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the magazine for democratic psychiatry

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**CHILD ABUSE & MENTAL HEALTH
WORK CAPABILITY ASSESSMENTS
HEARING VOICES: READERS' VIEWS**



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

Incorporating the
Newsletter of Psychology
Politics Resistance

the magazine for democratic psychiatry

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Send letters, comments & submissions
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Thomas Riesner: 'Fixierung 3'

CONTENTS

THomAs sZAsZ (1920–2012): <i>life, liberty and politics</i> Ron Roberts	3
CHild Abuse And Adul T menTAI HeAl TH CHRis Holley 1958–2011	4
sAfeTy model foR Adul T suR vivoRs emeRge	5
WHAT To do if you ARe seCTioned: <i>six ideas from a survivor</i> Jeremy spandler	8
woRk CApAbiliTy AssessmentT : <i>squeezing the vulnerable</i> A seR viCe useR CommentS	9
CHALLENGing The benefiTs Regime phil Hutchinson	11
beyond ReCoveR y Jeremy gluck	12
HeARing voiCes	14
HeARing voiCes is noRmAi dr John Rowan	15
lisTening T o The inneR voiCe: <i>consciousness and mental distress</i> John myhill	16
WHAT does HeARing voiCes HA ve T o do wiTH me? (<i>connecting professional and private selves</i>) Caroline von Taysen	18
news And findings	19
depReSSion & mediCATion on The inCReAse	19
26% of uk woRkeRs TAke Time off foR depReSSion	20
middle-Aged men now HighesT suiCide Risk	20
menTAI HeAl TH disCRiminATIOn T o be AXed	21
CReATiviTy & menTAI illness	21
sTigma & disCRiminATIOn sTill impoRTAnT	22
inCReAse in Admissions foR self-HARm	22
CReATive wRiTing	23
inTeR view wiTH peTeR CAMPbell	23
poems - peTeR CAMPbell	23
poems don weiTZ And Jenny JoHnson	25
How well do AnTi-CApiTAlisT Camp AigneRs Respond To menTAI deviAnCe? Ronny w orsey	26
book Reviews	27
mindful oCCup ATion: Rising up wiTHouT buRning ouT	27
nARRATIVE psyCHiATR y: How sT oRies cAn sHApe CliNiCAI pRACTiCe	27
Agnes's JACkeT : A psyCHologisT's seARCH foR The meAning of mAdness	28
Al TeRnATive souRCes of suppoRT	
bACk Cover	

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

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

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THOMAS SZASZ

(1920 – 2012)

Life, Liberty and Politics

Dr Thomas Szasz's life-long defence of basic human freedoms came to an end on September 8th.



Although sidelined for years by mainstream toxic psychiatry, Szasz's work remains far from irrelevant. On both sides of the Atlantic, the government of the people by corporate and business representatives against the people appears committed to eroding or abolishing those liberties that have been won through determination and hard-fought struggle. It was always clear where Szasz stood in this contest.

I believe Szasz's work is much misunderstood – and not just by the unimaginative, slavish adherents to the totems of biological psychiatry. Considered a fascist in some quarters and radically liberal in others, this apparent conundrum is resolved if we understand that Szasz was distrustful of all forms of organised power, from the state downwards. Remember that he grew up in Hungary, a country occupied first by the Nazis and then by the Moscow Communists, those twin totalitarian monsters of the 20th century.

However, Szasz should not be seen as simply reacting emotionally to the horrors of mass political crimes. His views were always reasoned and eloquently expressed, although perhaps sometimes difficult to digest emotionally. He supported the advanced psychiatric directive, the idea of people should be able to use the drugs of their choice, and that people have the right to commit suicide. He also argued that forms of sex therapy are essentially state-supported prostitution. All this amounted to the consistent expression that people own their own bodies and should be the final arbiters of what they do with them.

In the course of his career his voice was a beacon for the rights of mental health patients, of women, ethnic minorities and gay people. For example, it was Szasz who documented the shocking use of psychiatry against runaway slaves in the 19th century, and who ridiculed the idea that homosexuality was a disease.

However, Szasz's disdain for state healthcare systems (public health) has not enamoured him to many on the political left, where opinion still clings to a basic trust that the operations of the state can be harnessed for the good. The unfortunate truth is that they seldom are. The much lauded British National Health Service is a case in point: its current auctioning-off in bits and pieces to the highest bidders serves to demonstrate, if nothing else, that it was never in the people's hands to begin with. Szasz's criticisms ought to direct those on the left towards rethinking how the 'management' of their own healthcare

might be re-appropriated by the people – collectively and individually – so that everyone, including the most vulnerable, is truly valued and cared for. These are problems ultimately connected to how we relate to our fellow human travellers on the planet.

Szasz's argument about the threat posed by what he identified as 'The Therapeutic State' is of a different order. With the medicalisation of practically every aspect of day-to-day living, we have become de facto prisoners in a totalitarian medical nightmare – transformed from citizens into patients, our rights at the mercy of doctors who perform an increasingly political function. Szasz saw the doctors as a neoliberal management elite acting at the behest of an intrusive state; the state apparatus has evolved perennially to monitor and patrol proscribed deviations from the behavioural, psychological and political status quo. At a moment's notice, individual liberty may be curtailed with forceful interventions so as to mould the individual into a person who is compliant with institutional mores. In this respect, Szasz's fears seem better founded with each passing year.

A key under-explored theme arising from his work is how the liberty of the individual can be preserved whilst simultaneously preserving the social values and freedoms from group exploitation and oppression. In *The Ethics of Psychoanalysis*, Szasz expressively supports both the logic and the rights of people to organise and protect these social freedoms. He correctly recognised that too often restrictions on individual freedoms have resulted from perhaps well-meaning collective action. In which case, the challenge for libertarians and others on the left is to recognise that this is an unresolved problem worthy of serious attention. I am sure some readers might want to disagree, but Szasz's views do have much in common with those on the libertarian left of an anarchist bent – Chomsky for example – who are similarly distrustful of state power, and do not at all believe in a necessary trade-off between individual and collective freedom.

Like Sartre, Szasz twinned freedom with responsibility. He believed that human beings must always be considered as autonomous, responsible agents. This was not intended as a declaration of some objective scientific truth but as a basic moral position about the nature and dignity of human subjectivity. His criticisms of the pseudo-scientific ideology at the core of reductionist biological psychiatry were principally concerned with the elimination of notions of agency and selfhood by the psychiatric juggernaut, and the moral, psychological, social, legal and political trouble that this spells.

It is this fundamentally moral position that lay behind Szasz's most famous assertion – that mental illness is a myth.

Szasz's concern with the implications of scientific theory and practice for our view of ourselves overlaps with Laing's

existentialist musings, although Szasz's work explores more the legal, moral and social implications of the road we're on. While Szasz acknowledged a worthy contribution by RD Laing (in a footnote in *The Manufacture of Madness*), his more usual literary relationship to Laing was one of antipathy. He charged Laing with practising a mirror-image to mainstream psychiatry, and one which, like the mainstream, did not preclude either the deprivation of liberty or the resort to coercive 'treatment'.

In that respect, Szasz's opposition to psychiatry was far more consistent than Laing's. However, neither Laing's inconsistency nor his personal failings can undermine the brilliance and insight contained in such books as *The Divided Self* or *Sanity, Madness and the Family*, and it is hard not to imagine that Szasz's disregard for Laing had some basis in an acute sense of disappointment with what his Scottish counterpart might have achieved.

I think it is a mistake to identify these two as very similar practitioners of 'anti-psychiatry'. Yet I believe an accommodation between the best of Laing and the best of

Szasz is still possible, although future work will be required to set the boundaries on the scale of such an accommodation.

What is clear, though, is that Szasz never committed anybody to a mental institution. He never gave anybody electric shock 'treatment'. And he never administered drugs, against their will, to anybody in psychological difficulty. He once told a newspaper: "I am probably the only psychiatrist in the world whose hands are clean."

Nothing human was alien to Thomas Szasz. His profound respect and tolerance for all forms of human diversity, his belief that people should enjoy the right to pop their heads in the clouds and think what they want, free from state-sanctioned psychiatric interference, is something worth remembering.

Ron Roberts, Kingston University

September 2012

Asylum intends to devote a special issue to the life and ideas of Thomas Szasz. If anyone wishes to offer a contribution, please do. But so that a fair number are able to air their views, please keep it as short as possible!

CHILD ABUSE & ADULT MENTAL HEALTH



CHRIS HOLLEY 1958 – 2011

**Nurse consultant and expert
in sexual abuse and women's
mental health**

during the last twenty years or so, research has accumulated to definitely establish that most of the most serious adult emotional and mental distress is due to the trauma of child abuse, and particularly sexual abuse. This is now officially recognised by the nHs (see itzin) which has national policies in place to detect and deal with the problem.

A recent uk survey estimated the prevalence of childhood sexual abuse at about 11%, with physical abuse at about 24% (may-Chahal and Cawson). The dept of Health report in 2006 more or less agreed: it found childhood sexual abuse at a rate of 20–30% for girls and 5–10% for boys, and with up to 20% of all children subjected to regular physical abuse (itzin, p. 16). for both men and women, frequently reported long-term mental health effects of childhood sexual abuse include depression, anxiety, post-traumatic stress disorder, substance abuse, eating disorders, psychosis, self-harm and suicide. various studies report 50–60% of mental health in-patients and 40–60% of out-patients having been physically or sexually abused (or both) as children (itzin p. 17). There is also a clear 'dose' effect: the more the abuse, and the more the types of abuse experienced (emotional, physical or sexual abuse, or neglect) the more severe the psychological distress; almost all psychiatric in-patients diagnosed with psychosis

will have a history of childhood sexual abuse (Read).

As usual, this knowledge and policy takes its time to percolate through to practice 'on the ground': training and therapy have not been prioritised or adequately funded. The most useful response is fairly intensive and perhaps long-term psychotherapy or counselling, and most people still have to wait a long time to access that on the nHs.

However, this is not for want of the efforts of Chris Holley Rmn, Cert Couns, dn (Cpn), msc. for many years she was one of the UK's leading lights in the field of sexual abuse and women's mental health. from 2005–2010 she was national Clinical lead for the department of Health implementation of violence and Abuse policy programme.

when she died last year, RCn general secretary peter Carter said: "Chris Holley is an iconic figure in mental health nursing. what she has done over the years has been inspirational and brave. Through her pioneering work highlighting sexual abuse she has helped innumerable patients, service users and colleagues. Her early death is a major loss to nursing."

Chris was a nurse consultant at south staffordshire and shropshire Healthcare nHs foundation Trust, where she worked for 21 years. The Trust's chief executive neil Carr said: "Chris was almost single-handedly responsible for establishing the Trust's highly successful and award-winning sexual abuse service. she also set up a service training volunteers to work in this area. she was passionate about supporting adult survivors of sexual abuse and had an international reputation as an expert in this field. She will be much missed."

she was active in the south staffordshire branch of the RCn and was also an honorary lecturer at staffordshire

university. she helped to form the RCn women's mental health group and sat on the steering committee of the RCn's mental Health forum.

so as to support the survivors of sexual abuse and their families, in 1993 she set up the charity emerge. This provides training and volunteers who can give one-to-one support, and there are self-help groups and a telephone help-line (see below).

RCn mental health adviser ian Hulatt said: "Chris made an immeasurable contribution to the world of mental health nursing with her tireless activism to promote the welfare of those who were particularly vulnerable. she was an unflagging and passionate advocate for clients and carers."

largely due to Chris Holley's efforts, the nHs trust she worked for became a leader in the field. Nowadays NICE's national care programme approach guidance states that:

questions should be asked by suitably trained staff at assessment about the experience of physical, sexual or emotional abuse at any time in the service user's life. the response, with brief details, should be recorded in case records/care plans. If the specific question is not asked, the reason(s) for not doing so should be recorded. (refocusing the care programme approach, policy and positive practice, guidance section 4, march 2008)

Chris Holley's trust had set up a training program. This serves personnel in all types of nursing, psychiatrists, psychologists, occupational therapists, social services, the police and prison staff, magistrates and judges, mH service managers, the armed services, and the voluntary sector. Jackie sharratt, sexual Abuse specialist, wolverhampton City nHs primary Care Trust, recommends it:

this training should be attended by all mental health practitioners ... so we are equipping staff to confidently support adult survivors of child sexual abuse within our practice. the training is imperative so that we

can insure there is routine enquiry and consistency in addressing violence and abuse, within an emphasis on child sexual abuse.

A male service user has stated:

"this training is essential. i can't stress enough the feeling of relief – i need to know that i was able to talk to someone who understood what i had gone through, without being judged."

And dr enio semo, a local psychiatrist said:

"understanding sexual abuse has provided essential knowledge in my practice and has enabled me ... to provide holistic care for my patients who have suffered such trauma."

in the wake of the news of the bbC's disgraceful mishandling of revelations about Jimmy savile sexually abusing children for decades, charities which work with people who were victims when they were children have seen a big increase in the numbers calling their helplines. The national Association for people Abused in Childhood usually gets about 200–300 calls a day, according to the charity's director. but in the three or four weeks since the news broke it has been taking four or five times as many calls. (radio 4 news, 25 oct, 2012). The kind of service that Chris Holley campaigned for is needed as much as ever.

Sources

- C. itzin: *tackling the health and mental health effects of domestic and sexual violence and abuse*, department of Health, 2006.
- C. may-Chahal and p. Cawson: 'measuring child maltreatment in the united kingdom: a study of the prevalence of child abuse and neglect', *child abuse and neglect*, 29: 969–84, 2005
- 'obituary', *nursing standard*, RCn publishing, July 6, 25:44, 2011.
- J. Read et al: 'Childhood trauma, psychosis and schizophrenia – a literature review with theoretical and clinical implications', *acta psychiatrica scandinavica*, 112: 330–50, 2005.

SAFETY MODEL

below we reprint an nhs trust document devised by chris holley, and give information about the charity she set up – emerge.

