

# Asylum

the magazine for democratic psychiatry

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**~ LGBTQ SERVICE CUTS ~**

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**'News from Soteria Bradford' continues on page 4...**

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# The magazine for democratic psychiatry

Volume 23, Number 3, Autumn 2016

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

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

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# INTRODUCTION

There have been a fair number of themed editions of the magazine during the last couple of years. This time, ranging from the polemic to the poetic, the serious to the more humorous, the contents reflect a disparate variety of concerns to some of our readers, and these items have been waiting to see the light of day. Diana Rose's article

(page 5) particularly addresses our publishing policy, and as we say in reply, we agree that there probably is a lack of user/survivor research-based contributions, and we certainly do welcome those kinds of articles. All the same, we invite material from any quarter or point of view, so if you feel you have something to say – let us know! ■

***In the last issue (pages 16–19) we featured Soteria in Birmingham and Brighton. Now we bring...***

## News from Soteria Bradford

---

*He told me that it was the only place that he felt that he could turn to when he was in such a desperate state. I know he feels very grateful to you and the team of volunteers who have given him their support. (Mother of a Soteria housemate.)*

After many years of development, Soteria Bradford has successfully gone on to support five people and their families who are experiencing a crisis. This far surpasses our original aim of supporting one person, over a year, with our self-raised funds of £25,000.

There is nothing new or complicated about what we do, nor is there a convoluted psychological theory that underpins its ethos. It's simple really: we provide a home consisting of safety, comfort and warmth, and a community of acceptance and belonging for those suffering distress.

As we are volunteer-led, we don't have the time or patience to try get our heads around labels such as schizophrenia. Instead we put our time to better use by 'being with' the housemate within our community. And it's 'being with' that is key to all that we do. It involves sharing a space which encourages freedom of expression, connection and acceptance.

It is through creating an environment of exploration that we hope people can feel comfortable to process unusual experiences and, with support from the Soteria community, make steps to 'just get on with life'. With no pressure, criticism or judgement, housemates are demonstrating that people have the inner resource, no matter the difficulties, to take ownership over the direction of their life:

*It was the normality of being in the house that took away my psychosis. It was the mindful companionship ('being with') that set me on the road to recovery. The most productive part of being in the house was that they didn't focus their attention on me. Their normal living provided a distraction for me. I became an observer of them and that took me away from my own preoccupation with what was going on inside my head.*



*Regular contact brought back my socialisation. This was really important for me. My family have begun to speak with me again and what Soteria did for me was normalise this - that speaking with people who have this experience is OK. Soteria showed other people it was OK to speak to me. They spoke to me and showed the greater community it was OK to do that.*

*Soteria Bradford doesn't look at the illness. They don't judge, so you can't stay in that world. For me this was very powerful. Since leaving the house the continued contact has been so important. It's now passing over from mindful companionship to being part of the community.*

*When I became ill and reached crisis I only had limited options with what I could do... The NHS and the medication route or religion which I regard as dangerous for a suggestible mind. Soteria Bradford provided me with a third option. Without the support and care of this dedicated team I don't believe I'd be here writing this now.*

Only thanks to many people's generosity has it been possible to provide this community to those most in need. Please help us to continue this support – your donations could really help someone and their families get their lives back on track. Because we take pride in our ethos, we rely on donations to keep our independence and integrity. ■

If you're interested in supporting us, please visit us at: <http://soteriabradford.wixsite.com/soteria-bradford/donate>.

# Survivor Research (or not) in *Asylum*

**Diana Rose**

**Service User Research Enterprise/SURE,  
King's College London**

In 1986 I was medically retired from my first (and I thought last) academic job. I knew about the Asylum Collective. I was friends with some and disagreed with others – but as an academic not a survivor, that was a secret. The next ten years were grim, alleviated only by becoming part of the service-user/survivor movement, and no longer having to keep secrets.

In 1988, my local service-user group, Camden Mental Health Consortium, joined forces with an NGO called Good Practices in Mental Health so as to conduct one of the first pieces of user-led research in mental health. We interviewed people who had experience of acute wards both in the old asylum and in the new community hospital provision, to find out how they compared. Most of us, including me, had experience of both settings. So began my new identity as user-researcher. Our report was debated by the likes of Leonard Stein, the psychiatrist who developed assertive community treatment in the States, and clinicians at the Maudsley hospital in London (CHMC and GPMH 1988).

At the same time, work was being done in Bristol, and 10 years later there were two thriving programmes of user-led research in London NGOs (Faulkner and Layzell 2000, Rose 2001). None of this reached the pages of *Asylum* which for much of the time was focused on Italy – the magazine's subtitle is still 'democratic psychiatry', a direct translation of Basaglia. This was true also of some of the work of Nick Crossley, who was also in Sheffield at the time (Crossley 2005). Crossley, like *Asylum*, saw anti-psychiatry as the major paradigm shift in mental health, though this view was not shared by every survivor (The Survivors History Group 2012). So what I am saying is that for its first decade at least, *Asylum* paid little attention to the work of users and survivors of psychiatry. Instead, it contented itself with critiquing the establishment from a professional perspective.

