reducing dangerousness, yet it only targets people experiencing mental distress – and in fact this excludes most dangerous people.

Two articles of the UN Convention are particularly important. First, Article 12 says that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'. The World Network of Users and Survivors of Psychiatry suggests that Article 12 creates a paradigm-change in the attitude towards mental distress. They argue that it means that all people have the right to decide 'whether to accept medical treatment or go into a hospital', and that 'mental health commitment laws violate this Article'.[7] However, Article 12 allows states to place limits on a person's legal capacity in accordance with Human Rights legislation. In English law this means that the 'unsound mind' exceptions of the European Convention on Human Rights take precedence (but of course 'unsound mind' is not defined or static).

Similarly, Article 14 of the UN Convention states that countries should ensure 'that the existence of a disability shall in no case justify a deprivation of liberty'. Szmukler suggests that this appears to challenge the legitimacy of the inclusion of mental disorder as a ground for detention by the 1983 Mental Health Act. However Article 14 does recognise that detention may be lawful if it is in compliance with Human Rights

legislation. Hence, the legitimacy of detaining someone of unsound mind is still preserved.

Yet what seems to remain is the possibility of challenging the way in which 'unsound mind' is understood and used in psychiatric practice.

One group of people who are regularly detained and treated are those who 'hear voices'. While bio-medical psychiatry maintains that this experience is a symptom of a disease that should be eradicated, other explanations for this experience are sufficiently developed to challenge the continuing legitimacy and competence of psychiatric diagnoses of schizophrenia, especially when they are also used to legally define someone as 'of unsound mind'.

One way of approaching this might be through the Mental Health Act 'Code of Practice'. This makes provision for consulting with other professionals with a particular expertise when assessing, say, a young person or a person with learning difficulties. This is the recognition that most psychiatrists will not have the relevant expertise. Those involved in the process of 'sectioning', particularly the Approved Mental Health Professionals, could seek to apply the same provision to people who 'hear voices', since conventional pharmacological psychiatry has failed to prove itself as possessing the appropriate expertise to work with 'voices'. Instead, they might only be able to claim to work with 'schizophrenia'. While there are some mental health practitioners with expertise in working with 'voices', there are also many experts-by-experience within the Hearing Voices Network who could, and should, be consulted.

Another approach which might be taken would be to challenge coercive treatment through another UN Convention, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. In 2008, Manfred Nowak, the special rapporteur to the UN Human Rights Committee, reported to the General Assembly of the UN on his *Review of the Torture Framework in Relation to Persons With Disabilities*.[8] In this he wrote:

Inside institutions, as well as in the context of forced outpatient treatment, psychiatric medication, including neuroleptics and other mind-altering drugs, may be administered to persons with mental disabilities without their free and informed consent or against their will, under coercion, or as a form of punishment. The administration in detention and psychiatric institutions of drugs, including neuroleptics that cause trembling, shivering and contractions and make the subject apathetic and dull his or her intelligence, has been recognized as a form of torture.

If treating people with neuroleptics without their informed consent is torture, then it is contrary to Article 3 of the European Convention on Human Rights – and also to Section 134 of the UK's 1988 Criminal Justice Act.

Manfred Nowak was quoting from an earlier report to the Commission on Human Rights (February 1986), handed down from a previous special rapporteur.[9] This means that for more than a quarter of a century the UN has considered the use of neuroleptics without informed consent as a form of torture.

I believe that it is by now evident that psychiatrists and other mental health professionals ought to practise without coercion. This would make mental health interventions more effective in helping people and it would not compound the trauma that distressed people may have experienced. Psychiatrists and Approved Mental Health Professionals must be challenged to change the way they interpret the phrase: 'being of unsound mind'.

The UN Convention on the Rights of Persons with Disabilities, decisions of the European Court of Human Rights, and of the UN, all recognise that compulsory treatment with mind-altering and physically destructive drugs is a form of torture. These decisions can and should be used to combat psychiatric coercion, so as to defend and extend the human rights of people experiencing psychosis.

Bob Sapey is a lecturer at Lancaster University.

Endnotes

1. Szasz, T. (1962) *The Myth of Mental Illness*, London, Secker & Warburg.
2. Bentall, R. (2009) *Doctoring the Mind. Why Psychiatric Treatment Fails*, London, Allen Lane.
3. NHS Information Centre (2011) *Mental Health Bulletin. Fourth report from Mental Health Minimum Dataset (MHMDS) annual returns, 2010*, London, NHS Information Centre. Page 20.
4. NHS Information Centre (2010) *In-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, Annual Figures, England 2009/10*, London, NHS Information Centre. Page 7.
5. Winterwerp v Netherlands 6301/73 (1979) ECHR 4, Paragraph 37
6. Szmukler, G. (2010) *How mental health legislation discriminates unfairly against people with mental illness*, Gresham College lecture, 15th Nov. 2010, [www.gresham.ac.uk].
7. World Network of Users and Survivors of Psychiatry (February 2008) *Implementation Manual for the United Nations Convention on the Rights of Persons with Disabilities* [www.wnusp.net]
8. Nowak, M. (2008) *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, New York, United Nations.
9. E-CN_4-1986-15 pdf United Nations office of the High Commissioner for Human Rights.

RESISTING THE MOVEMENT FOR GLOBAL MENTAL HEALTH

China Mills

In 2011 I was doing fieldwork in India and met a psychiatrist at the Banyan Outpatient Clinic. This is a non-governmental organisation (NGO) that works in Chennai, mainly with homeless or poor people with mental health problems. He told me that they had wanted to make it a community resource centre. However, he felt it had never really developed beyond being a drug dispensary. The patients lined up outside to receive shiny packets of psychiatric medication. They were also given leaflets – Pfizer side-effect check lists for Daxid Sertraline (Zoloft), an antidepressant. The leaflets said 'Sertraline, power that speaks softly', and 'Pfizer, working together for a healthier world'.

Like many NGOs in India, the Banyan offers low-income families 'free medication for life'. It posts envelopes full of psychiatric medicines all over India. This highlights how NGOs are increasingly becoming distribution channels for psychiatric medications. In this manner, NGOs operate as key sites in the wider movement for Global Mental Health. This aims to 'scale up' (i.e., increase) services for 'mental disorders' in low-income countries. According to the World Health Organization (WHO), this is needed because neuro-psychiatric disorders do not have high prominence on the global health agenda, and "… in most parts of the world, mental health and mental disorders are not accorded anywhere the same importance as physical health."[1] The Movement for Global Mental Health calls for governments to take 'mental illness' more seriously by increasing public spending on mental health. It urges them "to scale-up the coverage of services for mental disorders in all countries, but especially in low-income and middle-income countries"[2] where "75% of people do not get the mental health services they need."[3]

A key strategy to measure the global 'economic burden' of mental health problems has been to group together neurological, mental disorders and substance-use disorders into one category: 'neuro-psychiatric disorders'. The Movement for Global Mental Health also urges HIV/AIDS activism to be used as a model for global mental health advocacy.[4] Both these strategies imply that mental health problems are really illnesses, and that such 'mental illnesses' have underlying biological components comparable to those for dementia and epilepsy, thereby invoking parallels between access to psychiatric medications and to medication for epilepsy, and anti-retrovirals for HIV/AIDS. This constructs mental illness as 'an illness like any other'. It is on this basis that the Movement for Global Mental Health then calls for a move beyond the 'scientific evidence base' of particular treatments – which are taken as well-established – and pushes the 'moral case': "That it is unethical to deny effective, acceptable, and affordable treatment to millions of persons suffering from treatable disorders."[5]

However there are some problems in making that argument, particularly because research shows that the evidence for the organic basis of mental health problems – such as schizophrenia – is not as considerable as some suggest. This is further complicated by the fact that research that uses placebos (for example in HIV/AIDS) has been widely criticised because it denies participants the best currently available treatment. Whereas in many trials for depression, drug-placebo differences have been found to be not statistically significant, this is not the case for the use of placebos in HIV/AIDS research.

Furthermore, findings from international comparative studies by WHO and the World Mental Health Survey suggest that low- and middle-income countries actually have better long-term outcomes for schizophrenia, and that despite so few people in low-income countries receiving treatment, prevalence of mental illness is much lower than in high income countries.[6] Halliburton (2004) suggests this may be linked to the pluralism in understandings of such distress in low-income countries.[7] This makes the globalisation of bio-psychiatry more worrying since it replaces traditional and alternative understandings of distress and healing that may be sites of resistance to the dominance of bio-psychiatry.

A 'Mental Health Literate Society'

A key mechanism of the globalisation of bio-psychiatry has been the promotion of 'mental health literacy'. This is defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention."[8] Global mental health advocacy aims to create a 'mental health literate society', where "mental health for all is a reality."[9] This points to increasingly bio-psychiatric interventions in the lives and health of those who live in the South, where it invokes new ways of thinking about ourselves, distress, and social justice in 'biologically coloured' language, and equating access to psychiatric medications with social justice.[10]

1. WHO (2003). Investing in Mental Health. (p7). www.who.int/mental_health/en/investing_in_mnh_final.pdf. (Accessed 29.07.11)
2. Lancet Global Mental Health Group (2007). Scale up services for mental disorders: a call for action. The Lancet, Vol. 370, No. 9594, pp. 1241-52.
3. WHO (2008). Launch video for the WHO Mental Health Gap Action Programme (mhGAP). http://www.youtube.com/watch?v=TqlafjsOaoM (Accessed 15.08.11).
4. Patel, Vikram., et al. (2006). Beyond Evidence: the Moral Case for International Mental Health. American Journal of Psychiatry, Vol. 163, No. 3, pp. 1312-15. (p1314).
5. Patel, V. (2006). Beyond Evidence: The Moral Case for International Mental Health. Editorial, Am J Psychiatry, Vol. 163, No. 8, p1312.
6. World Mental Health Survey http://www.hcp.med.harvard.edu/wmh/ (Accessed 29.9.11).
7. Halliburton, Murphy. (2004). Finding a Fit; Psychiatric Pluralism in South India and its implications for WHO Studies of Mental Disorder. Transcultural Psychiatry, Vol. 41 (1), 80-98.
8. Jorm, A. F. (2000) Mental Health Literacy: Public knowledge and beliefs about mental disorders, in British Journal of Psychiatry, 177; 396. (pp. 399, 396).
9. Patel, Vikram., et al. (2011) The Movement for Global Mental Health. British Journal of Psychiatry, Vol. 198. pp. 88-90. (p90).
10. Ecks, Stefan. (2005). Pharmaceutical Citizenship: Antidepressant Marketing and the Promise of Demarginalization in India, in Anthropology & Medicine Vol. 12, No. 3, pp. 239–254.

