

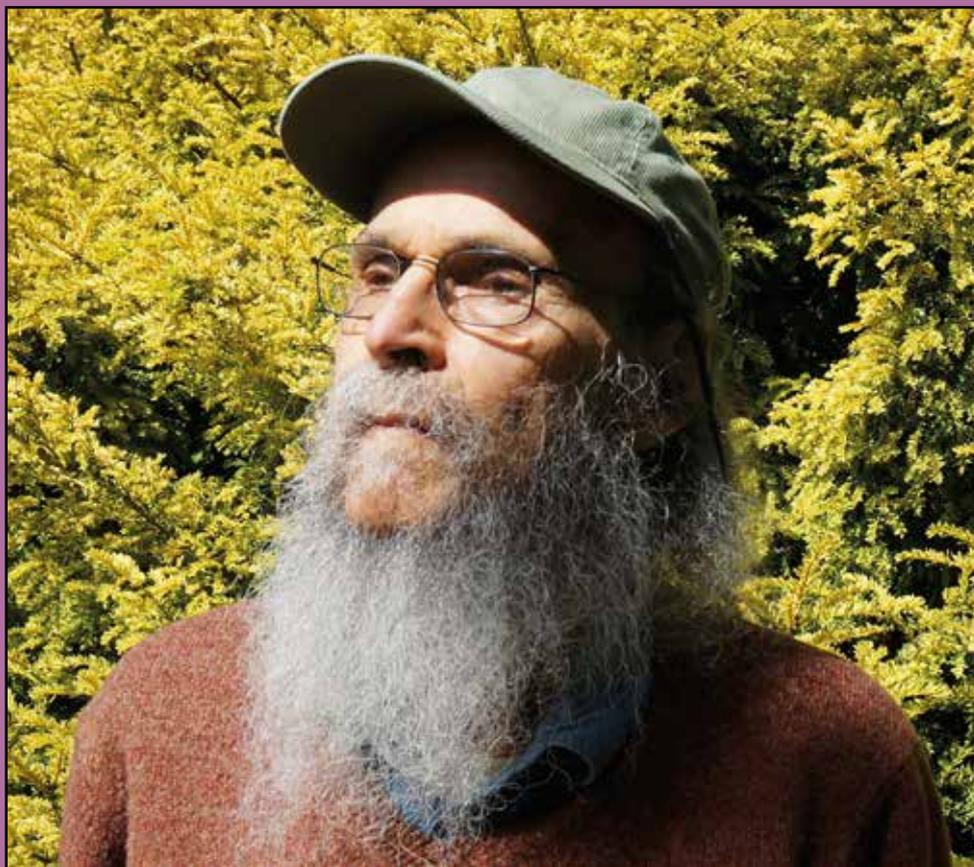
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the magazine for democratic psychiatry

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LEONARD ROY FRANK

1932 – 2015

Campaigner against electroshock



Comics & Mental Health Part 2
Articles - Review - News

i wondered if there is something wrong with me



I wondered if there was something wrong with me



are the things that happened to me...

"my problems?"



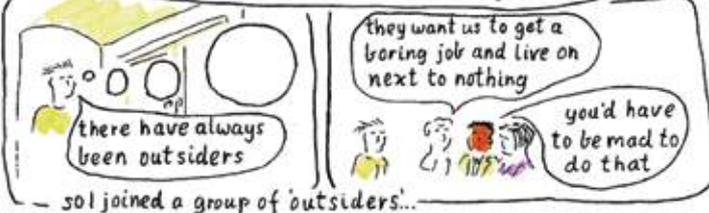
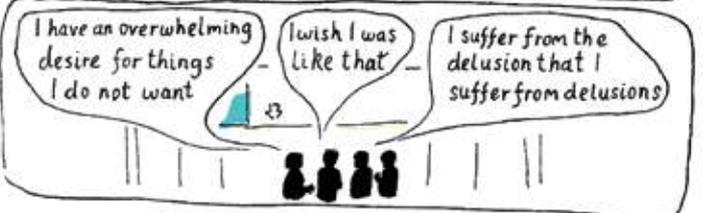
am I understandable?



will they be concerned that I am a risk?



is my response to being watched...



...at last I belonged



by Simon Wharne



the magazine for democratic psychiatry
 Volume 22, Number 2, Summer 2015

**An international magazine for
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 and community development**

**Incorporating the
 Newsletter of Psychology
 Politics Resistance**

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

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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INTRODUCTION

by the editors

We briefly featured the life and work Leonard Roy Frank on pages 7–10 of the recent *Electroshock* issue of the magazine – *Asylum* 21:3 (2014). Now we are sad to report that his long and principled struggle against the routine abuses of medical psychiatry has come to an end. If you missed it, we highly recommend that you check out that issue of our magazine, and also the fascinating blogs about LR Frank’s life and work: www.madinamerica.com/2015/01/memoriam-leonard-roy-frank/

There are several other great items of general interest, but this is also the second in the series featuring Comics & Mental Health. Guest editors Meg John Barker, Joseph De Lappe & Caroline Walters now focus on depictions of depression, anxiety and psychotic experiences. Meg John

writes about how drawing comics has helped the artists to understand and express some of their experiences, while Alex Reed considers the resonances of Marvel Comics with the anti-psychiatry movement. Wendy Couchman presents *Cheese or Ham?* – a lady with insights on aging, dementia ... and crab? Matthew Green interviews Ravi Thornton about her project HOAX, which concerns her brother’s struggle with schizophrenia. Katherine Hubbard writes about the character of Rorschach in *Watchmen*, and Sasha Garwood reflects on representations of mental illness in Neil Gaiman’s *Sandman* series. Finally we have some great work from the comics artist Brick (author of *Depresso*) and from Simon Wharne and Liz Greenfield, who are included in every feature this year. ■

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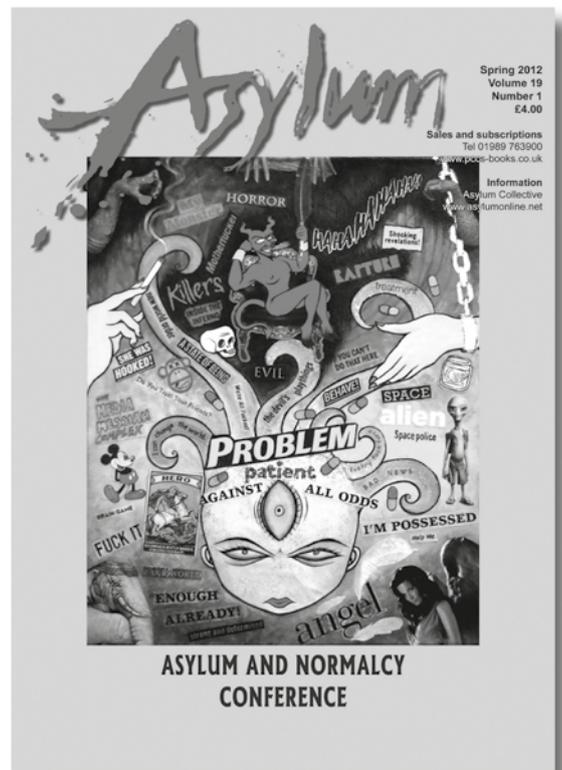
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Monotheist, Vegan, Gandhian, Social Reformer, Writer, Opponent of Involuntary Psychiatry, and Collector of Quotations

He led exactly the life he wanted to lead.

Leonard Roy Frank is remembered and celebrated on the Mad in America website, January 18, 2015. We highly recommend readers to visit the site and read more about the life and work of this extraordinary, resilient, combative and influential psychiatric survivor, someone who was determined never to give in. By kind permission, we reproduce a few of the blogs from:

www.madinamerica.com/2015/01/memori-am-leonard-roy-frank

Will Hall writes:

Principled, uncompromising, and fiercely literate, Leonard Frank survived psychiatric violence, spoke out against his oppressors, and became a great inspiration to human rights activists worldwide. To learn about his life and read his words – both about psychiatry and quite unrelated topics – is to encounter a brilliant soul.

He was a man whose very existence asked us two questions: how can a society that calls itself democratic inflict so much harm on someone so undeserving? And how can a person endure extreme suffering and still emerge with their integrity and creative passion intact? Leonard Frank is one of the lights that shine on my own moments of darkness. He will always be with us.

David Oaks: To My Friend, Activist Hero, Author, Survivor: Leonard Roy Frank

... All of us in the Mad Movement have lost one of our most powerful champions ...

Leonard, I always thought of you as one of the early beat drop-outs because, in 1954, you were to go into the business world after your graduation from the Wharton School of Business, but your spiritual journey brought you into conflict with this society. As part of your mystical experience you were one of the early Americans in that generation to renounce eating meat and dairy products, and of course you grew that big beard. In 1962, because of your cultural and religious rebellion, you experienced absolutely incredible psychiatric abuse, including both

forced insulin coma shock therapy and electroshock therapy. Many times I have told the story about how your psychiatrist checked to see if you had shaved or deviated from your vegetarianism, and when you persevered with your way of living he ordered more electroshock.

After the announcement of your death, one of the first things I thought of about our friendship, these nearly four decades, was your sense of humour. I know that many people will remember your serious biblical-like magnetism whenever you spoke out against psychiatric tyranny, which was frequent, but I recall that nearly every time we talked you always made me laugh with your subtle, witty spirit.

You died at the age of 82. Unquestionably, you were one of the main human rights activists in the field of mental health during the last century, so I hope many people reflect on your contribution to this community. For now, I make the following brief observations:

Ethics: You always framed your indictment of psychiatric abuse in moral ideals. From your nonviolence, I learned a lot about how the work of Gandhi and other leaders informed our work for those marginalized by a psychiatric label. You helped teach me that civil disobedience is important in the revolution that we require today.

Quotes: In order to re-create your memory following your psychiatric oppression by so much shock treatment, you became one of the foremost experts on quotes. I love the fact that one can now walk into seemingly every bookstore and find your *Quotationary*, which has more than 20,000 quotes, and woven throughout those quotes one can find zingers that skewer the psychiatric industry.

Don Weitz: To Leonard Roy Frank, a Brother Activist

... I lost, we lost a brother; we lost one of the most powerful anti-shock activists in the world; we lost a brilliant historian and educator about electroshock; we lost an awesome editor; we lost a most courageous and

inspiring leader in our movement's continuing fight to abolish electroshock and other psychiatric tortures that masquerade as 'treatment' and 'mental health'.

In California, in the 1960s, Leonard had suffered and courageously survived the horrific torture of 50 insulin coma shocks and 35 electroshocks (ECTs). Since I also survived over 100 insulin shocks, I felt close to Leonard, and I knew he immediately understood my personal struggle.

I first met Leonard in 1974 in Topeka, Kansas, site of the second annual Conference on Human Rights and Psychiatric Oppression. At that time, I believe he gave or participated in the first of many subsequent workshops, panels, and public speeches critiquing and denouncing electroshock as a human rights issue, urging us to abolish this psychiatric torture, this crime against humanity.

When speaking, Leonard always looked and sounded profoundly dignified and persuasive, proudly wearing his long grey beard, speaking in a measured, precise but always passionate voice. Sometimes, I felt he looked and sounded like a radical rabbi waging, if not leading, a struggle against immorality, evil and injustice. Leonard immediately inspired me and many others, and continued to do so for the next 35 to 40 years, at every conference, public demonstration and protest he participated in.

He and I began corresponding in the late 1970s, and his brilliant writing and editorial work on *Madness Network News* and the *Madness News Reader* (1974) mainly inspired Carla McKague (my very close friend and shock survivor) and I to launch *Phoenix Rising*, Canada's first antipsychiatry magazine.

Leonard totally believed in, advocated and practised nonviolent civil disobedience. He had thoroughly read and been deeply moved by the 'soul power' of Mahatma Gandhi and the nonviolent philosophy and marches led by Martin Luther King Jr during the US civil rights movement. Until 1986, if not later, he brought and widely shared this commitment to nonviolence to every protest demonstration in every city where the movement held its annual Conference. I still vividly recall his powerful presence and empowering voice during the 10th Conference, held in 1982 in Toronto. During a plenary session at the City Hall, I sat next to Leonard when he compared the brain-damaging effects of electroshock to the violence caused by "a bull in a china shop ... except you can't put the broken pieces back together again." Excerpts of this speech can be heard in the Toronto 1982 conference video *Psychiatry's Gonna Die*. At the same Conference, Leonard and fifteen other American survivor-activists held a nonviolent sit-in at Toronto's Sheraton Hotel, where the American Psychiatric Association (APA) was holding another annual meeting. (All the protestors were arrested and charged but released the same day.)

I was privileged to participate with Leonard and other brother and sister survivors at two acts of nonviolent civil disobedience as public protests against two US 'shock mills'.

In 1983, nine of us blocked the front doors of a meeting of the New York Academy of Medicine at Gracie Square Hospital, NYC, while staff psychiatrists were demonstrating electroshock and ECT machines to other psychiatrists. A few months later we held a nonviolent protest at Benjamin Rush Psychiatric Center in Syracuse, when several of us (including Leonard) blocked and chained ourselves to its front doors; we won a victory there since Benjamin Rush stopped administering ECT a few years later.