FOR ADULT SURVIVORS OF SEXUAL ABUSE PREPARING TO EXPLORE THE EXPERIENCE

COPING WITH CRISIS

safe ventilation techniques

- examine your coping mechanisms and make a commitment, to yourself, to stay within safe boundaries – aim to take control.
- Put together a personal self-injury first aid kit and aim to minimise the harm to yourself.
- explore different ways of ventilating your feelings safely – punch a cushion; write it down; talk to a friend; try a creative skill such as drawing, painting or poetry.

allow for personal space

- Reschedule time within your daily routine to consider and express your thoughts. A change of routine may be necessary.
- Tell those close to you that you may need space at times, and develop an agreed system so that they know when to leave you alone e.g.: "i need to take time out".

- Consider your needs and set boundaries with those around you regarding physical and sexual contact. who do you want to know about your disclosure?

form a list of safe contacts

- who do you feel safe talking to about these issues – family, friends, professionals, help lines?
- make a list of names and telephone numbers to use in a crisis including when they are available – keep the list at hand.
- Ask friends about their contact limits – how much support are they able to give, and how late at night is it acceptable for you to call them?

exercise safe grounding techniques

- Identify a place where you feel safe to go if you experience flashbacks, memories.
- Remind yourself of where you are; look at things around you; stay in the present.
- write down your experience as soon as you feel able to; discuss it with someone if possible.
- identify a safe grounding object – a piece of jewellery, a soft toy, a key ring, something you can keep at hand.

time out and relaxation

- explore several activities that you can use to take time out from dealing with the abuse.
- schedule daily time in your routine to take time and relax – and remind yourself that you deserve this.
- Try out new hobbies, or rediscover old ones.
- Consider your coping mechanisms and make a list of those that help you to relax, safely.

you are not alone

- Remind yourself that others have been at the stage you are in at the moment, and survived.
- Tell yourself that things will get better with time, patience and support.
- Join a support group, see how others are coping, and share your frustrations with those who understand what you are going through.

Chris Holley RMN Cert. Couns.; D.N. (C.P.N.); M.S.c.

Consultant Nurse, Sexual Abuse Service, South Staffordshire and Shropshire Healthcare NHS Foundation Trust,
Copyright © Holley 2006

emerge

SEXUAL ABUSE – Victim to survivor

“The hurting can be overcome”

Childhood sexual abuse has received a lot of recent media attention, but sadly it is not a new problem... sexual abuse has been happening for centuries. Many victims suffer in silence whilst plagued by guilt, constant reminders, and feelings such as:

“Who can I tell, who will believe me?”

“I can’t forget and put it out of my mind.”

“It comes back ... I’m constantly reminded by TV, magazines, newspapers and the internet ... ”

“The computer games my children are playing, the online games ... are they safe? I’m so worried.”

“It’s all my fault.”

“I told someone before and they said forget about it ... I can’t.”

“I can’t tell my family, what would they think? They would disown me.”

“It affects my whole life.”

Have you experienced any of the following?

- anger
- depression
- flashbacks
- nightmares
- confusion
- guilt
- sexual difficulties
- marital problems
- relationship difficulties
- lack of confidence
- low self esteem
- anxiety
- feelings of isolation
- suicidal thoughts

It will help to talk.

Even if you support someone who has been abused you may feel:

- isolated
- confused
- helpless
- angry
- frustrated

We can support you too

Many adults who were sexually abused as children, and sometimes re-abused in later years, have managed to live without feeling a desperate need to talk about it. Some have managed to block out the painful memories completely. Sadly, many find these feelings return in later life when they least expect it. For example: after childbirth; when your child reaches a certain age; following a bereavement; on watching a particular TV programme; at any point of

a crisis in your life.

Whatever or whenever the trigger, if you need to talk, help is at hand.

emerge has a team of trained and highly skilled volunteers, and access to specialists who will help you along the sometimes difficult and often painful path of healing. We offer help to men and women over the age of 16, and operate in the strictest confidence. We're here to help victims become survivors, regardless of gender, and for as long as you need us.

We provide someone:

You can trust

Who will believe you

Who will listen to you

Who will understand

Who will not judge you

emerge volunteers offer

- a telephone helpline.

Contact emerge on 01785 225991
or 01543 576174

- a befriending service
- support groups for survivors of sexual abuse
- support for those supporting survivors of sexual abuse – non-offending partners, parents, family members and friends

emerge is a partnership between volunteers and professional workers from South Staffordshire and Shropshire Healthcare NHS Foundation Trust. There is no charge for the service that **emerge** offers, however donations would be gratefully received, allowing us to fund and continue this vital work.

Reg. Charity no: 1142240.

APOLOGY

The editorial collective would like to apologise if any of our readers found any of the images in our previous issue disturbing or upsetting. Please feel free to send us images you would like us to include in future issues.

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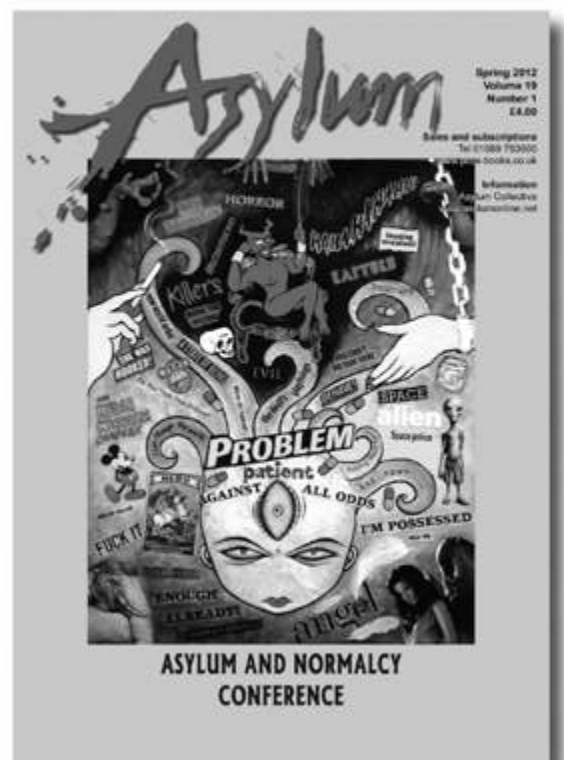
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WHAT TO DO IF YOU ARE SECTIONED

Six ideas from a survivor

Jeremy Spandler

1: Choose your own 'nearest relative'

i contend that it is best if your 'nearest relative' is the person you think is best able to treat you with unconditional positive regard. if you take no action, for the purposes of the mental Health Act (1983) your nearest relative will be decided automatically according to a specified hierarchy, and it will generally be your 'next of kin'. you can apply to the Crown Court to change this but i recommend that you persuade whoever is in fact your nearest relative (next of kin) to write a letter to the person you actually want to take the role, delegating the power to them. (for details see www.mind.org.uk) This can be done after you are sectioned but you can do so in advance if you fear sectioning before it happens. This person may be able to help with practical matters (e.g., clothes, money) but their primary role is to support your actions.

2: Is it really a good idea to appeal?

you are able to appeal against your section, and this may seem the natural thing to do. However, you will spend your energy (and other resources, such as money) on preparing and worrying about your appeal. instead, you might consider concentrating on persuading the Responsible Clinician (the psychiatrist) to discharge you from detention.

3: Write a letter to the Responsible Clinician

your task is to persuade the psychiatrist that you have insight into your condition, and that the medication and other actions you are willing to take will effectively control your condition. in my case, i agreed to take an anti-psychotic but not a mood stabilizer.



4: Negotiate on the basis of that letter

your letter is the starting point for a dialogue with the psychiatrist, and she will have the opportunity to question the points you have made.

5: Treat nurses and care assistants with respect

by all means ask for information about the medications you are told to take, and also the reasons you have been told to take them, including the expected side effects. but once you have made a decision not to take a medication, simply refuse politely: e.g., say 'i will take xxx mg of Quietepine XI at night but i refuse the rest.'

Although officials are able to force treatment upon you, under the detaining and treating powers of the 1983 mental Health Act, if you have explained your thinking in the letter it is unlikely that such measures will be taken.

6: Use your time in hospital effectively

Think about your medium- and long-term goals – for example, whether you want to seek promotion at work, the future of your relationships, your next holiday or what you are going to do at Christmas. but try not to think about the time before your section runs out. This is not easy, but i assure you will only get frustrated. good luck!

a member of the Asylum collective suggests that we should point out that although very helpful for Jeremy and possibly many others, some of his tips may not apply to everyone who gets sectioned.

for example, 'Write a letter to your responsible clinician'. from personal experience of sectioning, she can say positively that at least in the first few weeks of her detention she was heavily drugged-up and not really able to think, let alone write a letter with a coherent argument. Writing a letter by herself was out of the question, and also for most of the other people on her ward who were sectioned. perhaps if she had had a mental health advocate, the two of them could possibly have composed a letter. otherwise, she recognises that she was too distressed, and unable to think and reason very well.



'Mundschutz 2' Thomas Riesner

write to asylum ...

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SQUEEZING THE VULNERABLE

No doubt about it – a lot of people are ‘on the sick’. The last available figures (February 2012) show 3.24 million people claiming a Disability Living Allowance (DLA). A high proportion have claimed for more than three years, and about 10% for more than ten years.

But many people are worried that the mental health of some of the most vulnerable is increasingly put at risk by the government’s determination to push through massive cuts to the benefits system.

The plan is to review everyone currently receiving health disability benefits. Every week 11,000 people have to undergo a work capability assessment (WCA). These tests are ‘outsourced’ to the French healthcare firm Atos. Up to half of the decisions have been taken to an appeal, and 40% of the appeals have been successful. Atos is paid £100m a year, and the appeals cost the taxpayer another £50m.

WCA is supposed to identify people fit for work. But at the moment it looks like a crude way of reducing benefits by ‘getting people off the sick’ and onto the much lower benefits of Job Seeker’s Allowance (JSA), irrespective of their actual health and work capabilities. And who better to target but those with mental health problems? WCA has faced strong criticism from health professionals, campaigners and claimants alike.

The Guardian reported that a man arrived to sign on at Birkenhead Jobcentre in Merseyside in May. He was late. He had been late repeatedly and had missed several of his fortnightly appointments. The jobcentre supervisor told him that his poor timekeeping had become an issue and put him at risk of being ‘sanctioned’.

‘You have two options,’ he was told. ‘Start turning up to the appointments on time, or continue like this and your claim will be disallowed.’ According to a health and safety report passed on to the newspaper, the man replied: ‘I have a third option.’ He reached into his pocket, took out a knife and cut his wrists.

The police confirm this incident and say that the man was subsequently sectioned. He is understood to have had a history of mental illness dating back at least a year. He had been on Employment and Support Allowance (ESA) for depression and arthritis, but in February he was reassessed and found fit for work. He had started an appeal, but had withdrawn it and gone onto jobseeker’s allowance.

Critics say Atos often fails to pick up complex and fluctuating conditions such as mental health, and WCA is feared by vulnerable claimants: when it is decided that a claimant is fit for work, the best he or she can hope for is a long and stressful cycle of appeals.

In Birkenhead, many claimants who have trouble with their

benefits go to Mersey Advice, a welfare rights charity near the Jobcentre. Staff call it ‘the fourth emergency service in Birkenhead’. By mid-summer the centre was so swamped by people needing benefits advice that there was a three-week waiting list to see an advisor.

One case worker said: ‘We are getting people who are massively on the edge, people who are genuinely close to killing themselves. It’s not scaremongering, it’s absolutely real.’ He estimated he had been to 150 WCA tribunals in the previous eighteen months – and won 85% of them. Of these, at least half were related to mental health. ‘The crisis level here is massive, and I think it’s getting worse.’

Meanwhile, a woman in Wales who had worked all her life before she got ill considered herself ‘a highly employable go-getter’. She contracted a complex physical health problem, followed by depression (which is often associated with her condition). But she says it was her battle with the benefits and tribunals system that tipped her over the edge, and she tried to kill herself in January.

Pointing to a pile of benefits and appeals letters stretching back three years, she said: ‘I can honestly say it was because of all this. I have come to terms with my illness, not being the person I used to be. It’s just the constant being in limbo that’s the worst thing.’

She went through the appeals system three times, each time winning the right to keep her incapacity benefit. But weeks after her latest successful appeal, a letter arrived on her doormat, headed: ‘About your employment and support allowance’. It told her that the length of time she could claim the contributory form of Employment and Support Allowance (ESA) was restricted to one year.

This was devastating. ‘Every time I get another bit of bad news I just feel like I’ve been kicked again. It goes on and on. You constantly feel like you’re being doubted.’

Because her partner works and because the change was applied retrospectively, a month after getting that letter she lost her £400 a month ESA. This made her and her two daughters much more reliant on her partner for financial support. But her partner only earns about £800 a month. All this causes tension between them, and ‘humiliation’ for her. She has fallen behind with rent and bills, her bank has closed her account, and her doctor has doubled her dose of antidepressants.

In some of the most deprived areas of Scotland, 100 family doctor practices did a survey to see how the austerity measures and welfare reforms were affecting their patients. One issue dominated this survey: the number of people presenting with deteriorating mental health.

Patients fell into two main groups: the first were in work, and previously well. But now they came in complaining of anxiety and stress as they grappled with increased job

insecurity, cuts, and the pressure of extra work. The second group were patients with physical problems to begin with, and then chronic mental health issues. They had all been on incapacity benefit, but had been reassessed and found fit for work, and it had been decided to cut their benefits. Consequently, many were struggling financially. Some were self-medicating with drugs and alcohol, others were simply taking more antidepressants.

The GPs also found that this group of disabled and mentally unwell patients were gathering medical evidence to support appeals against WCA decisions they believed labelled them unfairly as 'scroungers'.

Many of the doctors thought the WCA tests took up far too much of their time, and their patients' energy, and were 'unnecessary [and] avoidable'. Others expressed disbelief and anger at the 'medical inappropriateness' of some WCA decisions. One doctor said: 'The last few months have been among the most depressing and disturbing times in my many years as a GP.'

Another said he saw a 'strong sense of hopelessness and self-destructiveness' among ill patients who are found fit for work. Part of what he calls the 'emotional intensity' felt by these patients about the WCA is caused by the way they feel the system fails to understand often complex mental health issues, and presumes that every claimant is a cheat. 'People feel more humiliated. People feel destroyed. It's partly financial, but behind it is a feeling that people are demeaned, not believed, their lives caricatured. People just come away [from a WCA] feeling belittled.'