But the complicity between the pharmaceutical industry and psychiatry needs to be recognised, as does their power to frame what is viewed as normal and abnormal in the first place. The employment of psychiatric drugs is entangled with certain conceptions of what people should be like: norms and judgements are internalized in the molecular makeup of these drugs. The globalisation of bio-psychiatry makes possible new ways of relating between people, and it frames what psycho-political demands these people and communities can make.

For example, in India, while human rights violations (such as chaining) have been documented in traditional healing sites and psychiatric hospitals, India's Supreme Court has ordered the building of more asylums and produced legislation that prevents those who are distressed from seeking help at temples.[11] While, on an international level, the Movement for Global Mental Health is keen to increase the involvement of users as advocates, in high-income countries many users of mental health services criticise psychiatry – e.g., the psychiatric survivor movement. Survivor testimony often sees psychiatric practices as dehumanising and violent: both the violence of forcible medication or electro-convulsive therapy (ECT), and of being labeled irrational and incompetent. Another key strand to survivor activism has centred on the politicisation of distress – understanding that it is not an illness but a way of coping with and resisting social inequality and trauma. This has historically marked a radical move by the psychiatric survivor movement against bio-psychiatry. For example, in the uK there is a campaign to abolish psychiatric diagnostic systems entirely. (See the article by Sami Timimi in this issue.) Diagnostic systems such as the *dsM* and the *iCd* have been key to the growth of transnational bio-psychiatry and Global Mental Health, since it is assumed that they enable the standardised diagnosis of diverse populations for comparison, and that diagnostic categories and hence 'mental illnesses' are transferable across cultures. The biologisation of psychiatry can be seen by the number of translations of the *dsM*, and its distribution by pharmaceutical companies in many low-income countries.[12]

However, much survivor critique seems to go unheard within the global mental health literature. This means that the individual brain remains the key site for intervention, often through medications. This glosses over social and economic causes of distress. The push to recognise distress as illness also works to situate experiences such as hearing voices as 'outside of normal human experience', and so to limit claims to universal human rights.[13]

'Survivor' as 'Western'
While I was in India, I facilitated Hearing Voices workshops with NGOs and psychiatric institutes, many of whom often rejected the concept of the psychiatric survivor. They said it was "a Western concept" and "a luxury alien to Indian culture". As a way of resisting the survivor critique of psychiatry, psychiatrists often told me that in coming over

to India to talk to people about the survivor movement I was being colonialist – despite the fact that in India psychiatry is itself a colonial legacy. To be honest, I found it rather hard to be told by a cognitive behaviour therapist in India that the survivor concept is Western!

If Global Mental Health is part of a new global bio-psychiatry, then is international resistance possible? Engaging with survivor testimony may enable a critical rethinking of calls to 'scale up' psychiatric treatments and psychological therapies from the global North to India. This may make space for an exchange in understandings of distress that do not flow only one way, and which help us to recognise that there are alternatives to what might be called 'Western knowledge systems', such as bio-psychiatry. This may enable a project of taking global distress seriously without medicalising it, and retaining an understanding of distress as personally and politically meaningful.

Photos from a Hearing Voices workshop at Iswar Sankalpa, Kolkata, India, in 2011.

11. Davar, Bhargavi. V. and Lohokare, Madhura. (2009). Recovering from psychosocial traumas: The place of dargahs in Maharashtra. *Economic and Political Weekly, Vol. 44, No. 16.*

12. Lakoff, Andrew. (2005). *Pharmaceutical Reason: Knowledge and Value in Global Psychiatry.* Cambridge University Press, Cambridge.

13. Spandler, Helen and Calton, Tim. (2009). Psychosis and Human Rights: Conflicts in Mental Health Policy and Practice'. *Social Policy and Society, Vol. 8, pp. 245–56.*

THE TEMPLE AND THE ASYLUM

Sabah Siddiqui, Kimberly Lacroix and Anup Dhar

This is a report on part of the project: 'The Experience of Gendered Violence: Developing Psychobiographies'. In this research we propose the concept of 'faith-healing site'. By this we mean a space where, perhaps somewhat paradoxically, experiences of violence and gendering can converge with possibilities for healing.

Conventionally there have been two approaches to this kind of site or space. The modern (and arguably Western) mindset, marked by 'psychiatrisation', treats this site as pre-modern and backward, and wants to re-diagnose and treat women in faith-healing sites in terms of psychiatry's *Diagnostic and Statistical Manual (DSM)*. In contrast, the perspective of cultural psychology sees this site as offering a culturally rooted method of healing that has to be understood in its own terms. In this second approach there is both a critique of (Western) psychiatry and a defence of the traditions of faith-healing.

In contrast to those traditions, we make a two-fold critique: of the Western European asylum and of the healing practices in India (and the way these practices have been colonised by the West).

Balaji Mandir

As part of the research project, in October 2010 we travelled to Mehandipur in India. This is a small town in Rajasthan which houses a famous temple, the Balaji Mandir. It is believed that the deity in this temple has a divine power to cure people possessed by evil spirits. Those afflicted by such spirits exhibit behaviours that have specific local names: in the Balaji Mandir, Rajasthan, it is called *peshi* – the English equivalent might be 'trance'.

In Mehandipur, the treatment of *peshi* is carried out through the divine intervention of the deities and the saints, through the medium of priests and mystics. This is usually accompanied by the full-hearted participation of the family of the possessed person, as well as of all those who gather to witness and participate in the event. The power of this process is called *sankat-mochan* or 'faith-healing'.

The people in Mehandipur who experience *peshi* are referred to as *sankatwalas*: people with *sankat*. Literally, *sankat* means 'crisis/danger/distress', but in this context it signifies a person possessed by a spirit. This difference between 'crisis/danger/distress' and 'being possessed by an evil spirit' is important since it determines (a) how women respond to the healing tradition, and (b) how we, as researchers, respond to the women's response to that healing tradition.

It is overwhelming to see the *aarti* at the Balaji Mandir for the first time! Words seemed to fail us when it came to a description of what exactly was happening there. It is pure spectacle – in the dusk-light with hundreds of bodies pressed together, clapping in unison to the *jai-jaikar* sung by the sweet, disembodied voices coming from the electronic speakers above. With the progression of the religious songs (known as *bhajans*), devotees seem to wait for the moment to go into *peshi* – the hypnotic frenzy which characterizes every person in a trance.

The most common motion of the women is the movement of the head which cuts a figure-of-eight from side to side, and the jerking of the body back and forth which gives momentum and continuity to the head movements. The woman's hair, loosened during this motion, either by the woman herself or by a helping hand, sweeps the space around her, and people move away to give her the space she needs.

Some of the men and the younger women perform somersaults which result in a resounding bang as the body comes to rest on the floor. Others beat their bodies into the wall or against the iron gates. As the tempo of the *kirtan* increases, along with the number of people entering *peshi*, extended cries, piercing screams, repetitive chants, mourns and praises – some expressing relief, some sorrow, some pain and some just anguish – can be heard from every part of the hall.

During our stay in Mehandipur we spent as much time as we could in the temple premises. We observed that around 90% of the afflicted were women. Most were between the ages of 14 and 25 – obviously girls and young women recently married or soon to be so. Yet on the whole there were more men present at the different shrines in Mehandipur.

In fact, as Gloria Bargen (1988) says, studies show that it is frequently women who fall victim to spirit possession. The question here is why do such spaces attract so many possessed women?

The Temple and the Asylum

Foucault (2007/1961) describes the beginning of the modern treatment of the insane as starting with the more humane interventions of Pinel in France and Tuke in England. Their 'moral treatment' was an approach to mental disorder derived partly from pre-modern medicine or psychiatry and partly from religious or moral concerns.

Foucault dwells on the apparent ease with which the York Retreat under Tuke looked after the mad: "the legends of Pinel and Tuke transmit mythical values, which 19th century psychiatry would accept as obvious in nature. But

beneath the myths themselves there was an operation, or rather a series of operations, which silently organised the world of the asylum, the method of cure and at the same time the concrete experience of madness" (p. 230).

Foucault sees "continuity between a form of religious morality and the modern asylum. Thus religion played the double role of nature and of rule, since it has assumed the depth of nature in ancestral habit, in education, in everyday exercise, and since it is at the same time a constant principle of coercion" (p. 231). This suggests that the asylum is not simply a modern phenomenon. Rather, the asylum is perhaps a secular reincarnation of religion's relation with madness. This is why a critique of modern methods is not enough. What is once again needed is a dual critique: a critique of religion and its secular reincarnation, the modern way (i.e., psychiatry).

However, this is not to discount completely the possibilities that non-Western traditions of faith (some pagan, some not) can offer. To look for such possibilities, let us first explore the dual meaning of the word 'asylum'. The Latin word 'asylum' means 'sanctuary' (Online Etymology Dictionary). Today it is used to signify:

1. political or social refuge in another nation or embassy;

2. an institution of confinement.

The politico-legal and the medical usages of 'asylum' are at odds.[1] In the first, the individual seeks sanctuary from persecution; in the second, the social order defends itself from the insane individual. In the context of these two meanings of 'asylum', what sense can we make of the temple?

Are the women *finding asylum* in the temple? Is it refuge from their narrowly defined gender roles? Does this mean that the site of faith-healing provides a space for intervention made available by a culture to and for women? Is this a space offered for redressing that suffering by women which does not find expression in the home and community? Have women managed to create this space for themselves?

For Pfleiderer (2006), *peshi* performed in public is a woman's agency in the face of society: when termed '*peshi*', this is made simultaneously subtle and not-so-subtle. She calls it "the necessary cunning of women that allows them to survive in a patriarchal society … The Indian woman has to be very cunning because she lives in a two-fold patriarchy, the Indian and the colonial."

On the other hand, has the temple enshrined the bodies and the protests of the woman, such that the woman herself becomes the temple, housing the deities within,

and permitting life to go on as before? The temple, like the mental asylum, becomes 'The Agency' through which the individual's 'agency' is controlled and rendered non-dangerous. Bargen says: "A protest that is merely tolerated by society cannot blossom into reform." And so we remain intrigued by the possibility of premises that the temple and the asylum share. This shakes our idea of Indian faith-healing as the Cultural Other to the European asylum.