Leonard Frank left us a rich and lasting legacy of resistance to electroshock and psychiatry. It wasn't just his personal presence and courageous leadership and powerful speeches that inspired and keeps inspiring our anti-shock protests and anti-psychiatry activism. It was also his brilliant and empowering writings like the movement classic *History of Shock Treatment* (1978) and *The Electroshock Quotationary* (online, 2006), a brilliant and empowering mosaic of statements and illustrations arranged chronologically, a rich resource for activists and researchers.

A voracious reader, Leonard also collected thousands of major and memorable quotations on a wide range of subjects and issues from hundreds of sources for books he edited such as *Influencing Minds: A reader in quotations* (1995), the awesomely comprehensive *Random House Webster's Quotationary* (1999), *Random House Webster's Wit and Humor Quotationary* (2000), and *Freedom: Quotes and passages from the world's greatest freethinkers* (2003). We used to email each other new quotes.

In mind, heart and soul, Leonard always 'spoke truth to power'. His words and life are well worth remembering, being inspired by and cherishing forever.

Don Weitz is an anti-psychiatry and social justice activist in Toronto. He is co-founder of the former anti-psychiatry magazine Phoenix Rising, co-editor of Shrink Resistant: The struggle against psychiatry in Canada (1988), co-founder of Psychiatric Survivor Archives Toronto, member of the Coalition Against Psychiatric Assault, and member of the Ontario Coalition Against Poverty.

Bonnie Burstow: Tribute to Leonard Roy Frank, a Comrade-at-Arms

This is a very sad day for the survivor movement, the anti-psychiatry movement, and for all those who organize against psychiatry. For one of our pillars of our community, and indeed, one of our guiding lights, has just passed – Leonard Roy Frank. Awful for us all who are facing this loss, though it is good that we are pulling together, and Leonard would have liked that.

I first came face-to-face with Leonard in 1982. Like Don Weitz, and so many others, Leonard was testifying at Toronto City Hall. There was a hushed moment just before Leonard got up to speak, and I had an eerie sense that something remarkable was about to transpire. Then Leonard, with his legendary long magnificent beard – which made him look so like an Old Testament prophet



– and his keen penetrating eyes, rose to speak. At first, Leonard’s voice was exceptionally gentle, almost as if he were soothing a child. And so the first impression was of a very soft-spoken guy. Gradually, however, with every word he spoke, as he elaborated on the appalling legacy of psychiatry, his voice grew louder and louder – as if a divine fury were overtaking the man. By the middle of his speech, his voice was thundering, his eyes grabbing you, so that there was no way that you would miss a syllable or fail to take in the seriousness of what was happening. It is as if his righteous anger itself were a way of knowing, a way of seeing that infallibly guided him and the rest of us.

Over the years, the pattern I witnessed that day was repeated again and again. Whenever clarity was needed, whenever someone was needed to spell out the profound violation of human rights or to cut through the tangle of psychobabble, there was Leonard, warrior that he was, uttering forbidden truths, articulating them loud and clear, never pulling his punches, never retreating an inch. Such was his strength and certainty. At once a friend, a team member, a social justice activist, a seer, and a voice in the wildness that willy-nilly spoke truth to power.

Leonard’s legacy is gargantuan and unquestionable: his stellar contributions to *Madness Network News*, his organizing, his various *Quotationaries*, his exceptionally well researched, scholarly yet accessible book *The History of Shock Treatment*, which we all reference to this day. And there was his quiet behind-the-scenes support of so much that his comrades-in-arms were doing. For example, solid support for those of us who were penning a feminist critique of ECT, for which I will always be grateful. I would also like to point out and add Leonard’s unwavering ability to keep his sights on what was important, and not to get sidetracked. Albeit there have at times been fractious divisions in our movement, as there have been with all movements, Leonard was never part of that. He was interested in working with anyone who was making a genuine contribution, and he was good at recognizing an ally when he saw one.

Leonard, we remember and cherish you for all the work you did both publicly and behind the scenes. We remember you for your wisdom, your good sense, and your generosity. We remember you for how you lived, who you were, what you cared about, what you made of your life.

What a privilege it has been working with you all these decades! And what mitzvah to have had you as a friend! Enjoy a well earned rest, comrade ours. And may your memory be as a blessing.

David Cohen writes:

Leonard Roy Frank touched my life as he has touched the lives of so many others, by his kindness, erudition, righteousness, generosity and voluntary simplicity. I first contacted him in early 1989, inviting him (and Judy Chamberlin) to contribute to a critique of psychiatry and the Therapeutic State in a special issue of *The Journal of Mind and Behavior*. I knew of his activist work, and had read several of his tracts, and believed his scholarship on electroshock was profoundly important.

Leonard responded enthusiastically, contributing a magnificent manuscript which was published in 1990 as ‘Electroshock: Death, brain damage, memory loss, and brainwashing.’ Next to his masterful book, *The History of Electroshock*, it became his most cited publication.

I was a Berkeley doctoral student at the time, was taking writing lessons, and was eager to apply my newfound insights to any manuscript that came my way. Leonard was extremely patient with all my requests, some of which must have seemed unreasonable at the time. He backed up every statement, mailing me copies of all the supporting articles. This was thorough scholarship indeed. Soon I had visited him in his tiny apartment on Webster Street in San Francisco, and of course was utterly amazed by his collection of books and the piles of papers filling every available space. We took to each other instantly and I knew I had made a lifelong friend.

Leonard was humble, though he knew much more than most about his favourite topic: the indoctrination of the many by the few by means of force, fear and propaganda. He could make someone feel important simply by asking them a question. He taught what he had learned from his own experience and learning. He was accurate to a fault, ensuring that he could locate the precise source of every quotation he came across.

To those who had tried to erase his memory with shock treatment, he responded with his life’s work of collecting and publishing extraordinary meaningful statements that inspired and enlightened all of us. He saw the unity in everyone, the inter-relationships of everything with everything. He took to the streets to protest against injustice, and he labored long and hard to free minds.

Leonard was a wise man, a teacher and a friend, and I shall always treasure his memory. ■

DRAWING COMICS & SOCIAL ASPECTS OF MENTAL HEALTH

Meg John Barker



Comics and mental health have always been linked for me. My early experiences of learning to enjoy my own solitude came with *The Beano* and *Topper* and a bag of sherbert pips. Later on, girls' comics were a mixed experience because I enjoyed the stories but learnt some rather restrictive messages about femininity and the importance of finding one perfect best friend – or later boyfriend. During my first adult experiences of depression, comics such as *Leonard & Larry*, *Calvin & Hobbes*, *The Sandman* series, and *Strangers in Paradise* became safe places to hide when the world was too much. They also opened up other possible ways of seeing things and relating with people in important ways for me.

In more recent years I have enjoyed many of the comics which tackle mental health more explicitly in the form of memoirs: graphic novels like *Fun Home*, *Marbles*, and *Lighter than my Shadow*, and web comics like *Hyperbole and a Half*. Like many people, I've noticed that it can be particularly powerful to see an experience of distress or suffering similar to my own depicted in comic form. It can lift the sense of isolation and enable me to get in touch with feelings that otherwise I struggle to find. Empathy and compassion for the author or character can help me to find kindness for myself that is otherwise difficult. Something

about the combination of pictures, words, and narrative seems to enable a connection that doesn't always happen for me with written memoirs, films, or other media.

However, my impression is that most of the comic memoirs so far have taken a fairly individual approach to mental health, similar to that taken in wider culture. Generally, mental health difficulties are located in a person's physiological make up and/or in their psychological development. There is not much of a sense of the ways in which social and cultural forces might be involved.

My own approach to mental health, as well as my personal experience of it, is very much a bio-psycho-social one. By this I mean that I think that biological, psychological and social aspects are interwoven in such complex ways that it is often impossible to tease apart the separate elements, or to answer questions about which caused which.

For myself, I imagine that there was some initial biological vulnerability, particularly to depression, given that this was present in both sides of my family. There was also a key role of the culture and class I was born into, and the messages I received about emotions, identity, and relationships due to that. This played out through a particular set of experiences whereby, like most kids, I learnt to monitor and criticise myself and to feel shame. For me,

it was a lot about being a middle- (or mixed-) class kid in a working-class school, and being a person who didn't fit the very strict gender binaries that were in place. Of course, all of these experiences influenced the way in which my body and brain developed, just as subsequent adult experiences of love and kindness, as well as conflict and pain, no doubt left their marks on my neural connections and chemistry, influencing the ways in which I approach the world, and making certain experiences more or less likely.

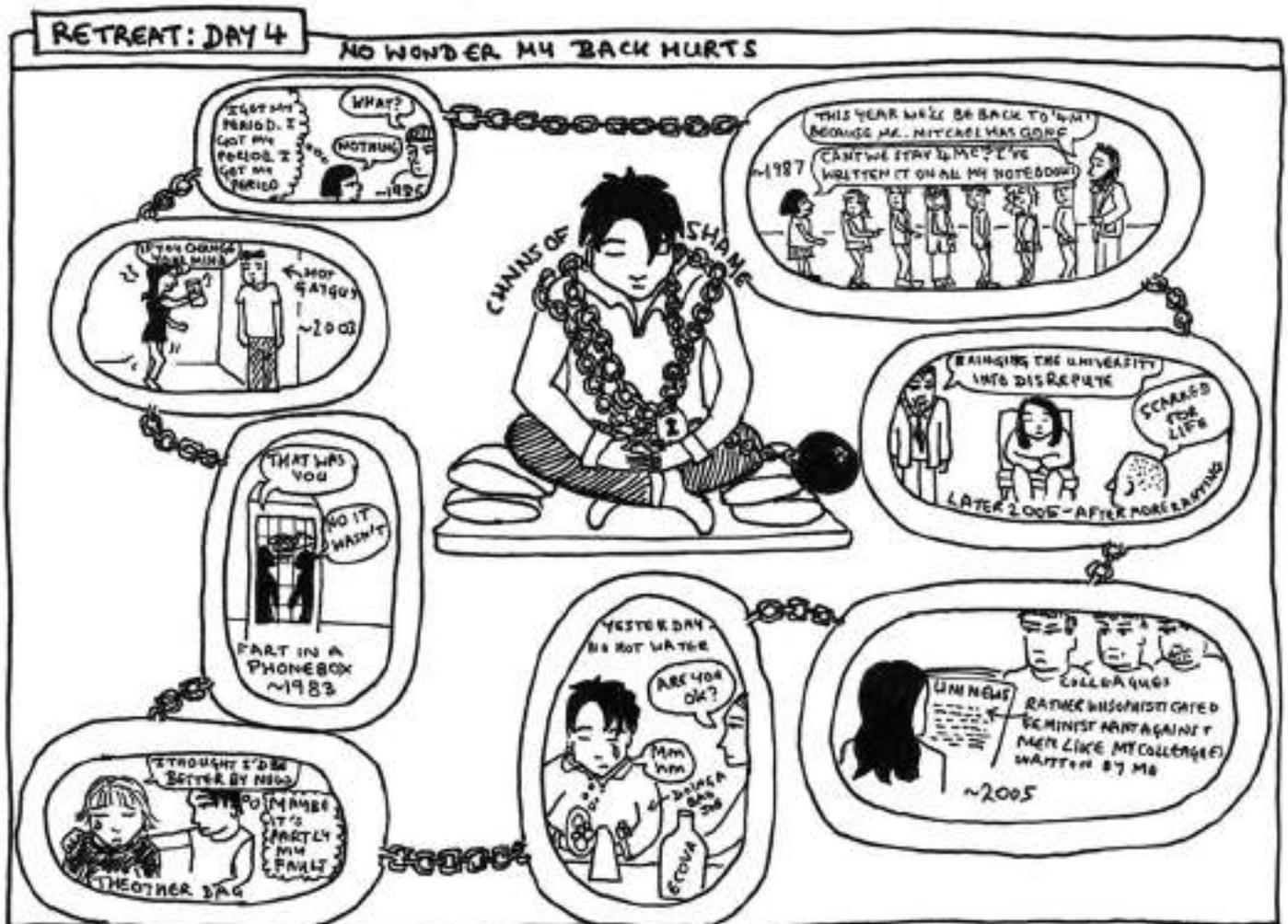
When I began creating comics – like many of the comic memoir authors who I have read – rather than fiction, it made sense to draw from my own life. With comics, I deliberately aimed just to draw whatever was most alive for me at the time, as a kind of escape from the more serious, academic, non-illustrated writing that I was doing. However, I found that what I often ended up drawing was about mental health related experiences and how, for me, they were embedded in social messages.

For example, one of my earliest comics, *Everybody Else*, saw me in my therapist role listening to the most common things I hear from virtually all clients: how they feel there must be something uniquely wrong with them when they compare themselves to everybody else who seems to be getting on just fine. In the comic, I tried to capture the impact of the culture we live in, which encourages us to constantly monitor ourselves, compare ourselves against (imagined) others, and find ourselves lacking and flawed.

In the last frame I tried to show how impossible it is to step outside of culture, as I found myself thinking the same thing as all my clients.

