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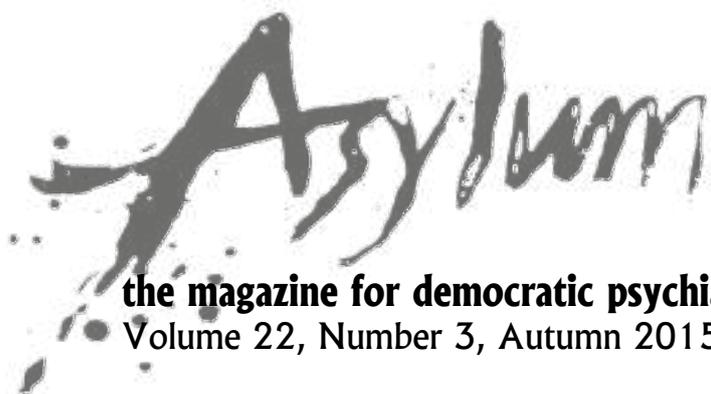
## Comics & Mental Health Part 3



Mental Health Action & More

# 'Personality Disorder'





**the magazine for democratic psychiatry**  
 Volume 22, Number 3, Autumn 2015

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**Back Cover:** *Click* by Liz Greenfield

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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: Meg John Barker, Joseph De Lappe and Caroline Walters

The special feature in this issue focuses on depictions of body and gender-related mental distress in comics. We kick off with a piece by Caroline reflecting on the recent spate of autobiographical comics, particularly *Marbles*. After that we have Kate Tibbets's *Lobotomobile* and Jason Darrah's piece about mental health in prisons. Next, focusing on masculinity, John Hatagan and Craig This write about *Iron Man and PTSD*, and Tony Keen writes about *Superman* as depicted by Alan Moore. After that we have a comic and piece by John G. Swogger and Liesl Swogger exploring Liesl's bulimia, and excerpts

from Katie Green's *Lighter than my Shadow*, concerning anorexia, along with an interview with Katie about her work. This is followed by a story from Caren Messing, *In the Studio*. We also have thoughts on anxiety disorders by Michelle Grimley, with cartoons by Natalie Dee. Finally we print the third page of Brick's cartoon, *A Dog is For Life*; this page got left out of the last issue due to it being lost somewhere in the emails, for which we apologise. And again we showcase comics from both Liz Greenfield and Simon Warne, in this issue dealing specifically with gender. ■

## GRAPHIC MEMOIRS, CREATIVITY & MENTAL DISTRESS

Caroline Walters

Graphic memoirs that deal with mental health are a genre in and of themselves. Some key examples are Alison Bechdel's *Fun Home* (2006) and *Are You My Mother?* (2012), Brick's *Depresso, or How I learned to stop worrying and embrace being bonkers* (2010), Ellen Forney's *Marbles: Mania, depression, Michelangelo & me* (2012), and Katie Green's *Lighter Than My Shadow* (2013). Due to a lifelong fascination, and my own struggles with mental distress, when I discovered this genre I started to hunt for them. I found that the form seemed to provide a kind of immediacy that I had struggled to discover in words alone. Language could be too ordered. Its need for punctuation, complete sentences and syntactical awareness had often left me silenced. Yet reading these memoirs, which combined words, images and narratives, gave me a voice, as I found a way to be able to discuss these issues with others without directly focusing on myself.

Here I will focus on a memoir I have re-read many times, Ellen Forney's *Marbles: Mania, depression, Michelangelo & me*. Its central theme explores questions that I have often asked myself, particularly concerning the relationship between creativity and her mental health. Forney provides the reader with no simple answers, but focuses on the journey itself. In it, she charts her trajectory from first being diagnosed with bi-polar, through many pharmacological and therapeutic interventions, until she reaches a place where she is able to experience balance while retaining her creativity.

Reading Forney's memoir speaks to very real fears that I often consider. In particular: Where does me begin and my difficulties end? What if my creativity is just a part of my illness and difficulties? If I seek medical help, particularly pills, will I lose my sense of self and creativity? Would treatment mean I lose my creativity?

These questions have haunted me for as long as I can remember and it felt a comfort to read a memoir that addresses them directly.

Creativity: what it means and its relationship with bipolar appear through the drawings as well as the words. Forney describes how she uses her comics as a way to explore and represent her various emotional states. When she is showing something – that is when she is a state of mania – the page becomes fragmented, with many layers of competing texts showing the scattered thoughts and way of thinking. There are fast frenetic sketches combined with disparate thought-bubbles for the many ideas competing with one another. These are contrasted by the tiny, wordless images which show her depression. She shows the struggle to get up from bed where she is in a cocoon, then moving to the sofa, where she becomes stuck and retreats into another cocoon. Yet on a half-page she shows that when she is in a ‘high’ or ‘up’ state, and thinking about her depression, it becomes choosing to cry and being tired so perhaps she should have a coffee or another nap. This depicts her difficulty in recalling a different emotion to the one that she experiences at the moment, because of how the emotions colour the way that she sees and understands everything.

One of the parts of the book I found irritating to read was that depicting the love and praise she felt for her therapist. Yet I realise that some of this is due to my own ambivalent relationship with what counts as a therapeutic relationship and with who makes the judgements and helps someone through. Yet while there is adherence to – and at times unquestioning praise of – the medical model throughout the book, it is understandable that it is there because Forney feels it is something that has helped her ‘save’ her life.

Forney offers a considered and careful reflection on the impact that receiving a diagnosis and her mental health difficulties had on her family. She focuses on her close relationship with her mum, who reveals to her the family history with mental difficulties. After the revelation of the diagnosis, in the spoken and unspoken conversations the very thing becomes an ever-present part of their relationship because Forney is always aware that it is there, and this knowledge can never be undone. Yet she does acknowledge that her family help to pay for her medication and therapy, and provide support without which she would have difficulties since she has struggled to maintain any kind of regular paid work that would otherwise enable her to survive. The financial implications of her experience, her life choices (e.g., to be an artist) and living alone are glossed over in the memoir. This is not necessarily a criticism

because it offers so many other strengths, particularly its central focus on creativity and the uncertainty of what managing looks like.

The final section of the memoir explores the complex journey of trying to find a balance of helping the person to manage her symptoms until she, rather than it, is in control. One of the most powerful images is a depiction of Ellen trying to keep her condition in check, and the complex array of medication, practices and checks she must engage in so as to be able to do so. It shows her face rushing forward but restrained by a bit-gag with its reins trailing behind. This image reminds me of something many people have told me, where the aim is to put you in control of the tiger (your diagnosis and symptoms) rather than have it control you. This is captured perfectly by Forney’s image.

Throughout the book, Ellen Forney shows the work involved in coping: the endless monitoring – How much sleep am I getting? How am I feeling? What am I eating? How much am I socialising? How much am I working? What are my energy levels like? She shows extracts of the backs of her notebooks that she carries everywhere, filled with endless lists and charts – frantic attempts to uncover patterns and see what makes a difference at what moment. These are meant to help her to follow the progress and impact of the various drugs that she takes. She does this for a long time without altering her relationship to smoking weed, which is her familiar friend and crutch that she is loathe to be without. Only after realising that for four years she has been willing to change all of her other medications before this habit does she question whether she should also change that, too. It is a choice she makes, but it is one of her hardest battles because it has become such an integral part of her identity – part of her social life, and something that she shares with her stoner mother. She is scared but also filled with a new journey and purpose when she considers that to find the sense of peace in herself that she has craved for so long she must learn to experience and find a balance that does not include her old familiar crutch.

After reading this memoir, some of the most powerful parts that I was left with were the ambivalence towards the recovery process and the space that Forney gave to explore questions and reflect on creativity, balance and our familiar attachments to habits regardless of whether they are good for us. This felt reassuring because she does not profess to have found all the answers. Instead, life and ‘recovery’ is a long process. I saw my own experience and myself in this journey. ■

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Kate Tibbetts

# A SINGLE BOUND

## Transcending mental illness through comic books

Jason Darrah

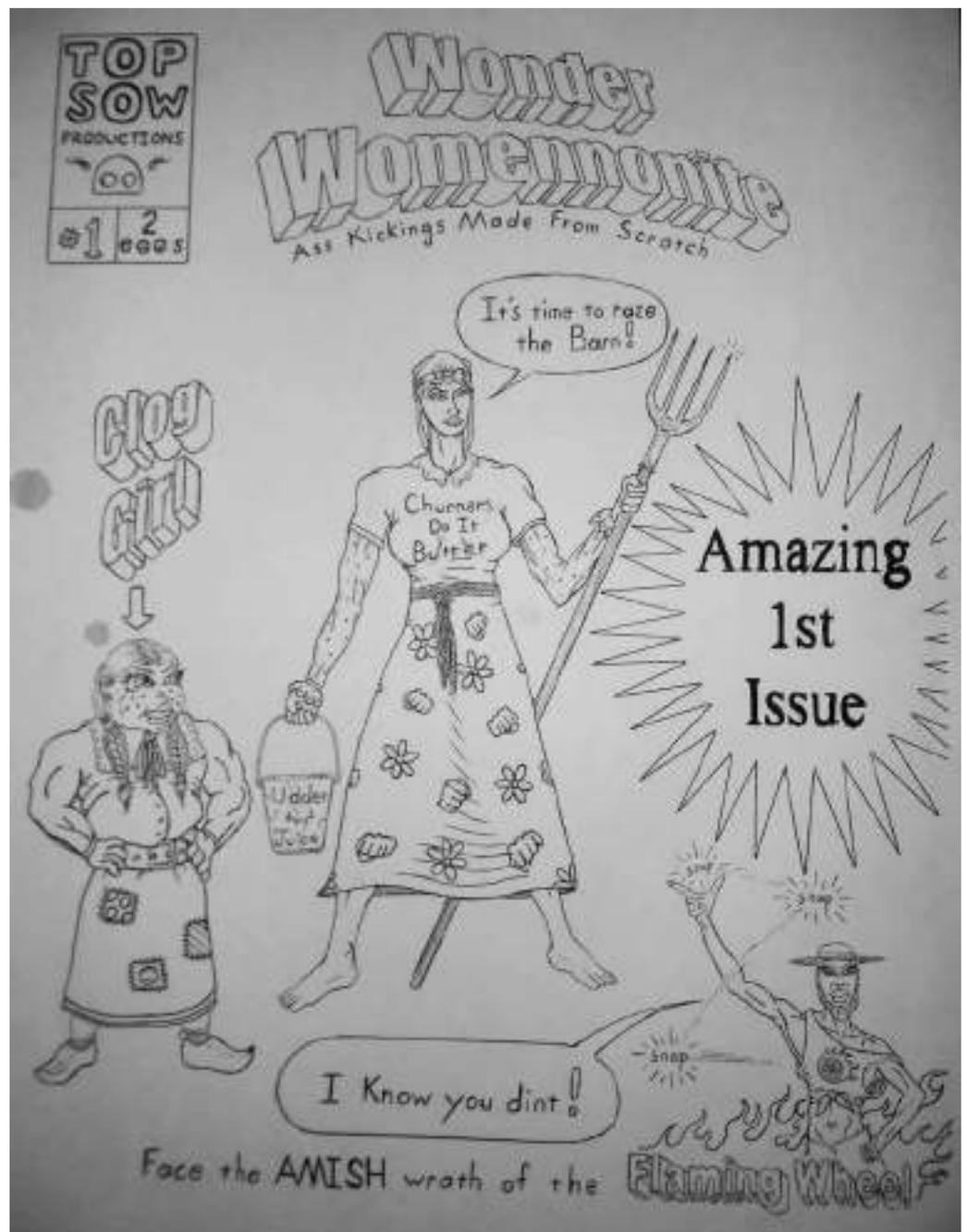
The bulk of my childhood education was imparted in cubicles – ‘Special Education’ classes where placation was stressed in lieu of inspiration. I also came from a broken home. Very broken. I was a ‘sped’ whose father left when I was six, and my bad behavior was regularly treated by savage beatings from a psychotic, chain-smoking mother. I found hard drugs and violent crime to be a natural companion to these problems, becoming a junky with a criminal record by the time I was twelve. My mental state was, of course, very unstable, changing constantly like a marred coin spinning through a tempest. I was sixteen when I went to prison.

When I entered the Anamosa State Penitentiary, in Iowa, there were only four other prisoners my age, all serving HUGE sentences. Prison is hard enough, but our meager ages provided another level of challenges. Fear was equated as respect, and I was willing to make people believe I was the most violent person on earth, threatening murder for the smallest of slights. I wore my insanity like a hi-tech suit of armor, protecting what I believed was a good heart, while using that same insanity to survive. It sometimes became hard to differentiate between the armor and the man. Comic books were the anchor that kept me from losing touch with myself. I coveted the small stack of comics my absent father had given me, and continued collecting them all the way until I walked into prison.