The debate about 'asylum', flanked by religion and science, and straddled between colonialism and nationalism, puts us in a situation where we can neither defend, nor oppose the temple-based practice of healing. How do we resolve this? If there are continuities between the temple and the asylum then a historical analysis is urgently required. (The European asylum could well predate the temple practices of spirit possession in India.) Further research will need to provide a genealogy of faith-healing. If there are discontinuities between the experience of the temple and the experience of the asylum, creating narratives of the experience is a necessary first step. Writing psycho-biographies could be a useful second step.

References

Asylum. (n.d.). In *Online Etymology Dictionary*. Retrieved September 08, 2011, from Dictionary.com website: http://dictionary.reference.com/browse/asylum

Bargen, Gloria (1988). Spirit Possession in The Context of Dramatic Expressions of Gender Conflict: The Aoi Episode of the Genji monogatari. *Harvard Journal of Asiatic Studies, Vol. 48,* No. 1 (Jun., 1988), pp. 95-130

Foucault, Michel (2007). *Madness and Civilization: A History of Insanity in the Age of Reason*. London: Routledge

Online Etymology Dictionary (n.d.) Asylum definition. Retrieved 24/02/2012.

Pfleiderer, Beatrix (2006). *Red thread: Healing possession at a Muslim shrine in North India*. Delhi: Aakar

1. Nonetheless, this makes us wonder whether the legal and the medical meanings attributed to the term asylum are as exclusive as they might appear. Could there be a link between the two conceptualisations of the term? For the legal usage of the term comes closer to the etymology of the word and also lends itself to the difficult question of agency when taken in the context of the women at Mehendipur, wherein the women seeking asylum (sanctuary) in the temple may also be contained in the asylum (confinement).

Lavanya Seshasayee

A FEMINIST SELF-ADVOCACY PERSPECTIVE ON RECOVERY
A personal journey through schizophrenia

Here I present a narrative of my journey through schizophrenia towards recovery. Primarily, this revisits the traditional roles of psychiatrist and patient, via an empowerment framework for mental-health intervention. I call this 'Feminist Self-Advocacy' (FSA). It evolved, over a period of five years, from my experiences as a consumer-cum-professional, when I was also taking medication.

I was a bright child but underwent socio-cultural pressures at puberty, due to a troublesome aunt who was also a neighbour. This resulted in depression, I think, because my parents didn't allow me to protect myself. However, I managed bravely and determinedly to pull myself out of my depression and finish High School with high academic credentials.

It was later that I again succumbed to mental illness (schizophrenia). This was precipitated by a series of very bitter experiences with the troublesome aunt. She had tremendous influence over my parents and I suffered from patriarchal oppression which rendered me helpless. Due to this my academic work suffered.

I was taken to a psychologist who had a private practice but who only seemed interested in controlling his clients and making money. Then I was taken to another psychologist who claimed to be practising Transactional Analysis. In my view wrongly, both psychologists advocated a rest cure.

So, very much against my wishes, I was made to stay at home and kept from attending college for a year. This only made me brood, and I deteriorated and completely lost confidence. Then I was taken to a third psychologist. The medicines thoroughly slowed me down and destroyed my spontaneity and high level of creativity, and I lost touch with the subject I had been studying. My attempts to get hold of the basics and to understand everything again were not encouraged by the college. Consequently, I found I just couldn't manage.

I returned to the paramedical college after this year of being made to stay at home.

During that critical year when I was forcibly kept at home, relatives kept coming by the house and taunting me since they thought I had dropped out of college. And when I tried to explain what had happened to the therapist she called me paranoid. Then, since I hadn't graduated, I couldn't get a job either.

I became so thoroughly dysfunctional that I couldn't hold a book and study for more than five minutes. I also developed severe writer's cramp which rendered me incapable of taking notes in class. When I consulted the psychiatrist again I was dubbed 'a medical failure'. This was instead of offering me viable alternatives to overcome my problem.

I felt terribly betrayed during that year. When I attributed my illness and problems to socio-cultural causes the psychiatrist said that the illness had nothing to do with my problems, but rather the problem was my "inability to take stress", and "a genetic propensity for mental illness". Later on she even refused to listen to the details of how my parents were ill-treating me.

Since the diagnosis of mental illness is based on a judgement of a person's behaviour as 'maladaptive', there is always the risk of altogether invalidating them as a person.

When I returned to college, after dropping out, I took an entirely different academic course. I desperately desired to study but found it impossible. With neither a decent job nor a graduate degree nor a husband to support me, what would become of me after the death of my parents? Would I not be on the streets?

The crisis that I was going through awakened my social conscience and made me evolve Feminist Self-Advocacy (FSA). This is a user-support model that trains users to support themselves and be self-reliant. Today I have a PhD in Women's Mental Health and a good job. I am very happily married and we are financially secure. I attribute my full recuperation to FSA.

What is FSA?

It is a derivative of feminist therapy. The essential ingredients are:

1. Recognition of patriarchal oppression .
2. Empowerment. The essence of this is to encourage the user to see herself as having the personal resources and bargaining power to change her pathological environment (Finfgeld, 2001).
3. Self-reflection
4. An egalitarian relationship between the therapist and the user.

As part of FSA, I abandoned traditional controls and constraints placed on my sexuality, and told the professionals to stop assessing me purely on the basis of criteria like 'cognitive distortions', 'delusions of grandeur', etc. Many professionals think users suffer from such cognitive distortions. However, research indicates that it is actually non-depressed persons who show the most cognitive distortions: they tend to have greater illusions of personal

control, they show unrealistic expectations of future success, and they maintain and overestimate the amount of positive feedback that they receive (Alloy & Abramson, 1988).

So who are the real "distorters of reality"? If there really are cognitive distortions, cognitive techniques need to be implemented without the use of pathologising labels and user-blaming attributions.

In this manner, I told my psychiatrist and caregiver not to say or do anything that could hurt my self-esteem; not to judge me as 'loose' or 'crazy', nor jump to conclusions regarding my moral proclivities whenever I reported misbehaviour on the part of a member of the opposite sex. Neither should they indulge in gender stereotyping during therapy. They should help me take decisions for myself, instead of letting my relatives decide for me. As far as possible, they should refrain from over-sedating me when I talk about my problems, and instead they should offer me viable alternatives.

More than anything else, I empowered myself by means of an academic education that went a long way towards my rehabilitation. My psychiatrist had rudely suggested that if I recovered, then that, in itself, would be a big thing. Another psychiatrist tried treating me without my informed consent – but failed because I was too smart for him.

The question of why those diagnosed as 'schizophrenic' are so eager to 'deny their illness' is very threatening to psychiatrists: it undermines their medical authority and reflects the flaws in their profession.

The professionals also asked me why I had allowed myself to be so affected by what my mother had done to me.

We question whether such an approach really serves the long-term interests of patients. To date, it has certainly not encouraged therapeutic alternatives which are acceptable to service users. 'Nothing about us, without us!'

It was in the context of user/survivor experiences with mental health systems that the UN Convention of the Rights of Persons with Disabilities (UNCRPD) evolved. FSA is a rights-based, user-support model.

In short, when I was in the first year of my Bachelors course, after the medical professional and the psychologist had declared me a medical failure, I stopped going to see them. This was because they simply indulged in exercises of professional negativity. But I did take the prescribed medication, in combination with FSA.

When I recovered and studied for a PhD in mental health, they asked me to share my FSA treatment approach with them. I told them it was I and not they who were eligible to use it since I was trained professionally and was an experiential expert, whilst they lacked first-hand experience.

What had begun as a psychiatric power-play ended up being a role-reversal designed to shock the medical community at large and to make them stop being so arrogant. And that was the grit and determination with which FSA was evolved so as to facilitate true recovery. I spoke truth to power and can legitimately say with Robert Frost:

> Two roads diverged in a wood, and I
> took the one less travelled by,
> And that has made all the difference.

Finally, as always, I thank my Lord and Saviour Jesus Christ for having rescued me and shown me the way out of the morbid reality which at one time engulfed my life. I also thank my mother, Mrs. Lalitha, whose extraordinary sacrifices, infused with love, enabled me to reach where I am currently in my life. And, yes, my exceptionally brilliant husband, as well.

Dr. Lavanya Seshasayee formerly held a fellowship at the BAPU Trust (Pune, India) and is currently Director of the Indian Women's Recovery Movement Trust.

References

Finfgeld, D.L. (2001). New Directions for Feminist Therapy Based on Social Constructionism. *Archives of Psychiatric Nursing, 15*, 148–54.

Alloy, L.B., & Abramson, L.Y. (1988). Depressive realism: Four theoretical perspectives. In L.B. Alloy's (Ed.), *Cognitive Processes in Depression* (pp.223–65). New York: Guilford.

Robert Frost (1916): 'The Road Not Taken'.

Members of the *ASYLUM* collective took part in a series of talks and discussions called *'Psychopolitics: Occupy the Madness'* at Tent City University in January 2012.

Tent City University is part of the Occupy London camp outside St. Pauls. The talks concerned the connections between the political and the psychological and were organised in conjunction with the welfare tent and various organisations such as Psychologists and Counsellors for Social Responsibility (PCSR) and the Critical Psychiatry Network. A Special issue of *ASYLUM* and the anti-capitalism movement is now being planned. Please get in touch if you'd like to contribute!

VOICES OUT OF AFRICA
Dean Smith

During the many years that I was a patient in the mental health system in the uK I often wondered how mental health was understood in other countries. When I was discharged I continued to wonder. So last year I decided to fly to Kenya to set up peer-support groups with a Kenyan colleague. While I was there I started to do some research about voice-hearing and psychosis. Both seemed to be a lot more accepted in Kenya than in the uK. This was despite the fact that in Kenya the psychiatric hospitals seemed a lot worse than in the uK, yet there is more freedom in the grounds of the hospitals.

Talking to people in Kenya about 'hearing voices' made me think about how we treat such people in the uK. In Kenya, some people who heard voices were seen as gifted and others as possessed. But it was notable that those understood as 'mentally ill' had more social integration than in Western society, and a lot of contact with their families. It was the family that was seen as failing if someone was taken away from it. In the villages there were people classed as 'crazy', but these people were cared for by those in the village and there was more freedom for them to do what they wanted. Although there were people who were treated badly, this seemed mainly to be in the big cities.