A while later I wrote a short series of comics about a Buddhist retreat, which I subsequently used to illustrate my book on mindful therapy. In one comic, I reflected on my own painful experience of sitting in meditation and feeling wave upon wave of shameful memories and feelings. Again, the bio-psycho-social link is there. My physical pain is linked to the emotional experience which is, in turn, linked to social messages I have learnt (again relating to class, culture, sexuality and gender) about the importance of pleasing others, the embarrassment of bodily functions, and the necessity of fitting in, for example.

When Caroline, Joseph and I were preparing this special comics issue, and running the 9 Worlds Conference workshop which some of the contributors attended, one thing that was pointed out to me was that there are many comics which deal with mental health and social aspects of experience. It is just that we probably don't think of them as 'mental health' comics. For example, comics such as *Maus* and *Persepolis* deal with the psychological impact of trauma on individuals and subsequent generations, as well as how people are influenced by discrimination, war, poverty and alienation. So perhaps all that is needed to find a fuller, more bio-psychosocial understanding of mental health in comics is to cast our net a little wider. ■



RONNIE LAING, JACK KIRBY & ME

When the World Turned DayGlo

You know, you know,
The world turned dayglo ...
X-Ray Spex, 1978

by Alex Read

There's a poignant scene in Ken Loach and David Mercer's 1971 film *Family Life* in which the central character, Janice, sneaks at night into the garden of her parents' dull suburban house with her boyfriend, Tim. They proceed to spray the plants and grey garden ornaments with vivid blue paint. As they do this, Tim remarks to Janice that she can't change the world of her parents, but she can make her mark on it.

Inspired by RD Laing's work on psychosis and families, *Family Life* explores a young woman's reactions to a stilted, repressive family. Janice is struggling to break free from the monochrome existence of her mother and father; she longs for colour and vitality. Her actions are a comprehensible, 'sane' reaction to her stultifying social context, but they are unintelligible and intolerable to her parents who take her behaviour to indicate that she is mad. The Laingian psychiatrist who the family initially consulted is abruptly removed from his position by the old guard of the psychiatric establishment, and the opinion that she is ill is reinforced by the psychiatric professionals, who prescribe drugs and ECT.

Laing's theory about mental illness and the family has been much criticized for stereotyping and blaming parents, and there is more than a hint of fairness in this. But to watch *Family Life* or to read the case histories in Laing and Esterson's *Sanity, Madness and the Family* (1964), is to be reminded of just how grey and conformist the post-war world was, and just how claustrophobic family life could be. For those who struggled with conformity, the consequences of being 'outside' could be serious: being an outsider could lead to ostracism and classification as deviant. As Jenny Diski points out in her excellent book, *The Sixties* (2009), whatever the limitations and excesses of Laing's writings – however much they now seem a product of that peculiar era in which they were produced – much of his work remains intelligent and compelling.

In 1970 I was in my mid-teens, growing up in a monochrome ex-pit town in the North East of England. Like Janice in *Family Life*, I was longing for life and colour. The impulse to sneak out at night and paint the world brighter would have been immediately recognizable to me. Don't get me wrong, my family were loving, and both my parents had jobs, so I never knew the real emotional or material hardships endured by some of the other kids I knew. But working-class Northern culture was highly conformist at that time. To find that you didn't quite fit in, with no language to conceptualize what was going on, could be miserable, a mild version of the 'mystification' of experience that Laing described as leading to craziness.¹

Looking back, I was a kid looking out for signs: on the alert for messages from alternative, more colourful worlds beyond the familiar, humdrum world around me. From my mid-teens onwards, these new cultural messages came mainly via pop music, books and counter-culture magazines like *OZ*, *FRENDZ* and *IT*. But in my pre-teenage years, it was comics that beckoned towards new worlds of imagination and colour. The work of Jack Kirby, Steve Ditko, and Stan Lee and company from the Marvel bull-pen captivated me. This was Marvel's fertile 'silver age', when Kirby and Lee were at the peak of their powers, creating an entire gallery of fabulous imaginants: the Hulk, the Fantastic Four, the Black Panther, the Silver Surfer, the Avengers, the X-Men. Add to this Kirby's genius as a graphic storyteller who was 'straining towards the cosmically wondrous' (Hatfield, 2012, p. 146), and little wonder I was dazzled!

In the 1960s, comics also carried an attractive whiff of the disreputable. My parents disapproved of my reading them, without being able to articulate exactly what it was that they disliked. Presumably this was a hangover from the 1950s controversy stoked up by Dr Fredric Wertham, a ludicrous New York child psychologist with a loathing for comic books. Wertham regarded comics as a corrupting influence on young minds (Alexander 2011), and his campaign against them contributed to a US Senate subcommittee examining the relationship between comics and juvenile delinquency. Shortly afterwards, the restrictive 'Comics Code' was introduced. This led to a slump in creativity and commercial success that took years for the artists in this medium to turn around (Howe 2012).

As well as this hint of deviancy and the sheer graphic brilliance of the Marvel silver age, I was also drawn to themes that Kirby and Lee explored. The storylines tapped directly into the cold war anxieties that were 'looming, hazy and ever-present, like cultural smog' (Hatfield, 2012, p. 115). Threats of world annihilation were a recurrent theme, along with the destructive capacities of technology and the dangers of radioactivity. Alongside cold war anxieties about nuclear destruction, Kirby and Lee also explored micro-level psychological tensions to do with identity, ostracism and fraught relationships. Most Marvel superheroes had secret identities in the mundane world, of course, and in their ordinary lives they grappled with the most ordinary problems. Hatfield (ibid., p.120) writes, '...the Fantastic Four battled world-threatening menaces from other dimensions, lost kingdoms, and far-flung planets, even as their members ... were routinely stricken by failed or uncertain relationships, self-hatred and self-doubt, and

other everyday problems.' Marvel's heroes simultaneously inhabited the prosaic, everyday world in which they struggled to find a place, and also dwelled in mysterious, often mythical, worlds of imagination and colour.

In a political and cultural era of rampant othering, themes of difference were recurrent in the pages of Marvel. When not swinging across rooftops as Spider Man, the teenage Peter Parker wasn't the kind of guy who was captain of the football team, hung with the jocks, or won the girl. Peter was the unpopular kid, bullied and humiliated by his rival Flash Thompson. Marvel heroes were also outsiders. Even when saving the planet from annihilation, superheroes like Spider Man, X-Men, and particularly the Hulk, were regarded ambivalently by the public because of their strangeness. Their public acceptance was contingent on doing the 'acceptable' thing by serving the needs of the populace, and they would be turned-on immediately when they deviated from expectations or something went wrong. Hatfield (2012, p. 119) puts it well: 'Marvel, in short, empathized with the freaks.'

So in the Marvel 'Silver age', Jack Kirby and Stan Lee tapped into social and psychological themes of conformity and transgression, difference and othering. Similar concerns were also addressed in the work of Laing and his colleagues in the so-called 'anti-psychiatry' movement,² with their analysis of the processes whereby behaviour and experience that deviates from a repressive norm becomes characterized as illness. This was the sixties, of course, when a generational tussle was also being enacted - a broad shift in attitudes and values from forties and fifties conformity to greater permissiveness. Both Marvel and the anti-psychiatry folk were messengers for those kids who were longing to wake up one morning, look out over their parents' gardens, and discover that the world, at last, had gone dayglo. ■

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1. 'Mystification' can denote both an act (masking of the processes within a relationship) or a condition (being mystified). Mystification serves to maintain stability and stereotypical family roles by masking conflict. See: Howarth-Williams 1977.

2. A term Laing subsequently rejected (Mullan 1995).

CHEESE OR HAM?

Wendy Couchman (London South Bank University)
Trish Hafford-Letchfield (Middlesex University)
& Kate Leonard (London South Bank University)

This strip is one of the arts-based approaches we have used in teaching students in health and social care because they are powerful in addressing an emotional or affective level of learning that counterbalances the mechanistic and technical-rational teaching so prevalent in the professions.

Cheese or Ham? was reproduced as a comic-strip handout for students on the topic of communication in services for people with dementia. It has shown the potential for an effective and economic learning-aid in mental health and related issues. In fact, it was a simplification from one of a series of digital story films on that topic, following the idea that, for any subject, key concepts need first to be identified and simplified in order to communicate them.

Drawing a comic-strip has many parallels with storyboards in film-making and, in turn, the organization of teaching. Each requires an exercise in editing, in order to get the key issues of a narrative across. The key concepts are like metaphors that allow the learner to make interconnections and make sense of the topic, using their everyday skills.

The process can be understood by reference to theories in the arts, where metaphors are identified as a characteristic of communication. 'What artists, poets and novelists all have in common is their skill at forming metaphors, linking seemingly unrelated concepts in the brain.' (Ramachandran, 2003, p.83)

The skill of making connections between metaphors, therefore, is one of the characteristics of the brain that Ramachandran identifies as important in making sense of the environment that the individual is embodied in or engaged with. He notes that the brain seems to respond well to puzzles, and learning is stronger because the brain will work hard to make connections.

Simplification of concepts is another characteristic of the brain identified by Ramachandran. Of course, this has implications for the choice of images for comics, and it guided our comic-strip version of the digital story *Cheese or Ham?*: in order to engage the brain of the learner and leave room for interconnections to consolidate learning, incongruous elements that cannot be made sense of needed to be edited out. ■

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Here's your sandwich love - you can have cheese or ham ...

CHEESE OR HAM?

... ham or cheese, cheese or ham ...

What'll it be? Ham or CHEEEESE ...

Come on, which one do you fancy?

Cheese or HAAAM?

'I'll have CRAB please!' she said ...

COMICS, CROSS-MEDIA & MENTAL HEALTH

Matthew Green interviews Ravi Thornton

MG: What role do you see for art, and specifically for comics, in the process of healing and recovery?

RT: I see a growing role. Talking about health, healing and recovery via the voice of artists has proved an effective way of communicating difficult medical health messages – mental health, trauma and abuse, for example – in ways that are more accessible to patients and their families, to healthcare professionals, and to the general population.

The interest in this interface is becoming more widely explored and exposed, as indicated by organisations like Medicine Unboxed, who offer a substantial Creative Prize. In many ways comics are flying the flag, lifting this interface beyond art, through storytelling, to widely- and commercially-distributed personal connections. Comics such as Art Spiegelman's *Maus* and Bryan Talbot's *The Tale of One Bad Rat* have sold in huge numbers and been translated into a vast array of different languages. This popularity speaks volumes, but also telling is the fact that such books are cropping up on medical training reading lists, have been themselves the subject of medical research, and are featuring in prominent medical forums. *The Lancet Psychiatry*, for example, actually approached the publishing collective, Ziggy's Wish, to review *HOAX Psychosis Blues* in their October 2014 issue.

MG: Your project, *HOAX*, focuses on your brother Rob's ultimately fatal struggle with schizophrenia. The project itself combines the dark musical stage performance, *HOAX My Lonely Heart*, with the graphic novel, *HOAX Psychosis Blues*, making it a collaborative work involving at its core a composer, producer, director, ten different artists and myself as an academic. The musical introduces the early effects of Rob's mental illness through the medium of a tragic love story in which you reconstruct the growth and dissolution of his relationship with a woman, Helen, who was to have a lasting impact on him. The graphic novel, meanwhile, uses Rob's own poetry as the basis for a series of chapters that communicate various mental states he experienced after his diagnosis. Whereas your earlier work, *The Tale of Brin & Bent and Minno Marylebone*, uses metaphor to externalise your own psychological state following a brutal rape, *HOAX* attempts the even more complicated task of representing the subjective position of someone else. Though the chapters in *Psychosis Blues* are tied together with narrative interludes focused through your own perspective, and though Rob was a close family member, the process of imagining things from his perspective must have had certain challenges, especially in view of the collaborative nature of the project. How did

you go about negotiating the demands of honouring Rob and staying true to his memory while also producing a work of art rather than a straightforward biography or anthology of his poetry?

RT: The first thing I did was wait. I waited a number of years after Rob's death until I was sure I could go back to his poetry – his words, thoughts, the times and writing that we'd shared during the years of his illness – with true objectivity. Then, when I did go back, I spent time with the memories elicited, and treated those memories like a medium itself. Having not just one medium – poetry – but now two, I had my starting point to build a cross-media project.

As a cross-media writer, I construct narrative systems using a specific medium to tell specific parts of a story in specific ways, with an understanding of both passive and participatory audience behaviours. With *HOAX*, I had to balance telling the story of a young man with telling the story of a man suffering mental health difficulties. Only if I achieved the former would I be able to elicit the feelings of empathy around mental health that was my intention. Cross-media methodologies allowed me a very effective approach to finding this balance.

Similarly, it's the intuitiveness of the systems inherent in cross-media writing that allows for such true collaborations. The message – Rob's story, in this case – is written into the system. It can be thought of as an emotional architecture, and the collaborators provide the moods, manifestations, embodiments and provocations that then populate the system. The architecture puts together these various interpretations into a whole, and the result is a very effective, polyphonic amplification of the original message, made accessible on and in a multitude of levels.

MG: While your writing presents itself first and foremost as art, you are currently exploring ways that this work, and in particular *HOAX*, can be used to intervene in positive ways in the lives of those affected by mental illness. Can you describe your thoughts on the ability, maybe even the responsibility, of writers to intervene in the lives of their readers?