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Back in 2011 several senior academics and charity chief executives wrote to *The Guardian* to warn about the potentially fatal consequences of the 'deeply flawed' Work Capability Assessment. They said it was 'causing huge amounts of distress' among people with mental illness. They called on the government to develop a 'more sympathetic and supportive system'.

One signatory was Dr Jed Boardman, a consultant psychiatrist and spokesman on social inclusion at the Royal College of Psychiatrists. A year later he said he saw no improvements. Another signatory was Paul Farmer, Chief Executive of Mind. In April 2012 he resigned from the government's WCA Advisory Panel to protest at what he felt was a lack of urgency on the part of ministers to change a flawed system. Ministers accused both of them of 'scaremongering'.

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A year ago, Boardman and Farmer had warned that mentally ill people do kill themselves because of benefits-related problems. Since then the process of reassessing people on incapacity benefit has accelerated and reports from coroners' courts reveals several cases in which benefits-related anxieties are mentioned as a contributory factor to a person's suicide.

The Department for Work and Pensions (DWP) says it

always strives to improve the system. Jobcentre staff are 'well trained' to deal with vulnerable customers and those at risk of self-harm. It says that the framework used to assess whether a mentally ill person was fit for work – known as the 'descriptors' – has now been made clearer and more consistent. A spokesman said: 'We have worked hard – and continue to do so – to improve the way the work capability assessment works for those with mental health issues. But it is right to reform the welfare system. The old incapacity benefits system let down too many people by simply writing them off to a life on benefits, which did nothing for their wellbeing.'

A spokesman for Atos said: 'Atos does not set the criteria for assessments or make benefit decisions but we have improved the way we assess those with fluctuating and mental health conditions. All our doctors, nurses and physiotherapists have received specific training in mental health and there are now mental function champions in place across our centres to offer specialist advice and support.'

So far there seems to be no statistical evidence of any increase in benefits-related suicides. But most concerned professionals accept that there is a growing accumulation of tragic stories that reflect the extreme despair felt by many claimants.

Neil Coyle of the charity Disability Rights UK, said: 'The government is cutting direct support for thousands of disabled people and using a process to do so which is unfit for purpose. The assessment process for out-of-work benefits needs urgent improvement to ensure genuine needs are identified properly and to avoid further tragic consequences ... We and our members warned the government – and DWP [Dept of Work & Pensions] especially – of the impact of cuts in support, but the problem has been swept under the carpet in the rush to deliver cuts in welfare expenditure. Sadly, numbers on a balance sheet have been considered more important than the lived reality of disabled people.'

The government continues to play-down the problems but during the summer, just before a change in the system that would see thousands of sickness benefit claimants with a working partner or some savings lose up to £91 a week in support, an email was sent to all job centre staff asking them to ensure that 'every customer contact is handled with the utmost care and sensitivity'. The email said staff must be 'empathetic' with vulnerable clients, by 'taking the time to properly understand their circumstances ... and talking through their options or signposting them to other sources of support/advice ... The consequences of getting this wrong can have profound results.'

However, Jobcentre staff say they are ill-equipped to deal with vulnerable customers with serious health problems who are being found fit for work. According to one union rep: 'The vast majority of [staff] don't have any training whatsoever for dealing with people with mental health issues, so they are unequipped to deal with them.' Another said: 'Sometimes the customer asks, "What am I supposed to do ... how am I

supposed to live?” There is nothing we can tell them. When they [claimants] realise there is no safety net for them, the phone goes silent and they hang up. You wonder what will happen to that person. It’s heartbreaking.’

Meanwhile, the government says too many people are being overpaid DLA when their circumstances actually improve. And so in 2013 DLA will be replaced by the new Personal Independence Allowance. The Hardest Hit campaign is a coalition of ninety disabled groups. In October, it reckoned that half a million people currently on DLA will lose money under the new system. They also published a survey. Out of 4,500 people now on DLA, 90% feared that the change to PIA would mean a cut in their payments and that this would be bad for their health, and 80% felt that the increased poverty will make them isolated.

Sources:

J. Domokos and P. Butler ‘Mental health of benefit claimants is put at risk by welfare reform’ and ‘Jobcentre bosses warn of suicide risk among benefit claimants’ *The Guardian*, 20 June, 2012.

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A SERVICE USER COMMENTS

People might recall that before Work Capability Assessment came in there was a protracted period of propaganda making many groups of people feel hated, as though the government actively desired the demise of those groups. A couple of years ago some of us predicted that the government would be mounting an assault on people suffering from illness and mental health problems. This assault has begun and it is called Work Capability Assessment (WCA).

Despite the efforts of Black Triangle, Sue Marsh etc., there remains a feeling that this assault is unstoppable. *The Daily Mirror* recently estimated 32 deaths a week due to people failing assessments, either indirectly due to stress or by actual suicide. Jobcentres know there is a problem.

But none of this is highlighted on the BBC, on *Newsnight*, or in the other papers. The DWP claims there are no statistics on suicides in relation to WCA outcomes, but coroners must surely be able to provide the figures. Mind does not seem interested in collecting such statistics but it has conducted a survey amongst service users in which half stated that they felt suicidal after going to a WCA. Mind is aware of people suffering from ill health who, out of fear, have stopped their DLA claim. Many service users say they would like to find some sort of work, but they are not so stupid as to imagine that the current economic crisis has made their poor employment prospects any better. Rather than the current attempt to cull as many as possible of the unwell and dump them onto lower benefits, what people would like from WCA is provision of better health management so as to enhance their abilities to get back to some kind of work.

Everyone on DLA now has to suffer from ‘fear of the brown envelope’ – those suffering from physical illnesses as well as those with a mental health diagnosis.

The fact is that service users now fear WCA more than being sectioned. Frankly, sectioning is not a big issue these days because of the pressure on beds: even if you are sectioned, consultants are forced to discharge you within days to the Crisis Service or to Home Treatment. And those services can’t offer much beyond phone calls or couriered meds via a nurse, for four weeks. It’s not like the old days, with the prospect of six months forcible treatment and fear of the section being renewed.

Yet ironically, now more than ever, people actually *need* a diagnosis in order to access or hold onto even short-term access to services, and to bolster their standing in benefits reviews. People are required to fit a stereotype – or else face being placed on JSA/workfare.

There is a complete picture which slots together like a jigsaw: criteria for referral to secondary services, and care clusters with their emphasis on symptom severity; this dovetails with Atos assessment, ESA and the upcoming Personal Independence Payment (PIP – due in 2013), with their emphasis on fixed symptom severity.

‘Care clusters’ is the new accounting device for sorting patients so as to pay doctors’ consortiums according to the numbers of patients with the various types of illness and severities of symptoms. When I first looked at this idea I wondered if the private firm, Atos, had any input.

It also seems to me that the concept of ‘recovery’ has been a gift to the ring-wing libertarian cost cutters because of its malleability: it fits any agenda. Nowadays ‘recovery’ means exiting services within six months, going on a course and (the ultimate) – being employed no matter what the emotional or financial costs to the person involved.

To need anything more than CBT, meds and a six-week ‘recovery’ course is now universally framed by consultants and commissioners as ‘dependency’. So we have the Tory Minister Iain Duncan Smith who blames poverty on the poor and the NH Service which blames anyone’s needs other than a short-term ‘tweaking’ as ‘dependency’ and ‘personal ineptitude’.

This means that people with a diagnosis of schizophrenia and with homes like a landfill site are now offered a six-week recovery course or a year of Personality Disorder (PD) groups. This is because PD is now the diagnosis for ‘failing to recover’, and the PD service is now the only one offering longer-term support (i.e., for one year).

And the main object of the government’s support for Improving Access to Psychological Therapies (IAPT) is to get people into work – or onto JSA; but at the same time it rejects people of certain diagnoses (psychosis, PD) and certain behaviours (self-harm).

I remember hearing an IAPT consultant say that the benefits issue was nothing to do with him, and if people needed benefits they had to go elsewhere.

I see this attitude reflected in the delivery of today's services – amongst staff in Community Mental Health Teams (CMHTs) and Assessment and Short Term Intervention Teams (ASTIs), and with junior psychiatrists who sneer at patients who ask for help with an ESA/DLA form. I witnessed a nurse sneering at my friend, telling her to go to the Jobcentre.

Nowadays there seems to be a high level of collusion between Health Service workers and government. Psychologists are also under to pressure to promote employment, as are the Support, Time and Recovery (STR) workers employed by the voluntary sector.

And I am not aware of a single charity which will stand up for people to have options other than 'fit for work' or 'unfit' – options such as being medically-supported so as to do the voluntary work of their choice. (It has to be medical support until we junk *The Diagnostic and Statistical Manual*).

Then there are all the high-profile survivors who are either celebrities who don't have any income or housing benefit concerns, or people like Rachel Perkins who is a complete sell-out to ordinary survivors since she also insists that work and paying more taxes are a must.

People receiving benefits cannot write about any of this in their own name. Activists such as the authors of *The Spartacus Report* have paid with their health and lives for doing so. It is not a medical decision but a political act to deny the proper level of benefits to people who are seriously physically ill or distressed.

At a conference a few years ago, well before this WCA juggernaut smashed into people's lives, I remember Paul Farmer saying to me that in his travels around the local Mind associations the number-one topic for service users was *benefits*.

CHALLENGING THE BENEFITS REGIME

Phil Hutchinson

I am 51 and receive Employment and Support Allowance. After an ATOS Healthcare plc assessment and Job Centre Plus interviews, I was put on a work programme.

I didn't understand the implications of the process I was being put through. It wasn't explained in clear language. As far as I am concerned I am able to do a limited amount of unpaid voluntary work and have little realistic chance of obtaining any post in the job market for any length of time. I live in Sheffield, and a combination of personal circumstances and leaving school when the country was being de-industrialised by the Thatcher Government meant that paying jobs have been thin on the ground. I have always been unemployed for

long periods, often being put on government programmes and having benefits restricted or stopped altogether. Eventually I had had enough and signed off sick, something I was in a position to do years before I actually did it. Then the Coalition Government decided to change the welfare system, and I became one of the undeserving lead swingers, indolent, malingering – and apparently best helped by "getting into a job". Sure, whatever you say, guv.

In the light of how I am, there isn't much point in putting me through any more work programmes, but that was what I'd been set up for.

This meant pointless exercises in computerised Maths and English tests, compiling the usual cv, and doing any "work-related activity", as set by the private profit-making company I'd been directed to by Job Centre Plus. From what I could gather, this company delivered people as cheap labour to service industries such as cleaning, security, retail and 'care'. It would have been simpler and less expensive for the Department of Work and Pensions (DWP) to acknowledge my limitations, and that I contribute through working unpaid and voluntarily *when I can*.

The government though, especially under the direction of Iain Duncan Smith at the DWP, insists that it is trying to help the millions of scroungers like me, whilst threatening to stop payment of subsistence money at every turn, in every communication they make, if we don't comply with their "assistance".

The latest media debate on "benefit caps" has featured many "working families" carping about how others receive more in benefits get than they can earn by working. Yet it is the private landlords who actually benefit the most – from rents paid in Housing Benefit for poor, cramped, exploitative 'homes'. You are very lucky if you can get a decent home. The phrase in adverts, "No DSS", says it all. We are the undeserving poor, we are scum.

So what we now see is a monstrosity: the wealthy passing puritanical, moralistic judgement on our lives – when it could be said that much of their wealth is built on us. We see the politicians representing those people. It has become Them against Us. But while *they* get *their* faces and voices in the media every day, turning the 'have-nots' against each other, *we* feel intimidated and are silenced. Where are the people and the arguments for a fair, unconditional system of welfare, the reflection of a civilised society? At the moment it seems, few and far between.

Letters to claimants from the DWP "requesting" (instructing) them to attend appointments always carry the veiled threat of a reduction or halt to payments should the person not attend. When you have no other means of support this undermines words like "help" and "support". It's like having a gun put to your head and being told what will happen if you resist.

In this respect, the word “mandatory” is entirely appropriate – if also contradictory to “help” and “support” – subverting any notion that the relationship between the official and the citizen may be benign or equal and based on a recognition of the complex realities of an advanced capitalist economy and the person’s circumstances. It isn’t. The relationship is more like that between an authoritarian parent and a child who “doesn’t know his own mind”, who needs strict guidance and will be punished if he is naughty.

Of course, this means that the cost of policing people and assessing their abilities and occupying their time is incredibly high. A few years ago, before the Lib-Dems joined the government, they pointed out that whether they worked or not it would be cheaper to give *everyone* £100 a week than to continue to run the huge monitoring apparatus of the welfare system. No chance of that sensible solution. Instead, Job Centres have become secure units. £billions are spent by the state on “capability assessments” and “Work Programmes”, all of which have little or no real impact on real employment – after all, in most places there is high unemployment and very few new jobs.

So who really gets helped? When someone works unpaid at something they know they can do, having dedicated a significant part of their life to it, he contributes to society. Can that really be said to be “staying at home doing nothing” or “swinging the lead”? Over the years, there have probably been millions of people who received a long-term state benefit and who have contributed millions of hours of unpaid voluntary work. This is the most “helpful” thing they can do in their circumstances, and is an incalculable social good. But it seems to be something that the government wants to stop.

Trust has been thrown out of the window and replaced by mandatory assessments and “work programmes”. Reasonable dialogue has been replaced by a rhetorical, philistine slanging match played out in the media.

A major problem is that the system does not really recognise different abilities. The DWP Job Centre Plus “Personal Adviser” is *impersonal*. He is governed by the strictures of the system: he speaks about “help”, “support”, and “recovery” at the same time as making “the client” or “customer” well aware that he has little choice – any “offer of help” *will* be forced on him.

The general idea is that this will deter and catch-out people who are earning money (or otherwise getting it) without

declaring it. This assumes that *all* claimants are guilty – hence the respectable currency of words like “scrounger”, “sponger”, “cheat”, “life-style claimant” and “swinging the lead”. And yet most of us would be quite happy to be employed if the pay would ensure a decent standard of living (enough to pay for a home, the bills, food and clothing) and if the work wasn’t always so temporary. And why shouldn’t people look for employment in something that they enjoy and know they can do? Someone who cares about his work is a good worker, paid or not.



It seems to me that in a fair and just society within a global economy that is undergoing restructuring, a developed country should protect the economically weakest and the most vulnerable, and accept what people *can* give, according to their abilities, paid or unpaid, and without attaching stringent and futile assessments and conditions.