How was I going to succeed in prison? Indeed, can a sixteen-year-old kid succeed in such an unhealthy, violent, and negative environment? No longer under the influence of drugs or maternal abuse, I began to think of comic heroes who fascinated me as a child with renewed passion and inspiration. I thought of Batman, with his dedication to self-improvement through physical discipline and education. I considered Superman and his fantastical ideologies. I smiled as I imagined Peter Parker’s corny

and innocent views toward his day-to-day challenges. Combining all these elements, I began a quest to replace my ‘insanity armor’ with something more durable. It didn’t take long for me to realize that the method for me to accomplish this goal was through education.

First, I acquired my GED. Then I earned my high school diploma. By that time, my confidence began to grow and I started to see possibilities for my future that I previously had no right considering. My fellow inmates began showing me respect, not out of fear, but because they admired me taking the initiative to improve myself. I then attended college through correspondence classes, until prisoners were discontinued access to the Pell Grant, in 1994. But was I dissuaded? Did Spiderman quit when



the Green Goblin threw Gwen Stacy from the Brooklyn Bridge? Nope, and neither did I.

I spent the greater portion of the next ten years improving myself in every way I could. I won various writing competitions, using the scholarship awards to take more college classes. I learned a trade in woodworking. I trained rigorously, transforming a junky body into a model of healthy choices. And during that whole time, my inspiration – my comics – were guiding me. They were always there, reminding me of the good and what I was capable of.

I started to get opportunities that affected me on a deeper level, leaving an indelible mark and shaping me into the man I am today. I learned braille transcription, and for the first time in my life I understood the intrinsic reward that comes from helping others. Daredevil would be proud. I began speaking to troubled youth, advising school teachers on methods for dealing with at-risk kids, and tutored for various treatment programs. I returned to college through a comprehensive volunteer program offered by Grinnell College, where I was able to further explore heroic archetypes and Joseph Campbell's template for the heroic journey, learning that the need for heroes is something that has been in all of us since before the time of Homer. (There were even multiple comics classes! At my request, of course.)

Knowledge is power. As Peter's Uncle Ben said, 'With power, [koff!] comes great responsibility [koff!].' I took these words to heart. Using the lessons taught to me by Grinnell, I started my own liberal arts program in another prison, where I trained guide dogs for the blind, became head of an inmate-run non-profit, and was certified in Mental Health First Aid. Not bad for a guy who thought he would be dead by his eighteenth birthday.

As a child, I had a damaged mind. I was paranoid, afraid, violent, and had absolutely no belief in myself. I carried those injuries into prison, a place not known for its redemptive qualities. But I was fortunate. I had heroes to inspire me, education to train me, and volunteers who, for the first time in my life, exposed me to the transformative power of compassion. Each of these things were irreplaceable tools in my utility belt for healing and change, each a single bound in a long journey.

So now, after twenty-four years in prison, I have been free for six months. I'm a garbage man. I wear brightly colored clothes and run around the city cleaning it of unwanted filth. I am a mentor for others who have recently been released, I formed an exploratory group of former prisoners searching for ways to help others, and I am in the beginning stages of a public speaking group to help marginalized people develop their social skills. In my spare time, I like to draw comics, superheroes, and satires. (Humor is the most important ingredient to self-change.) As a former criminal, I understand that I can never be a hero, but that will never stop me from striving to be hero-like. This is a belief that was given to me through comic books and the day-to-day superheroes who selflessly volunteered to make my life better.

And that, true believers, is pretty damn heroic. ■

# TONY

by John Hatagan & Craig This

The origin of Tony Stark/Iron Man is shown in the first few pages of *Tales of Suspense #39*. Tony Stark accompanies some soldiers on an inspection of Stark Industries weapons when they come under fire. In the attempt to take cover, Tony Stark trips over an anti-personnel mine and it explodes. Injured and apparently left for dead, Tony Stark is taken prisoner by the red guerillas, and the reader learns that he has a lot of shrapnel near his heart that will kill him. The guerilla leaders offer surgery that will save his life, if he will build them 'the most fantastic weapon of all time'. Tony Stark does this, but the weapon is Iron Man and its life-giving heart of iron (Leiber). A wounded warrior of the Vietnam War, Tony Stark is also a disabled veteran, and his prosthetic - his artificial heart and his suit - become part of him, become part of the warrior.

The emergence of Tony Stark as a wounded veteran serves as a powerful metaphor for the returning war veteran. True, Tony Stark/Iron Man fits the Marvel aesthetic that comics scholar Charles Hatfield writes about: '... soap opera-like ... unresolved problems. Marvel's heroes ... had baggage. They shared memories and carted them around, seldom forgetting' (p. 139). In that sense, Tony Stark fits this 'Marvel aesthetic,' like other Marvel characters – Peter Parker/Spider-Man, Bruce Banner/The Hulk, and so on. But the unresolved problems and carting around memories sounds a lot like a war veteran who cannot escape the damages of war, who is haunted by post-traumatic stress disorder (PTSD).

Post-traumatic stress disorder is 'the most common mental health disorder diagnosed in veterans returning from the Iraq and Afghanistan wars' (Hoge, Auchterlonie & Milliken). And 65% of the casualties from Operation Enduring Freedom and Operation Iraqi Freedom were caused by improvised explosive devices (IEDs), much like Tony Stark and his casualty (Carlock). The symptoms of PTSD are as numerous as the people affected. They include flashbacks, avoidance and isolation, hyper-arousal, negative thoughts, guilt, anxiety, stress and tension, and also aggression, alcoholism, and suicide ideation (Hellmuth et al). Tony Stark exhibits some of these symptoms and therefore he provides a good, albeit limited, view

# STARK / IRON MAN

## and PTSD

of PTSD. Throughout the Iron Man comic books, it is apparent that Tony Stark exhibits the PTSD symptoms of aggression (based on hyper-arousal), alcohol misuse, avoidance and isolation.

Aggression is a key symptom of PTSD, and Tony Stark, as Iron Man, seems very aggressive. Granted, the superhero genre does tend to focus on violence and aggression against villains and evil-doers. However, viewing Tony Stark as a wounded warrior who suffers from PTSD, it does not take much to see the violence and aggression coming forth in him. It should be noted that PTSD, in the case of veterans, is locked in their minds and is unlocked by triggers – situations in which they find themselves, which can be as ‘harmless’ as a traffic jam or as a dangerous as a firecracker exploding. The villains that Tony Stark interacts with could be classified as the triggers which unleash the aggression. And, like veterans suffering from PTSD, Tony Stark sees every situation as ‘fight or flight’; since the hyper-arousal fuels the aggression, the PTSD veteran (and thus Tony Stark) tends to fight. He constantly uses aggression and violence as a means to conflict resolution. Yes, it could be argued that he is provoked, but his reactions could also be due to the hyper-arousal of PTSD, an overly sensitive reaction to the slightest event viewed as aggression.

Aggression and alcohol misuse or abuse are closely linked symptoms of PTSD. Tony Stark faces alcohol misuse and abuse in the storyline, Iron Man (#120–129), in which he battles alcoholism (Michelinie & Layton). This story arc created a debate as to whether or not Tony Stark was an alcoholic (Novy). The storyline focused on his addiction in response to his role as businessman/entrepreneur. However, when he is viewed as a veteran dealing with PTSD, the alcoholism becomes understandable. And, like PTSD, the disease of alcoholism does not go away because, as Alcoholic Anonymous tells its clients: once an alcoholic, always an alcoholic.

Finally, there are Tony Stark’s avoidance of women, and his isolation (Mangels). Despite his playboy persona, he isolates himself from others. Not only does he keep to himself at Stark Industries, and alone in his lab, but he also has trouble with women. His administrative assistant, Pepper Potts, has feelings for him which he does not return. However, he tends to end up fighting the women for whom he does have affection – Black

Widow, Madame Masque and Madame Menace. Note the PTSD symptom of aggression returning because of his inability to interact with women (Housel & Housel).

In the end, the question that can be posed is, ‘What kind of reaction would a veteran display after losing an arm or leg?’ And then we must ask, ‘How did the shrapnel that landed near his heart affect Tony Stark?’ He suffers from PTSD. However, his is just one story in the long line of PTSD victims and, as such, it is limited. But it does show the challenge that many veterans have in reintegrating into society. ■

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### References

- Carlock, D (2014) A Guide to Resources for Severely Wounded Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans. *Issues in Science and Technology Librarianship*. Online, Sept 16.
- Hatfield, C (2013) Jack Kirby and the Marvel Aesthetic. In Hatfield, C, Heer, J & Worcester, K (Eds) *The Superhero Reader*. Jackson: University of Mississippi Press, 136–154.
- Hellmuth, JC et al. (2012) Modeling PTSD Symptom Clusters, Alcohol Misuse, Anger, and Depression as They Relate to Aggression and Suicidality in Returning U.S. Veterans. *Journal of Traumatic Stress*, Oct 25, 527–534.
- Hoge, CW, Auchterlonie, JL & Milliken, CS (2006) Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan. *Journal of the American Medical Association*, 295: 1023–1032.
- Housel, R & Housel, G (2010) Engendering Justice in Iron Man. In White, MD (Ed.) *Iron Man and Philosophy*. Hoboken: John Wiley & Sons, 245–255.
- Leiber, L (w) & Heck, D (a) (1963) *Tales of Suspense #39*. New York: Marvel Comics, March 10.
- Mangels, A (2008) *Iron Man: Beneath the Armor*. New York: Del Rey Books.
- Michelinie, D & Layton, R (2008) *Iron Man: Demon in a Bottle*. New York: Marvel.
- Novy, R (2010) Fate at the Bottom of a Bottle: Alcohol and Tony Stark. In White, MD, op. cit., 80–94.

# THE MADNESS OF SUPERMAN, as depicted by Alan Moore

Tony Keen

Alan Moore is widely regarded as one of the best writers of comics of the latter part of the twentieth century and the early part of the twenty-first. In the mid-1980s he wrote mainly for DC Comics, most notably on the titles *Swamp Thing* (1984–87) and *Watchmen* (1986–87). He also wrote a number of one-off stories, now all collected in DC Universe: *The Stories of Alan Moore* (2006: available as a Kindle edition). Three of these stories concerned the most iconic character in the whole of the DC Universe, Superman.

One story, the two-part 'Whatever Happened to the Man of Tomorrow?' was a celebration of the Superman legend, written to be the last story before DC revised the character and his mythology. It lies outside the interests of this article. The two others, 'For the Man Who Has Everything' and 'The Jungle Line', are my present concern. Both stories revolve around attacks on Superman that are outside the physical, and instead separate him mentally from reality.

'For the Man Who Has Everything' was originally published in 1985, in *Superman Annual #11* (available through [Comixology.co.uk](http://Comixology.co.uk)). Superman's enemy, an interstellar warlord called Mongul, gives him a present of a 'Black Mercy'. This is a plant that feeds off organic life-forms, and to prevent them resisting, sends them into a trance where they believe they are living out a life of contentment in the universe as they wish it was. In Superman's case, that is a life where his home planet Krypton was never destroyed.

Superman's vision of Krypton, however, proves to be not as perfect as he presumably hoped. Alan Moore wrote this story as a response to the idealisation of Krypton that he perceived in most stories, so his Krypton is a place riven by factionalism, in which Superman (under his real name of Kal-El) and his family are attacked because of the ultra-conservative political views of his father Jor-El. The imperfections of Krypton lead Kal-El to doubt its reality. In terms of the concept of the plant this doesn't make too much sense – neither of the other characters subjected to the plant's influence (Batman, and finally Mongul himself) are shown to have such doubts about the 'reality' they end up in – but in terms of the story it allows Superman to free himself from the mental prison the Black Mercy has placed him in. It also suggests that Superman knows in his heart that Krypton was not truly the paradise that he had idealized.

'The Jungle Line' appeared in *DC Comics Presents #85* (1985). This was a team-up book, in which each issue paired Superman with other characters from the DC Universe, such as Green Lantern, the Flash, or more obscure characters such as The Creeper (another DC character with sanity issues). In #85, the other character

was Swamp Thing, a man-monster originally appearing in DC's horror comics. In 1985, the character's own book was being written, extremely successfully, by Alan Moore, so he was the obvious choice for writing that issue.

Again, the story links Superman back to Krypton. In his civilian identity of Clark Kent, Superman goes to a lecture about a meteorite on which some extra-terrestrial living organic material has been found. This material turns out to be from Krypton, and deadly to Kryptonians. Superman has already been infected by it, and this affects him both physically – his powers are randomly taken away – and mentally. In a memorable scene, he imagines that he is talking to his street clothes and to his Superman costume, embodying the idea that both Clark Kent and Superman are roles that are played by the 'real' Kal-El. (Though it is likely that, having been raised as Clark, although born as Kal, Superman's identities actually interact in a more complex fashion.)

Superman then heads south to Louisiana to die, on the grounds that the state is devoid of indigenous superheroes. What he does not know is that the swamps are the home of the Swamp Thing, a sentient plant-creature. Because Superman's infection is fungus-based, Swamp Thing is able to make a mental link to Superman, and help him survive the otherwise deadly fever.