RT: *HOAX* has now extended its collaborative reach to work directly with mental health researchers and service-users in its next stage of development: touring, wider reach, and practical application. In particular we'll be investigating the effectiveness of a cross-media approach to anti-stigma messaging in the early intervention of psychosis. It's a very thrilling development in direction for me.

However, I didn't set out with this kind of collaboration, or level of responsibility, in mind. Of course I had a keen awareness of audience vulnerability, care and risk whilst building the HOAX project, but that's really about as far as I had thought responsibility through. And yes, I do believe you have a responsibility to build audience-care into your works, if those works could potentially be damaging to someone.

But this new level of ability and responsibility developing around HOAX has resulted purely from the feedback of those who have engaged with the project. Since launching in June 2014, the feedback provided about the effects of HOAX on people's feelings around mental health after their experience has suggested positive influence. As a result I do now feel a responsibility to do something with the evident power that projects like HOAX have to effect social change. ■



Ravi Thornton is a multi-award-winning cross-media writer from Manchester. She has been spearheading the HOAX project since August 2012.

Matthew Green is Associate Professor of English Literature at the University of Nottingham. He has published numerous books and articles on comics, culture, and the artistic legacy of William Blake.

Image: 'Of Zeus and Leda' by Rhiana Jade

DREAMS OF THE ENDLESS

Despair, delirium & representations of mental health

by Sasha Garwood

In the late 90s, I was a teenage goth. I was also (in no particular order): bookish, intense, crazy in various ways, a slightly manic pixie dream girl, and infinitely susceptible to narrative and tall, thin, tormented boys with messy hair and too much eyeliner. As such, it's possibly unsurprising that Neil Gaiman's epic *Sandman* series (which came to a sort-of end in 1996) was and is absolutely seminal in forming my sense of the stories we use to shape ourselves and our fragile, limited, contextual definition of sanity.

It would take far more than my allotted thousand words to summarise the whole *Sandman* story arc, so I won't try (although Gaiman's summary: 'The Lord of Dreams learns that sometimes one must change or die, and makes his decision,' has much to recommend it). It's probably sufficient to explain that Gaiman weaves an impressive selection of world mythology around seven personified aspects of human existence known as The Endless; they are (in order of age) Destiny, Death, Dream, Destruction, the twins Desire and Despair, and the youngest, Delirium (who was once Delight).

Whilst the series focuses on Dream, the eponymous Sandman, the others and their worlds recur, collide, counterpose, and frequently cause trouble. With the exception of an unexpected, deliciously cheery Death and (tellingly) the renegade Destruction, none of The Endless are particularly notable, in human terms, for their well-adjusted natures. But it's Despair and Delirium, who after all pretty much personify human madness between them, where shit gets real.

Or unreal, maybe. It's central to the concept of the novels to remember that although The Endless may look and speak (to us) like they're human, they're really not. With the arguable exception of Death, they behave the way they do because of what, not who, they are.

(An example: we first meet the family at a meeting called by Destiny, where Desire creates candles to kill Delirium's hovering butterflies, and Death gathers them, glowing, to herself, and Dream learns, alongside the rest of us, that performing one's function isn't much of an excuse for being a dick.)

The Endless both embody and inhabit their functions.

Despair is short and squat, always naked, with grey skin and jagged, crooked, unexpectedly brutal teeth. She wears her sigil, a hooked ring, on her finger. Primarily, perhaps, for catching into people's hearts, but the scene where she distracts herself from grief for her lost brother by pushing it into her eye and ripping remains one of the most vivid and disturbing representations of emotional pain I've ever read.

(There is another essay to be written about Despair and self-harm as articulation; but this is not it.) Despair's realm is grey and misty and leached of all form and colour, hung with empty frames, each of which corresponds to a mirror in our world. Despair appears only rarely in the main narrative arc, and when she does it is mostly to collude with Desire (irony decidedly intentional) or to remember. 'Death or life will take him from your minds,' she says at Dream's funeral, 'but I shall remember him.' The Gaiman/Barron Storey/Dave McKean short story *Fifteen Portraits of Despair*, in the 2003 *Endless Nights* collection, does exactly what it says on the tin, not just in representing Gaiman's character, but in conveying her meaning. 'When the eyes that look back at you know you too well, and no longer care for what they see, they are her eyes.' Despair isn't depression, exactly, but *Fifteen Portraits* vividly and disturbingly recreates the sense in which depression sucks everything into itself and becomes the numb meaningless everything you breathe and see and feel. 'Take away the despair and there is nothing left.' Infinitely the most disturbing vignette is the depressed woman who commits suicide – 'You'd think she'd have everything to live for,' says the patrolwoman who finds her body – and awakens by the side of the road 'all bodiless and afraid, waiting for the happiness to start.'

Delirium, on the other hand, is a small adolescent girl – forever! Like that wouldn't drive anyone mad! – ripped teenage punk clothes, shaven, ginger-multi-coloured hair, semi-nonsensical rainbow words. She's childlike, a vein of damage at the core, pain and confusion seeping from beneath her fractured surface; she is everyone's lost innocence, after all. But she's also the most affection-driven of the siblings. It's Delirium who, in *Brief Lives*, co-opts Dream into helping her find the absconded Destruction, thus precipitating his own tumultuous demise; it's Delirium to whom Destruction gives his dog Barnabas as memento and guardian, recognising his sister's inability to cope and his own inability to help her. I once had a very polite disagreement with a respected friend at a conference over whether Delirium constitutes a Manic Pixie Dream Girl, and is therefore a black mark against Gaiman's characterisation. Leaving aside the facts that a) the concept of MPDG was fifteen years away from creation at the time Gaiman was writing, and b) involves a woman existing exclusively in romantic relation to a man in terms entirely inapplicable here, it left me angrier than maybe was reasonable. Partly because Delirium explicitly isn't human, and partly because, growing up, she was me.

It helps that I resemble her physically. Delirium has been my default cosplay since before ‘cosplay’ was a thing and disparaging terms like ‘dressing up’ and ‘fancy dress’ were used. But this runs deeper. With my inconvenient emotional needs and profound inability to make sense of the world, I identified with her passionately, and occasionally, obsessively. I was an awkwardly intense, uncomfortably intelligent, sensitive and troubled teenager – and Gaiman gave me a world where Delirium and her crazy were voice and power, necessary and human, as much part of the world as the wise and kindly Death. Delirium – and Despair, come to that - manifested the dark elements of the human psyche I sometimes felt condemned to: and

there they were, existing and functioning and very much themselves. Between them, Delirium and The Endless gave me and my myriad crazies the right to exist, and I would be a profoundly different (and more tormented) person if I’d never encountered them.

But then, the stories we take into ourselves undoubtedly shape us. Years after I discovered the *Sandman* series, I ended up in intensive care in starvation psychosis. Asked afterwards to describe it, I pointed to the chapter of *Season of Mists*, where a character wakes from nightmare into nightmare for ‘seventy-five years. But it felt like longer.’ I remember thinking, somewhere in the back of my fractured mind, about Delirium. ■

AFTER DEPRESSO

or How I learned to do something useful with being bonkers

by Brick

In 2010, Knockabout published what they call a ‘graphic novel’ entitled *Depresso*. The clue to its content was in the title, underlined with the byeline: *or How I Learned to Stop Worrying and Embrace Being Bonkers!* It wasn’t the first comic book about mental distress, but maybe it was the first to proffer a critique of the UK’s mental health services and dare to be funny about ‘the illness’, about sufferers and about the professionals.

The book received rave reviews from the critics and it was short-listed for a number of underwhelming book-of-the-year awards, but *Depresso* was never conceived as a consumable for the reading public. It was only ever an exercise in keeping track of the bizarre world I journeyed through during my recovery from serial breakdowns (as the trade called them). Some keep diaries, and a couple of fellow-travellers had trusted me sufficiently to show me theirs. I couldn’t do that stream-of-consciousness thing without the editor in me wanting to kick-in. Besides, some things could only be portrayed in pictures rather than prose.

I wrote the script day-by-day, while madness piled upon madness as I crawled on all fours through the system. I wrote it on buses, park benches, toilets, walks, and while waiting for my jackbooted shrink (I kid you not) to call, “John!” In the evening I tried to make sense of the scrawl, ready to bolt myself to the drawing-board the next morning. The drawing-board was my only refuge during those dark days, the only place I was at peace with myself. I cared less if the world imploded. I was drawing, and by teatime could look at something that told me I existed and was as sane as we come.

Over a hundred pages in, it struck me I could be saying something that might reassure others, if not lighten their sadness. I filled-in gaps, dragged my back-story from

the medicated mush that was now my brain, threw in an outrage of potted mental health history, and spent months trying to shape order out of the chaos. I finally gave up. “It is what it is,” was my passing comment as I handed the printout to a friend in the comics trade. He read it at one sitting and said, “Wow!”

It all happened rather too quickly after that. I was still very much in recovery, forced to cope with book launches, pressing flesh, feigning interest, sitting on panels, suffering the weasely literati. But then the emails and missives from readers began drifting through cable and letterbox. The very first I read was so humbling in its praise and gratitude that it made me cry. I was pleased I had gone public. Four years on, I still receive a trickle, and continue to be delighted that the message most seem to take from *Depresso* is simply ‘I will survive’. And all found a laugh somewhere in the book. Good enough.

Meantime ... while I was shuffling in pursuit of order, I bumped into an old pal I used to do aerobics with, eons ago. He was now running some kind of ‘service user’ mental health organisation. I told him about my struggle to find any kind of local support group, outside of the totally disheartening Depressives Anonymous. Rightly so, there were plenty of mental health groups focused on minorities, women, LGBT, and dual diagnosis bods, but a white male heterosexual needed to jump a bus from the city to a distant town to find MIND, for example. Perhaps detecting a potential ‘Glad to be Mad’ conscript, he reeled me in to work with his organization, sponsored by Nottingham University, called Making Waves.

Making Waves is a ‘social firm’ staffed and facilitated by members who all have experience of mental distress. Aside from undertaking research, hospital visits and

service evaluation, the bulk of their work is in providing experiential narratives to mostly mature university students on either mental health nursing or social work courses. I was a mental distress rookie, knew precious little about how the system worked (nobody tells you) and didn't even have the language (I thought I was a 'patient', durrr!). But I was comforted to discover that, to a person, the team I joined not only challenged the stigma we all experience but also the twisted logic of the mental health care services the students would end up working in or with.

More than just a ragbag of nutters who filed into a classroom to deliver tales of woe at the hands of The System, Making Waves trained us to deliver a handful of specific sessions that dovetailed into the university's curricula. All were extremely interactive and drew heavily on the personal experiences of both deliverers and the students. Participation in Nurse Education (PINE) sessions promoted alternatives to mainstream psychiatric thinking, and were close to every Making Waver's heart. POTNOT (Professionals On Tap, Not On Top) adapted the 'Circle of Abuse' to explore how professional practice can be refocused to put the patient's needs at the centre, even within the current Cinderella service.

There were other courses, not least Drink'n'-Drugs'n'Rock-Bottom Blues (!), and spin-off projects I became involved in, such as a Life Story Resource and Recovery film. But after a couple of years of repeating my story, I started to tire of the role and questioned whether I wasn't living too much in the past, or even (horror of horrors!) rapidly becoming a mental health professional. Around the same time I fell victim to Atos, who decided that, because I made it down to the assessment without internally combusting, I must be a sponger. I departed Making Waves with some sadness.

The work had been fulfilling, and hugely beneficial for students who had never considered how other cultures cope with mental distress, for example, or questioned the premise of the DSMMD (Diagnostic and Statistical Manual of Mental Disorders). A number collared us to talk privately about their personal parlous mental or emotional states, and we were open to that. More importantly for my own wellbeing, I was going to miss being around people who were kind, sensitive, imaginative and thoroughly encouraging to me and each other – a rare support team to have on one's recovery journey.

I returned to my first love of cartooning with trepidation, aware that the world had moved on, and the chances of picking up commissions where I left off were pretty remote. Editors expect, even like, their satirists to be a little crazy, but medically certified is one step beyond. Since I work from home, like most in this business, there was also the double-edged sword of the isolation of the job to cope with, and the ease with which bad news (is there ever any other?) could spiral me down. As it happened, the body blow came from an unexpected quarter.

I was shocked to discover *Depresso* had not been well received by the UK's comics community. Its strength as a 'graphic memoir' was under question, because it was

the story of Tom Freeman and not Brick, or even the man behind the pseudonym. Its artistic merit was condemned, because I used Photoshop and a plethora of found images. And on a popular comics blog, one GP-cum-creator disputed whether the book's stated reason for my first breakdown (a lifetime spent drawing political cartoons about emotionally upsetting issues like AIDS, famine, poverty, war) could ever induce a breakdown. Or was it simply me they didn't like?

During the launch period I had challenged a number of fellow creators about their mainstream and somewhat reactionary attitudes to mental distress, as expressed either in their own recently published 'graphic memoir', works in progress or on public platforms. This was uncool, I was discovering, as was being old and extremely experienced in the art of combining words and pictures sequentially. Invitations to comic festivals promoting other creators of 'graphic memoirs' did not arrive, and opportunities to share thirty-five years of wisdom at forums and events 'focused on comic works based on life narratives' never appeared.