Are things any different now? Ostensibly. The new orthodoxy is Mad Studies, but still very few survivor voices are present. Of the UK authors who have contributed to this literature, only Peter Beresford is a survivor. One survivor researcher – Dina Poursanidou – is a member of the *Asylum* collective. For the rest of this piece I will say why I think this absence is a structuring absence and needs to be turned into a presence.

I am not one who thinks that first-hand experience is a straightforward and uncomplicated matter and always the best grounding for research and theory. I believe experience is social through and through and not from an academic perspective only – that is how I think about myself. However, I do think this collective voice can be harnessed to change things and that research has a role to play. In terms of research in the mental health field, this should be led by service-users who are clear about their standpoint, political and theoretical, and who are also reflective and collectively grounded. (There are those who have a clear theoretical and political standpoint who are resolutely not open to argument.)

The absence of such survivor researchers in the pages of magazines like *Asylum* can lead to unthinking acceptance of some of the wilder claims of, for example, Mad Studies. For example, Ian Parker's positive review of Bonnie Burstow's recent book (Burstow 2015). Some survivors are almost hagiographic about this work (Prax 2015). Other survivors do not hold this view. I can only be anecdotal but it has been said that the book is 'nihilistic and hysterical' or 'like a conspiracy theory'. I have submitted a written critique of this to the journal *Disability and Society*. I do not think the service-users and survivors I speak to during my research would give a wholehearted endorsement, either. This is because they know, and I know, that distress and responses to distress are both complex issues. What is on offer may be seriously wanting and in need of wholesale dismantling but trauma therapy and being nice to each other are not panaceas. The world is not a nice place, and we are seers not dupes.

My aim in service-user/survivor-led research is to challenge orthodoxy (psychology, nursing and social work as well as psychiatry) by developing what Sandra Harding calls a 'science from below' (Harding 2008). I am not wedded to it being called 'a science' – 'studies' will do fine. This field would include empirical as well as conceptual work, it must pay attention to intersectionality, and today social media is a great source of information as much debate goes on there that previously went on in face-to-face groups. Harding does not think experience is uncomplicated, either. (It's hardly my idea). She argues, much like some in the Mad Studies domain, that a standpoint is achieved, not assigned by nature or nurture. It is political and it is achieved through struggle. That much maybe we can all agree.

But what may be relatively recent is the argument that research is also like this. Even in our most private work, we are not lonely scholars. Each sentence I am writing refers back to other work and anticipates yet more. Experience, in Harding's words again, must be 'studied up'. So when we come together to plan or conduct empirical research it is a collective endeavour, even if it doesn't look like it. Of course, steps can be taken to maximise the centrality of survivor voices: having reference groups of service-users who are not academics; disclosing our own histories to participants so making an attempt to level power relations and mark ourselves out as different from conventional research and researchers. This does not always work, and the steps might seem small or minor but as well as encouraging people to speak frankly, it ensures user-governance and a different ethics.

For the most part, the voice of survivors in *Asylum* is that of a story-teller. The role seems to be to narrate first-hand experience in such a way that it confirms or illuminates dominant positions in the magazine. To the extent that these stories are theorised, it is usually not by survivors themselves. First-hand experience is important but, as I indicated above, it is not enough. It needs to be collectivised and validated as has always been done in user/survivor groups. From a research perspective, it needs to be 'studied up' in a conceptually and politically informed way.

As long as service user experience only has a place as personal story, and personal story confirming largely professional positions, then it can never be an autonomous and critical discourse. An autonomous and critical discourse is what it needs to be, grounded in experience but an experience that is neither raw nor naïve but is collectively produced. I am not arguing for radical separatism here but for a recognition by even radical professionals, clinicians and academics and others, that you cannot tell our story for us nor organise its meaning and consequences without us.

I would not like to see *Asylum* as party to the current turf war between psychiatrists and psychologists where the two struggle for who can provide the most help and who can speak on our behalf. I find this unedifying and patronising on both sides. I'd really prefer to have nothing to do with either at least in terms of their logic, if not all their personnel.