There are interesting parallels between the two stories. In each, Superman's mental collapse is completely triggered by extraordinary outside circumstances: there is no suggestion that he is generally teetering on the edge of mental illness (unlike, for instance, Batman). Nevertheless, the ways in which Superman's collapse manifest themselves are linked to long-term issues, specifically to his (usually suppressed) survivor's guilt for being the Last Son of Krypton. In 'For the Man Who Has Everything', his subconscious constructs a world in which he is not the lone survivor of Krypton; in 'The Jungle Line' it berates him for not having died with everyone else.

As is inevitable in one-off stories such as this, a reset button is applied at the end of the story, and there are no lasting consequences. Superman reverts to his usual status as the happy, beaming, big blue-and-red cheese (to paraphrase a nickname of his 1940s rival and imitator, Captain Marvel). Nevertheless, Moore leaves the reader with a feeling that these issues haven't really been resolved – they've just been boxed away again, into a part of Superman's mind where he generally doesn't go.

Alan Moore's comics have always shown him to be interested in the psychology of the superhero – what makes someone go out and dress in a fancy costume to fight crime. His knowledge of psychology is that of the interested amateur. (As, indeed, is mine.) In these two stories, he gives an interesting insight into what he believes are the thought processes of the most powerful being on the planet. ■

*Tony Keen has been writing on comics since the 1990s. He co-edits the comics website FA Online (<http://comiczine-fa.com/>).*

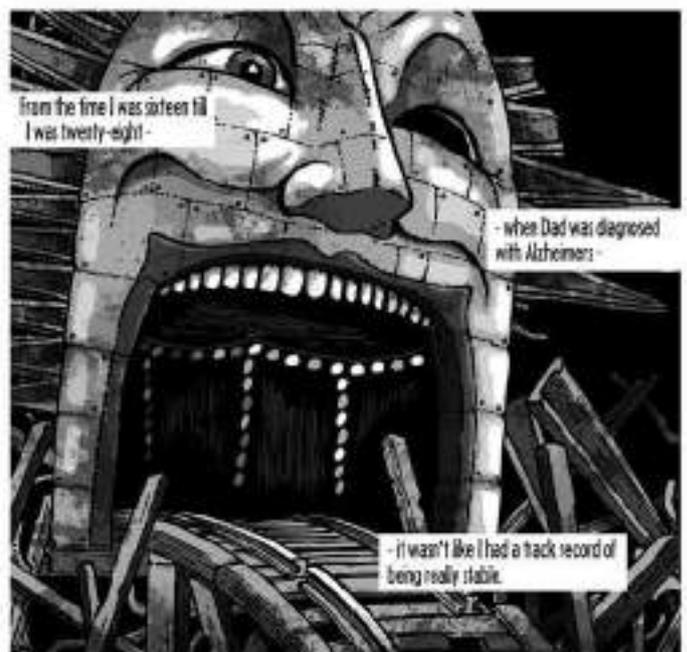


relate'. While I do want to tell my story, and I think there is value in telling it, I also think there are universal themes that drive us, and I wanted the story to speak to those broader subjects as well. In this way, instead of the specifics of a particular illness being a way to alienate a person and push them outside of 'the norm', we see how these symptoms fit into a broader diagnosis: the human condition.

For example, the image of the Jabberwocky looming over an Alice-in-Wonderland figure captures the universal theme of fear. Who can't relate to being afraid? What exactly we're afraid of really doesn't matter, which is why the Jabberwocky works so well as the pictorial representation of that fear. Whatever the specifics might be, anyone can look at that image and see reflected back at them the fear that looms over them that is so overwhelming, so monstrous and predatory that the desire to escape may drive them to behave in ways that are irrational and self-destructive.

Another image that captures both the very specific nature of my story and the more universal theme of duplicity is the Trojan Elephant. Everyone, to some degree, has two personas: the public and the private. With eating disorders like bulimia, or addictions like alcoholism, the separation between public and private becomes distorted, exaggerated to a degree where one self hides inside the other. Sometimes those around us are aware of what's happening, but the burden of knowing someone else's secret is too much for most people, so rather than bringing the secret out into the light, it becomes the 'pink elephant in the living room', and the private self continues to secrete itself away inside the protection of the public self. And everyone looks away.

For me, this project is an incredible journey. In collaborating with my brother I've had the opportunity to tell my story to someone who has listened without judgment – a gift we should all be so lucky to receive. Creating a graphic novel also serves the dual purposes of giving me a public forum from which to share my experiences and the opportunity to challenge public perceptions of mental illness and health. I tell my story with the hope that people come away with a sense of hope and an understanding that things can be different, and to question the line that divides 'us' from 'them', and to suggest, in some cases, that the line is more fluid than we realize.





Only this time it was bulimia.



... which is much easier to hide.



And when I complained about the exercise thing, he said:

You know, you should just be grateful you can get up in the morning.

And when I said about work and stuff...

He'd just shake his head and say:

In the history of psychiatry, the perception of mental health and illness as static states of being dictated by genetics and controlled by medication is relatively new. Mental health or illness is sometimes biologically grounded, but not always. And when they are not, the states of being are fluid and the lines that divide them are at times unclear. Can you stand in judgment of someone, and point the finger and declare them mentally healthy or mentally ill? When you look into my story and see yourself reflected back, can you stand in judgment?

**John:**

I'm a professional illustrator, and my usual field is archaeology and history. Both are aspects of the past that only echo the presence of human experience. Working with my sister on this graphic novel has been different. For her, the experiences in her past are not a distant echo, but a constant and present voice. For me, these experiences represent an entirely new kind of past to try and give visual form.

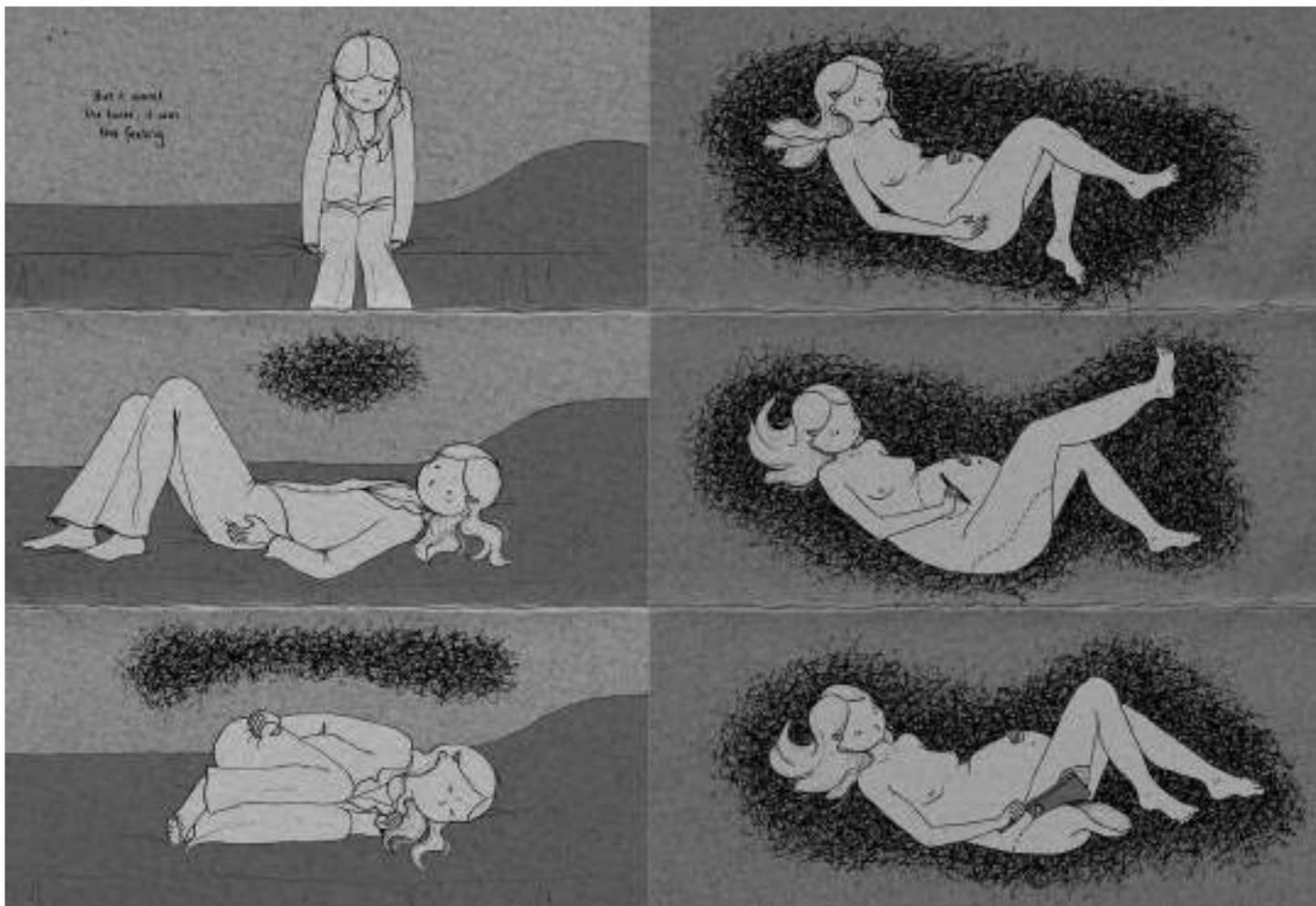
We began working on this collaboration almost by accident. My sister and I, although fairly close, had never really spoken about her experiences – her battles with various eating disorders, depression, addiction. They were parts of her past that were like another country, distant and foreign.

But suddenly we started talking. It was as if the prospect of giving these things visual life made it okay to start talking about them. I heard stories from Liesl that I had never heard before – frightening, scary, terrible stories. But also stories about hope, strength and change.

As we talked, I drew. I drew not the 'historical' past that I am used to drawing, but the past of experiences and feelings. The past I drew seemed more abstract, more allegorical, even mythological. In our collaboration, the words are Liesl's alone – unedited and unaltered. The drawings respond to those words. Partly they reflect my own attempt to understand, partly they are my attempt to help Liesl understand.

The collaboration we are engaged in is a form of dialogue. In that visual conversation we are jointly exploring a personal past from which I thought I was excluded. But I feel like I am discovering that the role I am to play in that story is now, in the present. ■

# Sasha Garwood interviews Katie Green



Ten years ago, I was an anorexic horror story. The kind with hospitalisation, multiple organ failure, starvation psychosis, heart attacks, intensive care. I almost died, several times, and then decided not to. Recovering – mostly – I started to specialise academically in women’s experiences with food and their bodies. My PhD is in the early modern history of women and self-starvation, and its distinction from today’s ‘anorexia nervosa’. I’ve read an unfeasible and certainly inadvisable number of eating disorder (ED) memoirs, most of which are basically a footnote to Marya Hornbacher’s *Wasted: A memoir of anorexia and bulimia* (1998).

But before Katie Green’s *Lighter than My Shadow* thudded comprehensively on the doorstep, I hadn’t read many – any – graphic novels dealing with the topic explicitly and in detail. The story of Katie’s journey from a fussy-eating childhood through anorexia, bulimia and abuse to art, is drawn in gentle outlines, shades of grey, sweet round faces, drifting hair. It’s pretty, mostly. This – and, I have to confess, the title – made me uneasy at

first; the concept of starving girls as delicate, fairylike, unworldly creatures, pure, stripped to the clean bone of messy human flesh and feeling, is an incredibly, dangerously powerful one both for sufferers and those around them.

To my initial surprise and her certain credit, though, despite the delicacy of her style, Green has quite definitely got this covered. *Lighter than My Shadow* tells a whole bunch of uncomfortable truths, uncomfortably. Its symbolism is genius – the black scribbles that convey despair, depression and dysfunction hovering around the edge of the pages, cracking her head open and spilling out over panels and pages in a vivid visual representation of the blinding chaos madnnesses so often become. Pages shatter as Katie falls apart; the swollen grotesques of her imagined self-image are uncomfortable, shocking, pitiful, and believable. If anorexic Katie tends inevitably to the fey, she regains her painful humanity in bulimic Katie, tortured by a gaping mouth in her stomach, her breakdown and attempted suicide symbolised in stripped

flesh, exposed organs. The minimalism of her faces belies the effectiveness of her work's emotional evocativeness – it is impressive the depth of anguish three tiny dots and a line can convey.

I loved the book, mostly because of its unexpected brutality. People have this idea that being anorexic is somehow beautifully dramatic, model cheekbones and artistic shadows, while being bulimic is a joke or a punch-line. They're wrong, in both cases. Eating disorders are solidly, sharply, horrifyingly physical, like a punch in the face. I caught up with Katie Green to ask her about her experiences and the process of turning them into a novel, and the responses she's had to her commendable and surely occasionally terrifying public honesty.