I had ruffled some powerful feathers in my trade. Rather than cresting on the public success of *Depresso*, I found myself sliding inexorably back into the dungeon, this at a time when I had to erect fences and dig ditches to earn a crust. F'sure, I am opinionated and can be abrasive around bullshit, but it was a killer to find the rug yanked away at precisely the time I needed the confidence to return to what I do best. It took six months, but applying everything learned while working with Making Waves, I steadily hauled myself out of the quagmire and regrouped.

Ironically, I created Tom Freeman to protect myself from what befell me anyway. Had *Depresso* been in the first person singular, maybe I would have become a hero of the chattering classes, as some of my contemporaries have become. I have never trusted what I call the Angela's Ashes School of Autobiography, less for the narrative (though there be dragons), more for what the media circus does to the creator. To successfully surf that wave, you need a whole lot of front a depressive like me simply doesn't possess, so be warned. If you are contemplating a confessional comic, anonymity is a wonderful thing.

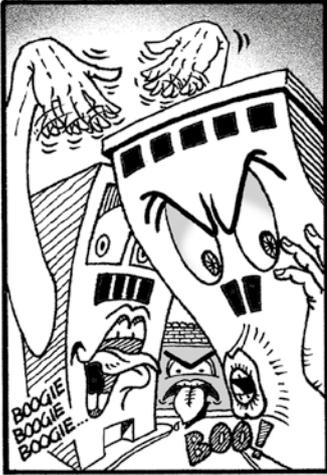
I now lead as quiet a life as the need to turn a buck allows. Still devoted to comics and cartoons and the sanctuary of my drawing-board, I would rather take my Border Collie for a walk on the wild side than strive for recognition amongst my peers and public. I am broke but rich in skills, imagination and desires. And I have a new book out, so life is sweet. ■

Brick (aka John Stuart Clark) is a professional cartoonist, comics creator and writer who has had good and bad experiences at the hands of the psychiatric services. His latest book is a graphic anthology of WW1 short stories: *To End All Wars* (Soaring Penguin Press, 2014). He shuns meds in favour of Beethoven. Visit his website: www.brickbats.co.uk

A DOG IS FOR



The city spooked me...



the people terrified me...



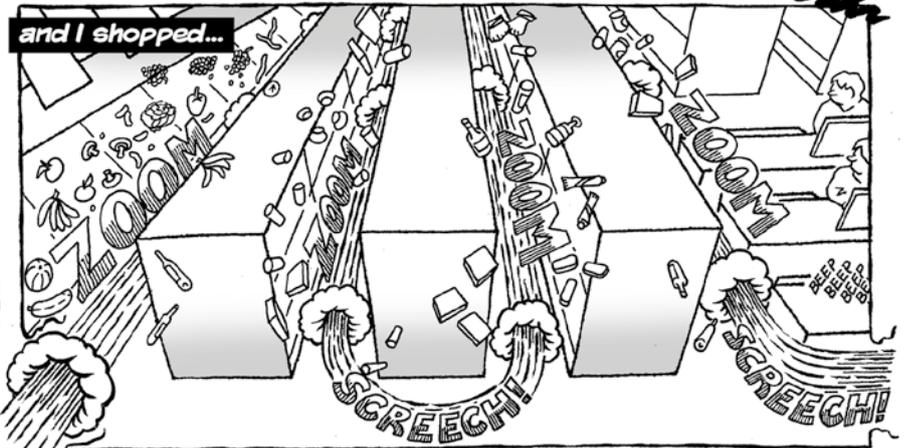
and those damn pigeons...



Okay, I kept appointments with my shrink...



and I shopped...

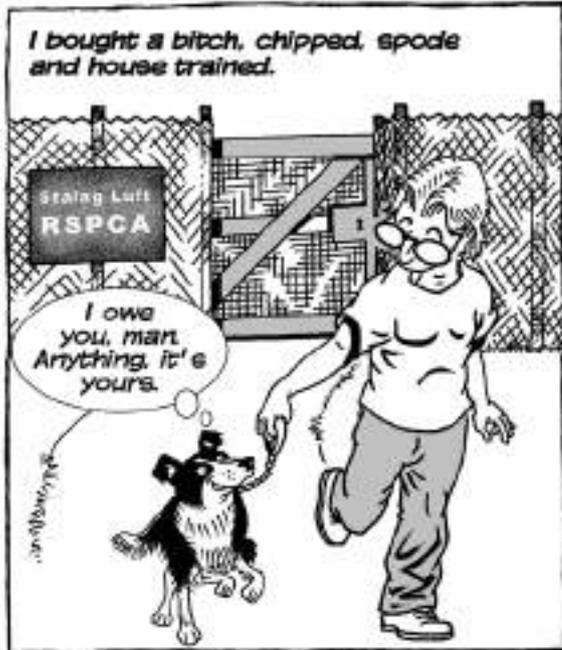


but mostly I was, well...



Then a pal (yep, still had one) suggested...





'... Rorschach. He's sick in his mind.'

Katherine Hubbard

Hermann Rorschach developed his inkblot test in 1921, and by the 1950s and 1960s it was the most popular psychological test in the USA.

But the Rorschach is no longer just a test; it is also a vigilante crime-fighter. In Alan Moore and Dave Gibbons' graphic novel *Watchmen* (1987), Walter Kovacs becomes 'Rorschach', an inkblot-masked superhero with an 'unhealthy fantasy personality'. In writing and drawing Rorschach – blots and all – Moore and Gibbons contributed to the history of the Rorschach in a very important way. Throughout the novel there are clear references to psychology, mental health and to the Rorschach test itself. Here I illustrate the ways in which the Rorschach is depicted in *Watchmen* and highlight the character's interactions with psychiatry.

The association with Rorschach and mental illness within *Watchmen* is clear. His decision-making is described by other characters as 'crazy', and he is considered both withdrawn and depressed. Besides being diagnosed with an 'unhealthy fantasy personality', he is said to have been 'conditioned with a negative world view'. Perhaps the most common theme throughout the novel is Rorschach's paranoia. This is especially emphasised by his mask.

The inkblot mask, or as Rorschach himself describes it, his 'face', is 'all that's necessary ... All [he] needs.' Interestingly, within the psychological literature, to 'see' a mask in a Rorschach blot was considered a sign of paranoia. In turn, paranoia was also viewed as an indicator of homosexuality (until 1973, classified as a mental illness). Unlike other superheroes whose masks represent temporary person to persona shifts, Rorschach describes becoming Rorschach permanently: he is no longer Walter, and responds at his bail hearing only when referred to as 'Rorschach'.

The explanation Rorschach provides for this shift of identity is that he responded to the death of a young woman named Kitty Genovese. Her death, and the witnesses who apparently did nothing to help her, has become a parable within Psychology. This is because Kitty is not just a character in *Watchmen*, but a real woman who was raped and murdered in New York in 1964. Her murder not only inspired Rorschach in *Watchmen* but also inspired psychologists' research into what is now known as 'the bystander effect'. In *Watchmen*, Rorschach reports that: 'Almost 40 neighbours heard screams, nobody did anything. Nobody called cops. Some of them even watched.' The true story of Kitty has since been somewhat more reliably revealed; however, importantly it is this parable-telling which inspires Rorschach. In the novel, it is also from her dress that Rorschach makes the mask,

or what later becomes his 'face'. The dress is said to have been designed for Kitty at a fabric factory where Rorschach worked; it is black and white and moves without the colour bleeding, giving an array of different inkblot effects.

This explanation for Rorschach's motives, and his shift of identity is positioned within the graphic novel while he is incarcerated and in discussion with a psychiatrist, Malcolm Long. In this sequence, Rorschach does the famous inkblot test. Initially, Rorschach deliberately tricks the psychiatrist into believing he sees more positive images within the ambiguous blots. When the psychiatrist asks: 'What can you see?' Rorschach replies: 'a pretty butterfly' and 'some nice flowers'. Later it emerges that Rorschach really sees much more disturbing images, and what Rorschach tells the doctor goes on to impact him irreversibly. Rorschach, on the other hand, appears quite untroubled by the therapeutic encounter. But he is critical of the motives of the psychiatrist, saying: 'Other people down in the cells. Behaviour more extreme than mine ... But then, they're not famous. Won't get your name in the journals. You don't want to make me well. Just want to know what makes me sick.'



Rorschach's ambivalent attitude towards the test is revealing since some of Rorschach's actions mirror certain characteristics of the actual inkblot test. For example, Rorschach becomes a vigilante crime-fighter due to failed ethical systems within an American city that 'reeks of fornication and bad consciences'. Similarly, the Rorschach test became popular in America due to the lack of successful tests available for the screenings of officers in the Second World War. Therefore, both have good initial intentions which are responsive to others' failings. However both are viewed as invalid, unreliable, and potentially dangerous.

Importantly, both the test and Rorschach (the character) are considered to have questionable ethics with little evidence for their claims. Central to Rorschach's ethical outlook is that he only sees things in black and white - much like five of the original Rorschach blots. When faced with the ultimate ethical dilemma, at the end of the novel, Rorschach refuses to keep quiet about the evil that had unfolded. When pleaded with, Rorschach replies: 'No.

Not even in the face of Armageddon. Never compromise.' And his mantra is: 'Evil must be punished.' Eventually his commitment to the truth is what gets Rorschach killed. Nevertheless, the great revelation at the end of the novel, which confirms that Rorschach's supposedly groundless suspicions were in fact correct all along, indicates that he was never truly paranoid or 'crazy'. Rorschach's commitment to telling the truth echoes the historical belief that the Rorschach test did work as a way of revealing a person's true unconscious personality.

In *Watchmen*, the Rorschach test is depicted in ways which reflect common beliefs about the test, and to some extent the history of the test itself. Rorschach is also presented as having some mental health problems, though

these are later questioned. In all, Moore and Gibbons provide an account of the Rorschach which includes many aspects of psychology and mental health. Essentially, they personified a psychological test and transformed it into a masked vigilante. In doing so, we are left with the realisation that despite continuous difficulties with psychiatry, Rorschach still identifies with the test. And it is this juxtaposition which makes the character and the comic so compelling. ■

Katherine Hubbard is currently at the University of Surrey, doing a PhD on the history of the Rorschach in Britain. If you have any experience of being tested using the Rorschach, and would be interested in being interviewed about your experience, please email: k.a.hubbard@surrey.ac.uk

THE AUTISTIC RIGHTS MOVEMENT UK (ARM UK)

THE NATIONAL AUTISTIC PEOPLE'S ORGANISATION

In 2002 our Government signed up to the Madrid Declaration: **NOTHING ABOUT DISABLED PEOPLE WITHOUT DISABLED PEOPLE**. And in 2009 the Government signed the UN Convention on the Rights of Persons with Disabilities. Article 4.3 states: "In decision-making processes concerning issues relating to persons with disabilities, [Governments and their departments] shall closely consult and actively involve persons with disabilities, including children with disabilities, through their representative organisations."

Successive Governments have failed to understand (or wilfully refused to understand) the importance of disabled people's organisations (DPOs) – organisations of disabled people not **for** them. The UK's National Autism Programme Board has been meeting since 2010, and **there is still no involvement of the autistic community**.

The Dept of Health says its 'Strategy for Adults with Autism in England' was developed "using the core principles of inclusivity and co-production, with extensive public consultation." This is simply not true. "Consultation" was only a broad survey of opinions about autism, and no proposals or draft versions of the Strategy were submitted for public consideration or consultation.

In 2010, when the Strategy was implemented, the DoH said: "Organisations that represent adults with autism have been invited to join the national Adult Autism Strategy Programme Board." This is also untrue. The only voluntary sector organisation invited was the National Autistic Society (NAS), and out of its 17,400 members, less than 500 identify themselves as autistic – the great majority are parents. Later in 2010, two autistic people and two carers were appointed to the AASP Board. This is tokenism: they represent no one but themselves, and the public has no clear way of contacting or lobbying them.



The Autism Strategy, as currently written and implemented, is making no significant improvements to services: levels of unmet need remain massive. **The Autism Strategy is something we didn't ask for being imposed on us without our consent.** But with the appropriate involvement of autistic people, carers and the voluntary sector it could be transformed into a blueprint for a better future.

From No.7 in the ARM UK 'Need to Know' series, March 2012

BRISTOL AUTISTIC VOICE/RIGHTS GROUP involves people identifying as autistic who would like their voices to be included in strategies, planning and decisions about their lives. At our meetings we discuss and listen to each other's needs. We send representatives to decision-making meetings to ensure autistic people are represented, included, consulted and listened to. We welcome the participation of individuals, advocate services and anyone who senses a common cause with us.

What are your thoughts? Your issues? Do you have skills you could contribute? Where and when would you like to meet?

Contact: James **07895541872**
or jamesdeane@myway.com

Contact ARM UK for information about a group near you, or for help with setting up a local group.

www.autisticrightsmovementuk.org
info.armuk@googlemail.com
t: 0191 259 6384 m: 0774 234 7384

VALIDATION OR INVALIDATION: To Be or not to Be?