To find out more about 'hearing voices' in Kenya, I spent some time with a tribal church founded by a preacher who 'heard voices from God'. This was in a place close to the border with uganda. The 'voices' told him to preach to those who lived in that area, but his preaching eventually spread throughout West Africa. ultimately, the preacher was killed for 'hearing voices' and for preaching what he heard. I went to the celebrations of the founding of this church. The celebrations consisted of drumming and euphoric dancing for three days solid. It was accepted that everyone at the celebration 'heard voices', and so I felt at home. It makes me wonder why we are so quick in the uK to view 'hearing voices' as a symptom of an illness and not simply as an experience that perhaps reflects something that happened to the person.

Medicine men had been around for a long time before Western psychiatric treatments, and the majority of people in Kenya and other parts of Africa prefer to consult one, rather than a doctor or psychiatrist. Later in my visit I spent some time with a medicine man. Just as being a part of the tribal or religious group seemed to really work for people, so did the herbs and treatments that the medicine man used. However, organisations such as the World Health Organization (WHO) are pushing for psychiatric treatments to be increased in East Africa.

In the uK and other Western countries we have seen the effect that Big Pharma has had by spreading a bio-psychiatric view of 'hearing voices' as an illness to be treated by medication. It makes me so sad to think this is beginning to happen in Eastern Africa. Why try to replace something that has helped people for many years? Of course, there are those in Kenya who are treated badly, as are many people in the uK. However, I feel that while Kenya is considered 'Third World', the uK is more so when it comes to treating those with emotional distress.

In the uK, it is often said that people from Black Minority Ethnic (BME) groups do not engage enough with the mental health services, but I feel those who provide services should engage with BME cultures and ways of life, as they are valuable to a person's well-being, and key to our own education.

I feel we need to combine some of the practices that work for people from both Kenya, the uK and other countries, to give us a better way of understanding how, over hundreds of years, people have coped with experiences like 'hearing voices'.
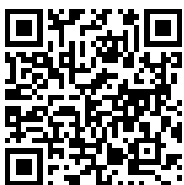
THE SHADES OF MADNESS

Nicky Forsythe

Here's a question to reflect on. Who reading this – in the spirit of reclaiming the word 'madness' – would say they have definitely been mad? Who would say they have never been mad? Who would say they have been partly mad? (That is, still able to function in everyday life but with experiences that a psychiatrist might call psychotic.)

If you're in this last group do you find it difficult to define your 'madness status'? Do you feel obliged to state clearly that you are have either been mentally ill or not – and that there are no terms to define a midway experience?

That's how I feel, and because I've come to think it would be helpful, I'm interested in opening up and exploring a conceptual territory of shades of madness.

In explaining this, I'll write about my personal experiences first.

I had three close relatives who were sectioned when I was young, and I grew up with the fear of madness like Damocles' sword over my head. Sure enough, in my early twenties I had a year of intense mental distress where, amongst other things, I experienced what is called 'de-realisation' – the frightening experience that the world is not real. This is a type of dissociation.

In my later 20s I had an anomalous experience of a different kind. It seemed a spiritual 'breakthrough', and I believed that a deep secret of the universe had been revealed to me. I was elated and ecstatic for about a year. Since I believed that ordinary reality was just an illusion, I behaved in ways that seemed strange to my friends – and looking back, they seem strange to me too.

My most extreme episodes were in my mid-twenties, but when under stress I have had turbulent or unusual subjective experiences throughout life.

Although these episodes were at times very disturbing, I saw the distress, humiliation and harm caused to my close relatives by the psychiatric system. So I avoided NHS services and did many years of private therapy, as well as a series of workshops with psychiatrist Stan Grof. He sees psychotic episodes as opportunities for personal growth. Perhaps most importantly, I found other people who understood these experiences – most recently the Spiritual Crisis Network. The process of talking to others who understood has been most relieving of all.

I have been lucky and sufficiently resourced to afford these alternatives, and frankly I was never so annoying to anyone else that I was forced into psychiatric treatment. So I was never diagnosed as 'mad', let alone as having this or that variety of madness.

I came to believe – as Grof has suggested – that in truth the difference between a mad person and, say, a yogi, lies, at least partly, in who you speak to.

I chose not to talk to psychiatrists, and that seemed to work pretty well.

However, it didn't solve the problem of how I talked to other people – or indeed myself – about my experiences. For many years I said nothing. However, after training as a therapist I decided to explore the area of my own 'madness' in more depth and to make some sense of it.

As part of this process, I went to a service-user conference some years ago. The tears streamed down my face for much of the day – an outpouring of relief – since I had found a place where people were 'out' about all the things that I and my family had been 'in the closet' about for all those years.

It felt like a homecoming. Or was it?

After a time I came to think that I only really belonged in service-user circles if I had a psychiatric diagnosis or had been 'sectioned'. There were only two options for self-identification: either 'properly mad' or 'not mad'. I didn't belong in either category, and that felt frustrating.

It was no good unilaterally declaring that one was, or had been, 'a shade of mad'. This wasn't a recognised category.

I wanted to 'come out'. But what should I come out as? It felt frustrating that I didn't have a name, label or category for my experiences, one that was both acceptable to me and recognisable by others.

I also noticed how others were liable to construe areas of madness or mental health within black and white categories. The public, in particular, seemed to struggle with the idea of degrees of mental health or sanity.

Earlier this year I did some qualitative research with groups on a project for the New Economics Foundation, looking at how to engage the public in caring for their mental health. A common response to the topic was:

> Yes, well, I can see that for people who are mentally ill [often referred to as 'people like that'] looking after your mental health would be useful. But it wouldn't be relevant to me.

The perception was that 'normal people' do not have degrees of mental health that they need to – or indeed can – take care of.

This attitude was also revealed in research I did recently on a peer-to-peer therapy programme I have developed, called Talk for Health. The programme teaches people the skills to share their inner experiences and listen empathically to each other. There is pretty convincing evidence that this kind of practice is good for everyday mental health, and prevents mental illness. I have certainly found that to be so in my own

life. Yet in trial sessions with members of the public, I could summarise the response as:

> I loved the session. It was so liberating to talk freely about my inner experience. I think it would be great for mentally ill people (but not me).

Here again was the notion that if you are 'normal' then it's irrelevant to do something for your mental health since degrees of mental health do not exist and one has no influence over them, anyway.

I was puzzled about all this, and came to realise that the world has a problem seeing shades of madness or mental health.

I turned to the academic literature and found that, by contrast, in this realm there is a great deal of thinking and research which supports the idea of 'shades'.

For example, a 2011 literature review found that there are more 'voice-hearers' in the general population than there are dyslexics, left-handed people, bisexuals, vegetarians, and people with heart disease. It is just one aspect of human diversity (Longden, 2011).

Gordon Claridge (2006) developed the idea of Schizotypy. This refers to a normal personality trait, distributed throughout the population, which on the one hand makes people prone to psychoses but on the other predisposes them to positive experiences such as creativity and good lateral thinking.

Isobel Clarke (2010) talks about Teasdale and Barnard's model of interacting cognitive subsystems. In this theory, madness occurs when a normal stream of cognitive processing (the 'implicational subsystem') becomes dominant.

Many have proposed – and I happen to believe this –– that psychosis is simply an experience anyone would have if exposed to extreme circumstances (e.g. Read et al, 2008).

One respected psychiatrist summed it up it like this in a recent interview I carried out:

> Everyone has Mental Health problems at some time or another, which affect them to different degrees. People with Mental Health problems are not different – they are just people who need help at the moment. Rather than having Schizophrenia or Depression – and they're distinct entities – there is a continuum which needs to be accepted. It's more like high and low blood pressure, than discrete disorders, and depression could lead on to severe mental illness.

WHY DOES BLACK AND WHITE THINKING PERSIST?

I have come to believe that, amongst the general public, there is perhaps an investment in black and white thinking about madness.

If you are judged by a psychiatric professional to be not 'in your right mind' you can effectively be imprisoned for it. So it's not surprising that people wouldn't want to own up to bit of madness. It would be a bit like owning up to being a bit of a criminal.

And if we don't want to acknowledge any madness within us, one way of managing that is through projection. This is the psychological defence mechanism whereby a person denies their own undesirable characteristics and attributes them to others.

> Emotions or excitations which the ego tries to ward off are 'split out' and then felt as being outside the ego ...perceived in another person. (Fenichel, 1946)

In other words, the belief that madness is a very particular property that belongs only to a group of people who are 'very different' is a relief to the majority. But it also bolsters stigma (Read & Haslam, 2004).

What if – in a utopian future – we could break down this perception of discrete categories, and accept that there is a whole spectrum of sanity or mental health?

I believe that if we can acknowledge this we could have a breakthrough of insight and tolerance similar to what we have concerning homosexuality.

An important catalyst for the breakthrough with homosexuality was Alfred Kinsey's research. This led him to declare that that hetero- and homosexuality were not binary categories but instead on a spectrum ranging from 0 to 6: 0 represented exclusively heterosexual behaviour and 6 exclusively homosexual behaviour, with shades (1–5) inbetween.
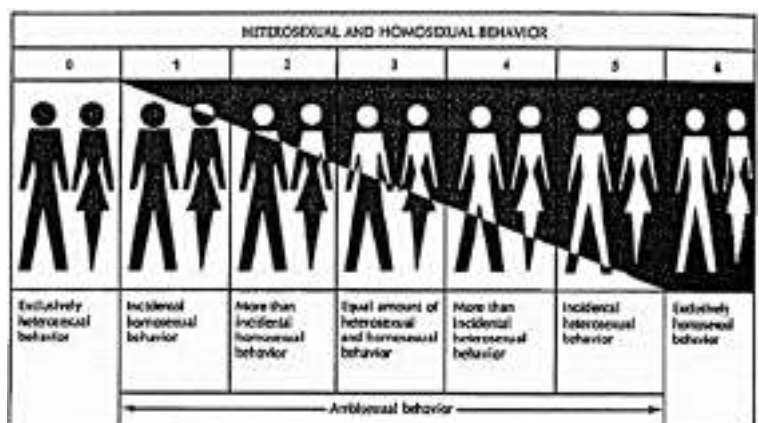
What if we thought in terms of a scale of sanity or mental health, where there are many shades of experience and behaviour?

WHAT WOULD BE THE CONSEQUENCES OF ACKNOWLEDGING SHADES?