*Why a graphic novel? What drew you to the medium?*

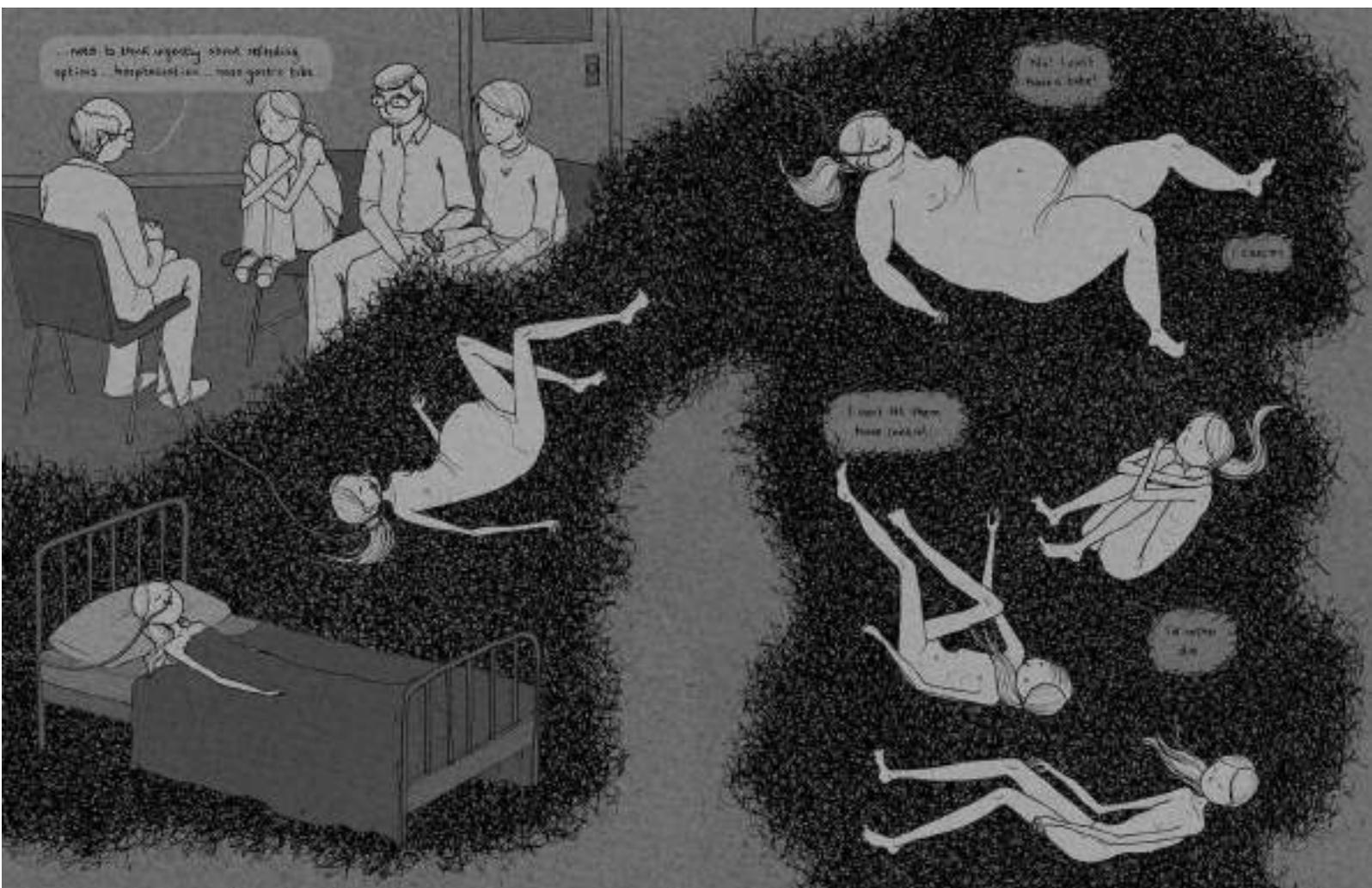
That's an interesting question, because I'm not one of these people who grew up reading comics. Rather the opposite actually: I was something of a snob and thought comics were for people who couldn't read 'proper' books. It wasn't until my twenties when I was getting into illustration that I discovered there was so much more to the medium. My first two graphic novel reads were *Blankets* by Craig Thompson and *Maus* by Art Spiegelman. Both were completely captivating, and it was like discovering a whole new language, one far more apt for recounting my own story than words could ever have been.

*What was the writing process like, creating something so incredibly intimate and personal?*

I wrote the book over many, many years, which was a strange and odd experience that required me to gain some distance from the events I was writing about. Particularly in working on the narrative with an editor, I had to cast a critical eye effectively over my life looking for moments of 'dramatic emphasis'. It was quite surreal! But I'd be lying if I said I was always able to remain distant, and I think actually the book would have suffered if I had. The nature of the story I told is that it's incredibly affecting, even years after the events. In drawing the scenes of abuse, even though there's very little explicitly shown, what I did put on paper was so painful for me that I had to cover up certain panels to enable me to keep working on the rest of the page.

*Your style is in some ways deceptively cute and delicate, and yet you effectively convey some really horrible and traumatic experiences. How did it evolve? Did you know how you wanted the book to look and feel from the start?*

Actually no, I didn't have a clear idea of the visual style at all. In the earlier years of my eating disorder I'd described anorexia as a monster, and I returned to that metaphor when I began trying to draw it – quite literally. I was still at art college and working quite experimentally, using lots



of colour and collage, drawing big green scaly monsters and all sorts. It came as quite a surprise when an image evolved of me standing on some scales with this scribbly black cloud hovering over my head. Compared to my other work at the time, it was very pared down and quiet, but it felt just right. It became the source for all the visual language I used in the book.

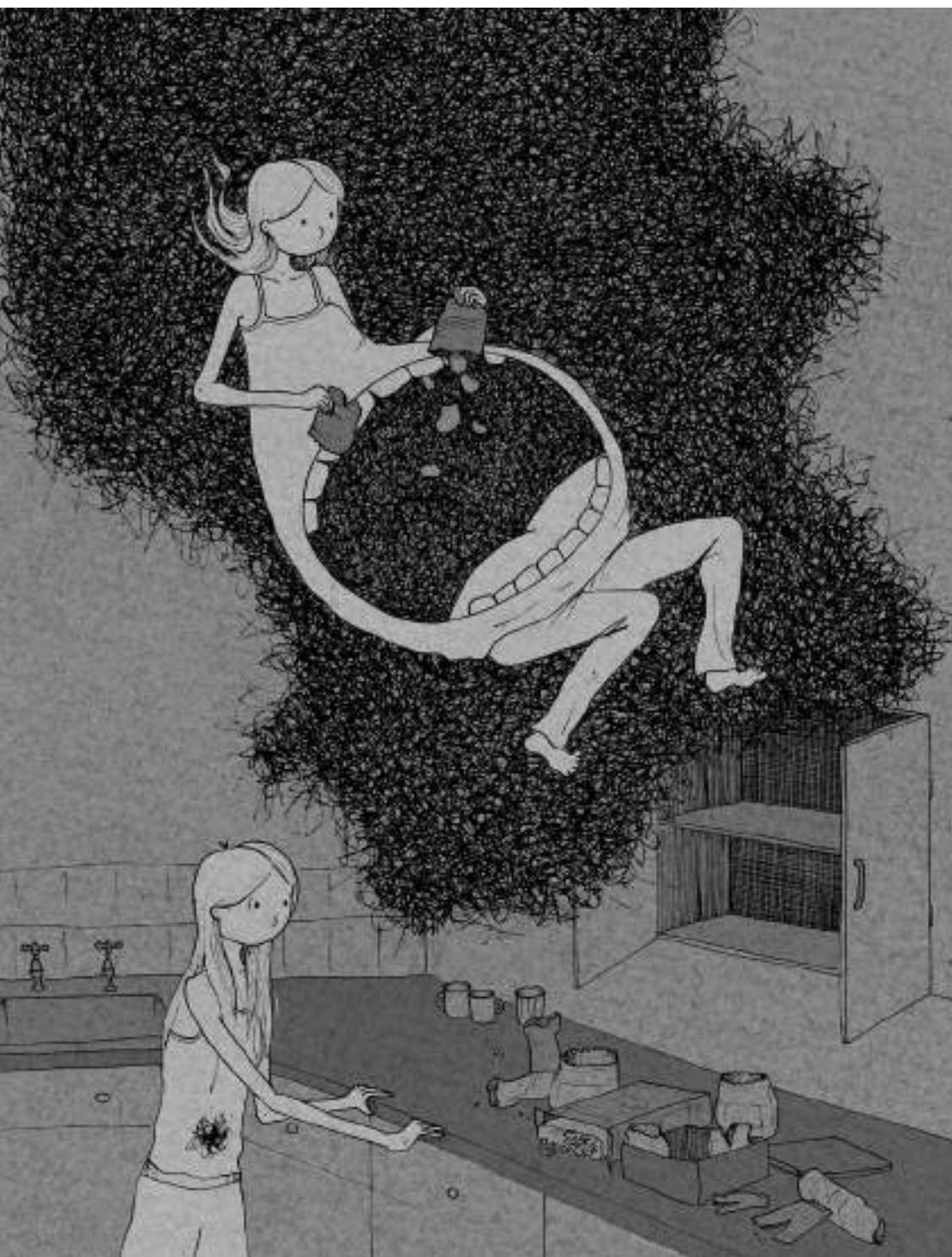
*How does it feel to have your story so publicly available?*

I'm still not really sure how I feel about it. In one sense, it feels like a great relief. I've always been very honest and upfront about my experiences, not ashamed in any way, but it is awkward trying to explain to people. It's nice now I can just offer them a book to read. But it is also quite weird, and interesting dealing with the assumptions

and judgments people make about my recovery. I've felt like there's an expectation to be a role model, to have all the answers, and perhaps in publishing a book I've put myself in that position. By necessity books have endings – after 500 pages, the publishers Jonathan Cape were pretty keen that I wrap it up – but recovery stories don't, and I'm still navigating ups and downs. This doesn't mean I can't be a role model, but it's interesting to find I have to keep impressing that this work is ongoing, rather than the closed book version of events people seem to want to hear.

*What kinds of responses have you had, from eating disorder sufferers or their families or from professionals?*

The response from all of these groups of people has been humbling and completely overwhelming. I've struggled to really take it in. I always hoped that in putting my story out there it might connect with someone, help them realise they are not alone in the world, but to hear from people who've been affected in such a way has been both heart-warming and heartbreaking. It's wonderful to have been able to touch so many people, but I also find it devastating to hear from so many who've struggled and suffered and felt the same depths of pain. That I might have done something that can bring a little hope to them is overwhelming to me. I've heard from eating disorder sufferers, abuse survivors, families who've gained understanding of their loved ones, and professionals, some of whom have invited me to speak at events and training days. To be a part of spreading understanding and compassion in this way has been such a great privilege, and beyond anything I could have hoped when I started drawing monsters all those years ago. ■



# In The Studio

by Caren Messing

In dangling suspense, she rocks to and fro  
against the side of the building, by three curled fingers.

Will I fall?

Can I hold on?

Who is watching?

The graphic novelist turns to his coffee and notices a dead fly afloat at the rim. Brimming with heroic pride he teases the exquisite corpse up and out of the roasted elixir and drapes it over a paper clip, now an altar.

'University one, zero, five, four, six,' the disembodied voice cries.

From where did he hear this? The graphic novelist sighs in recognition of the insurmountable task of differentiating the voices he hears from the storyboards he creates versus 'real' life.

He sips his tepid coffee. He notices the reflection of his nostrils in the drink. Carefully, he tilts and rocks the cup so the liquid-image stretches and undulates: his nostrils are dilating and constricting ... Yes, like phases of the moon: they're waxing and, now, they're waning in arrhythmic parallax, in a sort of celestial wobble.

'Now THAT'S nostril flare!' he says aloud.

Perhaps this declaration of discovery will arouse the lifeless body of the fly on the paper clip. Hmm. No response.

He enjoys his mornings in the studio: such noisy contemplation, disarray and solitude. The despair? It doesn't rise up until later in the day—like a thinly veiled aroma, evanescent and bitter sweet, he has accepted that the despondency is like a recurring old friend. If welcomed and not shunned—demands very little of him really: only a polite acknowledgement that he shares the space and time with the familiar visitor.

So, before the arrival of this 'old friend' these mornings are peculiarly sanctified with the perplexity of creating narratives in his studio about Heroes and Villains. So far, he has not completed the turn in the story where the innocent vixen is dangling from a window ledge. Her breasts in blue cashmere pounce and press against red brick and limestone ledging. She prays for heroic interception as her encroaching surrender to gravity imminently waits ...

'Should I draw a close-up of her hands and flexed fingers grasping the window ledge? Or perhaps the image of her curvaceous frame suspending against the rectilinear building is evocative enough?' (Fingers thrap-thrap-thrapping.)

'What color nail polish should I use for this close-up?' He remembers the master artist (in his university-daze) who impressed upon him the 'use of specific choices and vivid detail to gain the adherence of ones audience'.

He slurps his coffee. The air feels good on his gum-ridge. 'I'll draw her nostrils flaring in the adrenaline crisis awaiting rescue ... Yes, so we'll cut from nails to nostrils ...' He cannot tell if he said this aloud or merely thought this but his skin is tingling with anticipatory delight. Any rush of creative energy not only gives him goose bumps but also makes his balls tingle.