If the State really must, perhaps the DWP could audit the voluntary unpaid work-

time of a claimant, as an alternative for those who, in a shrinking labour market, have little realistic chance of getting and holding either a full-time or a part-time paying job.

“Basic English and Maths”, “Compiling CVs”, and training in “How to Get A Job” in the capitalist jobs market could be further incorporated into already existing government and voluntary sector initiatives in prisons, probationary services, drug and alcohol rehabilitation programmes, “integration programmes” and the like, to reduce spending on assessments and “Work Programmes” for people presently on JSA and ESA.

Above all the state should recognise the different forms of work and contributions to society rather than the DWP’s narrow, wasteful attitude which focuses *only* on private capitalist work contracts.

- Break the link between health and paid work as a condition of benefits
- Audit the hours worked unpaid and voluntarily
- Axe “Capability Assessments”
- Stop unpaid work placement
- Axe “Work Programmes” for ESA and JSA claimants except where they exist in prisons, probationary services, and drug and alcohol rehabilitation services
- Offer people who are working unpaid on “Community Payback” schemes a chance of paid work in the same roles at the end of their CP time.

not so long ago i had an interesting conversation with my uncle, who is now 84. He practised medicine all his life and has also frequently been depressive. As a medical professional and often as a patient, he knows a lot about psychiatry.

i mentioned that i am feeling better in various ways due to ever-improving 'self-management'. (All this jargon is due an overhaul!) This includes yoga and, of all things, oatmeal porridge.

He commented that he thought i had 'burn-out'. Then he explained that he had also seen many people with so-called 'serious and enduring' mental illnesses go into remission due to the illness 'burning out', especially as they got older.

This encouraged me enormously. i did some research and predictably the so-called advice, evidence and discursive material about the 'illness' bipolar disorder is heavily prejudiced in favor of received psychiatric wisdom. but there are a few outposts of conviction and lived experience persevering with the message that 'severe mental illness' need not be a life sentence.

i'm beginning to see that half the struggle of recovery is getting even beyond the idea that there is anything to recover from. This is not denial, but only a way of reconditioning oneself. like it or not, mental illness and its treatment can be a ghetto. is it time for us to begin to throw off all our assumptions?

what is the basis for society's current and growing obsession with mental illness? As someone apparently (hypothetically?) 'recovering from a severe and enduring mental illness', you would think this opening-up to mental illness would represent a breakthrough to me, relief and even a kind of opportunity. indeed, at various times it has been one or more of those. yet now i wonder how much i want to live in what i call a 'supersick me society', where it seems everybody is due a diagnosis or seeks one.

what are the causes of this awareness of mental illness, if that is what it is? perhaps its time has come – it is now safe to be open about it. is it now 'fashionable' to be mentally ill? or is it just that society is sicker of itself and from itself?

furthermore, what is the basis for my being sick of the whole subject of mental illness?

firstly, i don't see myself as mentally ill. i am medicated. but that doesn't mean i am mentally ill. Call me deluded, but it is possible that i have been misdiagnosed (many people are) or that my medication has itself necessitated further medication (possibly true in my case) so that half of my illness is due to the treatment itself. given all of this, and that some people can grasp and act on the subtleties of their situation as service users, is it automatically a negative if the idea of 'recovery' might include overcoming and eventual rejection of the idea and belief that i am 'mentally ill' and need 'to recover'?

At one time or another since my diagnosis i have bought into, believed and usually experienced most of the issues and ideas attributed to someone in my situation. notably this includes the notion (so glibly said) that bipolar disorder is 'a disease' – whereas there is no biological proof that it exists, much less that it is a disease, a lifelong, incurable illness.

let's leave out of this discussion for now questions such as: if there is no hard biological (genetic) evidence that my 'disease' exists, how can it be incurable? i may be wrong, it

BEYOND RECOVERY

Jeremy gluck

may be incurable, but forgive me for not wanting to see myself all my life as some kind of tolerable leper. grant me real hope.

Assuming i am ill, then i feel there is room for what i call 'an aware denial'. This would be a new way, beyond 'recovery', which involves an aware denial of illness. by this i mean that, as an aid to recovery, i do not involve myself more than i need to in any aspect of 'mental illness'. Clearly, medication has to be continued, though if possible reduced en route. (i am at last in the process of reducing mine.) but meanwhile i can maintain an aware avoidance and denial of anything to do with mental illness: no support group dependencies, no reading of or (as much as possible) discussion of mental illness, never thinking of or describing oneself as mentally ill.

doing this i feed myself the most positive message that i can: getting better is not just maintenance, it's deliverance.

i had an interesting experience last autumn when i was interviewed for a documentary on a musician i worked with who has since passed on. for 90 minutes i gave forth on my musical pursuits and so forth, and never once mentioned mental illness, being bipolar or anything else of the kind. i left feeling wonderful, free and, i suppose, genuinely recovered. it made me realise how polluted i had let myself become with the idea that 'i am ill'. i experienced myself as i was before diagnosis, with all my liabilities and issues but wholly myself and not half a creature of somebody else's description and invention. i remembered who and what i am, the least of which is 'ill'.

This is not about pretending one is or may not be mentally ill. it is about rising above it as a self-description. ideally, there also must be no acknowledgement that one is 'recovering' – because that means there is something to recover from.

This is all about taking stereotypes such as 'it's all in your head' and making them work for you: now that mental illness has been legitimised we have to talk and think and feel and be our own way back out of it.

it's important for those branding themselves mentally ill – if possible, and it may not be easy – to spend as little time as possible with others who 'have a mental illness'. The accepted wisdom is that people with mental illnesses should spend a lot of the time with those like themselves. but what does this really accomplish?

There could be many reasons for my 'burn-out'. given long enough, perhaps many people experience this phenomenon, but it is little remarked or documented, not because of some conspiracy of silence but simply because life beyond diagnosis and self-conscious 'recovery' overtakes more ephemeral concerns.

i'm still medicated and frequently consider myself 'mentally ill'. However, i see that all kinds of tantalising possibilities lie in store if i can just stop telling myself that i have a mental illness.

when you begin to embrace the idea that 'there is nothing wrong with you', you realise that ideas can become facts, and that a lot of what you thought was wrong with you was simply the idea of it.

The fact is that you are better than you thought.

HEARING VOICES

Contributors to Asylum quite often refer to 'hearing voices', and in the 17:3 and 18:4 editions there were articles specifically addressing the phenomenon. Below we print three other views on the issue.

HEARING VOICES IS NORMAL

Dr John Rowan

i hope it is clear that voices are emotions and not the signs or symptoms of a psychosis. rather, they are a kind of protector against overwhelming emotions, and yet at the same time they express those conflicting emotions. therefore, on any road to recovery, a person has to discover that those emotions are actually his or her own. to hear a voice is to experience an emotion which is not easy to cope with or accept. (Romme, p.6)

The theory of the dialogical self (Hermans & dimaggio) says that we are all multiple. from the earliest age, we understand the possibility of having dialogues with different aspects of ourselves. For example, a mother finds her young child beating up his teddy bear. "why are you hitting the teddy?" "He has been very naughty." "And what does the teddy say?" "He says he didn't do it."

A child finds it very easy and natural to enter into the psyche of a teddy bear. And this is not just about projection, it is about a striking variety of different ways in which i-positions can come into play.

more formally, Hermans says very succinctly that he sees the dialogical self as "a dynamic multiplicity of i-positions in the landscape of the mind". by this he means that the idea of a single self that does everything is not a necessary idea. it is convenient for many purposes, but it leads us wildly astray when we try to understand 'hearing voices'.

so long as we think of hearing voices as an aberration, as something which should not be happening – and certainly could not be happening normally – we cannot deal with them very easily. but as soon as we think of them as normal – as part of the repertoire of responses which may come into play in different circumstances – we find it much easier to frame a response.

marius Romme quotes a voice-hearer who says: "The contempt and loathing that he [the voice] expresses is actually to do with me, in that it reflects how I feel about myself. He is like a very external form of my own insecurities, my own self-doubt, and that is the part that is relevant and needs attending to." (Romme, p.5)

This is an important step in working with voices – the ability to realise that the voice represents a part of oneself, or better stated, an i-position.

in normal everyday therapy, this idea can be used for most people, whether they hear voices or not (see Rowan). i-positions come and go with the needs of the situation, and are not conceived as permanent members of an internal commune or committee. They often represent two sides of an internal conflict of some kind. Sometimes they represent a higher self or other level of the person, which needs to be listened to. They can be conversed with and interrogated in

most instances, and they do not need to be thought of as threatening.

The blurb to a Romme book says that the people described therein "now accept their voices as personal" and have benefited from that realisation. We can all accept our inner conflicts and issues as personal, and work through them in therapy, and the theory of the dialogical self helps us to do that.

dialogical voices can be reasoned or emotional. they can argue, negotiate, and convince, but can also shout, accuse, beg, regret, laugh and cry, and express anger, joy, sympathy, love, fear, anxiety, hate, or disgust, to mention just a few ways in which people relate to their environment or to themselves. (Hermans & Hermans-konopka, p.41)

This makes it clear that the question of voices is definitely connected with the theory of the dialogical self. However the theory of the dialogical self does not rest content with voices as the primary entity. more fundamental is the question of position, which is why the labelling of i-positions was used in the first place.

as we have argued in this book, the processes of positioning and being positioned determine to a large degree which voices are actualized, what they have to say, and under what circumstances they are constrained in their expression. (ibid, p.227)

Here is a very valuable addition to our knowledge about how human beings work, personally and socially. it seems to me that all those who work with 'voices' would do well to take account of this body of work. with a wealth of examples, my own work shows just how to work with i-positions in any form of therapy (Rowan, 2010). This is now a valuable resource for anyone who wants to work with voice-hearers.

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LISTENING TO THE INNER VOICE: CONSCIOUSNESS AND MENTAL DISTRESS John Myhill



Listening to those whose voices cause them distress

voices are a metaphor. There is no desire to identify where the voices come from, nor fear that the speaker will suddenly appear. There is no wonder about the mechanics, or the appearance of those who are manipulating the sense experiences. such questions are beside the point. voice hearers are not "credulous", nor do they exist in some primitive pre-rational state. They are often strongly detached from what they say, and capable of irony to deflate their own statements. There may be a mannered, conscious mockery of everything, including themselves. far from "taking everything literally, or losing awareness of the mind's role in constituting reality", they are emphasising the significance of the mind's role, explaining how representation of reality works and what subjectivity really is. They are living a "form of transcendental idealism", as if the world was not substance but ideas, "an emanation of consciousness itself". or as wittgenstein put it: "the world is the totality of facts not of things". but to the person in distress it is Truth that is important – facts are of no significance. This is sometimes referred to as seeing the world in concrete terms: even abstractions become solid individual objects.

Metaphoric explanations

when presented with a picture and asked to tell the story, some voice hearers may speak as if the people in the picture really do exist, *in two dimensions* in that moment in time, unable to escape the permanence of the representation. The voice hearer may feel trapped, and two dimensional in his own moment.

film has had a profound impact upon the way we conceptualise our relationship to a higher power. it is routine for people to see themselves as if they are in a film – to wonder if they are really living or just being played back, to believe that those around them are merely projections, animations, holograms, whilst they are directing the production of the movie. Some people in simple societies when first faced with a camera were afraid that it would steal their soul. not an unreasonable belief given the numbers of people who believe (with more in *last year at marienbad*) that they have been swallowed into new technology (as in *the matrix* trilogy).

A reflection of this may be seen in the obsessive need of some criminals to film their crimes. To enjoy them at a later date? or to distance themselves from their actions by reducing them to film? Or to present themselves to an audience as movie stars? They may imagine themselves as watching a film: moving images moving past. Yet at the same time they feel that there is nothing which the images float past. (The objects are merely film and the observer/actor is merely camera/projector, controlled by unknown forces.)

similarly, computers lead us to think in terms of retrieval and processing of memory as a mechanical task, rather than as thinking. such processing is seen as banal in comparison with the transcendental experience of hearing voices.

A form of consciousness like fantasy

voice hearers are not contradicting biological reality. They give an unconstrained expression to their passing fancies, the imaginary realm where such strange transformations can occur (but only as thoughts).

Thus a delusion such as "The prime minister is preventing me from getting a wife" makes no reference to a person out there, but to an internal experience of being prevented

from imagining a successful outcome by the cultural constraints of early childhood, symbolised by the concept of a political leader. similarly "mi5 have chosen me to direct great changes in the world" does not relate to the real organisation, but to a symbol of power and control, which in the internal mind produces a grandiose fantasy that is not taken as literally true.

facts are nothing: truth is all that matters. doubt, distance and deconstruction are seen as essential roads to this truth. Rational arguments are seen as attempts to suppress mysticism and sensuality, as well as the inner voice.

such fantasies might be compared with sexual fantasies, which excite because of the threat of disaster. Just as sexual fantasies are addictive, so that the fantasist quite often feels controlled by the fantasy, so the voice hearer feels controlled by the ideas – he feels he is the victim of thoughts rather than the person who thinks. As with all fantasies, they generally prevent action rather than produce it.

in *David Copperfield*, the inability of the historian to "keep Charles the first's head out of his book" was not an expression of a mad obsession, certainly not an indication that the writer would try to chop off someone's head or revenge the death of Charles i. but it did show that he felt controlled by an idea. freud might interpret this as a castration fear, whilst others might see a delusion of grandeur. somehow the fantasy allows the individual to live out experiences impossible to him or her in the real world. Computer games are an example of capitalism cashing in on this need.

A form of consciousness like dreaming

This is my explanation for the voice hearer's "*enhanced ability* to see non-obvious similarities".

The interesting thing is why one fantasy rather than another? How do some people become totally drawn into their fantasy and controlled by it, whilst others enjoy a fantasy but remain detached? why would anyone allow a negative fantasy (in which they always lose, or suffer, or are evil or stupid) to dominate their consciousness?