Shades of Grey
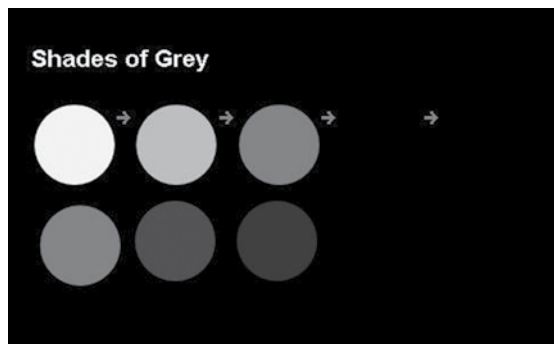
I believe that a more nuanced concept like this would have extraordinarily positive consequences, including the following:

- It would be easier to engage people with the idea of caring for their mental health.
- It would add a sense of fluidity and transition between categories which could enhance hopes for recovery.
- It would lead to a more accurate professional concept of recovery.
- People like me, who have learned to live well with experiences that seem like mental illness, would have a voice and contribute to a more rounded understanding.
- It would reduce stigma. If we could openly acknowledge and articulate more neutral and less 'scary' zones of madness there would be more people willing to open up about their experiences. Widespread disclosure of personal experience is a key factor in eradicating stigma (Queensland Alliance, 2009).

Then, in a Kinseyan spirit, we could show that many or most people from time to time feel inner chaos and strong emotions, or hold perceptions and ideas that don't fit in with consensual reality. What a difference that might make to the current climate of myth, fear and taboo in mental health!

Nicky is a qualitative researcher and therapist, who runs a peer to peer therapy training called Talk for Health. For more information see www.positive-therapy.co.uk or email Nicky on nicky@positive-therapy.co.uk

References

Claridge G., (2006) Divided selves as nervous types *The Psychologist, Vol 19*, no 11, Nov.

Clarke I. ed., (2010) *Psychosis and Spirituality: Consolidating the New Paradigm.* John Wiley & Sons.

Fenichel O., (1946) *The Psychoanalytic Theory of Neurosis.* Reprinted by Taylor and Francis, 1999

Longden E., (2011) Epidemiological research on voices, 3rd International Congress on Hearing Voices, University of Savona.

Queensland Alliance, (2009) From Discrimination to Social Inclusion.

Read, J., Goodman, L., Morrison, A. P., Ross, C.A., Aderhold, V., (2008) Childhood trauma, loss and stress, Chapter 16 in *Models of Madness*.

CAN UNIVERSITIES BE RADICAL PLACES?

Mick McKeown & Fiona Jones

It might seem unusual, or even plain silly, that our starting point is the idea of making universities a focal point for radical action. We do, however, think there are some interesting reasons why this is worth pursuing. In any event, the university is one place which throws together service-user or survivor activists and academics (and others, such as trade unionists) in a context of so-called 'involvement initiatives' or 'community engagement' programmes. We are interested in the potential for such initiatives to become radicalised rather than be left to conservative forces or result in tokenism, co-option or incorporation of radicalism.

There is a culture of community activism and social movements within society, at a local and global level. These embody progressive values for change and are often quite the opposite of right-wing prescriptions for a Big Society. This includes a range of health and welfare groupings calling for radical changes to psychiatric services and societal shifts in attitudes and reactions to mental distress. All of this is carrying on against a backdrop of government persistence with failed neo-liberal policies, unprecedented austerity, cuts and privatisations visited on health and welfare programmes. In

the midst of this, universities are faced with a huge retraction in public funding and managerial approaches that emphasise commodification and commercialisation over the implicit value of education.

Within such settings there has been a call for greater involvement of the public in decision making, promoting the desirability of service-user involvement in health services, but also in the training of practitioners and research which is the province of universities. Survivor movement politics are often at odds with bland, de-politicised service-user involvement practices, yet even these opportunities represent openings for radical voices to have their say. Arguably, this is

more likely to occur if there is support from like-minded staff within the university.

Similarly, the trade unions which represent academic staff and practitioners in health and social care workplaces may also see the value of forging alliances with social movement groups, including user movements. Such developments are emerging and need to be seen as part of broader processes of trade union renewal. We think it is possible for these various forces to come together and forge a new inclusive politics of mental health.

However, in order to achieve this, it is important to think about what kinds of social spaces and what sort of communication within these spaces will best foster solidarity and alliances.

Communicative action

Jurgen Habermas (1986) said that social change can be achieved through a form of dialogue which is consensus driven and might be found in the decision-making practices of movement activists. He called this communicative action. This type of deliberative democracy is only able to flourish if participants in discussions are respectful of each other and their differences, and efforts are taken to ensure that everyone enters into the process with broadly equivalent power. For Habermas, these unconstrained communications result in the 'best ideas' emerging eventually from reasoned arguments; and by 'best ideas', he means politically progressive ones.

The reference to rationality in Habermas's theories of communication might be criticised for opening the door to a continued silencing of the voices of those diagnosed mad. However, we think that decision-making in mental health and survivor movements has, or could have, the features that Habermas talks about. No one could really argue that survivor contributions to the politics of mental health are without reason, or, indeed, that the so-called mad have a monopoly on irrational ideas or uncivil communications. For example, it can be argued quite plausibly, from a left-wing perspective, that our current government's plans for the economy are without doubt irrational and fly in the face of any reasoned reflection.

However, communicative action is dependent on facilitative social spaces. Sometimes these are referred to as prefigurative or utopian spaces wherein the active participants try to model the behaviour of the world as they would like to see it. These are spaces where critical ideas are discussed and different perspectives, interests and arguments can be disputed. Helen Spandler (2009) has borrowed from geographers the idea of convergent or paradoxical spaces where we can come together with mutual interests but also express (and face up to) our differences. This is a good starting point for dialogue about change in mental health settings.

We think university spaces which allow for service-user involvement or community engagement activity could be one of these facilitative social spaces where radical communication can thrive and grow. Other features of university environments, such as availability of rooms, information and, crucially, the presence of radical thinkers amongst the staff, might also support the emergence of such a critical social space. Perhaps *Asylum* magazine is an example of this.

Radical academics

For some commentators, universities are closed off to most of their local community, being distant or ivory tower institutions. Others, including radical elements within universities, would prefer a more inclusive and valued role within communities, where each brings reciprocal benefit to the other, and the identities of academic or community activist might blur around the edges. A good example of this was the recent anti-cuts 'teach-in' organised at the University of Central Lancashire (UCLan) alongside Preston Against the Cuts.

There has been a tradition of public intellectuals making a useful contribution to politics and thinking about social change. Another dimension to all of this might be the idea of critically engaged academics with closer links to movements, supporting these inside and outside of the university, and, importantly seeking change within the university (see Cresswell & Spandler 2011). Of course, such academics may relate positively to movement activists but this role can also be unsettling because, for example, academics do not always share the day-to-day experiences of user/survivor activists. Once again, openly engaging with such differences or tensions can help to build solidarity and help think more clearly about political objectives. This was one of the purposes of a day called Unsettling Relations: Mad Activism and the Academy, organised at UCLan with survivor activists and mad positive academics from Toronto (David Reville and Kathryn Church).

Trade unions, communities and social movements

If we are to change the relationship of universities to communities, they must also connect with other progressive institutions. Public sector trade unions are in the vanguard of struggles to respond to neo-liberal forces and threats to health, education and welfare. Yet they face something of a legitimacy crisis in building their appeal and power base amongst workers and the wider public. Arguably, they have become hollowed out in their internal relationships and democracy, falling into a trap of over-emphasising servicing rather than organising approaches to connecting with their members.

One way out of this is for trade unions to work hard at improving their own links with community activism. There is renewed interest in unions becoming more dynamic around organising, including relational models and ideas of reciprocal community unionism. These organising methods stress the potential creativity of industrial action, preferably in defence of valued social institutions in strong alliance with user movements and others. Making the case for this involves unions being better at communicating their aims more widely.

The public sector union Unison has recently adopted resolutions promoting alliances with service-user and survivor movements, and we welcome this. But local links at community and branch level need to be established, nurtured and strengthened. We know that many survivor activists may need persuading that the chequered history of union organising in relation to survivor politics can be overcome. Even some recent examples of effective alliances in defence of services have been hampered by a lack of critical attention to the politics of mental health in wider society. For example, union campaigns often overemphasise the risk and danger of clients to defend workers and services,

playing into the hands of the media stereotypes (McKeown, 2009). That said, there have been numerous examples of meaningful alliances between progressives on both sides of any perceived staff-survivor divide, and these roles are not, in any case, mutually exclusive.

So, basically, universities need to reinvent themselves. So do trade unions. Let us hope and work for a progressive manifesto for social change in solidarity with service user and survivor groups, supported by critically engaged academics. This would allow us to forge a social space that supports deliberative democracy within university settings and raises the possibility of thinking and talking about a new politics of mental health which is transformative of industrial and social relations.

References

Cresswell, M. & Spandler, H. 2011 The engaged academic: academic intellectuals and the psychiatric survivor movement. Alternative Futures and Popular Protest Conference, Manchester, April 18-20.

Habermas, J. 1986. *The theory of communicative action. Volume 1&2.* Polity Press, Cambridge.

Spandler, H. 2009. Spaces of psychiatric contention: a case study of a therapeutic community. *Health & Place, 15,* 672-678.

McKeown, M. 2009. Alliances in action: Opportunities and threats to solidarity between workers and service users in health and social care disputes. *Social Theory & Health 7* (2) 148-69.

Mick is an academic at UCLan, and a Unison activist who works closely with user groups connected to the university. Fiona is a survivor activist who also works on research projects at UCLan.

NEWS NEWS NEWS

In amongst the Christmas festivities, readers may not have noticed reports that since the start of the current economic crisis the number of NHS prescriptions for antidepressants has risen dramatically. Between April 2007 and April 2011 the numbers were up 26%, from 39.5m to 49.8m items. Yet this is probably an underestimate since it does not include some of the drugs used to treat anxiety, such as the beta blocker propranolol hydrochloride.

The most widely used prescription antidepressant is citalopram hydrobromide (12.1m items). Also popular are amitriptyline HCL (8.8m) and fluoxetine (Prozac: 5.2m). The most widely prescribed anti-anxiety drug is diazepam (Valium: 1.5m).

The Co-operative Pharmacy derived these statistics from more than 150 local Health Authorities. There was a fairly consistent increase of 22% - 26% across eight of England's ten strategic Health Authority Regions. But the highest increases were in the East Midlands (prescriptions up 44%) and the North East (up 29%). However, there is little evidence of a specifically North-South divide: in the West Midlands the rise was only 25% whilst the North West showed the lowest increase of all, at 22%.