'Perfect: her fingernails, clutching like talons, are ruby red. Then, cut to her nostrils flaring—let's anoint the ruby red color on her upper lip in this frame.' Now, it's time to let go. She releases her grip and yells, 'Yooooo!' Succumbing to the constancy of gravity is never an easy transition for him; he interiorizes everything from the storyboard prior to moving forward with the graphic narrative.

The immortality of the present moment widens. Echoing nullity, creeping murmur, the poring dark flood his senses and then, a well-spring of images: orgiastic displays of bestial bliss with flesh-clutching desperation and forceful penetration, the whimpering surrender of contractions and expansions pulling him in ecstatic inebriation and chaos. The seismic shifting of earth perforates, widens and floods. Desolation on a universal scale resonating in ancestral memory: a primordial apprehension and ritual reluctance towards the capricious powers of Nature. Such havoc. Such mass extinction of Life—for the sake of what? Feels so alive, so on the Precipice of Falling ...

'Yooooo!'

Stillness.

Nothing is better than an orgasm weaving in and out of apocalyptic cataclysm.

Skin sensitive and spearmint humming in his pelvic floor, the pressure behind his neck is gone. Allowing himself to be a vessel for creativity has always aroused him and he no longer suppresses these overages in self-violation and pleasure.

'Yooooo!' were the vixen's last words as she surrenders to her descent from the building's window-ledge. 'Yooo yooo-iversity one you won-you-won-you won ...'

In stammering incredulity he looks around the room—did he say this? Or merely think it?

His eyes are empty like coffee cups. A sip from the cup:

now his coffee is cold. Carelessly, he clunks the cup down—the concussion audibly felt in the back of his head ... Is the headache returning?

This is typically when the heroic interception is summoned. How can he rise above the wish to, now, lie down and stare at the ceiling? The vixen in the storyboard needs to be saved. He must commit and draw her limp body a-splat on the pavement ... Similar to photographic paper slowly developing in its tray (don't tamper with it—just let the emulsion and sensitive silver salt interplay on the paper) the image in his mind starts to emerge.

'I'll draw her like a lipstick stained napkin and cigarette butts crushed like dreams', (Fingers thrap-thrap-thrapping.)

Despondency and grief overwhelm him. His expression becomes dour glancing over to the spiritless body of the fly he meticulously draped over the paper clip.

'Ah-huh.'

(Tracing the spine of the table.)

'Hello, old friend. You, you, you won ...' he says aloud welcoming the ineluctable visitation of despair. Turning away from his table he notices the sun peeking through the low-hanging clouds of mourning.

The ruby-red-manicured vixen is in the static-fixity of falling.

'University one, zero, five, four, six,' says the distant voice, reaching for another shape like words making their way through dreams.

(Just an eye-twitch away ...)

Why this is his family's original phone number!

Yes, that army-green, rotary phone with that extra long, tangling cord. The actual ring-ring-ring of the phone: sounds had sounds then, nothing electric, nothing pretend.

'What if I dial this phone number right now? Whose disembodied voice would be on the other side?'

His fingers are curled in dangling suspense.

Will I fall?

Can I hold on?

Who is watching? ■

# THE LIGHTER SIDE OF ANXIETY DISORDERS

by Michelle Grimley

Cartoonist Natalie Dee's website features daily single-panel webcomics with a playful, colourful visual style.<sup>1</sup> These almost childlike images contrast the underlying dark humour and themes that pinpoint the frustration and absurdity of life. Dee's webcomic characters animate her biting wit and include anthropomorphised stick figures, animals, household objects, blobs, and food. Her artwork ranges from seemingly simple to highly complex and detailed, subverting the traditional comic format and style. The tone of her messages are often nonsensical and nihilistic: a refreshingly honest expression of everyday mediocrity and disappointment.<sup>2</sup> Dee's comics make light of her personal experiences with depression and anxiety without diminishing the severity of their toll on her well-being. Like Dee, I often use humour to put my anxiety disorder in perspective. Self-deprecation and sarcasm help me to make sense of, and communicate, painful times. On a larger scale, comedic interpretations of psychological difference work to dismantle the authoritative medical terminology that primarily seeks to categorize and cure.



Dee's *Anxiety Girl* webcomic presents a young woman clad in superhero garb, positioned to leap off the page.<sup>3</sup> Playing on Superman's ability to leap tall buildings in a single bound, Anxiety Girl is 'able to jump to the worst conclusion in a single bound!' Anxiety Girl's intense reaction to her constrictive hosiery illustrates this extraordinary talent: 'Oh, god ... these tights are too tight. I think I'm gonna die!!' The caption on the image reads: 'Now I'm a superhero.' The title confirms that the character of Anxiety Girl is, at least loosely, based on the artist's identity. This connection gives some context to the work, with Dee transforming her faulty anxious thoughts into superpowers. This exciting approach propelled me to

recast my diagnosed symptoms of obsessive compulsive disorder (OCD) as positive traits. It is invigorating to re-imagine excessive hand-washing, listing, sorting, and worrying as celebrated, sought after superpowers.

It is empowering to try on a version of myself that is not only unashamed of living with OCD, but can actually benefit from the stigmatized identity. Illustrating the humour in anxious thoughts is a highly compelling counter-narrative to that of trauma, distress, treatment, and overcoming. Playing with perspectives on mental illness can lend itself to a deeper exploration of the ways psychological diagnoses stigmatize and harm. Ritualistic and obsessive expressions can emerge swiftly and unexpectedly – similar to the transformations made by superheroes when they take on their heroic form. A latent condition that transforms a person when they perceive a threat is considered fundamental to both superheroes and people with a mental illness. It seems worth interrogating why we idolize the former group while condemning the latter.

With hilarious honesty and compelling authenticity, Dee cleverly takes on the stigma of living with chronic depression. She illustrates the humour in annoyingly having to explain and defend her seemingly strange actions to others. One of the comics directly addressing depression features her signature (quasi-stick-figure) cartoon woman sitting at a table. She balances her head in her hand, and wears a bored, straight lipped expression on her face.<sup>4</sup> A beam of light washes over the figure and the text on the comic reads: ‘Don’t mind me! I’m just sitting in front of my SAD lamp on a September afternoon. Totally normal.’ Seasonal affective disorder (SAD) is the experience of depressive symptoms during particular seasons. Usually, the disorder is linked to the common mood changes that accompany colder, darker, sedentary winter days. Light therapy is one treatment for SAD, and it is typically for use during months that have little or no natural sunlight and drastically low temperatures.<sup>5</sup> Experiencing SAD in the late-Summer, early-Fall climate is the basis of the comic’s humorous title: ‘What if every season affects my disorder? Oh, that’s just called depressed as fuck.’

Dee’s description of her depression is a bold self-representation. Being normal (or at least appearing to be) is bestowed a high value in a society that stigmatizes mental illness. Dee reclaims what is often considered a shameful disorder and, with sarcastic self-awareness, nonchalantly refers to it as ‘totally normal’. She confronts the socialized pressure to conceal her depression, thereby stripping the psychiatric label of its prescribed power. Telling the reader ‘Don’t mind me’, invites a rare opportunity to glimpse into the life of a person living with depression, without the expectation of pity or judgment. Dee’s comics present an embodied knowledge of living with depression. Her work is incredibly important because representations of anxiety disorders that do not focus solely on the eradication of troublesome symptoms are scarce.



It is difficult to communicate neutral or positive experiences of living with obsessive compulsive disorder. The labelling of traits inherent to my personality as harmful symptoms of OCD can be disparaging. Dee’s artistic approach reveals possibilities for innovative ways of sharing distressing experiences without shame. Viewing peculiar thoughts and actions as valuable qualities allows a fresh perspective on socially stigmatized behaviours. Recognizing our expertise and agency as depressed, anxious beings advances self-determination and self-acceptance. I believe this lays the groundwork for shifting our cultural understanding and judgment of anxiety disorders. The prevalent stories of conquering psychological symptoms with medication and therapy contribute to feelings of failure and self-loathing if we are unable to change, or when we relapse. As an alternative, reconciling the illogical and absurd parts of our unique personalities may be a better path to openness and acceptance. ■

*Michelle Grimley is a critical disability scholar at York University. By working to dismantle dominant understandings of this embodied difference as an individual and societal burden, she attempts to reinterpret the unusual, repetitive thoughts and behaviours labelled as undesirable symptoms of obsessive compulsive disorder ... One day at a time.*

## References

1. Dee, N. *Natalie Dee: America's Favorite Cracker 2002–2014*. 28 Sept. 2014. [www.nataliedee.com](http://www.nataliedee.com)
2. John, J. The Rumpus Interview with Natalie Dee. *The Rumpus* 31 Jan. 2013. [www.therumpus.net/2013/01/the-rumpus-interview-with-natalie-dee/](http://www.therumpus.net/2013/01/the-rumpus-interview-with-natalie-dee/).
3. Dee, N. Now I'm a Superhero. *Natalie Dee: America's Favorite Cracker*. 9 May 2008. [www.nataliedee.com/050908/now-im-a-superhero](http://www.nataliedee.com/050908/now-im-a-superhero).
4. Dee, N. What if Every Season Affects My Disorder? Oh That's Just Called Depressed as Fuck. *Natalie Dee: America's Favorite Cracker*. 28 Sept. 2012. [www.nataliedee.com/092812/what-if-every-season-affects-my-disorder-oh-thats-just-called-depressed-as-fuck](http://www.nataliedee.com/092812/what-if-every-season-affects-my-disorder-oh-thats-just-called-depressed-as-fuck).
5. Rosenthal, NE. Issues for DSM-V: Seasonal Affective Disorder and Seasonality. *The American Journal of Psychiatry* 166:8 (2009) 852–853. 28 Sept., 2014, PsychiatryOnline.

This is page 3, continuing after the two-page strip by Brick that we published in the previous issue of Asylum (22.2, pages 18-19). Many apologies to Brick and to our readers for this 3rd page getting mislaid somewhere along the editorial lines.

On the down side, the damn animal's internal ticker makes an atomic clock appear slack.



But punctuality was the least of my early problems with her...



Taking on a dog daily confronts depressives with two of their worst nightmares...



**TAKING RESPONSIBILITY**



**IMPOSING STRUCTURE**

Feelings of security, purpose, optimism and self-worth blossom...



Once overcome, confidence and self-esteem shoot up...



...and a whole wonderful world of beauty, balance and butterflies becomes yours and your mutt's for embracing!



# RECOVERY IN THE BIN

**Key Principles**, agreed and adopted by group members 6th February 2015.

- We oppose the ways in which the concept of 'recovery' has been colonised by mental health services, commissioners and policy-makers.
- We believe the growing development of this form of 'The Recovery Model' is a symptom of neoliberalism, and capitalism is the crisis! Many of us will never be able to 'recover' while living under these intolerable social and economic conditions, due to the effects of social and economic circumstances such as poor housing, poverty, stigma, racism, sexism, unreasonable work expectations, and countless other barriers.
- We believe 'UnRecovered' is a valid and legitimate self-definition, and we emphasise its political and social contrast to 'Recovered'. This doesn't mean we want to remain 'unwell' or 'ill', but that we reject the new neoliberal intrusion on the word 'recovery' that has been redefined and taken-over by market forces, humiliating treatment techniques, and atomising outcome measurements.
- We are critical of tools such as 'Recovery Stars' as a means of measuring 'progress', since they represent a narrow and judgemental view of wellness and self-definition. We do not believe outcome measures are a helpful way to steer policy, techniques or services towards helping people cope with mental distress.
- We believe that mental health services are using 'recovery' ideology to mask greater coercion. For example, the claim that Community Treatment Orders are imposed as 'a step towards recovery'.
- We demand that the mental health services put no-one under unnecessary pressure or unreasonable expectations to 'recover'. For example, being discharged too soon or being pushed into inappropriate employment.
- We object to therapeutic techniques like 'mindfulness' and 'positive thinking' being used to pacify patients and stifle collective dissent.
- We propose to spread awareness of how neoliberalism and market forces shape the way mental health 'recovery' is planned and delivered by services, including those within the voluntary sector. We want a robust social model of madness and distress from the political left, placing mental health within the context of the wider class struggle. From evidence and experience, we know that capitalism and social inequality can be bad for your mental health!
- We demand an immediate halt to the erosion of the welfare state, an end to benefits cuts, delays and sanctions, and the abolition of Work Capability Assessments and Workfare, which are both unfit for purpose. As a consequence of austerity, people are killing themselves, and policy-makers must be held to account.
- We want genuine non-medicalised alternatives, like Open Dialogue and Soteria-type houses to be given far greater credence, and sufficient funding, in order to be planned and delivered effectively. No half measures: redistribution of resources from traditional mental health services if necessary.
- We demand the immediate fair redistribution of the country's wealth, and that all capital for military and nuclear purposes be redirected to progressive user-led community/social care mental health services.
- We need a broader range of survivor narratives to be recognised, honoured, respected and promoted. Rather than only 'successful recovery' stories, we need more of an understanding of the difficulties and struggles that people face every day when they are unable to 'recover'.
- We oppose the policy that 'Peer Support Workers' are expected to have acceptable 'recovery stories' which entail gratuitous self-exploration and versions of 'successful recovery' that fulfil expectations, while no such job requirement is expected of any other workers in the mental health sector.
- We refuse to feel compelled to tell our 'stories' in order to be validated, whether as Peer Support Workers, activists, campaigners or academics. We believe that being made to feel you have to tell your 'story' to justify your experience is a form of disempowerment, under the guise of empowerment.
- We are opposed to the establishment of 'Recovery Colleges', as a cheap alternative to more effective services. Their course contents fall short of being 'evidence based', and fail to lead to academic accreditation recognised by employers.
- We believe that there are core principles of 'recovery' that are worth saving, and that the colonisation of 'recovery' undermines those principles, which have hitherto championed autonomy and self-determination. These principles cannot be found in a one-size-fits-all technique, or calibrated by an ...

outcome measure. We also believe that, since we are social beings, autonomy and self-determination can only be attained by means of collective struggle rather than through individualistic striving and aspiration.