Mark Bertram

Validation: Demonstrate or support the truth or value of (OED)

Invalidation: Invalidat - annulled annulare + nullam - nothing (OED)

Introduction

The concepts of validation and invalidation have been around a long time in the world of mental health. Thirty-five years ago Jo Berke (1979) was saying:

‘The problem remains how to develop forms of social organisation and activity that are validating ... My hope is that by a multiplicity of effort people can respond ...’*

The problem still remains. I haven’t seen, heard or read anything about the concept of validation or invalidation being developed. In terms of the literature, theory or practice, it seems to have dropped off the radar. The purpose of this brief article is to begin raising awareness by reiterating how important validation and invalidation are.

Validation and Invalidation

How we are perceived and treated will determine the extent of validation or invalidation we experience. This is a clear and simple proposition. For most people, being greeted with a warm friendly smile is going to feel better than a slap in the face. The following are examples of validation or invalidation in important areas of living:

Validating = promoting wellbeing	Invalidating = creating distress
Somewhere to dwell: safe, warm and peaceful.	Nowhere to dwell: homeless, incarcerated or noisy and unsafe.
Something to do: employment, hobbies, fun things to do, and achieving personal goals.	Nothing to do: boredom, frustration and no fun; easy to slide into apathy and lose confidence and hope.
Someone to love: personal and social relationships, friends and networks.	No one to love: isolated and alienated.
Economic inclusion: enough income to thrive. You can have nice choices.	Economic exclusion: not enough income to survive. Hard choices to be made, like eat or heat.
Accepted: as a citizen in society with rights and responsibilities.	Stigmatised: rejection and discrimination.
Healthy communication: heard and understood. What happened to you? How are you feeling?	Unhealthy communication: Judged, ignored and talked at; told what to do. What’s wrong with you?

Few people would disagree with these examples: they make sense. However, if we apply the validation/

invalidation perspective to the mental health field, a lot of disagreement emerges. The main bone of contention is how people are perceived and treated in mental health systems. Based on my experience here are some examples:

Validating	Invalidating
Extreme emotional distress and problems of living stem from understandable causes – usually social inequalities, trauma events or oppressions: living in extreme poverty, being abused, neglected, or any intolerable experiences that overwhelm people’s ability to cope.	Thoughts, feelings and actions are the product of chemical interactions in the brain. ‘Dysfunction’ emerges due to a brain disorder that can be diagnosed and treated with psychiatric medication.
Painful and extreme feelings and thoughts are expressed, acknowledged and validated by a trusted listener. They then tend to diminish.	Painful and extreme feelings and thoughts are observed by medical staff as ‘symptoms’, to be suppressed and medicated away.
Access and support with activities that promote enjoyment, learning, confidence-building and the achievement of personal and vocational goals in mainstream society.	A primary focus on medication-monitoring and risk-management. A slim chance of referral to a mental health-specific organisation. Staff generally have low expectations about employability.
People in crisis ask for care and support in friendly, homelike settings that feel safe (internally and externally), with an emphasis on non-coercion, validation and integration.	People get sectioned and treated in locked acute wards. Staff undertake observation, to record the effectiveness of the medication. Compulsory treatment can involve restraint and enforced medication.
Many service users report knowing better than anyone else what is helpful for them. This is never ‘standard’ because different things help people at different times on their individual journeys.	Psychiatric staff are the experts in mental health care and are responsible as professional clinicians. Treatment is standardised.

The striking thing about looking at mental health care through this validation/invalidation perspective is that the care and support people ask for is often exactly opposite to what they receive. In my experience, people say they want to be in a safe space, and heard, understood and validated. And yet they often get told what to do (they must be compliant), or are even forcibly subjected to treatment in a stressful institutional environment.

So there is a problem: in what other service industry would it be acceptable to provide the opposite of what the customer wants? Imagine hiring a decorator and telling him you want your room painted white, but he paints it black, and you still have to pay the bill. How about going to a clothes shop, to be told they will only sell you lawnmowers? How would you feel if your dentist said: ‘By the way, I’m going to do a bit of physiotherapy on you’?

And so a key question in mental health provision is: to what extent does current theory and practice validate or invalidate people?

One example I encountered was at a friend’s psychiatric assessment. She asked me to be present for support. During the assessment the consultant psychiatrist said:

‘Don’t worry, all of your thoughts, feelings and actions are the product of a chemical imbalance in your brain and we can give you medication, so it will be alright.’

But it wasn’t alright. Far from it, my friend looked very confused and scared.

I said to the doctor: ‘I don’t think that was a helpful thing to say. There are a lot of assumptions in what you just stated.’

He replied: ‘You are not a medically qualified professional. Just let me do my job and treat the illness.’

My friend started to get angry and bewildered. The doctor left the room saying:

‘I’ll come back later – don’t worry.’

In my experience, the quality of engagement with people in the here and now is simply everything. Different types of communication will either validate or invalidate. So when someone tells you not to feel what you are feeling, that is always invalidating.

For example: ‘Don’t be angry, don’t cry, don’t be anxious, don’t be sad – stop being so emotional.’ People may also say it is all right, when it isn’t. It’s easy to end up feeling there is something fundamentally wrong with feeling what we feel.

Some further examples of invalidation that most people can relate to are:

Being undermined	‘You have got everything wrong. You just don’t understand what is going on. I knew you were going to say that.’
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Being guilt-tripped	‘Can’t you think of anyone but yourself? It’s your fault. You are making life hell. What is wrong with you?’
Being isolated and ridiculed	‘Typical. Only you feel like that. You’re weird/stupid.’
Being rejected	‘I hate you for doing/thinking/feeling/saying that. I’m leaving you/fuck off!’
Being labelled	‘You are mad/crazy/irrational/mentally ill.’
Being threatened	‘If you say/do that again I will hit/hurt/kill you.’
Being done to	You get abused or attacked; somehow you are blamed as ‘the problem’.
Being blamed	‘What is wrong with you? What is your problem?’
Being told you should	‘Just get over it/be happy/pull yourself together/not say that/not look at me like that/not do that/not be like that.’

The obvious antidote to invalidation is validation. People say that feeling safe, internally and externally, helps them begin the process of learning, change and growth. Safety emerges from building a trusting relationship in which people are listened to, accepted for all of who they are, and all of their experiences are heard and validated. It is essential that people explore, define and develop their own pathway through their distress – on their own terms – rather than being told what to do. In my experience, self-developed insight can be learnt, but not taught. Emotions need to be registered and worked through – not interfered with. People have to find their own way. Rather than focusing on what is ‘wrong’ with them, it is crucial to find out what happened to people and what they want to do. Anyway, how can a personal experience ever be wrong?

Conclusion

Invalidation can be slow and erosive over time or it can impact quickly, e.g. through being subjected to a highly traumatic event. In my experience, the extent of personal and social invalidation is relative to the extent of the distress, e.g. from mild invalidation such as non-verbal disapproval (eye-ball rolling, or side-to-side head-shaking) to extreme invalidation, such as being assaulted or abused. Those kinds of traumatic experiences can break hearts and minds. To improve wellbeing, it is crucial we develop approaches that resonate with what people say works for them. Validation creates the possibility of

learning, change and growth. How people are perceived and treated is simply everything.

The natural conclusion is that theory and practice in the mental health field ought to validate people's life experiences. But do they at the moment?

As it stands, there is so much disagreement in the mental health field about what constitutes effective care and treatment. One way of trying to resolve this could stem from co-producing and using a validation/

invalidation framework to guide the future development and facilitation of effective approaches. ■

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* Berke, J. (1979) *I Haven't Had To Go Mad Here*. London: Pelican Books.

SUPERTANKER ON A SIXPENCE

Adrian Kenton

Author of

Four Jammy Biscuits Saved My Life Today
(How to NOT kill yourself)

'Is there anything good about mental illness? We're told not. It's all negative, and negative is bad. The End.'

Off-radar

The Torrey Canyon supertanker was built to carry 60,000 tons of oil. It was later enlarged to a capacity of 120,000, the amount it was carrying when it hit a reef off Cornwall in 1967. Salvage crews repeatedly tried to save the vessel, but failed. In the end the RAF bombed it. The inquiry pinned blame on the captain, who had tried to take a 'short cut'.

The UK populace is in the grip of personal siege mentality as a direct result of short-cuts when, prior to this demise, a recorded one-quarter of them suffered from mental health issues. With the mental health system sinking under the increased load, official policy turns to 'every man for himself'. Many are jumping overboard and, as yet, no one is compiling a body-count. Include collateral damage, and nearly everybody feels like they're being dragged under. This is no accident. It is sabotage.

The 'supertanker' analogy to mental health provision attests to an imposed reality only lazy-minded self-congratulating abusers are satisfied with. The perception is that there is no alternative that would not be more expensive and unattainable. This is a fallacy and symptomatic of a deceptive mental illness, a pre-meditated form of collective self-abuse.

Frankenst-ine

We restrict horror
to fantasy, so we can feel
disturbed, safely
while making lethal monsters
of those around us
and ourselves, then
never want to face them.

Lack of investment in responding to the biggest sector of illness in the country is a betrayal of human nature under its gravest duress. Insane. With so many dedicated, skilled practitioners, why is it so difficult to turn this ship around?

About-face

The main reason ... a revolution in mental health ... is needed? In 2003 I asked members of a depression mutual support group – some of them long-term sufferers and very perceptive people – 'Have you ever considered that there might be anything good about depression, anxiety, trauma and distress?'

The looks I got ranged from 'are you being real?' to betrayal, to 'oh, god ... don't make us go there,' to apoplexy. The most significant thing about their reactions was that this idea had never occurred to them: they had never been encouraged to explore this question by any mental health professional.

The reason for this is because serious emotional distress and mental disorder is more excruciating and devastating than almost any other illness. No one in his or her 'right mind' would wish to go there, given the choice. 'The spirit of a man can put up with his malady, but, as for a stricken spirit who can bear it?' (Proverb)

We must make that choice easier, before it is taken from us?

'The antidote? Biscuits.'

Life-saver

Instead of throwing the mental health system a life-ring, how about a jam-ring? Seriously. This isn't the indigestible 'biscuit' the National Service Framework forced providers to choke on by co-opting service-user input. It is more direct and encompassing.

'Stood there, naked in my bathroom, ready for the final time to step into the clear warm water with a razor blade in my hand, I asked myself, "Is there nothing left, nothing at all, that I want?" No ... Nothing, was the answer.

'Em ... ehh ... that's weird ... actually, there was something else ... ehh ... I could eat a Jammie-dodger biscuit!'

This is bare fact. It doesn't convey the turmoil of life pitted against eating a biscuit; nor the unforeseen phenomenon that resolved this knife-edge; or more disturbingly, when no agony was involved but 'life or death?' was a decision as simple as: 'Tea or coffee?' With as little resistance.

You can dismiss this as flippant, a design, sensationalistic, or extreme. But it isn't and this is the entire point. I am not an extreme example.

If you allow yourself to dwell on it, to ask what's good about choosing between ending your life and eating a biscuit, it should help you reflect on the potency of your own decisions.

'Think about it ... End life/eat biscuit.'

I succeeded in addressing self-condemnation and other psychological intolerances, but the consequences of preferring death to life still plague me.

'This was just one of many suicidal periods ... I have experienced six different "types" of suicidal feelings over countless episodes ... I learned to resist or evade suicide over the years, since. Sometimes it was dependent on the flimsiest, most haphazard of interventions ...'

Four Jammy Biscuits Saved My Life Today is my account of this phenomenon, written over a period of fifteen years. It attempts to convey some of the dynamics similar sufferers are unable to revisit or recount, to get into proper perspective the factors that lead to such a pitiful state. The implications for healthcare and to the individual are shocking but astonishingly empowering. There is currently no accommodation of what I am talking about, practically and barely philosophically, within mental health practice. This constitutes part of the 'supertanker' mentality – not the mentality of the sufferers.

Foreign waters

From receptionist to chief executive, front-line emergencies to long-term palliative care, the biggest obstacle in supporting and treating mental illness is engagement. It involves acceptance of a common language. Not only the psychological language that has been analysed and theorised to death. A core human language of physicality as much as mentality and spirituality, but not in any prescribed sense. Most sufferers subconsciously understand this language, without any effort. Yet it isn't remotely understood by most non-sufferers, and it perplexes many eloquent 'experts' – mainly due to their not owning it.

Still, this language is essentially human and the only effective communication when instincts become primal. But how can you engage if you consider foreign the language that you encounter?

The resistance is as much physical as mental. It's a language people run from. It causes mental blocks and

imposes no-go areas, seemingly impregnable barriers that effectively mute people. It is distasteful and unnerving, because it undermines the staples that 'non-sufferers' depend upon. Hence, it encounters disbelief or a sense of subversion of the standards a person bases his 'sound' mentality on. Restraints on language are imposed on sufferers by social sensitivities and by the official services, and they are designed to protect those who are well. Yet everyone actually employs this language in their everyday life. 'It is why we get toilet-humour and Radiohead, even if we turn our noses up at them.'

In the UK, treatment largely sustains this polarity. Denial and dissociation are common reactions. So long as this language is circumvented as foreign, a misfiring of the one we are familiar with – a dyslexia at best – it scapegoats sufferers and excuses carers from addressing the realities to which they actually contribute. The result? Transference of historical misconceptions regarding 'strength' and 'weakness', 'positives' and 'negatives'. Precepts we are aware of, but do little to overturn. It's pathological.