"i felt *trapped*, caught in a story, absorbed by a device for recording my thoughts, watched in everything i did, everything i saw was being recorded elsewhere. it thinks therefore i am not." These epistemological delusions are symbols for the subjective, for the isolation of individual consciousness from real understanding by any other individual consciousness. such symbols are evidence that the person is developing a theory of being, not that they are ineffective at testing reality.

imagine that your *waking life* seemed like a dream, where you are involved and see everything, but weird and impossible things happen all the time, and you have no sense of control. in dreaming, our thoughts and perceptions do not pass through the usual filters that limit imagination in waking life.

imagine it is like a nightmare and your only desire is to wake up. you can see huge distances yet touch objects on the horizon, but you cannot move to avoid an approaching bus. you can make a steep hill become a slow descent, by wishing it would be so, yet you cannot control who takes centre stage, or what they say, or even who you are. you remember people and places you know you have never seen before. even your most intimate thoughts and desires appear to come



from outside, from someone else.

This is like “*the solipsist* whose acute awareness of his experience-as-such, feels and declares that the world is his own idea, existing only because he is conscious of it. This is not a reversion to the infant’s ignorance of ego boundaries, but the consequence of exaggerated awareness or sense of the role of consciousness in constituting its world.”

A form of consciousness that determines brain function

psychiatrists usually assume that measurably aberrant brain functioning causes strange thoughts. but what if the thoughts could produce changes in the brain? for example, someone spending all the time in listening to an inner voice and reflecting on his own thoughts might clearly impact upon his muscle-to-fat ratio, due to inactivity. why should it surprise us if certain parts of the brain: (e.g. those controlling physical activity) should atrophy in the same way as the muscles? people suffering from organic brain changes sometimes recover of their own accord. This suggests that, by changing mental activity, brain changes are reversible. people coming off antipsychotic drugs suffer the same symptoms as those to whom the drugs are still being given.

A form of religious belief?

like the solipsist, the voice-hearer does not seek *converts*. in contrast, the convert to a new religion may appear to be playing a role, imitating the behaviour of the leader of the cult to such an extent that his speech is almost a parody of the voice hearer. (in *asylums*, erving goffman described mimicking behaviour in psychiatric hospitals in just these terms.)

The ideas are of tremendous importance to the person having them, and they are happy to talk about the ideas, but they do not expect to be understood, as they are expressing an inner experience which cannot be explained by language. T.s. eliot: “i have to use words when i speak to you.” wittgenstein: “of what we cannot speak we must remain silent.” The internal experience is not an image, fantasy or delusion of the mind.

yet there is a very thin line between the believer’s statement that he listens to the *voice of god*, discerns Truth through the guidance of the spirit, speaks directly to god, etc. and the schizophrenic’s idea that he deals directly with god. The voice hearer is excited by the ideas but does not expect others to take him literally. “The shadows, reflections and phantasms” (derrida) have taken over from a world out there.

The problem of the voice hearer is how to separate delusions from a whole new mode of thinking (the categories, concepts and mode of logic are all new). it appears that the voice often speaks tersely, using cryptic words and not expecting to be understood. but careful analysis will reveal deep and interesting meanings (as in lucky’s speech in samuel becket’s *Waiting for godot*).

As with religious language, *the voice* emphasises what is not said, the transitory, the fugitive and the contingent – where obscure references are felt to be more authentic than the ordinary language used by other people. everyday life is seen as the weak exploiting the strong, greed destroying both rich and poor, regulations preventing love. in simple societies the voice hearer is often seen as someone who is too close to god: they may need healing to recover, or they may be guides for the people, bringing gifts from the spiritual world. The lack of pragmatism, the refusal to be bribed, and the general *unworldliness* of voices inevitably reminds us of the teachings of the great religious leaders.

if the distress gets no worse, how can it be illness? if the voices start suddenly and leave just as suddenly, it makes more sense to talk about ‘a message’ rather than ‘an illness’.

“*embodiment*” is a central idea in Christianity and some other religions. How does the consciousness, the voice, the god, become embodied in the person? And is this a limitation or a gift of grace? This is not to be confused with the young child who is focused on its physical needs and lacks self-awareness. The voice-hearer is much closer to the existential philosopher – fascinated by being, mind and language. everything is more real than non-voice hearers are used to. (for example, the experience of the doorknob in J-p sartre’s *nausea*.) but, what the voice says may sometimes be banal, with pompous phrases providing formality, calling attention to ambiguities in language in an ironic rather than a meaningful way. it may just be bluster to throw others off the scent of what is really being thought.

for many people *inner reflection* is an ideal: they may call it meditation, or seeking the way, being in touch with the spiritual or following the path of the mystics. it is a chosen objective to be reached through silence, through clearing the mind, through asceticism, through chanting, but it is always an attempt to shut out the external world. it is the human condition that any attempt to overthrow conditioning, culture, upbringing, genetic determinism, habits and obedience may lead to “a paralysing ambivalence, an anxious self-awareness, an endless deliberation, self-criticism and doubt.” This loss of self has been compared to the surrender of the self in buddhism, which leads to enlightenment.

successful meditation can blank out all reality and memory, and this may be as frightening as being in a flotation tank, where all physical stimuli are removed, or a long period of solitary confinement. There can be a loss of all sense of reality, of being alive. The same experience can be produced by a trauma, when the person becomes catatonic. sometimes people imitate what others are doing so as to escape from such catatonia, but more extreme actions involving self-harm are common.

Constant self-analysis

The voice hearer does not choose to be hyper-reflexive. That intense state is irresistible to them, and much of what they say is an attempt to express what it feels like to be constantly in the inner world: “The splitting of egos which inspect each other”, “the self monitoring, so that in a discussion, i am the other person, and i am saying things, but i am unable to stop myself, because by the time i have heard what i say and analysed it, it is too late and i am alone again.”

every culture, discipline, tribe, organisation or social group has boundaries laying down what cannot be thought. Those who test such boundaries may become the new leaders of the group, but those who go well over the boundaries and become fascinated with what lies beyond may be expelled from the group or suffer its control.

people who hear voices are usually in the latter category and rarely belong to a group. Their isolation makes them vulnerable. To live entirely within the subjective experience is to understand the impossibility of conveying to others what it feels like to be you.

They want to be in control, and cannot allow the ongoing flow of practical activity. It is the fear of missing the opportunity to make a free choice that ultimately prevents them from choosing. They are concerned with choice at a high metaphysical level: the choice between self-abnegation and self-deification, between self as object and self as



subject, between the finite and the infinite. To someone who doesn't know about it, the voice hearer (or the religious mystic, artist, theoretical scientist, poet or philosopher) may appear to be in a vegetative state. but in fact the voice hearer's inner consciousness is working overtime, often producing thoughts of great lucidity and truth, so interesting that the person cannot leave them alone. "i felt myself capable of thinking myself to death – i felt an incredible sense of calm come over me."

modern western society emphasises self-organisation and personal responsibility, so much so that anyone who is hyper-reflexive tends to be seen as sick. Modern people fear mystical experience, so the individual is left to flounder until he is labelled mad or bad. The emphasis on individual privacy and rationality positively encourages self-analysis, but no support is provided for coping with the hyper-reflexivity which it often produces. Society expects such reflection to produce nonsense, so those who express their experience are called 'demented', 'depressed', 'schizophrenic' or 'manic', or said to suffer from 'a neurological disorder'. The real problem is one of poor translation. in themselves, these labels isolate the reflective person from normal interaction.

Escape through obedience

A command hallucination is a way out of this dithering: it externalises authority and relieves the individual of all the inner heart-searching and the weight of responsibility. "if i could just stop noticing what i am doing, i would get things done a lot faster." many people would call this 'being open to the light', or to god or to logic, 'following conscience', or

the religious way, or Truth. immediate response replaces the impossibility of choosing and the frozen state of self-blame. Another alternative is to return to routine mundane tasks – like shoemaking for dr manette in a *tale of two cities*, but this is an escape used by all kinds of people trying to forget a traumatic event: where the alcoholic hears voices relating to his senses, these voices are conceptual or cognitive; where the apparently rational person obeys established authority or a crazy idea, all the way to genocide. most command hallucinations demand that the individual sacrifice himself for the needs of the least fortunate, and this rarely involves the suffering of other individuals.

Through self-fulfilling prophecy of doom

There is a tendency towards catastrophe. The Jeremiah element found in many religions can contain an element of self-fulfilling prophecy: the prophet deliberately brings about the disaster. we see this in capitalism where bankers engineer a recession by over-investment in certain commodities, selling at far more than the commodities are worth, and reinvesting the capital in undervalued goods. The voice hearer may also attempt to deny responsibility for any catastrophe caused, on the grounds that his or her actions were controlled from an external source: not that he was 'just obeying orders', but that he was totally controlled like a puppet.

Unless otherwise referenced, the direct quotations are taken from Louis A. Sass: *Madness and Modernism*, Harvard University Press, 1992.

WHAT DOES HEARING VOICES HAVE TO DO WITH ME? (Connecting professional and private selves) Caroline von Taysen

i am a psychologist, and this is a question that has challenged me ever since i joined the german Hearing v oices network, in about 2000. i used to attend a triologue group in berlin. This is where people who hear voices, friends, family members and mental health professionals come together to talk about their experiences. everybody is considered an expert on their personal experiences, and the group is all about broadening each others' minds by engaging in different perspectives, understandings and backgrounds.

one of the few rules of the group is to always speak for ourselves. but what happened regularly was that the experts by profession used a very different language from the experts by experience. while we professionals tended to talk about theories, tried to find generalizations and abstract explanations, the voice-hearers told their personal stories and shared their emotions and their struggles to recover.

Hannelore klafki is a voice-hearer and founder of the german Hearing v oices network. i remember her repeatedly encouraging me to talk about myself and to let go of my professional language. This was a challenge. years of university training had taught me that scientific theories are far more valid than personal stories.

but thanks to Hannelore's perseverance, i was able to gain a whole new insight into my relationship with different realities and unusual perceptions. i realized that there are very good reasons why i chose to work in this field, that there are connections to my own life story, and that in some ways i feel

quite close to the phenomena, while in other ways they make me scared and insecure. It definitely encouraged me to take a closer look at my own unquestioned beliefs and at my own 'weirdnesses'.

over the years the Hearing v oices movement has expanded and developed in all kinds of directions. but while visiting conferences, workshops and meetings i have realized that we experts by profession need more Hannelore klafkis to remind us to open up and actually dare to talk about ourselves. for me, one of the most precious gifts of the Hearing v oices movement is that i can be part of an emancipating mental health network, first of all as a unique individual and only secondly as a clinical psychologist. It is not my first responsibility during a hearing voices meeting to 'help others while keeping my professional distance'. during these meetings we can actually all grow together and support each other in our struggles to change ourselves and the mental health system. it is so easy to hide behind the safe professional front while telling others to disclose their most personal stories. And yet how much can we gain from discarding that front, having a good look at ourselves and making our own weak spots a little more visible!

This is why i came up with the idea of self-awareness training especially for people who do not hear voices but who would like to find out more about their relationship to the phenomenon.

my workshop begins with a hearing voices exercise. groups of three people come together. while two of them hold a conversation, the third one is 'a voice' and speaks right into one person's ear. everybody gets to be a voice-hearer, and then we share the experiences.





participants are usually amazed by the intensity of the experience and by how quickly they fail to keep up a 'normal' conversation. They realize that within only a few minutes of 'hearing a voice', they already show 'psychotic' symptoms, such as disrupted thoughts, inadequate emotional reactions, talking to the voice and feeling exhausted.

Then we look at the following questions:

- How do we define 'insanity'?
- What aspects scare me, make me feel insecure, helpless, angry, impatient?
- What aspects do I like, do I find intriguing, empowering?
- How can the effects of drugs, spiritual exercises or sleep deprivation relate to a phenomenon such as hearing voices?
- Have we ourselves had 'strange' experiences or altered states of mind?
- Are there any connections to our own biographies?
- What are our personal reasons for engaging with these kinds of experiences professionally?

it is usually quite a challenge to get a whole group of trained-up mental health professionals to share their own and not their clients' stories. but at some point the ice usually breaks and it becomes obvious that there are no distinct black or white categories of 'normal' or 'abnormal' beliefs or perceptions, that we all live in a whole spectrum of different shades of perceiving the world in and around us, and that we all move within certain ranges of the spectrum, depending on all kinds of different influences. It is just so normal to be different! And even for experts by profession this can be a healing experience.

After this round of exchanges and getting to know each other, there is an opportunity to do another exercise. we use a part of the room as a spatial representation of the spectrum, ranging from the greatest possible approach to unusual experiences on one far side of the room to the greatest possible feelings of distance towards them on the other side of the room. by moving around the room between the two extremes we get the chance to find out for ourselves what spot within the spectrum we feel most comfortable in. we also try to position ourselves away from the comfortable spot, to try out the extremes, and to observe what thoughts, associations and feelings are evoked.

At the end of the exercise, we leave the defined space and have a look at it from the outside. does this new perspective - the 'outsider's view' - offer any more insights?

We use the last part of the workshop to reflect on these exercises, and to exchange our experiences. Here are some participants' quotes:

- "While walking through the spectrum of experiences i felt i was on my own, but that is normal."
- "I've realized that I've spent my whole life talking to myself, self-reflecting. That makes me feel a little closer to the experience of hearing voices."
- "I'm overwhelmed by all the distance that so many people still are from hearing voices."
- "It is a bewildering feeling to get the professional and private self together."
- "We are all multiple."

These kind of comments spark a lively discussion about the question of whether there really is a dimension ranging from everyday experiences to hearing voices or if, after all, they are still two separate categories of phenomena.

The theory behind the 'Voice Dialogue' argues for the first assumption. This method was developed to explore our different conscious and sub-conscious inner selves, and was adapted by dr. dirk Corstens (maastricht, netherlands) to explore people's voices. it makes the point that we are all indeed 'multiple'. The trick is to know our different sub-personalities and to learn about the unwanted and repressed ones, in order to accept and integrate them and free ourselves from rules or norms that maybe don't really do us any good. At the same time, this will help us to relate to our own 'insanities' better, and to talk about them more openly – maybe even now and then to our clients.

This article is based on Caroline von Taysen's workshop at the 2nd world Hearing voices Congress, sherwood forest, november 2010.

for more information:

- www.intervoiceonline.org Intervoice, the International Community for Hearing voices
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NEWS&FINDINGS NEWS & FINDINGS

DEPRESSION & MEDICATION ON THE INCREASE

Between 2008 and 2011 the numbers in England seeing a doctor for depression increased by nearly half a million (494,087). Research by SSentif finds that there are now 4.7 million people registered for depression. This increase was seen across the country.