- We demand that an independent enquiry is commissioned into the so-called 'Recovery Model' and the associated ideology from which it stems.
- We call for our fellow mental health survivors and allies to adopt our principles, and join us in campaigning against this new 'recovery' ideology, by means of non-violent protest. We know our views about 'recovery' will be controversial and used by supporters of the ideologies behind 'recovery' colonisation, so as to try to divide us. However, we seek to balance agitation for fundamental change with the protection of existing services valued by survivors.

**JOIN US AT  
RECOVERY IN THE BIN FACEBOOK GROUP.**

## Put Poetry into the Jobcentre and Leave CBT for Somewhere More Appropriate ...

**Janet Haney**

26 June, 2015. There is a meeting today at 1.30pm at the Streatham Memorial Gardens. I shall be there early. The meeting will gather together a group of people, perhaps 100, maybe more judging from the Facebook page, who will then march up the road, not far, to the Streatham Jobcentre. It is a mark of our varying dissatisfactions with the Government's idea of putting CBT therapists in job centres, supposedly in an attempt to get people 'off the dole and back to work'.

What a beautiful day for a protest, the roses are blooming and the birds are singing. I barely have time to look at the statue with its inscription 'To Our Glorious Dead', and the list of names inscribed below. It's 1.15pm and already there are twelve people standing in the shade of the trees, and two are holding up a banner which the other ten are photographing. The gist of the banner is this: 'CBT practitioners: Are you a professional or a collaborator?'



I set to work introducing myself and asking people why they bothered to come today.

'It's a human right to be able to refuse medical treatment. To not be made to be part of an experiment. It's written in the UN Declaration of Human Rights.'

'I'm just gutted. Council houses, Brixton Arches, rent increases, everything.'

'I want to support people facing cuts to their allowances. I have friends with distress who are scared by the way things work.'

'It seems a really bad idea to combine a disciplinary system with social care.'

The next person turns out to be a national spokesperson for the Green Party: 'The Government is crossing a line – it's written in their Manifesto, their intention is clear. Don't believe them when they say there's no coercion, it's written in their Manifesto.'

'It's an inappropriate setting – it is not a place to speak freely, which it should be for any therapy.'

'It's wrong to make a mental health service part of a sanction system.'

'To cut public spending, they are hitting the most vulnerable.'

'It's clearly wrong.'

'Mental Health isn't something you can flick a switch and fix'.



‘The problem, in my opinion, is that we live in a system which makes us ill – unemployment, poverty. Actually I’m doing therapy, CBT, over there (points just over the main road which is throbbing with traffic fighting its way into the narrowing Streatham High Road). The services become part of the problem. They mean well, the people who work there, but it’s done in a way that, well, you are made to feel uncooperative if you turn it down. And the political, social situation is not up for discussion – these are the things we really need to talk about if we are going to get better.’

‘The problem with CBT is that it makes you the problem, and tries to change your attitude.’

‘Debt. Struggling with debt leads to suicide.’

‘I’m horrified, instead of funding mental health services in clinical settings, I had to wait six months for CBT. Why not fund it more in places where people actually go to talk about their health?’

‘My girlfriend is terrified, and she has taken on the language of officialdom. She says that she is a ‘shirker’! She is terrified of psychiatrists, of the ways of the medical system. She feels like a terrible burden on everybody. She has been invited to go to job centres, I go with her, but she panics in waiting rooms, and she panics when she sees the security guards – it freaks her out. She was on DLA, and they said, ‘Would you like to work?’ and she said, ‘Yes, I would like to work!’ and they said, ‘We will help you to go to work.’ So we went there together, I held her hand, she wanted to work, but her expectations were really unrealistic.’

‘Its funny, they speak of parity don’t they, of parity between mental health and physical health? So, if you break your leg and can’t work, will they send you to the job centre to fix it?’

‘It’s about dignity. My partner has worked, she has paid her National Insurance, she has contributed, but now she has taken on their vocabulary, she calls herself a burden ...’

‘Treatment should be voluntary. If the Jobcentre should suggest that people go to the doctor, well, are they qualified to tell people to go to the doctor? If I was working in a Jobcentre I would be very uncomfortable raising it with people, because you have to be very diplomatic when you suggest to someone that they might need counselling. Even when your friend says so, you might feel offended! I mean, you have a personal relation with your Jobcentre advisor when you are unemployed, you don’t want them prying into your personal life, do you? You have to be careful if you speak to someone about their mental health, it could be negligent to raise the question. It is a bit like the oppression we associate with Russia. When I was unemployed you had to sit in an open plan office every

day for two weeks, and look for work. There were people who lectured you about looking for work. There were a lot of vulnerable people there then. Imagine if you had to raise the question of mental health with someone who is clearly in distress and struggling. It could be negligent. Are the people in the Jobcentre qualified?’

‘How dare they take food away from someone? It’s against human rights.’

‘It is a symptom of our civilisation’s discontent, and therefore, worth punctuating. It might not be necessary, never mind possible, to remove it.’



By this time there were about 60 people gathered in the Memorial Gardens, some holding placards and banners and others taking photos. I asked one man what he planned to do with his photos. It turned out he was a freelance photographer commissioned by the South London Press to cover the demo.

Two women picked up the sticks to the Alliance for Counselling and Psychotherapy banner. They were sisters, and they had another sister with a learning difficulty. They told me that they were ‘watching and listening’ to what was happening in the country with the politics, and one said: ‘We have noticed that they go for the weakest first.’

Now we slowly start to muster together and walk across the road. A bloke rolled down his lorry window and shouted: ‘Get outta the fucking road, go get a fucking job.’

While we edge ourselves in amongst the traffic and move slowly up the main lanes of the road, I recognise someone from my early training days.

‘I used to be head of psychotherapy,’ he said, ‘and I would have been raising hell against a move like this made by the management’.

‘Who is the head of therapy now?’ I asked.

‘A CBT guy,’ he replied with a wry smile.

‘And is he raising hell against this new policy?’ I asked.

A broad grin and a loud laugh was all that I gathered of the reply against the roar of the traffic and the shouts of the London drivers.

Someone next to me said that she was concerned about therapy being put next to the Jobcentre function, because 'it puts fear into people's minds'. Then she added, 'Which is not desirable.'

'It is the very thing isn't it, fear?' she went on. 'This is what CBT people try to resolve, isn't it? Yet the people who might need it most would be the ones most vulnerable to exactly this kind of fear.'

This paradox had not escaped her, so she wonders how had it escaped our civil servants and government ministers.



People with microphones are raising our spirits with their strong voices. There is a discreet police presence up the hill and also down the hill, and the security guards in the building are checking people's 'tickets' before letting any one in. Too late! An advance guard from the protest has snuck into the building and is creeping up the stairs as we listen to the man with the mic doing his best to rouse the rabble. A few people take it in turns to move the crowd through the mic, and then a cheer goes up, and everyone moves to the other side of the street and looks up at the top floor of the building. A large red banner is unfurling in the wind, with the words: 'Back To Work Therapy Is No Therapy At All'. It is now 2.30pm.



Someone with the microphone is haranguing Ian Duncan Smith, and talking about the suicides of people who have lost their benefit, and I remember Stevie Smith's (no relation) wonderful poem 'Not Waving but Drowning': *Nobody heard him, the dead man, but still he lay moaning.*

Nobody heard him? We can hear him because he is not yet fully dead, only half dead, still moaning. Threatened and pushed out of the symbolic order, off the benefits, deprived of a means to live with dignity, turned into an object, treated as any old piece of rubbish, but not yet dead. Not yet.

Stevie Smith wrote her poem, 'Not Waving but Drowning', in April 1953. On the 1st of July she self-harmed in the office, and her doctor decreed that she was not emotionally stable enough to go back to work. She was retired with a small pension, and dedicated her life to writing and looking after her ailing aunt. In 1957, the publication of her collection under the heading *Not Waving but Drowning* established her firmly as a major poet worldwide, and opened a new life for her of poetry readings and broadcasts. She soon became a cult poet, and was sought after by the likes of John Betjeman, Philip Larkin and Sylvia Plath.

Should we, perhaps, rather put poetry into Jobcentres, and save the CBT for somewhere more fitting?

*This report was originally written for the Alliance for Counselling and Psychotherapy.*

# SWIMMING UPSTREAM

## HEALTHCARE PROFESSIONALS AND ELECTROSHOCK

**Bonnie Burstow**

*Since the shock treatment, I'm missing between eight and fifteen years ... People come up to me ... they tell me about things we've done. I don't know who they are. I don't know what they're talking about.* (Connie Neil, quoted from the Phoenix Rising Collective, 1984)

This article addresses the continued use of ECT (Electroconvulsive Therapy) and the great need to put an end to it, as evidenced by statements like the above. The damaging nature of ECT is witnessed by survivors throughout the world and is also demonstrated by statistical research (see Sackeim 2007). However, the official discourse around shock treatment – the official ‘medical’ line – positions the procedure as ‘safe and effective’, ‘new and improved’. The fact is that ECT continues unabated and with its reputation intact. Those of us who fight against this state of affairs are in a difficult battle. At the forefront of this struggle are survivors and researchers. What we seldom encounter in the battle, and who might well be able to tip the balance, especially if organized, are the voices of concerned healthcare professionals.

And yet, given the credibility afforded healthcare professionals by society, what they say could be a game-changer. Now, for sure, there have long been specific healthcare professionals, myself included, who have dedicated much of their lives to unmasking the reality of ECT (e.g., Breggin, 1998, and Burstow, 2006). Nonetheless, there are hardly any professional advocacy groups calling for an end to ECT. Moreover, most health professionals either trot out the official line or, more commonly, remain silent.

Why are most healthcare professionals silent about ECT? This article unearths some worrisome dynamics that scream out to be faced. And it ends with concrete suggestions.

### **Why are health professionals not speaking out?**

Discussions with concerned professionals suggest several reasons for this silence. One is that, like everyone else, health professionals often simply believe what the psychiatrists say. The more closely affiliated with

psychiatry, and indeed medicine in general, the more likely are they to assume that the official line on ECT is correct. Given their obvious subordination to doctors, nurses are particularly situated to function this way.

If this is worrisome, what is also worrying is that, like a good part of the population, many health professionals – even those working in hospitals – assume that ECT is no longer used. Nurse researcher Simon Adam says:

You know, for nurses that I have had conversations with about ECT, many of them don't know that it still happens ... So I am wondering: What is happening to nursing consciousness? (Burstow et al, 2011)

How it can be that so many health professionals either do not know ECT is still being given (even when many are uniquely positioned to know) or believe that it is a benign kind of treatment? I suggest that this question of consciousness connects to a larger dynamic: that of power. One way power operates is that it is more convenient to believe the official line, not to question it, or to keep oneself unaware of important details, even to keep oneself unaware that the procedure is still carried out. This is a reality exacerbated by the degree to which professionals are set up to serve institutional ends. In this regard, Adam further states:

There is a power difference there. Nurses, they carry out orders. They respond to institutional needs and institutional interests without ... political questioning and without ... critical thinking ... So even if they were aware that ECT is being administered as much as it is now, they wouldn't even criticize it. They don't know the ‘side effects’ of ECT and the damage that it does.

Albeit nurses are particularly tied to institutional needs, they are hardly the only ones who are ‘professionally ignorant’. Many psychologists, counselors, doctors and social workers, for example, also ‘don't know’, don't think about ECT, or repeat the party line. Once again, the issue is at least partly that of power. Insofar as professionals are unaware – and again, they are uniquely situated to be aware – this would appear to be what Sartre (1956) calls ‘bad faith’. That is, they are unaware or uninformed because, on some level, they would rather not know. This is because to be aware is to feel a responsibility, to open oneself up to the possibility of acting, which, given the power of psychiatry, is to put oneself in danger. So one remains unaware: one does not know that ECT is still carried out, or imagines that unassailable proofs have materialized to establish that the procedure is now ‘safe and effective’.