In the four financial years between 2007 and 2011, the NHS spent over £1 billion on antidepressant and anti-anxiety drugs. But at the same time commercial licenses on

USE OF ANTI-DEPRESSANTS UP 26% IN FOUR YEARS

various popular drugs lapsed and cheaper 'generic' versions were purchased, so unit-costs fell by 30%. As a result, the total annual cost of these drugs actually fell slightly: from £291m in 2007/08 to £258m 2010/11.

However, this NHS cost is the least of it. According to research by the House of Commons, the escalating crisis of personal depression is costing Britain more like £11bn a year - in lost earnings, in demands on the health service and in prescriptions. People unable to work due to depression lose £8.97bn of potential earnings per year. Loss of earnings from those committing suicide is estimated at a further £1.47bn. And the total cost to the NHS of treating depression is put at more than £520m a year - this is estimated at £237m for hospital care, £230m for antidepressant drugs, £46m for doctors' time and £9m for outpatients' appointments.

The main mental health charities all seem to agree that job losses, job insecurity and the increasingly difficult task of simply making ends meet at a time of price rises and static wages have led to increasing numbers resorting to drugs to help them cope with anxiety and depression.

Apparently, women are almost four times more likely than men to go to a doctor with such a problem. So these statistics are just the tip of an iceberg. And neither

the Co-op survey nor the House of Commons report take into account the hidden costs of silent suffering, of 'self-medication' by means of alcohol or non-prescription and illegal drugs, or of the increase in violence, especially domestic violence.

At the same time, more evidence emerges about the health risks associated with the use of antidepressants. According to research reported in *The British Journal of Clinical Pharmacology*, there is a direct relationship between an increased risk of an injury by falling and the level of SSRI dosage when residents who have

dementia and live in a nursing home are prescribed such an antidepressant. For example, those prescribed an average dose are three times more likely to suffer such a fall compared to otherwise similar residents who are not on SSRIs. Since about two-thirds of all nursing home residents are diagnosed with depression, this is a fairly serious matter.

See articles by S. Adams in The Telegraph, and N. Morris in The Independent, both 30th December, 2011; and a report on The Alzheimer's Society website, 19th January, 2012.

LETTERS   Dear Asylum ...

Dear *Asylum*

I wonder if the *Asylum* Collective realise what an important historical record of service user/survivor/mad activism *Asylum* magazines are? I have an archive, *Ear to the Ground: Survivor and Ally Voices (Organisation and Action)* consisting of flyers, pamphlets, press reports, poems, articles, publications, etc. This includes an almost complete set of *Asylums* (*Asylum* 9:1, 1996 is missing along with 11:1, 1999, while 5:1, 1990 is a poor copy). From these *Asylums*, I have references to nearly 400 items in my archive, reminders of the activists, issues, action, and, crucially, the dates. Nice as it would be for all earlier copies to be accessible on the web, I know this isn't realistic but maybe there is or could be a set available, say, in a university library that could be visited, for reference?

Credit to the Collective for enabling survivor voices to be heard over the years and to the sellers who appeared at, for example, Survivor Speak Out AGMs in the late 1980s/90s. Curiously, Alec Jenner (a psychiatrist), who helped set up Asylum as a magazine for democratic psychiatry and gave personal and financial support over many years, held the view that:

> … many called schizophrenic passionately notice and are depressed by the madness of the world, but they fail to see they have to live in it, opting out and protesting, etc., etc. only makes it all worse for themselves. I believe the major tranquillisers help them in fact to reflect peacefully enough to compromise with the reality that they perhaps rightly enough dislike. *(asylum* 10:1,1996/7, p. 27.)

Perhaps this is a paradox of democracy – all of us having a say but perhaps no-one really listening to what anybody else is saying? Nevertheless, space was given to us. Our protests are recorded alongside the views of Professor Jenner. Psychiatry and psychiatrists are tough nuts to crack but might there be a few cracks appearing in a few places these days?

Anne Plumb

Thanks for the endorsement! And the idea of a library holding an Asylum *archive and making it accessible on the net is a very good one. We will look into it. Anyone who thinks they know somewhere which might be interested, please contact us.*

As regards differences expressed within the magazine: Asylum *was always intended as a forum for debate and not as a vehicle for any particular point of view. This meant that some contributors might express a certain opinion and Prof Jenner (for example) maybe quite a different one. At least, as you imply, his heart was in the right place – and, in fact, he did believe that it was imperative to listen to patients.*

write to *asylum* …

The Editor
Asylum
c/o Limbrick Centre
Limbrick Rd
Sheffield, S6 2PE

email: tigerpapers@btinternet.com

CREATIVE SUICIDAL ANXIETY: SELF-DIAGNOSIS OF CHAOS

William Park

In the epigraph to Will Self's novel *Dorian: An Imitation* (2002) Schopenhauer is quoted:

> There is an unconscious appositeness in the use of the word *person* to designate the human individual, as is done in all European languages: for *persona* really means an actor's mask, and it is true that no one reveals himself as he is; we all wear a mask and play a role.

For some, the mask fragments and slips entirely. For a number of individuals they may then be labelled with a term which unfortunately, sets them apart: 'bipolar, schizophrenic, depressed, neurotic, personality-disordered …' And then, if they seek help, they are lumbered with another limiting label: 'service user'.

I've come to the conclusion I am none of these. If pressed, I'll say now that I experience creative suicidal anxiety – a diagnosis originated by me.

I don't see this as a negative label, though the words 'suicidal' and 'anxiety' may indeed provoke some concern. These are acknowledgements, rather, of a stage along the way towards something creative, whether such creativity is in artistic expression or a change of direction in one's life. The change is not towards death, or remaining in a state of turmoil and anguish, but being open and receptive to the inner provocations of the psyche. It is very much a transformative 'condition', and holds within it the possibility of 'self-actualisation'.

Someone with Creative Suicidal Anxiety is likely to be a deep thinker, with a leaning towards imaginative/creative expression, possibly in the arts. The sufferer often senses a dichotomy between the inner world of the imagination and social, practical reality. This can produce an initial feeling of over-anxiety (which is sometimes panicky and destructive), of inwardness, of not wanting to face the world.

Such sensitivity can exacerbate or conflict with the bouts of productive, intense thinking, and this experience can be draining, with periods of lethargy. Too many thoughts, along with external pressures, can be confusing and frustrating, although one of the most irritating pieces of advice sometimes given to me – "You think too much" – is unlikely to be helpful! There is also an increased sensitivity to noise, and periodic, unexplained feelings of dread. At its worst, in order to simply 'survive', reactions

to such internal upheaval and challenge may, in my experience, result in days of 'freezing' (that is, not being able to move) or, alternatively, an obsessive checking of details, whether analysing writings, ruminating upon what someone has expressed verbally, or an elaborate examination of memories and sensations.

However, this sensitivity (which is also apparent as sensing other people's feelings), can potentially be a positive quality. Positive traits, the flipside of this turmoil and deepening of experience, may then emerge. These include creativity, expressiveness, the generation of many ideas, a depth of feeling, empathy, compassion, and a resourceful attention to detail.

The trouble is that this hyper-awareness can be chaotic and is sometimes overwhelming. It needs to be harnessed. I've recognised the need to channel the awareness creatively, along with periodically calming the mind. I focus my mind by using meditation.

I used to dampen my over-active perceptions by means of alcohol. Being in the grip of overwhelming thoughts or compulsive drives can be frightening, and the temptation may be to subdue these thoughts or drives with drugs or drink, or retreat by staying indoors and avoiding people. Perhaps, too, I would succumb to the compulsions in a chaotic manner by buying lots of items – books in my case – in an attempt to understand everything about the universe. But then I would become exhausted and not be able to finish reading, or instead become lost in an intricate labyrinth of disparate journals and stationery.

My need for perfection, to embrace everything philosophically, so to speak, is often difficult to manage. Some of my attempts to do so led to reams of notes, ideas spiralling and connecting, words highlighted with coloured pens. An increased excitability about concepts would also manifest. It could be difficult to abandon objects too, as their relative significance or insignificance could be in doubt, and this used to lead to hoarding.

Because words are important to me, their physical manifestation in collections, books and papers is precious, and I can be overly concerned, even traumatised, if a book or magazine is damaged in some way. (Particularly one in which I may have appeared!) However slight the damage, I will go through elaborate rituals, or attempt to repair the damage. In addition, when misunderstandings have occurred between me and others, I've experienced

crippling reactive sadness due to remorse and regret.

I realise that Creative Suicidal Anxiety, my new amalgamation of previous 'conditions' – which might be identified as hypomania, depressive rumination and an attempt at controlling anxiety through obsessive compulsions – doesn't escape the dangers of labelling. But at least it is a term that *I* have generated, so there is a certain amount of empowerment attached. And I believe the ultimate emphasis is on the positive – the creative part. The suicidal/anxious areas are the triggering, messy, chaotic pre-conditions for a creative outpouring, a series of insights, or even the beginning of a new direction or pathway in life.

'Creative Suicidal Anxiety' implies a vortex of chaos, depth, and creativity. Over-sensitivity is indicated, as well as creative and suicidal traits. The 'suicidal' element is obviously to be avoided, not to be encouraged, but it forms part of the psychological picture. My one true suicide attempt, when I did indeed almost die, was in reality a shaking my fist at 'God'. This was many years ago, and it was the act of an immature ego, a very dramatic gesture. But what I would not want to lose is that very particular kind of rawness and intensity which can lead to creative production as well as periods of being completely overwhelmed.

On the negative side, I feel my own make-up is a blend of various obsessional, depressive, and anxious states, with elements of hoarding. On the positive side, I can be sensitive and aware of others, or even the universe or the environment, on a deep emotional/psychic level, and the richness of my inner world can lead to progress through prayer, meditation and creative writing. It actually grants me a form of power and authenticity. By that, I mean that I am still in touch with all the dark, unusual recesses of the psyche, and this attentiveness and willingness to stay in tune with the 'edge' and 'detail' of myself and my surroundings increases my inner confidence and inner purpose. There is a significant danger of destabilisation only when the 'dark side' or the sheer intensity of 'insight' – such as an awareness of the brevity of life – becomes overwhelming.

Through time I have come to realise that one of the key factors for me to maintain a healthy self has been to ensure that 'normal' things like diet, exercise and social interaction are a part of any plan for the future. It's important to seek positive responses to feelings, and this might involve painting, writing, musical expression, exercise and meditation.