The director of SSentif said: "Spending by PCTs on mental health services has only increased by an average of 10% in the last three years while nationally the prevalence of mental illness has increased by 14% - and we have to remember that the real numbers are likely to be much higher as many people do not seek GP support for their conditions. These are significant increases and analysing this information in terms of service provision, as well as prevalence, only serves to underline the importance of the reliance that the country has on voluntary sector organisations to help people with mental health conditions."

Meanwhile, in Scotland one in seven people (14%) now take an antidepressant, and over the last twenty years there has been a four-fold increase in prescriptions (to more than

5 million. Twice as many are for women as are for men. At the same time, prescriptions for antipsychotics have nearly doubled, whilst the use of drugs for Attention Deficit Disorder (mainly for children) is now twenty times higher than it was 15 years ago.

Sources: *Evening Standard*, 17 Oct 2012; *Sky News*, 25 Sept 2012.

26% OF UK WORKERS TAKE TIME OFF FOR DEPRESSION

More than 30 million Europeans will suffer from depression at some point during their life. It is the main mental health challenge among working-age people.

MORI polled more than 7,000 Europeans and found that at some time 20% of them had received a diagnosis of depression. At 26% of all respondents, the UK scored the highest rate. The lowest was Italy, at 12%.

The new survey, commissioned by the European Depression Association, finds that one in ten European employees take time off work because of depression. On average, 36 working days are lost per episode.

Among workers experiencing depression, those in Germany (61%), Denmark (60%) and the UK (58%) were most likely to take time off work, while those in Turkey were the least likely (25%).

In 2010, depression in the EU cost an estimated 92 billion euros (£73b). Lost productivity due to absenteeism and presenteeism (being depressed at work) amounted to over 50% of all the costs related to depression. In the UK and Germany the average number of days off was 41; Italy was the lowest, at 23 days.

Despite the high rates of absenteeism due to depression, one in four of those experiencing depression said they did not tell their employer about their problem - one-third of these respondents thought their job would be put at risk.

The cognitive symptoms of depression - concentration difficulties, indecisiveness or forgetfulness - cause significant impairment in work function and productivity, and are present 94% of the time during an episode. But the survey shows that awareness of the symptoms is poor. Eighty-eight percent identified low mood or sadness as a sign of depression but only 33% identified forgetfulness, 44% indecisiveness and 57% trouble concentrating.

Amongst managers, about one in three reported having no formal support to help them deal with depressed employees. Lack of support was highest in Germany (44%) and lowest in Turkey (10%). Managers in the UK were most likely to have support from their HR department (55%). When asked what is needed to support employees with depression in the workplace, managers mostly cited more counselling services and better government legislation and policies; 43% called for better policies and legislation to protect employees.

Source: 'One in 10 Employees in Europe Have Missed Work Due to Depression', redOrbit.com, 2 Oct 2012

MIDDLE-AGED MEN NOW HIGHEST SUICIDE RISK

In England, more than 4000 people commit suicide every year. Historically, the suicide rate always increases in 'hard times' - anxiety about finances and employment are bound to grow. During the the recent decade-long boom the rate of suicides in England fell but, as to be expected with a recession, there has been a rise in the last few years.

Men are still three times more likely to take their own lives. But the latest statistics show that whereas it used to be young males who were most at risk, now it is middle-aged men. From 2008-2010, the average suicide rate for men aged 35-49 was 20.8 per 100,000 population - the highest for any group.

The government has launched a strategy it calls World Suicide Prevention Day. It is to put £1.5m in new research into how to tackle suicide and self-harm. Four key research areas are identified: 1) Understanding why people commit suicide and how it can be prevented. 2) How better to support high-risk groups, such as people with mental health problems and those who self-harm. 3) How to reduce opportunities for suicide, e.g., by making prisons and mental health facilities safer and by safer prescribing

of potentially lethal drugs. 4) How to provide better information and support to those bereaved or affected by suicide.

The Samaritans have launched a Call to Action initiative, hoping for organisations from across the country to take action to reduce suicides and help people affected.

Sources: *BBC News*, 10 Sept, 2012; G. Smith: 'Men aged between 35 and 49 are now at higher risk of killing themselves than young men', *The Daily Mail*, 10 Sept.

MENTAL HEALTH DISCRIMINATION TO BE AXED

At the moment, there is a legal ban on people who have had serious mental health issues being MPs, company directors or serving on juries. MPs detained for more than six months under the Mental Health Act lose their seat. But the government now backs Tory MP Gavin Barwell's private member's bill to end the ban. This means the discrimination will soon finish.

Mr Barwell told the Commons: "The current law is both discriminatory and an ass. My bill's purpose is very simple: to tackle the last legal form of discrimination in our society. It's ludicrous in this day and age that a person can't contribute to public life if they've had issues with their mental health. To our shame the law of the land still discriminates against those with a mental health condition." He said that the disqualification law applied to MPs and members of its devolved institutions - but not to peers. [!]

Deputy Prime Minister Nick Clegg agrees: "An MP or a company director can be removed from their job because of mental ill health even if they go on to make a full recovery. Many people who are fully capable of performing jury service are ineligible to do so. The law as it stands sends out a clear message that if someone has a mental health condition their contribution to public life is not welcome. That is an affront to a decent civilised society."

But, by the way, the Law Society had warned that the UK's current rules could be in breach of the United Nations Convention on the Rights of Persons with Disabilities, which has been ratified by the UK.

Source: *BBC News*, 14 Sept, 2012.

CREATIVITY & MENTAL ILLNESS

A recent study shows that people in the creative professions are treated more often for mental illness than the general population. And there is a particular association between writing and schizophrenia.

The study by the Karolinska Institutet is the most comprehensive ever. Over the last few decades it has tracked nearly 1.2 million patients and their relatives. These were all matched with non-patient controls, so the study included nearly the whole of the Swedish population.

Compared to the general population, it seems that scientists and artists are more commonly from families where bipolar disorder and schizophrenia are present. The creative professions are also better represented in the relatives of patients with anorexia nervosa and, to some extent, autism.

It was noticeable that authors were more common among most of the other psychiatric disorders (including depression, anxiety syndrome and substance abuse), and they were almost 50% more likely to commit suicide than the general population.

Researcher Simon Kyaga commented: "If one takes the view that certain phenomena associated with the patient's illness are beneficial, it opens the way for a new approach to treatment. In that case, the doctor and patient must come to an agreement on what is to be treated, and at what cost. In psychiatry and medicine generally there has been a tradition to see the disease in black-and-white terms and to endeavour to treat the patient by removing everything regarded as morbid."

Source: *ScienceDaily.com*, 16 Oct, 2012

NEWS & FINDINGS

STIGMA & DISCRIMINATION STILL IMPORTANT

Depression is the third leading contributor to the worldwide burden of disease. If you suffer from depression and also get a mental health diagnosis, this brings its own problems of stigma and discrimination. In a recent study, people diagnosed with major depressive disorder were interviewed in 35 different countries. This was to assess the nature and severity of experienced and anticipated discrimination.

Out of 1080 participants, 79% said they experienced discrimination in at least one aspect of their life. Because of this, 37% had stopped themselves from initiating a close personal relationship, 25% from applying for work, and 20% from applying for education or training. In other words, discrimination related to depression acts as a barrier to social participation and successful integration into work and education.

Unsurprisingly, higher levels of experienced discrimination were associated with either several lifetime depressive episodes or at least one psychiatric hospital admission, or both. More discrimination was also associated with poorer levels of social functioning (being widowed, separated or divorced), with being in unpaid employment, and with being unemployed.

People fear discrimination even if there isn't any – anticipated discrimination did not necessarily go with the experience of it. Forty-seven percent of the 316 participants who anticipated discrimination in finding or keeping a job, and 45% of the 353 who anticipated discrimination in their intimate relationships, had not actually experienced it.

Because of real or anticipated stigma and discrimination, non-disclosure of depression was found to be a barrier to seeking help and to receiving effective treatment.

Source: Dr Antonio Lasalvia et al: 'Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey' *The Lancet*, Early Online Publication, 18 Oct, 2012.

INCREASE IN ADMISSIONS FOR SELF-HARM

According to the charity YoungMinds, a national inquiry estimated that one in twelve (8%) of young people self-harm. Last year 38,000 young people were admitted to hospital because of their injuries – but one study found that only 12.6% of 15-16 year-olds who self-harmed actually went to a hospital. All the same, over the last ten years in-patient admissions due to young people self-harming has increased by 68%.

Young people who self-harm often feel very isolated and often have no ideas about how to get help. Parents, schools, NHS staff and youth services all show a lack of understanding and effective strategies for supporting these young people.

Source: YoungMinds.org website, 23 Oct, 2012.

... continued from page 13

Those with power and advantages are trying to shape the welfare system to close off the opportunities to cheat but also so that *all* claimants must serve the jobs market. Since there is no prospect of unemployment falling significantly for years (if ever) this is simply unrealistic, not to say insulting to the intelligence of claimants. In the meantime, little has been done to claw back the wealth steadily accumulated by the rich over the last thirty years, and use it to make a better society.

The rioting and looting in August 2011 was a visible and frightening sign of a large class of people who feel little or no affinity with the aspirations of the insulated political and middle and upper classes. In effect this was an angry

manifestation by young people who feel they've been cut adrift from meaningful involvement in society – detached and not wanted in democratic political discussion, their votes left unused or, when they are used, rendered meaningless by corrupt politicians. This is an alienated "underclass", disproportionately policed and imprisoned. While there are the rich, the poor and desperate will always be with us. I feel that the riots, along with low turn-outs at elections and opinion polls indicate deep distrust of politicians and the leaders of our institutions. They show that many disaffected people would simply like to be treated as responsible adults rather than forever patronised like errant children.

CREATIVE WRITING

‘All poems must carry a Government warning. Words can seriously affect your heart.’

(from ‘This pen’ by elma mitchell)

Welcome to the creative writing section ... welcome to the power of words ... welcome to the wonderful work of peter campbell, don Weitz and Jenny Johnson.

*as usual, this section highlights the work of a featured writer – peter campbell – alongside selected submissions from readers of **Asylum**. please do continue to send us your writing, particularly work which explores issues and perspectives relevant to **Asylum**. We welcome poems of up to 50 lines, and short stories or excerpts from longer pieces of work (up to 500 words).*

as a founder member of survivors speak out and survivors poetry, the holder of honorary degrees in education at anglia ruskin university and the open university, and as the author of one of the most powerful poetic representations of life as a survivor of mental health services – brown linoleum, green lawns (hearing eye, 2006) – you might have already heard of peter campbell. for those who have not, be warned. his words will seriously affect your heart.

A short interview with Peter Campbell

*If psychiatry were a meal, what would it be? ... Medication and chips, with extra meds to follow.
Mental health, heroes and heroines. ... Judi Chamberlin, respected by survivors worldwide. Louise
Pembroke – a bonny wee fighter. Professor Peter Beresford – still banging the drum.*

Which celebrity would you most like to give a depot to? ... Simon Cowell

Who would you like to section? ... Rupert Murdoch

In the psychiatrist’s chair – who would be the psychiatrist and who would be the interviewee?

R.D. Laing as the psychiatrist, Thomas Szasz in the chair.

.

Peter’s Poetry

DECISIONS

I tell him I am Zeop the Centurion.
He writes it down into my case notes.
In the green room he plays with paper clips,
Talks to the girl from the Migraine Unit
Decides he will sleep on it.

Next morning the staff team convenes.
Porcelain cups for psychiatrists
Plastic for everyone else.
Decisions have to be reached.
I sit in a straight backed chair.
‘We don’t think that you are Zeop the Centurion’
He says.
‘I know that’, I say,
‘Why else do you think I’m in here?’

CRISIS ADVOCATE

They all smiled
But the drapes were down
Thirteen nutters seen this morning
Even the constitutional niceties
Sometimes wear thin.

She did not smile
Sat next to me
Erect
In black
With Doc Martens boots on.

‘We would get along much better, doctor,
If you didn’t keep interrupting him.’

There was a pause
The shifting of spines

A page in my history
Turning irreversibly
Forwards.

NEW LOONY (Having moved to Dollis Hill from Cricklewood)

'You must be the new loony around here,'
The man in the park said
As we looked to the front down the long slope.

Clouds were rolling slowly in –
Willesden, Harlesden, Neasden Lane.

'I can see how you're always here at first stirrings,
Set your stall out at one end of the bench,
Always tuck your plastic bag behind the bench leg.
You're just prevaricating until the dormitory door re-opens.'

He had a smart tie and a clever look.
He must have bossed the workers like a gentleman.

He mentioned the Mozart Club: intelligent talk
And welcoming flowers in the window.
He said I would never lack a friendly eye
Or someone to point me right.

He recommended good fellowship and moving away
from the past.

At least it was starting to rain.
At least it was the same rain that falls on
Cricklewood.

He pinched me briefly at the elbow
And departed.
No smile. No thumbs up.

In the dark when I sit quietly
His touch is entering the room.

A GOOD NURSE (Much Respect)

She'd learned a lot.
Carried off a few diplomas.
Cognitive Therapy, Dialectical Determinism,
Lunacy, Linguistics. Clinical Obstinacy.
They jingle a bit when you're seeking a fine career.

But she looked good too.
Leaning slightly forwards, not held away.
Not formal, keen not flash.
She wore her name badge where you could see it.
Not down there on the belt.

She'd picked up some frills right enough
But I'd have said that the basics were good.

On the back shift
She was playing Scrabble with us.
The dead hour before the night crew clock-in.
Brian came at her with a knife.
Christ, what was that all about?

She stood straight up.
I'd never seen anyone move so smoothly.
Took him by the elbow as he came on to her,
Swung him nicely into the armchair.

It was the minute waltz,
A trip back to Vienna.

One moment he was over us,
The next he was safe among the cushions,
The knife on the carpet
And she was kneeling by his side.

Norman still had his Scrabble letters.

'I was going to put down FRIGID,' he said,
'but I think I'll change it.'

MAKING IT GOOD

The night we took Aubretia Ward

It was a cool night
There was nothing wrong going on in our heads
The cats in the foundations were curled and still
The birds in the bushes had fled
The night we took Aubretia Ward as we'd dreamed we
would.