A related category of professionals who do not speak out are those who actively suspect that something is amiss, and yet probe no further. Their knowledge may occasionally keep them up at night. They may even confess to trusted friends that what is happening is abysmal, and

still not act. Again, power is the issue, at times with the person's very job in the balance. Indeed, so real is this threat and so acutely is it felt that even someone who is normally conscientiously ethical and who is fully aware of the extent of the damage done by shock treatment can go so far as to prescribe and administer it. Peter Breggin said:

As I look back on my career as a psychiatrist, one shame seems unforgivable – my involvement with electroshock. As a resident, I prescribed electroshock, I supervised a ward on which patients were given the treatment, and for a time I personally administered it. Why did I do it, even when I knew it was wrong? ... One of my fellow psychiatric residents refused to give the treatment, and he was summarily fired. (Breggin, 1985)

If members of the medical profession are in jeopardy (and uniquely positioned to violate their ethical calling), other hospital workers are also in a precarious position, with serious risks to their self-interests, to the point of losing their jobs. So they tend to hold their peace. Hospital psychologists make up a sub-class of a larger class of professionals in special jeopardy. The psychology intern Terra Dafoe said:

Psychiatry has all the power ... And we have seen psychology disappear in hospitals across America. So ... there is a real fear of saying anything that is against the grain ... never mind coming out against a treatment that is quote, unquote psychiatry's treatment of choice for lots of things. You know, people will lose their jobs. They've lost their jobs for a lot less. (Burstow et al, 2011)

While nurses and psychologists in hospitals are at greater risk than most healthcare professionals, other professionals are also at risk if they speak out. They can lose their professional credibility. They can be sabotaged. They can fail to get employed, even by quasi-liberal institutions.

In other words, the obstacles presented to 'knowing', and the reasons for not speaking out, are real. All the same, the ethical imperative remains. What is also significant, achieving a critical mass of naysayers would shift the balance. The more professionals speak out, the safer it will become to do so.

All of the professionals quoted in this piece have spoken out. They are also members of a healthcare professionals' organization which I helped form that is committed to ending ECT. Our organization serves as an example, albeit a modest one, of what can be done.

### **Health Care Professionals Against Electroshock Speakers Bureau**

Healthcare Professionals Against Electroshock Speakers Bureau is quite new: a professionals' anti-ECT group. Formed in 2011, it is a Canadian group with international consultants. Our mandate statement in part reads:

The Healthcare Professionals Against Electroshock Speakers Bureau is a diverse group of informed and concerned health care professionals ... What unites us is an ethics of care and responsibility ... which places us in opposition to the continued use of electroconvulsive therapy (ECT) ... We call upon government to ... withdraw its support for this procedure. (Healthcare Professionals Against Electroshock Speakers Bureau, 2011)

The Bureau mounts presentations, gives interviews in the media, and educates people. It also encourages sister groups – the creation of which is one of my primary recommendations.

### **As a professional, what can I do?**

There are a number of ways of helping in this struggle. Begin by facing your fear. And not by denying the very real jeopardy but by working it through, perhaps starting by getting back in touch with the reasons you entered a helping profession in the first place.

The next step is self-education. Read the literature on electroshock. Learn how to distinguish, for example, good from poorly conducted or badly theorized research.

Moves you might consider as you become more knowledgeable and confident include:

- bit by bit, publicly challenging the party line;
- encouraging colleagues to question ECT;
- writing articles or giving presentations at conferences, including discussing the problem of healthcare professionals' silence;
- making deputations at hearings and public inquiries;
- helping create a group or network of professionals in your country that can provide education, speak to the media, advocate and raise awareness;
- encourage professional organizations to which you belong to issue statements calling for an end to ECT.

Arriving at a place where you are strategic is important. And being part of an organized group or network is optimal because a lone individual can more easily be dismissed. While not achievable quickly, one particularly apt strategic long-term goal to consider is winning over big professional organizations with established credibility. Can you imagine the impact, for example, of an organization such as Registered Nurses Association of Ontario taking a public stand against ECT? Even one such organization doing this anywhere in the world would be newsworthy. It would indeed be a game-changer, and as such, this is a goal worth pursuing.

### **In conclusion**

I began this article with a horrific quote from shock survivor, Connie Neil. If stories such as hers are to become a thing

of the past, ECT must end. That means everyone doing their bit – including health professionals. The point is, while psychiatry has very real power and professionals are loathe to become involved, we are called on to dare to know. Moreover, despite the risks – which I do not minimize – as clinicians, we are called upon to say what we know, to speak out: in essence, to ‘swim against the tide’.

Now, as everyone who has ever taken a plunge like this knows, swimming upstream is a curious, even paradoxical process. It is hard, seemingly impossible. The powerful flow of the river pushes you back. However, if enough of us were to do it, and if we were to do it strategically, in the long run not only would we create more safety for everybody, we would alter the course of the current. ■

### References

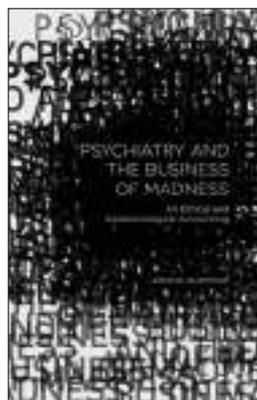
- Breggin, P (1998). Electroshock: Scientific, ethical, and political issues. *International Journal of Risk and Safety in Medicine*, 11, 5–40.
- Breggin, P (1985). The shame of my life. *AHP Perspective*, August, 22.
- Burstow, B (2006). Electroshock as a form of violence against women. *Violence Against Women*, 12, 372–392.
- Burstow, B et al (2011). Electroshock: A conversation (video). Toronto: Healthcare Professionals Against Electroshock.
- Health Care Professionals Against Electroshock Speakers Bureau (2011). Mandate Statement. Toronto: Author.
- Phoenix Rising Collective (Ed.) (1984). Testimony on electroshock. *Phoenix Rising*, 4 (3 & 4), 16A–22A.
- Sackeim, H et al. (2007). The cognitive effects of electroconvulsive therapy in community settings. *Neuropsychopharmacology*, 32, 244–255.
- Sartre, J-P (1956). *Being and Nothingness*. New York: Pocket Books.

*Due to lack of space, we couldn't fit this article into our recent special ECT edition (Asylum 21:3). If you missed it, we recommend you check it out. We also recommend Bonnie Burstow's book, Psychiatry and the Business of Madness, recently published by Palgrave (London: 316 pages) at £22.50.*

*And here are some useful links:*

- [www.comingoff.com](http://www.comingoff.com)
- [www.ectresources.org](http://www.ectresources.org)
- [www.mindfreedom.org](http://www.mindfreedom.org)
- [www.beyondmeds.com](http://www.beyondmeds.com)
- [www.madinamerica.com](http://www.madinamerica.com)
- [www.soterianetwork.org.uk](http://www.soterianetwork.org.uk)
- [www.psychcrime.webs.com/](http://www.psychcrime.webs.com/)
- [www.electricshocktherapy.info/](http://www.electricshocktherapy.info/)
- [www.professionalsagainstect.com](http://www.professionalsagainstect.com)
- [www.endofshock.com/truth\\_about\\_electroshock.htm](http://www.endofshock.com/truth_about_electroshock.htm)

## BOOK REVIEWS



### *Psychiatry and the Business of Madness: An ethical and epistemological accounting*

by Bonnie Burstow  
(London: Palgrave, 2015)

316 pages, £22.50

On behalf of all psychiatric survivors, and those in the system who have yet to come into the realisation that they are survivors too, I would like to thank Bonnie for this all-encompassing, incredible, readable book. It will have survivors nodding their heads in agreement and professionals shaking their heads in horrified realisation as their beliefs are methodically blown apart. It will have society re-examine itself.

I can't agree more with the excellent review by Phil Hickey: 'Normally when I write a book review, I include some quotes from the work to enable readers to judge for themselves the quality and content of the material. With *Psychiatry and the Business of Madness*, however, this presented a problem, in that virtually every one of the 264 pages of text contains eminently quotable material.' He then goes on to quote nine of them.

As for me, I had barely got to page 5 – I repeat, page 5 – before I was crying with joy that such a book had been written. It is my usual practice when reading a book to always take note of good quotes for future use. Like Phil Hickey I found so many that it was slowing me down! I did not want to lose those quotes!

I immediately identified with Julia, at the beginning of the book, whose son Kevin was tragically destroyed by psychiatry while still a young man. On page 13 there is a quote from Julia, 'If Kevin was mentally ill, then so am I, since we were temperamentally identical. And if I am mentally ill, it has never interfered with my ability to function at a high level, just as it has never interfered with Kevin's ability to function until he was given psychotropic drugs. I am an anxious person, and so is most of my family, but I think that ... society should rethink the trend to labelling all the people who are sad and worried and encouraging them to dull their feelings with drugs.'

In this book I found that Bonnie was putting into words all those gut feelings I had. And not only that, she was introducing me to ideas I had not even thought of.

**ABOLISH ECT**  
**SIGN OUR UK GOVERNMENT**  
**E-PETITION!**

**[HTTP://EPETITIONS.DIRECT.GOV.UK/PETITIONS/38309](http://epetitions.direct.gov.uk/petitions/38309)**

**[INFO@SHOCK.ORG.UK](mailto:INFO@SHOCK.ORG.UK)**

I like Bonnie's 'canary in a coal mine' analogy where the sensitive people are the first to fully sense the 'wrongness' of our society. I felt like that canary on the psych ward. I became visibly distressed because of the incarceration and the abuse I suffered there. Did that ailing canary alert anyone to the injustice? No, they just assumed the problem was with the canary, and I was injected in the bottom in a face down restraint. Canary down. Problem solved. What they fail to realise is that not listening to the canaries will be their downfall.

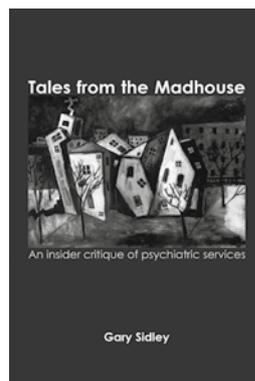
In *Psychiatry and the Business of Madness*, Bonnie inserts whole banks of questions, questions which you may be asking and questions which people may throw at you. She then goes on to answer those questions. It is a superb reference book.

What made me turn from a naive office worker into a psychiatric activist? I first realised the absurdity of psychiatry in 2009, when I was illegally dragged from my home under a section 136 after calling the police to report a crime. I was taken to a mental hospital, and without my knowledge put under a section 2. Within 35 hours they had taken my handbag and phone, broken my right arm in two places and refused treatment for 14 ½ hours and, as I mentioned, injected me in the bottom in a facedown restraint. After six days I was threatened with Electroshock. Luckily, my employer sourced a lawyer and got me out. I sued, and the hospital settled out of court. You can find my video story on the SOAP website: 'Kidnapped by Psychiatry'.

My main campaign is for the abolition of psychiatric Electroshock, and there were excellent worldwide protests this year, on 16th May, which I believe will become a regular event. The edition of *Asylum* magazine on Electroshock which I helped produce was a sell-out. My Government e-petition will be back on the net as soon as Her Majesty's Government sort themselves out after the recent election.

Finally, I would like to thank Bonnie again for the hard work that has gone into this remarkable book, and as Phil Hickey says: 'Please get a copy. Read it and tell others. This book is a major milestone in the anti-psychiatry effort, and stands as a monumental challenge to psychiatry's continued existence as a branch of medicine.' ■

*From a speech by Cheryl Prax of Speak Out Against Psychiatry (SOAP), at Bonnie Burstow's book launch.*



*Tales From the Madhouse:  
An insider critique of psychiatric services*

by Gary Sidley  
(PCCS Books, 2015)

225 pages: £18 (£16 direct from  
[www.pccs-books.co.uk](http://www.pccs-books.co.uk))

The dominant paradigm in the mental health services is variously known as 'the medical model', 'biological' or 'biomedical psychiatry', 'the biochemical imbalance approach', or 'illness like any other'. Whatever they call it, this 'model' is both theoretically invalid and practically damaging to service-users and society in general, and a paradigm shift is urgently required. This is the thesis of Gary Sidley's excellent book. But since this idea is probably accepted by most (all?) regular *Asylum* readers, is it a question of preaching to the converted or would we benefit from this book?

The book is cleverly and innovatively structured, with each of the first nine of the ten chapters divided into two parts. The first parts consist of clear, concise but scholarly – and well-referenced – reviews of the following issues: (1) how doctors have assumed control of the 'mentally disordered'; (2) the 'illness like any other' mantra; (3) the stigma, including self-stigma, of being a psychiatric patient; (4) the misuse of power by psychiatry and the powerless role of the psychiatric patient; (5) the promotion of passivity and submissiveness; (6) excessive bureaucracy and unrestrained risk aversion; (7) the professionals' low expectations of patients; (8) the symbiotic relationship between psychiatry and drug companies; and (9) the lack of compassion within psychiatry.

Based on Sidley's thirty-three years in NHS mental health services, as a psychiatric nurse and a then a clinical psychologist, the second part of each chapter provides anecdotal observations which dramatically illustrate how the issue he examines in practice affects the mental health system. This is effective because the examples he uses relate directly to the issue discussed earlier in each chapter, and it also avoids the problem of accounts that are either too technical for the non-professional or rely too much on examples divorced from any theoretical underpinning.