Travelling too far into the core of intensity can be tempting because the rewards might be world-changing. I've long been fascinated by individuals who have 'gone to the edge', and shown at least moments of sheer creative brilliance – people like John Nash or Bobby Fischer. Significant creative work is often going to be forged in isolation. But the dangers are in neglecting the 'ordinary' functioning self, the human need for love, for companionship, for proper food, for physical exercise.
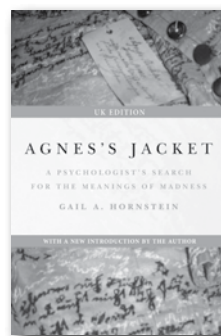
The psychological effort that goes into presenting an acceptable image or 'front' goes unnoticed or unknown, but it can be exhausting. I can worry enormously about the smallest of activities. For instance, I can be more anxious and semi-phobic about going to the hairdresser's – a place of conventional 'normality' and everyday conversation, as I perceive it – than appearing in front of a crowd of people and talking about poetry or ideas. (I love to do that for short periods, as long as I can make my escape afterwards!)

This, of course, is a draining medley of experiences which is chronic and ongoing. But it can also be overcome, if not 'cured', by summoning up the will, by making more effort, with adequate support, and ultimately, I suspect, by uniting my skills (e.g., creative writing and tutoring) with suitable opportunities and adequate recognition in the world. Indeed, suitable occupations for someone suffering from creative suicidal anxiety might include being an artist, a writer, a musician, a counsellor or a tutor.

I would urge anyone who feels 'different', or who plunges into realms of thought that are unsettling, captivating or overwhelming, to take stock and recognise that great and unique people have undergone such experiences in the past. I would feel heartened and elevated by this, and would recommend reading about such creative individuals in works by Kay Redfield Jamison, Anthony Storr (especially *The Dynamics of Creation*) and Colin Wilson (particularly *New Pathways in Psychology*).

William Park has a Major Eric Gregory Award for Poetry, and a Master's degree in Writing & Reading Poetry. His collection Surfacing *was reviewed in* London Magazine, Ambit, Tadeeb International Quarterly, The North, Other Poetry, *and* Critical Survey.

The Lawns Café

Once, in the mid-1980s,
I was a student nurse
training at Whittingham hospital.
The shop within the grounds
sold Crimplene ties:
they were either green, or brown.

Many patients
were shocked out of sanity
by clinicians;
others lost the love
they risked their life for.

One man wore
a creased, brown suit
and a green tie.
Another was whistling,
moving his arms
like a violin maestro.

In a corner
sat a small group of visitors.
They avoided the urge
to look with pity
at the obedient, trained
canteen assistant –
like a clockwork toy
he collected cups.

Those buttocks: flat, unprovocative,
although he wiggled from side to side.
Women, too,
abandoned for decades,
were undesirable, they'd missed
social clues.

The obedient man moved in closer,
his mouth a mess of chocolate.
"Surroundings are nice,"
said a visitor.
I sipped tea,
the cheapest in town,
stared through the window
at harsh, manicured lawns.

Whittingham (Ward D)

Clutching the gutter,
the turret roof
of the psychiatric ward,
the blackbird –
its head soaked in oil,
a beak like a yellow spire.

I was here,
admitted in 1991.

Opera played:
a soothing duet
from a patient's radio.

People, small
as fingernails,
watched black globes
roll across the bowling green.

Nearer, pegs clung
to a washing-line;
weeds grew
through crooked cracks
of concrete.

Images mingled
as my visitors, Mum and Dad,
headed for home.
I waited for supper:
reassuring heaped plates
of thick toast.

Through the doors
relatives left
as light followed.

Years later
this Victorian asylum
deserted, half-demolished,
is allowing trees to grow
through the School of Nursing.

WILLIAM PARK

Trains, Voices, Possible Narcoplexy Onset, I the Not Necessarily Divine, A New Theory Buds?

Matilda Melbert

There we were on a train, my son and I. Second row in, on the left. I was in the window seat. Behind my son, a man. In front of me, a lady in a pink coat, with pink nail varnish, on a pink mobile. Opposite us sat a man by the window. Behind him, on the first row, by the window, another man. I was aware of two ladies further up on our side and one lady further up at the end of the carriage, on the right. Well I do have SAS blood in me, ipso factso! Ridiculous, but a safety habit. Oh Bruce, where is the conveyor belt!

We needed the fifth stop. At the second, my son asked me, "Is this our stop?" I replied, "No." Then a female voice boomed out in the carriage, "Where are you going to?"

I looked at my son to see if he'd heard it too. But he sat there, motionless, expressionless, staring ahead. I was comfortably devastated as I felt the prickles and sweat of anxiety begin. I thought, "Why now, and how will this pan out?"

Suddenly my son said in a really booming voice, "Walsall!"

I turned to him and said, "No, we are not. We are going to Perry Barr."

He looked at me and I just knew, by his face, his concern about the voice. His expression reflected my feelings of curious and amazed concern as to what would happen next. I started to giggle. I asked if he'd heard it too. He nodded, staring me out with bulging eyes. I whispered, "Who do you think it was?" He shrugged his shoulders. Then the female voice again boomed out throughout the carriage: "We are not there yet!"

Michael widened his eyes at me. I thought, "My god, our first group session type thing, or what!!!!"

I started to laugh and couldn't stop. I became hysterical. Michael kept widening his eyes at me and told me to shush. I asked, "Where did it come from?"

He shook his head and, indicating further up the carriage, said, "I think up there." I asked, "Was it the pink lady in front?" He shushed me again saying, "No."

I was crying with laughter. I'd lost it. He told me they would think I was rude. "Who," I asked, "who??!!" He shrugged his shoulders and laughed too, but with control.

We arrived at our stop. I was bent double and staggering. Michael was cool but laughing in a normal manner. People were staring at me. I felt drunk, and was mortifyingly aware that I looked it.

Michael said, "I think it was the lady opposite." I said, "No, a man sat opposite."

He said, "No, a lady, mom. Do you think she fancied me and it was her who spoke?" Well, I screamed with laughter all the more. Poor Michael. "It was a man." We debated rights, lefts, opposites etc. Apart from the odd outburst, I regained control.

Then we were sitting in a warm lecture theatre at a university whilst a lively, deeply committed lecturer bored us both stupid. I began to feel afraid. I felt I was going to sleep and had no control. I lent forward and put my fingers over my eyelids so as to hold them up. It didn't work. My head was swimming. Michael said, "You've gone, Mom." I needed to giggle but hadn't the energy.

Well, he hadn't even applied for the course, and it was a year too early. But it was all an experience. On the tour we were split into parents and prospective students. I couldn't contain myself. Everything was so exciting to the guide but was truly excruciatingly dull to me. I kept snorting and giggling. I couldn't stop it. I felt so rude, and kept apologising. Then I saw Michael and called out with a wave. He seemed to ignore me. It seemed he never even saw me.

On the train going home Michael sat opposite me laughing and talking to the window (to his reflection, maybe). Next to me sat a smart, abnormally immaculate man straight out of the 1970s, bouffant and all. At eye level, and at arm's length in front of him, he held a book. It was entitled 'How To Deal With Difficult People'. Well, that started me off again. I was snorting to myself.

Then I sneezed, and a voice boomed from behind me way, way back: "Bless you!" Now did someone say that or was it a sprite of a voice? Because if I was on a packed train and a little old lady sneezed next to me, and although I'm not ordained, I may say quietly, "Bless you, dear." But I would not respond to a sneeze by someone half way up the blooming carriage. Who knows the answer? NOT ME!!!!!!!

I watched a television programme about children in the Gaza strip. How their lives have been obliterated, their innocence destroyed, their hatred fired and their hopes shot by adults! I cried tears of anger and sadness. Then it came to me again that I should correct this evil by taking my life. This thought had such a powerful impact. So I clenched my fists and said: "Think about it, Ange. You are NOT DIVINE. And it never worked for Jesus, anyway, who claimed he was."

But then I thought: "What is divine anyway? Maybe I am divine. Maybe this is how it is, yet I don't feel superior or invincible." Then I thought: "Martyrdom hasn't solved anything and I'd only destroy the lives of my own children, even if it was a beautiful peaceful world afterwards."

So here I am.

Strangely enough, the other morning, at 6 a.m., I heard a young girl call out "Hello!" in a desperate way. And guess what – so did my daughter. The voice came from downstairs. My daughter called out to me, "Who the hell was that, Mom?"
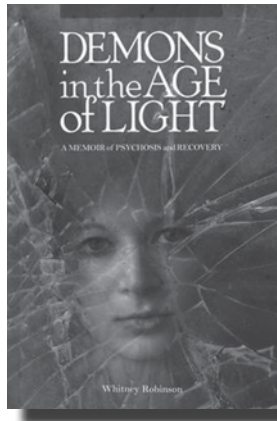
Now we both hear voices. But this sharing malarkey gets you thinking, doesn't it?

Book Review
By Anne Plumb

demons in the age of Light; a Memoir of psychosis and recovery
by Whitney Robinson,
Process Media Original Paperback,
2011

This is a revealing account of what is known, and treated, as psychosis. But the text means addressing dangerousness – including a chilling encounter with a child in the woods. I am a mental health system survivor, and I found reviewing this book difficult and disturbing.

In the Afterword, Whitney recognises a problem here for people with mental illness (sic): we have constantly to battle the stereotype that we are unpredictable and violent. And this narrative is consistently about the 'darker' side to human nature – pleasure in aggression and destruction – something that Whitney seemed to embrace even when young.

This worries me because of notions of 'inherent evil' or 'the psychopathic personality'. And I worry that people might glibly dismiss her difficulties with relationships as part of 'an autistic spectrum'. (Along with healthy living, hygiene and polite behaviour, making eye-contact was one of the patients' goals in a halfway house where Whitney had stayed.)

 The book is also gruelling when Whitney describes her time in 'psych units': discussions with her psychiatrist, which she describes as "a stalemate of words and will"; medication that causes limbs to twitch "with a restless activation to compensate for a lifeless interior"– which Whitney is told she will get used to; at one point, 'an adverse event' – a severe drug reaction; days which "pass with aching slowness, as if time, too, were taking sedatives"; a roommate who attempts suicide; staff who seem not to notice the contradiction in trying to instil a healthy lifestyle while insisting on drugs which induce weight-gain and sluggishness.