The night we took Aubretia Ward

It was a calm night
There was nothing disturbing us inside our heads
The keys were in the nightman's pocket
He slept as if he was dead
The night we took Aubretia Ward because we could.

The night we took Aubretia Ward

It was a clear night
There was nothing malevolent turning our heads
The psychiatrists tapped at the outer door
Remembering what we'd said
The night we took Aubretia Ward

Making our word good.

Don Weitz

MAYDAY – Doctors Who Can't Wait*

Dedicated to Elizabeth Ellis and other women shock survivors

Wake up everybody
it's shock day every monday-wednesday-friday
in psychoprison Anoka
where 67-year-old Elizabeth Ellis
waits in silence, refuses to talk to
doctors who can't wait
to label her 'catatonic'
doctors who can't wait
to fire 200 volts
into her fragile aging brain
doctors who can't wait
to perform electrical lobotomies on her sisters
doctors who can't wait
to commit elder abuse
doctors who can't wait
to commit psychiatric rape
doctors who can't wait
to conspire with sons and husbands
to lock up and shock
mothers/grandmothers/wives
doctors who can't wait to
re-traumatize oppressed women labelled
depressed
bipolar
post-partum

schizophrenic
doctors who can't wait to
destroy more brains/careers/lives – collateral damage –
your sister, girlfriend, mother or grandmother could
be next
doctors who can't wait to
silence voices of 'noncompliant patients' – freedom
fighters –
doctors who can't wait to
con health ministers to fund shock mills
doctors who can't wait to
lie to patients/families/lawyers/reporters
about 'safe, effective and lifesaving ECT'
to a disinterested disconnected world
ignorant, betrayed, brainwashed by
nazis in white coats who torture
in the name of DSM and ECT
who torture/lie/cover-up, in the name of mental health
time to rise up, fight back
against psychiatric fascism
everyday is mayday

* Revised & expanded. First read at the Mayworks Poetry Marathon on May 1, 2011, and at anti-shock protest 'Stop Shocking Our Mothers and Grandmothers', on May 7, 2011 in Toronto.

Jenny Johnson
RESERVOIR

When the basketry session is over she slips behind
her companions and makes for the reservoir. In her green suit
and cream shoes, she inches through hesitant grass,
a neglected fence hole.

Once on the wall she counts to ten, then lets herself
slide into the hazel of the water – which feels immediately
too shallow to veil her curls. More amazed than maddened,
eventually she emerges clasped by slime.

But here comes the lorry driver, plucking her off the bank:
canny enough to restore her to her unit, to the cohort of experts ...
In time, she is fêted by female attendants, escorted to her
sweetened, second water.

How devotedly they bathe her! When they lift her up in a
stiffened gown they can tell, they can tell she is more than a
doll ... Most other inhabitants are rather too frail,
too sedated, to contemplate dying before living.

HOW WELL DO ANTI-CAPITALIST CAMPAIGNERS RESPOND TO MENTAL DEVIANCE? Ronny Worsey

The last issue (*asylum* 19.3, 2012) made some important points about the role of capitalist ideology in the theory and delivery of mental health services. but an issue just as close to my heart is the lack of mental health awareness amongst anti-capitalist activists.

A year ago i took a call from a friend who was very upset about being chucked out of a squatted social centre in the early hours in the morning “for acting weird and talking too much”. He told me he’d tried to get involved in the occupy movement by turning up at camps with a sleeping bag and food to share, and each time had found it extremely difficult to fit in, despite the movement’s claim to welcome everybody.

it’s all very well for occupy activists to claim they represent ‘the 99% of society’, but does this include the 1% with psychiatric labels of severe mental illness, or even the 25% of people whom mainstream anti-stigma organisations claim ‘will experience mental health issues at some point in their lives’?

As a teenager back in the late 1980s, i got involved in animal rights and socialist groups and it didn’t take long to suss out that the corporations that test drugs on animals also offload defective and out-of-date ones onto the world’s poorest populations, whilst squeezing every bit of productivity out of their workforces and making huge donations to political parties. social justice issues are inter-linked, as the ideology we fight is the same: that individuals can be treated only as units of production, and that profit and convenience come before their rights to freedom and self-determination.

in all these overlapping movements, activists seek solidarity and community and have established standards and conventions. Tastes in music, clothes, intoxicating substances and even sexual habits are scrutinised by peers, and the pressure to conform as acceptably alternative is strong. Activists, particularly in the peace and environmental movements, are also expected to be educated and articulate.

i’ve attended hundreds of protests, gatherings and camps over the years, and the level of bureaucracy and efficiency can be staggering, though hardly surprising considering that such events are dominated by middle-class graduates. meetings are conducted to set agendas, and contributors are expected to be brief and to the point. Hand signals are often used to indicate agreement or disagreement, and participants are expected to pick these up almost instinctively. Ranting isn’t allowed. A contributor is expected to be a clear communicator, who understands activist jargon and is comfortable addressing groups.

so how do the distressed, angry and less-educated get their points across? How does a person whose childhood was full of pain, abuse and rough sleeping, who left school with no qualifications and a complete contempt for authority, fit in to this polite and ordered activist culture? How do the ranters, voice hearers, hyperactive dreamers and completely emotionally open people fit in?

sadly, at the moment, they aren’t allowed to. i’ve frequently seen campaigners pushed out and treated with hostility because their behaviour and manner of speech are misunderstood, ridiculed and judged by the very people they most want to be accepted by. i’ve lost count of the number of politically aware, experienced activists i’ve heard calling people ‘nutter’, ‘weirdo’ and ‘not right in the head’.

Activists need to understand that by doing this they’re judging and labelling people as deviant and different. in our social justice movement, they’re putting up barriers to participation that are as real as a flight of stairs or a shared meal full of meat. it’s only by questioning and challenging these barriers that we can kick them down.

experienced activists know that phone calls and emails are monitored, that ‘radical’ meeting places are likely to be bugged, and that talking about anything that can be interpreted as illegal in front of people you barely know is foolish. we have a healthy, shared awareness. yet, wider society does not consider this to be healthy, only paranoid. so, who draws the line between sensible and embarrassing paranoia?

Activists share a painful awareness about the worldwide extent of suffering. i can’t witness a child being shouted at by a teacher, or a cow waiting to be herded into a lorry and have her throat slit, without a lurch of sadness. once you open your mind to the reality and scale of exploitation, it’s very difficult to switch off your awareness. We all have different ways to express our feelings of outrage and confusion, but the state has chosen to give some of them labels, like “Oppositional Defiance Disorder”. Must activists do the same, with cruder labels?

i recall sitting in a mental health tribunal, at which a psychiatrist stated that her patient’s preoccupations with the suffering he saw everywhere were “deluded and obsessional”, and his eagerness to express his views was “a symptom of formal thought disorder”. it struck me that the only difference between that patient and the thousands of articulate, ‘mentally ordered’ activists i’ve met over the last few decades is the context: he stood in a shopping centre broadcasting his views to strangers, whereas they attend structured protests and meetings.

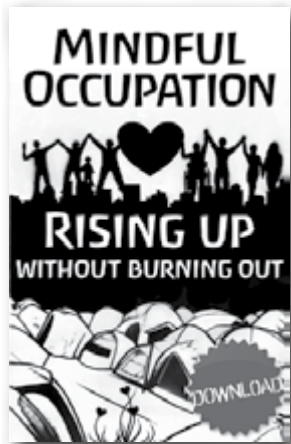
i had no consoling answer for my friend on the phone. i could only agree that prejudice exists everywhere, even in so-called inclusive protest movements. That conversation started me on a path towards challenging it, and i hope that, through discussion and debate, other activists will recognise the seriousness of this issue and join me on it.

ronny Worsey is a community mental health advocate, working in derbyshire.





BOOK REVIEWS



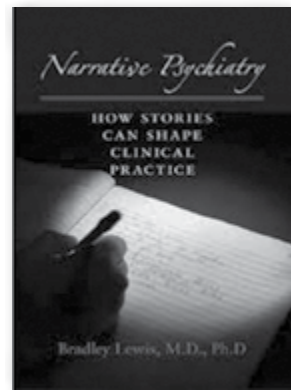
Mindful Occupation: Rising up without burning out

Free download: www.mindfuloccupation.org/
Review by Tamasin Knight

I found this book very positive, readable and compassionate. It is written by radical mental health activists in North America who have been involved in the Occupy movement. The book starts by introducing 'radical mental health' and linking this to wider economic issues, to social justice, and to the inequality of power in society. They write: 'There is an urgent need to talk publicly about the relationship between social injustice and our mental health. We need to start redefining what it actually means to be mentally healthy, not just on an individual level, but on collective, communal, and global levels.'

Much of the book focuses on practical strategies to create a movement which, while working for social change, also cares for the psychological and emotional wellbeing of those involved. There are sections about communicating with people we find difficult; psychological first aid; healing from and preventing sexual assault; and responding to those in crisis. Many of these strategies would also be of use to those interested in mental health but not directly involved in activism.

What I like about the book is that it doesn't only discuss inequality of power but also challenges this itself by providing knowledge and skills normally only available to 'professionals' or those with the money to buy mental health books and attend training courses. I also like the book's wide-reaching compassion, extending not only to those experiencing mental distress, but also to those around them, and to psychiatric staff. This is an important book which I would recommend.



Narrative Psychiatry: How stories can shape clinical practice

by Bradley Lewis. Johns
Hopkins University Press,
Baltimore
2011
Price £26

Biological psychiatry is afflicted by an ague. Or maybe it's the pox. The precise diagnosis is unimportant, and it may not even be a terminal decline, but there is serious discontent with the brain that was once thought to be broken.

The pharmaceutical industry is cutting back its funding for neuroscience research. AstraZeneca has cut 2,200 jobs from research and development for 2014. This follows similar cuts by GlaxoSmithKline, Pfizer, Merck, Sanofi and Novartis (*InPharm*). Most of these cuts are in 'serious mental illness' research, not in Alzheimer's.

Professor Tim Kendall, at the National Institute for Health and Clinical Excellence (NICE), develops clinical practice guidelines for the NHS. As far as day-to-day clinical practice is concerned he has pointed out that there is no evidence that so-called second generation neuroleptic drugs are any more effective than first generation in the management of psychosis (Kendall).

Blockbuster drugs are turning out to be a busted flush – their days are numbered. Their decline is hastened by the problem of the harm they cause. Long-term use is associated with seriously adverse effects on health, including obesity, heart disease, brain atrophy, sudden cardiac death and increased mortality. Graham Thornicroft has recently described this as a violation of the right to health, under Article 12 of the International Covenant on Economic, Social and Cultural Rights (Thornicroft). So where does psychiatry go from here?

In *Narrative Psychiatry*, New York psychiatrist Brad Lewis points out that neuroscience has restricted psychiatrists' ability to practise, especially when it comes



to working with people empathically and on a deeply personal level. The failure of neuroscience research to deliver interventions that are safe and effective means that the profession must face up to the question: Where do we go from here? The search for the answer is now the most pressing task facing critical and post-psychiatry. Lewis's book is an important step forward in this search.

I admire his approach. The style is approachable, with a gentle *pétillance*. He doesn't denigrate biological psychiatry. He doesn't attack neuroscience. He doesn't even develop a critique of the field. Rather, the real problem with biological psychiatry is its sterility. It has nothing to say about the complexity of human lives and their dilemmas.

He makes his point through a skilful use of Chekhov's play *Ivanov*, which he uses to illuminate what he means by 'a narrative view of psychiatry and psychiatric practice'. This perspective engages with the multiplicity of meanings, and thus the indeterminacy of human lives. There is no single, monological truth about a human being. But this does not mean a descent into the morass of relativism. Instead, Lewis argues that it forces mental health workers to engage with patients' values – and their own – and ultimately with the moral implications of psychiatric practice. This is because narrative psychiatry is not concerned with the truth of different stories about madness and distress but with the *consequences* of different stories, and with the sort of lives which arise from these stories.

In the second and third chapters, Lewis shows how narratives in medicine and psychotherapy have illuminated clinical practice. This is a prelude to his ideas about narrative psychiatry, set out in Chapter 4.

Narrative '...provides a way for savvy educators, reformers, and practitioners to negotiate the contradictions in the field without falling into swirling polemics or developing rigid "anti-this" or "pro-that" dichotomies – such as anti-psychiatry versus pro-psychiatry, or drug therapy versus talk therapy' (p. 64). Of course, this kind of talk will make biological fundamentalists – the seekers of the ultimate truth about madness – rail and rant.

Instead, Lewis sees psychiatric practice in terms of prioritising clinical stories. Psychiatric patients enter the clinic with a vast array of complex narratives. The most important task for the psychiatrist is to engage with these stories respectfully and empathically. This means caring for and about the person whose story you are listening to. In the final chapters of his book, his use of Chitra Divakaruni's short story *Mrs. Dutta Writes a Letter* sets out how narrative psychiatry works in practice, whilst drawing attention to the value of literary narratives in understanding clinical practice.

In my view, Brad Lewis's view of narrative psychiatry sits comfortably alongside Jo Moncrieff's critique of the drug-centred model of psychotropic medication

(Moncrieff). Both books are really important in moving from critique to practice. Furthermore, narrative psychiatry opens the way for much-needed future work, for example concerning how psychiatrists might use diagnosis, medication (especially the placebo effect), and psychotherapy (especially the non-specific factors common to all forms of psychotherapy).

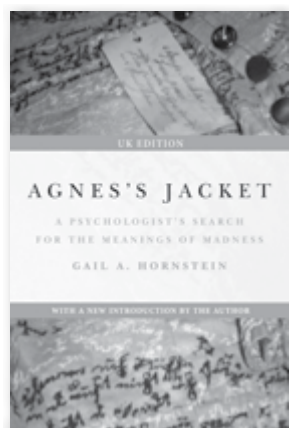
Most importantly, narrative psychiatry has the potential to equip us to work more respectfully with people whose cultural beliefs differ from our own. And, until such time as governments decide that the practice of psychiatry is to be uncoupled from social control, how we might work with coercion.

This is an important book. All psychiatrists, psychologists, and mental health professionals should read it.