I won't ruin the book for potential readers by repeating any of the anecdotes, but as well as apt they are always alarming, often horrifying and occasionally amusing. Sidley effectively employs RD Laing's quote: 'I am still more frightened by the fearless power in the eyes

of my fellow psychiatrists than by the powerless fear in the eyes of their patients.’ (*Wisdom, Madness and Folly*, 1985, p. 16)

The first part of Chapter 2 provides an excellent and pithy summary of the problems with attempts to prove that mental health problems (‘mental illnesses’) are primarily caused by biological and genetic factors. This is suitable for the non-specialist, and also encourages further reading. The first part of Chapter 8 does the same for exaggerated claims concerning the efficacy of psychiatric drugs.

Sidley describes how the medical model discourages service-users’ participation in treatment programmes, so that they simply passively follow the treatments provided by psychiatrists. This is particularly problematic when the paradigm defines recovery from mental health problems as ‘the elimination of symptoms’ rather than ‘living a worthwhile life irrespective of ongoing problems’. Controversially, he also suggests that making social security benefits depend on the continuation of mental health problems (‘psychiatric disorders’) is a barrier to recovery from conditions that are essentially reversible.

He also explains why the Care Programme Approach (CPA) – the central framework for service provision in the UK – results in excessive bureaucracy and a box-ticking culture. I have experience of this. A large proportion of my time with my care co-ordinator is spent jointly filling in forms which, essentially, ask for information I have already provided in a slightly different format.

In the last chapter Sidley examines the paradigm shift that is necessary to meaningfully promote positive mental health. He believes that the following, taken together, give grounds for optimism that the shift may be possible: (a) the heterogeneity of individuals and groups condemning traditional psychiatric practice; (b) the growing recognition within the psychiatric profession that all is not well; (c) the embryonic signs that biological psychiatry’s dominance of the mental health research agenda may be weakening; (d) the growing number of legal actions against pharmaceutical companies; and (e) the pressure to reduce the amount of public money dedicated to health services where the remuneration of consultant psychiatrists dwarfs that of other staff groups.

Sidley believes that at least five conditions are necessary for the paradigm shift to take place. Firstly, we must support existing positive practice such as the ‘recovery approach’. Secondly, we need to more effectively challenge the dominant medical paradigm. For example, recovery academies or colleges are a promising way forward: that is where courses are

provided to mixed groups of service users, staff and carers, and are jointly facilitated by staff and people with lived experience of mental health problems. I have benefited from such a college, based within the Norfolk and Suffolk Mental Health Trust. Thirdly, as proposed by Joanna Moncrieff, we need to promote informed decision-making about medication; this would be helped by moving from a disease-centred approach to a drug-centred approach – from ‘This drug will cure your biochemical imbalance’ to ‘This drug will have the following effects’. Fourthly, radical, whole-system transformation is required to create the type of society that enables people to flourish; it is also necessary for the prime responsibility for addressing human suffering to be moved from the NHS to a new dedicated Government ministerial department. Fifthly, as proposed by George Szukler, the Mental Capacity Act (2005) and the Mental Health Act (2007) should be revised in order to introduce a single comprehensive law dealing with involuntary treatment based solely on ‘capacity’ and ‘best interests’, and with no specific reference to mental disorder.

In conclusion, this book clearly summarises all the problems with the dominant medical paradigm within the mental health services, and illustrates them with telling anecdotal examples. The case Sidley makes for the need for a paradigm shift is exceptionally strong, and he capably introduces the nature of this shift and some of the conditions required to bring it about. He aims his book at mental health professionals, service-users and general readers concerned by the way our society responds to human suffering. I have no hesitation in recommending it to them, especially if they are not already critical of the dominant paradigm. As I mentioned, the issues covered in the book will be familiar to regular *Asylum* readers, but I believe they will find the anecdotes revealing, the research reviews helpful, and Sidley’s views on the necessary paradigm shift stimulating and occasionally controversial. ■

**Jeremy Spandler**

## NEWS & FINDINGS

### BEDS SHORTAGE PUTS MH PATIENTS AT RISK

The 'watchdog' Healthwatch England says that pressure to free up mental health beds may be putting vulnerable people at risk. They accessed data from 32 MH trusts that shows the average number of 'bed days' per psychiatric patient per year fell by 6 days (or 10%) during the year to April 2014. Chairwoman Anna Bradley said that some patients are discharged too early and without enough support, and they often struggle to access crisis treatment at home. Statistics from the last few years show that the number of suicides of patients being cared for at home has been double that of inpatients.

'What is particularly problematic is when people leave institutions, they cannot access the support they need in the community. We have heard of cases where people have taken their own lives ... Our concern is that people are being lost between hospitals and community services.'

Prof Louis Appleby, chairman of the National Suicide Prevention Strategy advisory group, says the numbers represent a change in the nature of acute psychiatric care, with treatment increasingly provided outside hospitals. While many patients prefer care at home, it can also represent a risk.

'The ideological drive towards services in the community and away from beds, can go too far. Eventually that drive crosses a line – and that line is safety... If you combine the ideological drive with pressure on resources, you have a toxic combination.'

According to the most recent report from the Chief Medical Officer, Prof. Dame Sally Davies, investment in the key community teams set up to replace inpatient care has fallen. Between 2010–11 and 2011–12, investment across the three priority areas – crisis resolution, early intervention and assertive outreach – fell for the first time, by £29.3m from £520m. Her annual report notes this is 'significant ... given ... the co-existing reduction in bed availability'.

Chris Naylor, of health think-tank The King's Fund, said there is evidence that mental health is under-funded compared with physical healthcare, despite recent government promises to ensure parity of esteem. 'Mental health accounts for about 23% of the burden of disease in England, but it only receives around 11% of the funding ... If the government is serious about putting mental health care on an equal footing with physical health, then it's going to need a really serious commitment in the next parliament.'

A Dept of Health spokesperson said: 'Commissioners are expected to give a real-terms funding increase to mental health this year. NHS funding for mental health increased by £300m last year.'

Champion, G (2015) Mentally ill patients sent home unsupported, experts warn. *BBC News* 19 May.

### POOR RESPONSE FROM MH CRISIS STAFF

The Care Quality Commission reviewed a sample of locations across England, received a survey return from 1,750 people who recently experienced a mental health crisis, and looked at national data. Although it is difficult to determine the exact number of people who have a crisis, more than 68,800 people were admitted to a mental health ward for urgent care in England as inpatients in 2013/14.

The CQC concludes that failings in NHS response are often resulting in the most vulnerable people being abandoned.

It is concerned that public services, such as local authorities, NHS trusts and clinical commissioning groups, are failing to work together to make sure that people in their local areas have access to crisis care around the clock. Delays in accessing quick and compassionate help mean that risks to the health of patients undergoing a crisis, including risks of self-harm, are increased.

The report also finds that healthcare professionals, such as those in A&E, 'can appear to lack compassion and warmth in how to care for and speak to people who are having a crisis', especially those who have self-harmed. In general, though, people suffering from a psychotic episode (experiencing delusions, hearing voices or losing a sense of reality), extreme anxiety or panic attacks, feeling suicidal, or behaving in ways considered dangerously irrational or 'out of control' most often find their mental distress compounded by unhelpful attitudes among doctors and nurses. Only one in seven (14%) of the patients surveyed said the care they received had provided the right response and helped to resolve their mental health crisis. 42% said it had helped a bit, but 40% said the care they had received was not right and had not helped them resolve their crisis.

The CQC's deputy chief inspector of hospitals, Dr Paul Lelliott, said that the behaviour of emergency department (A&E) staff in particular is 'quite shocking', as they should know much better. Although NICE introduced guidelines for treating people who have self-harmed a decade ago, 'many services are still failing to provide a caring, empathetic response when presented with a person who may have harmed themselves.' While some parts of England treat people experiencing a crisis well, 'far too many people in crisis have poor experiences due to service responses that fail to meet their needs and lack basic respect, warmth and compassion. This is unsafe, unfair and completely unacceptable.'

GPs received good ratings but many survey respondents said that the police and ambulance services were much better at helping them than the three key types of NHS teams that are trained to do so: A&E staff, community mental health teams and crisis resolution home treatment teams. The survey found that while 86% of those who had received care and support from charities and volunteers felt that their concerns had been taken seriously by them, only 37% said they felt this from A&E staff. [But of course: GPs, police, ambulance and

volunteers are all under much less stress since they can always pass on the responsibility to a MH official.]

Katherine Rake, the chief executive of the patient watchdog Healthwatch England, said its recent research involving 3,000 people with mental illness echoes the CQC's findings. 'We have heard reports from people that helpline staff were hanging up on them because they were seen as 'difficult' callers. Many others told us they constantly have to explain their circumstances to a chain of professionals because notes cannot be accessed out of hours.'

As well as staff training, CQC identifies a clear need for better 24-hour support for people in crisis, particularly between 11pm and 5am, when availability and accessibility is poor. The CQC says that this means that people often have to go to A&E departments or even to police cells while a 'place of safety' is found for them, rather than receive specialist care straight away. It fails to mention that too often, because it is such hard work finding a bed in a mental health unit, a person is sent home from A&E and has to wait for someone from a mental health team to turn up later; and that this sometimes ends badly. (See the following news item.)

Although there is no mention of it by the CQC, it really is time for establishing hospital departments specifically devoted to MH A&E. As if the funds will be found for that ...

Campbell, D. (2015) A&E staff attitudes to patients in mental health crisis 'often shocking'. *The Guardian*, 12 June; Public services must 'wake up' to gaps in mental health crisis care, warns CQC. [www.cqc.org.uk/](http://www.cqc.org.uk/) 12 June 2015.

## MH DISORGANISATION PUTS PATIENTS AT RISK

Evidence of the results of disorganisation and callousness in the mental health service rarely merits a mention in the national news, but occasionally it surfaces in the local news.

Recently a Mr Sims was found dead having 'deliberately killed himself by cutting off his hand with a hacksaw, although more could have been done to prevent his death, a coroner has concluded.' He was found by a crisis team who turned up to assess his mental health.

However, Mr Sims had already been diagnosed with psychosis, and had repeatedly complained to his doctor about tinnitus, insomnia, and his pacemaker being controlled by outside forces. Then he took an overdose, cut his wrist and called an ambulance. The MH nurse at A&E admitted that Mr Sims said he couldn't cope any longer, and felt anxious about going home. All the same, in the evening she sent him home in a taxi, and contacted someone in his local crisis team to visit him that night because there was 'a significant risk'. However, this next nurse testified: 'I wasn't aware of any particular risk, but I knew there was some concern. I explained I'd come to see how he was and see what support could be offered and told him he would be assessed the following day.' Another psychiatric nurse, also from the crisis team, explained that Mr Sims was not seen in the morning as the doctor was not available until the afternoon. He was

called by phone at 1pm, and finally visited by someone from the crisis team at 7.45pm – by which time it was too late. After the event, the local MH Trust 'raised concerns' because the man was not seen at home for 20 hours, and said 'the delay may have resulted in potential suicide prevention opportunities having been missed.'

The coroner considered this 'a missed opportunity', but that the two MH trusts 'had been thorough in implementing changes since [the man's] death and considered all matters had been addressed.' Well, let's hope so ...

Angear, V. (2015) Man died after cutting off hand, says coroner. *North Somerset Times*, 10 June.

## RISE IN REPORTS OF CHILD ABUSE & NEGLECT

By now it ought to be well known that mental health difficulties correlate closely with emotional and psychological trauma during childhood. Although too many in authority still seem disgustingly reluctant to respond properly, one positive to emerge from the Jimmy Savile debacle is that abuse is now more likely to be reported, believed and investigated.

But there are no indications that children are suffering any less. In the year 2013–14, sexual offences against children recorded by police in England and Wales soared by more than a third to 31,238. This equates to 85 such offences every day, or three every hour. The offences include rape, sexual assault and grooming.

Most victims were between the ages of 12 and 16. But more than a third (8,282) were under 11, including 2,895 aged five and under, and 94 babies. Nearly five times as many offences were recorded against girls than boys (24,457 and 5,292).

This information comes from the NSPCC: the report 'How safe are our children?' and the annual report on the extent of abuse and neglect in the UK. Official statistics show that all four countries in the UK have seen the number of recorded sexual offences against children increase by up to 40% in one year.

These reports also reveal the highest ever recorded number of children referred to social services in England: 570,800. The number of children in the child protection system in the UK has increased by 80% since 2002. The most common reason for children to be put on the system is neglect. The number of contacts by worried adults to the NSPCC helpline about neglect in 2014/15 was 228% higher than five years before (17,602 as against 5,363). And the number of children re-registered onto child protection registers in the UK for at least a second time has also increased.

Besides these depressing statistics, in 2013/14 one-in-fifteen 10–15-year-olds in England and Wales was a victim of a violent crime: an estimated 445,000 violent offences were experienced by children in that age group.

NSPCC/News. 17 and 18 June 2015.

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