Whitney does not see the staff as unkind but rather as ineffectual. She tries a church exorcism and a Peruvian shaman. These don't help much either, although the publisher seems to want to highlight them as 'topical'. The word 'recovery' in the subtitle is also misleading. Did Whitney feel this way when first submitting her manuscript, or is the publisher trying to appeal to a certain market?

It strikes me how lonely Whitney has been, struggling to make sense of her experiences, all in her own mind – in particular possession by a demon – because others do not understand or accept what she is talking about. Her thinking is indeed confused (although connected to her own life: her philosophy and biology classes at university). There is the complicated issue of agency here. When Whitney felt compelled by 'the Other' to cut her wrists, she replied to the doctor who asked her why – was this suicide or attempted murder? Whitney spells out the terrifying space she is in, but there is no one really to engage with her. Her doctor says she must listen to him.

Whitney touches on things which I would see as significant, but she doesn't explore them. Although not deliberately neglected, she had a solitary childhood, with much time to pass in her own adventures, alert and imaginative. She was home-schooled because her parents wanted to protect her from the world (for example, from MTV). And their Orthodox religion introduced her to a jealous God (Robinson's own words), a devil that offers the world for our souls, demons that, in Judaeo-Christianity, may find a dwelling place within us but can also be cast out into swine. She had hidden herself in an attic, three storeys up, so as to shut out her parents' arguing. And she left her familiar landscape for university whilst lacking the social experience to help with this transition.

For Whitney, her account has meant finding what compels her and that, so far, is enough. She writes that, if caught at the right moment, she might confess a continuing belief that

> *demons surround us … (that) they occupy no physical space, … have no meaning independent of their hosts. parasitic, without mercy, our constant shadows …*

Of psychiatry's explanations, Whitney says about her doctor:
> *it's probably better that you had to go and talk someone's giant spiders or communist spies into non-existence, to dispense more of your secular holy water that anaesthetizes demons but does not exorcise them.*

And of the doctor's being unable to:
> *restore order to … (her) shattered mind despite … (his) a Harvard degree and paternalistic attitude of material reductionism.*

Robinson writes that her account:
> *will surely make me more real than i am, and necessarily him (the other) as well. it's an indefensible risk to be sure. and yet the paper wills with words, the demon has a voice again, so serenely devoid just moments before, shatters into meaning.*

Who might read the book, and in what way? Might it be people with a voyeuristic fascination for other people's madness, or those compelled to find out more through their own fears? Might it be psychiatrists or psychologists, welcoming a detailed case study but upholding unshakeable beliefs about 'mental illness'? Might it be people who value personal narrative, or a service user/survivor, looking for hope? Might a service user find reassurance in experiences that echo her own?

For all her courage in writing it, I find it hard to see Whitney's book, her wry observations and poetic descriptions, as doing anything other than confirm the stereotypes that lead to our containment and coercion within the psychiatric system, and the stigma that is attached. I have never wished to kick a cat or harm anyone; indeed, I believed a time was coming when there would be no more suffering, only joy and peace (Plumb, 1993, p. 173). And yet those of us who feel accountable to some higher authority – be it a god, devil, demon, alien, invisible force – are at risk of believing we are being tested and must prove ourselves by some action. This is not surprising in, for example, Judaeo-Christian cultures, where young children in Sunday Schools absorb stories in which Abraham is lauded for being willing to sacrifice his son at God's command, where Moses is denied entry into the Promised Land because he hesitated to lead the Israelites out of Egypt, where Daniel was protected in a lions' den. And this is just one cultural source that may fill our imaginations and mould our beliefs.

Maybe because my brother was a medic, I found myself privileged, one might say, to be put in a small specialist unit of a teaching hospital, and later in a modern therapeutic 'hospital'. But it still pains me to think of those places. I remain convinced that the medication added to my confusion and, in no way could I see some deficit in my neurochemistry generating my 'extra-ordinary' experiences.

Neurophysiology is but medium between our various environments and what might be called psyche, self or soul (Plumb, 2002, p. 122). Our neurophysiology, when disrupted, may affect our perceptions – hallucinations can be side effects of epidurals – but we cannot assume on this basis that, in general, our situations and all the accumulated experiences which form the frameworks by which we live, play no part.

Or, as Whitney writes about the stained glass windows in an Orthodox church:

if mere patterns of coloured glass could stir in me … emotions as rich as the wine tones of their many facets, it seems there must be something here that was more than the by-products of chemicals and their collisions.

Of course, even one of the founders of the medical model, William Sargant, initially admitted social circumstances, but believed it was futile to try and change them, and that psychology was not really of much help to people whose emotional needs were urgent (Sargant 1967 p32). And he is correct that there are those who find suppressive medication helps them to cope and move on. But, for some of us this neither appeals nor provides answers. Different ways of engaging with and supporting us are long overdue.

What saved me from returning to the grasp of psychiatry was a variety of factors: some wise words from a church minister; a handful of people who reached out to me and trusted me; my discovering techniques and strategies so as to get by; meeting others, for example through Survivors Speak Out in the late 1980s – and, indeed, reading other people's first-hand accounts ; and luck – the guiding hand of a mysterious guardian spirit, maybe? (Plumb, 1999, p. 468-70)

Whitney writes that she decided to have her book published but still feared judgement, or "maybe desired it", and has come close to obliterating herself and her words. I hope people will read her book so long as it leaves them with an imperative: to find better ways to help and support people through such terrifying, isolating and, yes, sometimes dangerous experiences – a change of paradigm and practice. (Plumb, 1999. p. 465,472-4)

References

Plumb, Anne 1993. The Challenge of Self Advocacy. *feminism & psychology, 3*.2.

Plumb, Anne 1999. New Mental health legislation. A lifesaver? Changing paradigm and practice, *social Work education 18*: 459-76

Plumb, Anne 2002. From Psychiatric patient to Citizen: Overcoming Discrimination and Social Exclusion. Liz Sayce. A Review Article. *social Work education 21* .1.

Sargant, William 1967. *the unquiet Mind.* Atlantic, Little, Brown.

Film Review
Dave Harper

A DANGEROUS METHOD
directed by David Cronenberg

a dangerous Method is three love stories: that between Carl Jung and his wife, Emma; between Jung and a young patient, Sabina Spielrein; and, finally, between Jung and Sigmund Freud. The film is adapted from the play *the t alking Cure* by Christopher Hampton which, in turn, was based on John Kerr's book *a dangerous Method.*

The film opens in 1904 with Jung (played by Michael Fassbender) utilising Freud's experimental treatment with eighteen-year-old Sabina Spielrein (played by Keira Knightley), a patient at Burgholzi hospital in Zurich. (Eugen Bleuler, who coined the term 'the schizophrenias', was the medical director of Burgholzi at the time.) Sabina seems very disturbed and describes how her father beats her. Later she discloses that she becomes sexually aroused when beaten or humiliated. Jung begins a correspondence with Freud (played by Viggo Mortensen) about the case. Sabina responds well to therapy and subsequently leaves the hospital to begin a medical degree.

In 1907 Jung visits Freud and the two talk non-stop for thirteen hours. Freud sees Jung as a protégé, someone who, after him, might lead the psychoanalytic movement. Freud refers Jung to a fellow psychiatrist, Otto Gross (played by Vincent Cassel). Gross – whose motto is 'repress nothing!' – is an anarchist, an advocate of free love and copious drug user. (His first scene shows him snorting cocaine. Of course, Freud was an early advocate of the drug.)

Gross challenges Jung's ideas about monogamy, and Jung later has an affair with his patient, Sabina. The sexual element is sado-masochistic. This affair is completely unethical. Jung's wife, Emma, appears to suspect he is having the affair. As a result of the ensuing scandal, Jung breaks off the illicit relationship. Spielrein writes to Freud about the affair, which Jung initially denies but later acknowledges to Freud. This affair, together with Jung's criticism of tenets of Freud's theories and his unhappiness with what he sees as Freud's demand for unquestioning obedience, leads to an increasing distance between the two men. Intentional or not, one can read Gross, Jung and Freud as representing respectively the id, the ego and the superego of classic Freudian theory.

This film is beautifully made, from the opening credits which are presented as ink on paper, reminiscent of a Rorschach test, to locations which include Vienna and Bodensee in Germany (which stands in for Zurich). Without dominating our awareness, the film conjures up a good sense of the period.

Mortensen, Fassbender and Cassel are convincing in their roles, Knightley less so, but we see little of Emma, a part that is under-written. The material coincides well with Cronenberg's preoccupations with sex and violence and, following *a History of Violence* and *eastern promises*, this is Cronenberg's third more conventional film in a row (all featuring Mortensen). It is quite different from his earlier, 'body horror' films, such as *the naked Lunch, Crash* and *existenz*.

Although film and plot tend to focus on the melodrama, it does give space to some key debates in the early psychoanalytic movement, such as the nature and centrality of libido, the nature of the unconscious, how important a scientifically conservative strategy was for psychoanalysis to grow, and Jung's openness to ideas like synchronicity. We also see Freud, Jung and Sándor Ferenczi travel to America in 1909 – a visit which marks the foundation of psychoanalysis in America. Sadly, we see little of Jung's breakdown during the First World War, when he began his *red Book*, a kind of secular illuminated manuscript describing his own psychotic experiences. (This was kept secret by Jung's heirs and only published in 2009.)

The film includes some wryly humorous episodes, such as Freud's surprise that Jung does not need to worry about money since he is married to a woman who is independently wealthy, or when Jung discloses a dream to Freud which he goes ahead and interprets whilst refusing to share his own dreams.

What then happened to these characters? Otto Gross was found starving and frozen in a Berlin street, in 1920; he died of pneumonia. Sabina Spielrein trained as a psychoanalyst and returned to Russia in 1923. Her brother and her husband were killed during Stalin's Great Terror, and she and her children were shot by the Nazis in 1942. Freud fled the Nazis and moved to London in 1938. He died there in 1939, just weeks after war had been declared. Jung died in 1961.

a dangerous Method is in uK cinemas from 10 February 2012.

Sarafin

Sarafin writes and draws a webcomic called *asylum squad* http://www.asylumsquad.com. She started this during a year long stay in a notoriously oppressive psychiatric hospital in Toronto. The comic on page 29 was a form of self-therapy, as she received no other therapy while lin the hospital, except drugging. Since then, she has continued the strips and is preparing to self-publish her first collection. She is also a member of the Toronto Mad Pride movement. The artwork was produced by Sara*f*in after an extended stay in restraints, in locked seclusion.

Front and back cover images by Sarafin
Biography on inside back cover