Deflecting this common language compounds the depressive and traumatic illness in people who are dependent on the mentality of others. The mentality of the 'sane' perpetuates the illness in the sufferers. Asserting: 'We have rules, we're doing our best,' only incubates irresponsibility and condones abuse. It is the equivalent of Max Bialystock's response to Leo Bloom's simpering interjection in *The Producers*: 'SHUT UP! I'M HAVING A RHETORICAL CONVERSATION.'

Plimsoll-line

Bridging this chasm entails a re-evaluation of long established conventions, but contrived rationality remains the only language that support services, health practitioners and the general public rely on. In *Nostalghia*, Andrei Tarkovsky, one of the most cerebral movie makers, furnishes 'insane' Domenico with a suicidal discourse in which he asserts that society's demise can be halted only when the division between 'il patzo' and sane humanity is deconstructed. There is no distinction. Domenico's tragic and unnecessary sacrifice encapsulates the consequence of overwhelming fear and resistance.

According to one philosopher, we need not resistance, but insistence ... In *Welcome to the Desert of the Real*, Slavoj Žižek states '... The true choice apropos of historical traumas is not the one between remembering or forgetting them: traumas we are not ready or able to remember haunt us all the more forcefully. We should therefore accept the paradox that, in order to really forget an event, we must first summon up the strength to remember it properly. In order to account for this paradox, we should bear in mind that the opposite of existence is not non-existence, but insistence: that which does not exist continues to insist, striving for existence.'*

Instead of a valuable warning, this irresistible language amounts to babble. When fear should be the leveller – even the fear of the service-providers. The supertanker of ‘existence’ overrides, side-tracks, circumnavigates the ‘insistence’ of users’ real needs. It is a short-cut to – and transference of – gross denial.

What is needed is an institutional colonic irrigation and systematic re-examination of policy and practice from the perspective of experienced sufferers.

Safe passage (self-regard) through internal exploration depends upon eradicating stumbling blocks to recovery, or else every dedicated effort will hit the rocks. Outcomes, such as Domenico’s, are a direct consequence of that, not patient behaviour. But how many practitioners are going to re-evaluate the basis of their education and practices? When there is no pressing need, why should anyone of sound mind analyse for themselves the most painful issues? Why? Because that need can arise in a heartbeat. Because that need already exists in our coping and transference of personal issues and effects we are unaware of. Because care and dependency are not two sides of a coin.

Individuals and organisations dedicated to remedying stigma need to evaluate whether their methods and contents utilise and sustain mainstream values or seek to implement new approaches incorporating the perspective of this core language. It calls for a partnership of parity with ‘il pazzo’ as an expression of self – or no turnaround will occur. It demands ownership of responsibility.

Formal education involves accreditation and confirmation of projected staples and rewards. Self-congratulation and peer kudos is the ever-changing facemask of ‘success’. Some are as convinced as Captains of Industry. There is no such comfort for patients, except for those who learn to cope – mostly away from services and support. With such a global community of cerebral achievers, this monolith of engagement remains. Seminars, workshops and conferences encourage constant re-evaluation, but it invariably ends up on the cutting floor. The existing inflexibility is then backed by honours, or ticked boxes marking ‘progress’, and the ‘informed’ (and dismissed) knowledge of experience thus continues unrefined, reinforcing the set-course. Many conscientious mental health workers abandon ship, dismayed. Others are press-ganged into subservience.

Sub-version

Sadly, this ‘supertanker’ set sail from Southampton with a flawed keel around the time of the Mayflower, and sailed in ever increasing circles, the only remodelling to convert it to a container-ship.

The recent pseudo turnaround, reframing ‘positives’ and ‘negatives’ in mental health assessments, artfully contrived to prevent services delivering appropriate care, is the grossest abuse, myopic in outlook and costing

more in salvage than in precaution. NO recourse to its insanity or criminality. Who are really the self-indulgent? And who pays for this supertanker establishment? ‘No crumbs? Let them eat biscuit.’ Mental Health services prefer travelling through fog without radar or a horn; lighthouse keepers are now turned smugglers.

Biscuit-supplement

Who would have thought eating four jammy biscuits could make the passage through the darkest region of human experience a little lighter and bearable? But how does someone who struggles to communicate, even internally, find the empowering nature of this for him- or herself, if those with the ‘responsibility of care’ do not facilitate it? It involves including options beyond the ‘safe’ governance restricting what services offer. Recognised broad brush-strokes in mental health could benefit from immediate re-evaluation and more subtle facets, for self-assessment, would immediately impact on quality of care and outcomes, putting the priority where it deserves to be: for sufferers. A critical revolution built on equivalence, not co-opting but co-operating. What are the primary steps necessary for this?

Four Jammy Biscuits Saved My Life Today examines both external and internal influences that shaped my journey through familial abuse, torture, breakdown, dysfunction, self-condemnation, loss, homelessness, isolation, repeated suicidal episodes, religious intolerance, self-condemnation, psycho-analysis, endurance, partial recovery, involvement with statutory and voluntary support and health services, and successful management of bipolar and post-traumatic stress disorders without medication.

As soon as I say this, professionals and sufferers alike get suspicious. The usual response is to minimise what I went through: ‘It really couldn’t have been that bad, then, could it?’ Believing that undermines the most infinitesimal power open to us all, refuelling the supertanker as it frantically offloads its cargo.

When a captain places ship, crew and cargo at serious risk, he and his collaborators should walk the plank. Who else will turn the ship around but organised mutineers? It’s high tide. Is it really time for us to man the lifeboats and break out the biscuits? We are all in the same boat. ■

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LETTER: ALEC JENNER REMEMBERED by JAMES STALKER

I enjoyed Phil Virden's description of his first encountering Alec Jenner at a seminar, trailing an entourage of flunkey and acolyte students and associated professionals (*Asylum* 21:4, 2-3). Together with my own observations as an in-patient of this magnetic, charismatic phenomenon, it puts me in mind of Professor Zack Busner, a creation of Will Self, who features most prominently in the novels *Great Apes* and *Umbrella*.

It even made me wonder whether Self, during his own struggles, hadn't at some point come across Alec. But the questions posed by and asked of Psychiatry during the 1980s weren't that exclusive.

Self and Alec both took wider anthropological views of Psychiatry's power within Society. Alec's thought took in cultural and historical links with religion, philosophy and politics, as well as medicine. Self had the licence to satirise, which Alec was restrained from doing by his role.

I subscribe to the paradigm for Psychiatry proposed by Jenner and his colleagues in their book: *Schizophrenia: A*

disease or some ways of being human? (1993). But with a foot in both camps, it only makes matters worse when in my delusional state, where fact and fiction merge and confuse and make me paranoid, the fact that a Mental Health worker I now see is called Jane, and a Psychologist called Jane Bowen is part of the therapeutic community which Busner lords.

Later, in *The Book of Dave*, there is a Jane Bernal assigned to the eponymous taxi driver. I am also convinced that Self got the idea for *Dave* from me, after being one of the few people, along with Alec Jenner and Dorothy Rowe (who warned me that it was riddled with libellous material), to read my vain glorific diary, *Sicknote From Scapegoat Hill*. Yours sincerely, JS.

Phil Virden comments: 'Flunkeys and acolytes' sounds a bit harsh! Every idea or movement has its leaders... Dave is an ingenious novel, and your Sicknote From Scapegoat Hill sounds interesting...

DEPRESSION & GLADNESS

Gladness was there skipping along,
Happy day by day,
But turned around a corner and was so surprised,
It took her breath away!
There he stood, big and bold,
Stalking on his prey,
Enticing and tempting,
But really turned when things didn't go his way.

Depression beckoned "Come with me,
We will be happy you and I ..."
But Gladness stopped and shook her head,
Pretending she was shy.
And as he tried to grab her
And pull her to his side,
Gladness took a side step
And punched him in the eye!

Depression got up, cut and bruised,
He was mad as hell,
Gladness could see the damage she'd done -
His eye was beginning to swell!
But depression doesn't give up easy,
And he was feeling determined to win,
So he grabbed poor Gladness by the hair,
And put her in a spin.

The gravity caught up with them,
As they spun round and round,
Their brains were getting dizzy,
Then both of them hit the ground.
Although depression was big and strong,
Gladness wasted no time.
She jumped right up on top of him,
As if she were fighting crime.

She got him in a side mount,
Cause he was on his back,
She put him in an armlock,
Until his arm did snap!
Depression turned in pain,
Now he faced the other way,
So she put him in a headlock,
And held him there all day.

But as the time passed by,
And day turned into night,
Depression was still taunting,
And Gladness was losing fight.
But gladness had a friend called Hope,
Who happened to just skip past,
She saw her friend in trouble,
And helped her kick his ass.

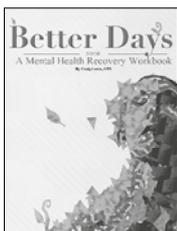
So in and out, and out and in,
All night the troubled three did spin,
The Hope and Gladness took a shin,
And with a last mighty effort, the pair did win.
Depression finally succumbed to fate,
And started to limp away,
Looks like Gladness with a little Hope,
Live to fight another day.

But Depression has to have last say,
And muttered back quietly:
"I'll never completely go away,
You'll have to learn to live with me."
The moral of the story is,
You have everything you need.
Let Gladness and Hope fight your depression,
Fight hard and you'll succeed!

BOOK REVIEW

Better Days:
**A mental health and
recovery workbook**
by Craig Lewis

Reviewed by **Jordan Reyes**



Mental illness, addiction, and other non-visible ailments are tough. Often, mental illness puts us in the role of the victim: we suffer from mental illness, we are addicts. These sicknesses of the mind can force us into becoming shadows of ourselves – we are told that we are less than human by way of mental differences. In my experience as a recovering alcoholic and a long-time depressive, treatment can be a means to shrug-off responsibility, admit defeat, and use illness to excuse living half as well as we should.

I got in touch with Craig through my friend Sean, when we were talking about mental illness and addiction. At the time, I was still in the thick of poor living habits and unhealthy substance intake. I interviewed Craig for my blog and purchased a copy of *Better Days*. Fast forward several months and I have decided to get sober and put my recovery first. Granted, I enlisted in a programme that helped give me the necessary tools to soften my triggers and bolster my ability for success. On the same token, there's something to be said for a visible reminder of where we came from and what we want to achieve.

Craig Lewis' *Better Days* is a good log for this. The book focuses on introspection that can be readily turned into applicable measures for life improvement. As a user of the book, I can assure any and all interested parties that, as well as being a simple document for the days during which we feel disheartened, it serves to better understand the recovery process. Craig is a master of giving the reader the resources to become an advocate for his or her own recovery. Rather than a simple recovery textbook, *Better Days* becomes a sort of beneficial sidekick to constantly remind the reader of the steps taken to better his or her life.

Craig Lewis is a peer specialist working in Massachusetts who uses his own struggles with mental health issues to try and help others. As a punk rocker, he also runs a website www.punksinrecovery.com

Jordan Reyes, in Chicago, runs a music blog called Delayed Graffiti-fication.

NEWS & REPORTS

INCREASED MALE SUICIDES DURING RECESSION

Before the recession, suicide rates had been falling consistently, from 15.6 deaths per 100,000 in 1981 to 10.6/100,000 in 2007. The rate for women has remained relatively constant since 2007 but the rate for men has significantly increased. According to a report from the Office for National Statistics, in 2013 there were 19 suicides for every 100,000 men.

In 2013, a total of 6,233 suicides were registered for people over the age of 15. This was 4% higher than in 2012, and 78% of these suicides were by men.

Except for those under the age of thirty, during the last decade the rates have increased for all age groups. The most vulnerable were those aged 45 to 59. Not wishing to get too political about it, the ONS suggested that '... the recent recession in the UK could be an influencing factor in the increase in suicides', and finds that 'areas with greater rises in unemployment had also experienced higher rises in male suicides'.

Marjorie Wallace (of the mental health charity, SANE) commented: 'SANE's own research shows that many suicides could be prevented, if people were able to talk more openly about their feelings and felt able to seek therapy or other help. Our concern is the number of suicides which are preventable and the fact that when people with mental illness hit crisis point, there are no available beds or units and they are sent home from A&E and left to suffer in silence.'

Gallagher, J (2015) Suicide in men 'highest since 2001'. *BBC News*, 19 Feb.

FOUR MH DEATHS IN CUSTODY EVERY WEEK

An inquiry by The Equality and Human Rights Commission has found that hundreds of deaths in the UK's psychiatric units, prisons and police cells are avoidable since they are due to 'basic errors' made by staff ignorant of mental health risks. The report concludes that, despite repeated warnings, '... serious mistakes have gone on for far too long ... The same errors are being made time and time again, leading to deaths and near misses.' Many suicides in detention come after failures to monitor patients or to remove hanging risks.

Between 2010 and 2013, 367 adults with mental health conditions died of 'non-natural causes' in detention in psychiatric wards and police cells. Another 295, many with known mental health problems, died in prisons. While not all the deaths were avoidable, the commission said that simple interventions could have prevented the majority.