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Give me the stories and I will take care of the rest? The case of *Agnes's Jacket: A Psychologist's Search for the Meaning of Madness*



Agnes's Jacket: A Psychologist's Search for the Meaning of Madness

by Gail A Hornstein
UK edition PCCS Books

Reviewed by Jasna Russo

In a field dominated by bio-medical opinions, any interest in mad 'sub-culture' and in the narratives of 'mental patients' should probably be taken as something positive in itself. But is this always so? Do such well-intended gestures raise any concerns? Is it possible that the academic re-telling and packaging of individual and collective survivor stories could even cause damage? Can the authority of lived experience be established by anybody besides the owners of those experiences themselves?

I want to explore this important issue through the

example of one text. *Agnes's Jacket* is the detailed diary of the American psychology professor Gail A. Hornstein when she journeyed through survivor groups in the UK and USA. Hornstein is known for her long-standing academic work with the narratives of psychiatric patients. The six years' research behind *Agnes's Jacket* started in 2002, with her discovery of the Mental Health Testimony Archive in the British Library. In the twenty-six chapters of her book, Hornstein summarises the information from some of the video-tapes she watched, describes her visits to voice hearers' groups and events, and interviews survivor activists. She acts as the observer documenting her impressions and reflections. She describes and quotes *us* – 'mental patients' as she often calls us.

In the introduction, Hornstein writes:

It is deeply unsettling to find myself in closer agreement with the views of patients than with the professionals who treat them. (Hornstein, p. xxi)

This troubling feeling doesn't stop her from proceeding with an often intrusive data-gathering journey in which she gets as physically close as she possibly can to self-help groups and user/survivor events:

After months of sleuthing, I did manage to locate a list of hearing voices groups around Britain but none would agree to release contact information to a 'non-voice hearer'. Finally, after dozens of calls, I persuaded a psychiatric nurse in North London who said he was 'co-facilitator' of a hearing voices group to ask the members if I might come for a visit. That meeting was my first glimpse into what felt like a parallel universe. (Ibid, pp. xviii-xix)

Hornstein's access to users/survivors sharing their experiences and supporting each other – or, as she puts it, "witnessing madness from the inside" – naturally leads to what, for her, is a seemingly unproblematic ambition:

In witnessing madness from the inside, I've tried to write from much the same place. (Ibid, p. xxv)

The long book which follows is testimony to what can happen when someone tries to 'assume much the same place' as another person, together with the very right to write from that place: in this case from the place of the mad, the psychiatrised, the silenced, the Other. As someone who is actually in the place that Hornstein aims to write from, in the beginning it felt odd reading this book. By the end, it had turned into a clearly negative experience, and one which made me question her overall purpose.

I asked myself: What sense does it make (for example) to read the re-narrated life of Peter Campbell, who is alive and who has written so many great texts himself? Providing a full bibliography of his published work would be far more valuable than being invited to join Hornstein

in her consumption of Peter's personal experiences (in the chapter: 'Peter, Who Comes from Jesus').

Whatever this book claims to be, it clearly rests on a widespread tradition accurately described by Peter Beresford and Jan Wallcraft:

As far as the dominant debate is concerned, survivors and the survivors' movement still seem to be primarily seen as a source of experiential data, rather than creators of our own analysis and theory. (Beresford & Wallcraft, p. 72)

What *Agnes's Jacket* systematically omits are the academic contributions of authors who identify as service users/survivors. Hornstein visited the UK on several occasions as part of her research, but she chooses not to include any information about the Survivor History Group or the Survivor Research Network, or any reference to the work of well-known survivor researchers who are based there – an omission that undoubtedly reveals her priorities.

Although professing that she is aware of 'subtle forms of silencing' preventing 'patients' from producing knowledge about madness on equal terms, she seems not to notice that her work also imposes a different, more contemporary kind of silencing:

More subtle forms of silencing are equally widespread. Patients cannot publish in any mainstream journal in psychiatry, clinical psychology, nursing or social work. (They are allowed only as case illustrations.) Patient support and activist organizations are denied the funding and research facilities that would allow them to evaluate the methods they develop. (Hornstein, p. 159)

The reality that there is very little of our own, survivor-authored analysis of our individual and collective histories, and that we face massive barriers when seeking scholarly recognition and resources, gives a bitter flavour to the expanding genre of narrative inquiry about madness by non-survivor academics. (See Estroff, 2004; Crossley, 2004). By her insistence on the 'patient' identity, by gathering and 'explaining' our experiences, and taking on the role of the bridge-builder between survivors and academia, Hornstein inevitably contributes to the very same process of silencing which she says she aims to combat.

At a time when service users/survivors write much more than just their personal stories, the exclusive focus on our narratives and on our self-help groups becomes a way to suppress our research and our academic work, which in consequence slows down the process of the development of users/survivors' own theories. On a mission to collect and interpret our individual and collective stories, academics like Hornstein are not really 'giving psychiatric patients a voice', as they claim. Rather they seem to be conquering another colony of narrative research.

Despite the strong evidence they present, individual survivor narratives have not as yet been able to mount a challenge to the bio-medical model, on an equal footing. The efforts of narrative researchers like Hornstein to mediate for us can be perceived as creating another subtle and persistent barrier to the establishment of first-person knowledge in psychiatry and psychology. Taking on the task of establishing *our* voice and performing it *for us*, is, in my opinion, no basis for a constructive alliance.

Because all oppressed groups and their political movements have a great need for allies, it is particularly hard to challenge practices that claim to subscribe to the same or similar goals but are not actually emancipating. I will draw one parallel in order to make this clearer.

Hornstein writes:

Patient memoirs are a kind of protest literature, like slave narratives or witness testimonies. (p. 163)

This comparison encourages me to refer to one of the six stories discussed by Arthur Frank in his book on socio-narratology (Frank, pp. 11-12). The story was originally told by Frederick Douglass, an escaped Afro-American slave who became a leading emancipator, orator and author. Douglass describes his experiences of abolitionist meetings in the 19th century:

During the first three or four months, my speeches were almost exclusively made up of narrations of my own personal experience as a slave. 'Let us have the facts,' said the people. So also said my Friend George Foster, who always wished to pin me down to my simple narrative. 'Give us the facts,' said Collins, 'and we will take care of the philosophy.' (Douglass, p. 367)

This excerpt, taken from a very different context and time, feels so close and expresses so pointedly the mixture of feelings that some survivors have towards undertakings such as *Agnes's Jacket*. 'Give me the stories and I will take care of the rest' remains the undertone, the distinctive flavour of Hornstein's approach. Furthermore, at several points in her long text she expresses attitudes which I would characterise as not at all supportive:

Psychiatric patients don't really need a national organization to give them a sense of shared identity (as professionals clearly do – think of the American Medical Association, the APA, the American Bar Association, the British Psychological Society etc.). What patients need most are support and advocacy which are best provided locally. (Hornstein, pp. 202-3)

If we substitute the words 'patients' or 'psychiatric patients' with (for example) 'women', 'people of colour' or 'people with disabilities', the retrograde nature of such a statement is easy to see. Furthermore, descriptions like the following

confirm the overall dubious nature of Hornstein's attempt to 'go native' in our communities:

Across from me is the heavysset woman wearing a 'Schizoid Personality' T-shirt. She hasn't said anything, just rocks back and forth, eyes closed, like she's in another world. Did people choose their own T-shirts? Hers certainly seems appropriate. (pp. 129-130)

Having been in the international user/survivor movement for long enough, I am aware that we hold different standpoints about the role of our 'allies'. We have different stands about the need to amplify our 'voice', and varying opinions on how much the overall feel of such a process matters. In my opinion, *Agnes's Jacket* is good fodder for those who share a voyeuristic interest in mad people, but it cannot be considered a serious contribution to our understanding of madness, and especially not to changing the way in which knowledge about madness is produced.

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AMAZIN'
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FICTION section



ALTERNATIVE SOURCES OF SUPPORT ... continued

Coping with distress

www.samaritans.org/ Samaritans: confidential emotional support for people experiencing distress, despair and suicidal feelings; tel: 08457 909090 email: jo@samaritans.org

www.spiritualcrisisnetwork.org.uk/ Spiritual Crisis Network: information and email support for people experiencing spiritual crisis.

www.lift-depression.com/ 'Lift depression – The Human Givens Approach'; includes practical self-help ways of overcoming depression.

www.hgi.org.uk/archive/human-givens.htm The Human Givens Institute.

www.sites.google.com/site/justpullyourselftogether/ Pull Yourself Together website: lists various categories of websites on topics related to mental health.

Helping people in crisis: see the resources above, plus

www.hesperian.org/books-and-resources/ *Where Women Nave No Doctor* by Hesperian. Book designed for those living in countries with few healthcare resources; Chapter 27: 'Mental Health' describes practical, non-medical ways to help women experiencing mental health problems. Free download.

www.freedom-center.org/files/trauma_first_aid_fact_sheet12-08.pdf First aid for emotional trauma.

www.theicarusproject.net/files/IcarusNavigatingCrisisHandoutLarge05-09.pdf Helping others in crisis.

www.selfinjurysupport.org.uk/helpful-responses-self-injury Responding to people who have self-harmed.

www.rapecrisis.org.uk/centres.php Rape Crisis Centres: provide support to people who have experienced sexual violence.

Tel: 0808 802 99 99 (open daily, noon - 2.30pm and 7 -9.30pm)

Alternative places of support in the UK

The projects and support services listed below are advertised as 'alternatives'. However, we have not visited them all and so we can't necessarily vouch for them. In good faith, we offer them as examples, without any endorsement. We are always interested in positive or negative feedback from people (including mental health workers) who have experience of any of these places. If you would like to share your experiences, or write a review of any of the listed places, please contact us (see contact details, above).

England: South-West

www.bridgecollective.org.uk/ Bridge Collective, Exeter: a democratic community of mutual support run by people who have experiences, beliefs, and feelings that have sometimes been labelled 'mental illness'. Tel: 01392 433358

South-East

www.maytree.org.uk/ Maytree, London: a short term retreat for the suicidal; stays are free of charge.

www.philadelphia-association.co.uk/ Philadelphia Association Community Houses, London: therapeutic houses for people going through personal crisis, serious distress or confusion; stays are longer term, not usually for less than a year; houses are open to people eligible for housing benefit or who can pay the low rent themselves. Tel: 0300 123 1708

The North

www.lslcs.org.uk/ Leeds Survivor-Led Crisis Service, Leeds: provides 'sanctuary and support in times of crisis'; has a telephone helpline and Dial House, a place of sanctuary where people in crisis may visit (6pm-2am, Fri-Mon); also group sessions. Helpline: 0808 800 1212 (every evening, 6 - 10.30)

www.sacredspace.org.uk/ Sacred Space Foundation, Cumbria: charity providing peaceful and confidential rest and recuperation facilities; helps those suffering from the extremes of stress, burn-out, emotional exhaustion or 'spiritual crisis'. No fixed charge for stays but a donation is requested. Tel: 01768 486868

www.sharingvoices.org.uk Sharing Voices Bradford: a community development mental health organisation for people from Black and Minority Ethnic communities; promotes self-help and mutual support, runs various groups, and offers one-to-one support: 'Giving power back to local people or people living in distress'. Tel: 01274 731166

Wales

www.hearingvoicescymru.org/ Hearing Voices Network, Cymru: includes information and a list of Hearing Voices groups in Wales.

Scotland

www.hearingvoicesnetwork.com/new/ HaVen, The Hearing Voices Network, Dundee: user-led charity seeking to create acceptance that hearing voices is a valid experience (includes voices, visions and distressing beliefs); self-help groups and social activities. Tel: 01382 223023

www.workingto recovery.co.uk/other-services/recovery-house Working to Recovery, Isle of Lewis: personalised respite and recovery breaks for individuals wishing to engage with their emotional, spiritual and mental health issues in a positive way; free to stay.

www.lothlorien.tc Lothlorien Therapeutic Community, South West Scotland: based on the therapeutic community model, including principles of collective responsibility and empowerment.



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www.pccs-books.co.uk

Information

Asylum Collective

www.asylumonline.net

ALTERNATIVE SOURCES OF SUPPORT

Readers sometimes say to us 'It's all very well criticising the mental health system, but where are the alternative sources of help?'

In order to address this we have made a list of resources giving practical support to help people cope with mental distress. We are also compiling a list of places in the UK that offer alternative support to people experiencing mental distress or madness – places that are not part of the official mental health system. This list is available at:

www.asylumonline.net/resources/alternative-sources-of-support/

If you know of any good resources or places in your local area which you feel should be on the list, please let us know.

We are always interested in both positive and negative feedback from people who have used any of these alternatives, and from mental health workers who have had contact with them. If you would like to share your experiences, or write a review of what is on offer, please contact us. We would like to include discussion about these in future pages of *Asylum*. Please head your message: 'Alternative sources of support', and contact us at: editors@asylumonline.net

or write to: Asylum magazine, Limbrick Centre, Limbrick Road, Sheffield, S6 2PE.

Coming off psychiatric medication

www.comingoff.com/ Coming Off Psychiatric Medication.

www.theicarusproject.net/HarmReductionGuideComingOffPsychDrugs Free download of *Harm Reduction Guide to Coming off Psychiatric Drugs and Withdrawal* by the Icarus Project and Freedom Center.

www.survivingantidepressants.org/ Surviving Antidepressants website: provides volunteer peer support for antidepressant withdrawal

Coping with hearing voices or unusual beliefs

www.hearing-voices.org/ Hearing Voices Network. Includes a list of Hearing Voices groups in England, Wales and Scotland; tel: temporary mobile number on website.

www.intervoiceonline.org/ Intervoice: the international community for hearing voices; includes *The Practical Guide to Coping with Voices*.

www.peter-lehmann-publishing.com/beyond-belief.htm *Beyond Belief - Alternative ways of working with delusions, obsessions and unusual experiences* by Tamasin Knight. Free download of a book that includes self-help strategies for people living with 'unusual' or distressing beliefs, and things friends, relatives and professionals can do to help.

www.rufusmay.com/ Rufus May's website.

Living with self-harm

www.kreativeinterventions.com/resources_7.html Kreative Interventions. Includes free downloads of the self-help books *The Hurt Yourself Less Workbook* and *Cutting the Risk: Self-Harm, Self-Care & Risk Reduction*.

www.selfinjurysupport.org.uk/home Bristol Crisis Service for Women. Includes many self-help resources related to self-injury, including strategies for dealing with feelings and flashbacks. Also includes a list of self-injury support groups in the UK.

continued on inside back cover