Often failures were due to not listening to or involving individuals and their families. The inquiry found that information which might have prevented deaths, such as warnings about painful anniversaries of bereavement

that might trigger self-harm, was often not made known to all staff, or acted on. Prisons were criticised for not monitoring the number of people with mental health conditions; prison officers are urged to ensure inmates are not punished for behaviours 'viewed as disruptive but in fact ... symptomatic of illness'.

But the report cited many reasons for this systematic negligence:

Misplaced concerns about data protection, which causes a failure to share important information, such as concerns raised by professionals in court not being passed to prison staff, or prison healthcare staff not telling officers on the prison wing that an inmate had suicidal tendencies.

Failure to involve families in support for detainees, making it more difficult for them to pass on information which they feel might have prevented deaths – such as previous treatment plans or trigger points for self-harm such as anniversaries of bereavement or relationship difficulties. Detainees were often refused contact with their family members at a time when they were particularly vulnerable, or unable to see them because they were held a long distance away from the family home.

Poor communication between staff, leading to crucial information being lost or delayed during the transfer of prisoners; a failure to update and share patients' risk assessments following self-harm or suicide attempts.

Access to drugs: including the increasing availability in prisons of 'legal highs' which can increase the risk of mental health crises.

Widespread evidence of bullying, threats and intimidating behaviour in the run-up to someone taking their own life: 20% of prisoners aged 18–24 experienced bullying in the month before their death. Conversely, inmates with mental health conditions were frequently held in segregation for their own safety or the safety of others, and this often led to deterioration in their mental state.

Inappropriate detention in police custody: too many people with mental health conditions are regularly detained in police stations for their own safety. In 2013–14 alone, there were 6,028 occasions – 16 times a day – when people were locked in a police cell as a place of safety because there was nowhere else for them to go. Some of those people subsequently died, often following the use of restraint.

Inappropriate and disproportionate use of restraint on people with mental health conditions, including 'face-down' restraint (which can lead to suffocation), and the use of tasers. There was also concern about an increasing call-out of the police to restrain detained patients on psychiatric wards.

A high number of deaths shortly after leaving detention; this questions whether appropriate follow-up mental health support is systematically put in place.

The report also criticised NHS regulation: no national body has responsibility for ensuring investigations into deaths in detention, and this has missed the opportunity to learn from mistakes.

Mark Hammond, CEO of the Equality and Human Rights Commission, commented: 'The improvements we recommend aren't necessarily complicated or costly: transparency and learning from mistakes.' The report recommends all prisons and psychiatric units should set up 'trigger systems' to alert staff to dates that could prompt someone to self-harm or attempt suicide.

According to figures released this January, in 2014 the number of suicides in prisons in England and Wales reached a seven-year high, at 82. The Howard League for Penal Reform blames staff cuts in the prisons. But there are also serious concerns for the state of the NHS services. Many local NHS areas in England have cut mental health budgets disproportionately in recent years in a bid to cope with the slowdown in Government health spending, and there is a shortage of beds in units for people with severe problems.

This report came a few days after a mental health trust became the first in England to be put in special measures. Norfolk and Suffolk NHS Foundation Trust has been made subject to an action plan by the NHS regulator Monitor, after the Care Quality Commission found that it was not providing a 'safe' service.

Deborah Coles, co-director of Inquest, which advises families bereaved after a death in custody, said: 'The most frustrating aspect of this report is how many of its recommendations have been made before. Too many deaths in detention are preventable and reflect a failure to implement learning from previous deaths.'

A Government spokesperson said: 'The Government is working with NHS England and CQC to improve the way these deaths are investigated and we've launched a zero-suicide ambition for the health service. We are reviewing the way we care for high-risk prisoners and already work closely with police forces and the Independent Police Complaints Commission to prevent deaths in custody.'

Deaths in detention of hundreds of people with mental health conditions could have been avoided, new inquiry finds, (2015) <http://www.equalityhumanrights.com> 23 Feb. Cooper, C. (2015) Too many deaths in custody are preventable but staff lack mental health expertise, says human rights body. *The Independent*, 24 Feb.

MH FUNDS DOWN 8%, REFERRALS UP 18.5% IN FIVE YEARS

Under this Government, budgets for mental health trusts in England have been cut by nearly £600m, i.e. more than 8% (taking into account inflation). At the same time, referrals to community mental health teams (which help people stay out of hospital) increased by 18.5%.

The journal *Community Care* and the BBC News team used Freedom of Information requests, annual reports and other research to compare the budgets of 2010–11 with this year, 2014–15. Out of 56 trusts contacted, 43 responded (but not all provided data on all areas). Taking into account changes to trust structures, etc., analysis suggests that MH trusts suffered a real terms cut of 8.25%

– the equivalent of stripping £598m from their budgets. A few trusts had funding increases, but most suffered cuts. Data from 34 trusts showed that community mental health budgets fell by 4.9% during this parliament; and figures from 29 trusts indicate referrals to those services increased by 18.5% over the same period.

Care minister Norman Lamb said budgets are ‘... not the full picture ... Mental health care is given through a range of services including the voluntary sector ... Funding for mental health has increased since last year but, for too long, mental health has lost out in local spending in many areas.’

He said the payment system in the NHS ‘disadvantaged mental health ... That’s why we are taking action, including introducing new standards for mental health services that local areas will have to meet, just as there are for physical health services. This is backed by £80m investment. This week we’ve also announced a £1.25 billion funding boost for children and young people’s mental health.’

The president of the Royal College of Psychiatrists, Prof. Sir Simon Wessely, said he was surprised the picture was not worse. ‘We are being asked to do more with less. We are campaigning and saying that people need to be more open about mental health problems and come forward earlier. But when they do, we find ourselves with less resources to treat them and they are getting short-changed.’

Paul Farmer, chief executive of Mind, said: ‘The treatment gap for mental health is huge – 75% of people with mental health problems get no help at all. Meanwhile, many more are being turned away from services when they need them the most, left to cope alone with self-harm and suicidal thoughts. The next government will need to hit the ground running on mental health. We need to see a permanent increase in the NHS mental health budget of at least £1bn if we are to reverse the damage caused by years of neglect and recent cuts.’

Buchanan, B (2015) Mental health service budgets ‘cut by 8%’. *BBC News*, 20 March.

NHS MH SICK LEAVE DOUBLES IN 4 YEARS

Over four years, NHS staff absences for mental health problems doubled at hospital trusts in England. In 2010, 20,207 staff were off sick with anxiety, stress or depression; by 2014 the number was 41,112.

The NHS employs 1.25 million people across all of its services throughout the country. But 3,000 nursing posts lost have been lost since 2010.

NHS England said it needed to do more to support staff. NHS Employers, the organisation which represents its managers, said it was doing more to support staff.

A staff survey conducted by the NHS five years ago revealed high levels of stress among medical staff. Tim Baggs of the Royal College of Nursing said:

‘These [new] figures are a real cause for concern to us but they don’t give us any surprises. They really do mirror what we have been hearing from our members and

staff surveys about the relentless pressure that nursing staff are under. We had what should have been a seismic report five years ago into the health and wellbeing of NHS staff which recommended that trusts should do more. Some have done that but clearly these figures suggest trusts could be doing better.’

Hospital staff absences for mental health reasons double. *BBC News*, 24 March 2015.

MoD KNOWINGLY CAUSES MH PROBLEMS FOR TROOPS

To date, nearly 1,000 British service personnel have needed psychiatric treatment after taking the discredited anti-malaria drug, Lariam (aka mefloquine). Even though it is clearly linked with mental health problems ranging from hallucinations, depression and psychosis to suicidal thoughts, actual suicides and homicides, it is still given to British forces. In the USA, Lariam was banned for service personnel more than a decade ago due to hundreds falling to such serious mental health effects. And yet between 2007 and 2014 more than 500 UK service personnel were given Lariam before deployment to Afghanistan. It is not known how many of these subsequently needed mental health treatment.

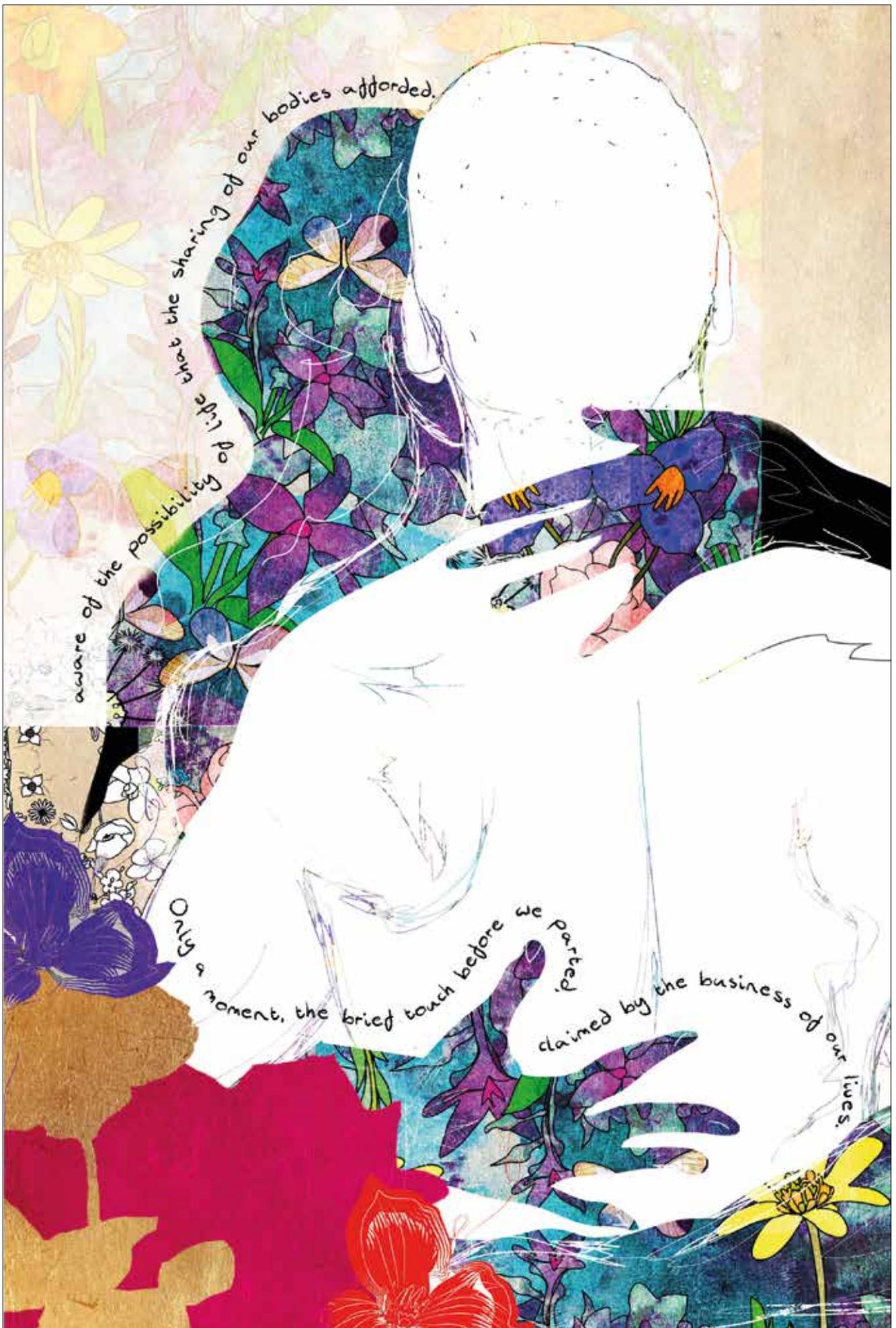
Lariam is either not used or regarded as a drug of last resort by the military in France, Germany, Denmark, Canada, the Netherlands and the US. Our Ministry of Defence (MoD) defends its continued use on the grounds that this follows Public Health England (PHE) guidelines. But PHE never did recommend Lariam: it advised a different product. Critics suggest that, on the grounds of economy (or back-handers), the MoD will use up all the stocks it already has rather than buy the alternative drug.

Lieutenant Colonel (retired) Ashley Croft served for more than 27 years in the Royal Army Medical Corps; an expert on malaria, he says: ‘This is a direct violation of Public Health England’s guidelines for UK travellers. This is another example of the MoD’s cynical disregard for the safety of deployed soldiers.’

The manufacturer is Roche. Almost a decade ago, they admitted there were ‘more effective’ alternatives to Lariam with ‘better side-effect profiles.’ There have been repeated warnings about Lariam, including one issued by Roche to British doctors in October 2013: it ‘may induce potentially serious neuropsychiatric disorders.’

Serving personnel say they have always been aware of the immediate ‘side-effects’ of Lariam, expecting to feel weird or even hallucinate and ‘feel crazy’ after taking the weekly pill. Lariam is no respecter of rank: the UK’s top army officer in Bosnia during the 1990 campaign, who had regularly taken the drug during his long career, is currently held in a secure psychiatric unit due to a violent psychosis that is reckoned to be caused by Lariam.

Hundreds of British soldiers sent to Afghanistan given anti-malaria drug known to be dangerous for mental health (2015). *The Independent*, 23 April.



'Of Zeus and Leda' by Rhiana Jade from *HOAX Psychosis Blues*

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