So my conclusion is that *Asylum* has always been dominated by professionals and academics, that in the early days survivor work was ignored, and that now the work is usually only permitted in the reduced form of personal stories. I therefore urge the editorial collective to open up a space where instead of being a structuring absence, survivor research – empirical and epistemological – has its own voice. ■

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## A Response from the editors

*Thank you, Diana, for this welcome contribution. We are always happy to receive and publish critical pieces – this is exactly what Asylum is all about!*

*The point about personal stories and collectively produced survivor knowledge is well-made. We actually think it is important, and needs addressing more widely. For example, we note that service-user's individual stories are often drawn upon in educational or policy arenas, rather than the collectively produced user/survivor knowledge that could be mobilised.*

*For our part, over the last thirty years we have regularly published material from survivor groups. Recently, for example, we published articles by organisations like the Survivors History Group and Recovery in the Bin, both collectively-produced endeavours. It is worth noting that back in 2002 we published Stronger Than Ever: The report of the National Conference of Survivor Workers, UK.*

*We also think it is worth pointing out that a fair number of the articles we publish are not simply personal stories but are in fact researched and referenced by their authors – even if they are not funded and badged as Research.*

*In addition, the personal stories we do publish are quite diverse – as are the views of the collective – and they don't necessarily endorse one dominant view. Our policy, however, is to prioritise voices that are not usually heard.*

*That probably means they are more likely to be considered 'wild' or controversial. We don't necessarily agree or disagree with them: the views of our contributors are their own but we think they deserve a hearing.*

*With respect to the specific criticism levelled against us, we could certainly do more to actively solicit survivor research, and we will take your comments on board. Having said that, we can only publish pieces that people submit. SURE and other survivor researchers and organisations have some responsibility for this: if they don't send us stuff, we can't publish it.*

*We do like to report research which questions received wisdom – whether 'conventional' or 'alternative' – although, for reasons of space and readability, we don't normally publish full research articles, survivor-led or not. We would also like to cover ethical or political issues arising from research, including the impact and/or co-option of survivor research.*

*So, if there are people out there with interesting survivor research they can report on, please let us know – or put the word out! And if anyone would like to guest-edit a special issue on this or any other topic, get in touch.*

*In the meantime, we welcome further discussion about the important issues raised by Diana Rose.*

# INSIDE OUT REVOLUTION

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## Yasmin Setarrah

Yesterday, June 29th 2016, was the best of days and the worst of days. As I sit here in aftermath, reflecting, I can truly say that progress was made. It will forever be a day I hold significant to my recovery.

I felt pain. In the first time in what felt like centuries within my mind, I felt pain and sadness. The emotional pain was so profound, it manifested through my body. Tears flooded from my eyes and the pain vibrated to the tips of my fingers. This was breaking point, but also the greatest breakthrough for me. Although I am such a long way away from feeling full of happiness and love, making my way out of the numbness is a significant step, only leading me closer to the destination.

This experience has taught me many lessons, in not even twelve hours of reflection. It has also rewarded me with the realisation that I have come further than I think. One of the greatest lessons for me is that I am learning to love myself again. I have made changes in my life that are acts of self love. One of the most important for me is who I allow in my personal space. After years of what seemed like being taken hostage by addicts and abusive people, I have finally taken action and closed the door to many. I finally valued myself enough and my pursuit of happiness to invite positive, loving, and good humans into my closest circles. The biggest growth for me is that, I can see I have emotionally matured enough to give such a beautiful person the opportunity to love me. A year ago, I had no interest in being in a relationship with a man who cared, respected, loved, and valued me. All because I never felt such a way about myself.

I truly believe this person saved me. But you can only be saved, if you allow yourself to be saved. I finally let someone in and I feel so blessed to have someone in my life that fought for it. Someone that cared enough about me that I was able to trust enough to break down the wall I built. When you are so closed off, and disconnected from all that is you, it is almost impossible to see your own reflection. I was so lost and so accustomed to the numbness and

apathy, I forgot that I had a life before all this. I forgot all about the little girl I once was, the truest form of me. I was lost and so out of touch, I wouldn't even know what she looked like if I tried to find her. Now, this is why I feel others are fundamental to one's recovery. Depression is a force and there is no shame in asking for help. Express yourself. You are worthy of love and support and good people will recognise this. Love yourself enough to be around people who see all the beauty and magic in you, that never really left, you just became so blind to it. They can help you find your way home.

Yesterday, I was able to express myself and confront pain that was buried so deep, I didn't even realise it was there and that it would still hurt. I had blocked so much of my past, or thought I had dealt with it, but all was locked away, compacted and compressed; there was not an iota of space to feel any of it. I felt my heart was so broken it would never work again. I am so proud of myself for being brave enough to let this incredible person care enough to draw out these emotions. If I cannot draw out the pain and feel it, I cannot truly heal from it and make no room for the beautiful feelings of love and happiness I so badly want.

After hours of crying, exhausted and drained I went to the bathroom and looked at my swollen, wet eyes in the mirror. I recognised her. She's still in there. I saw the magical little girl again, and I felt alive. And when I went outside at sunset, the world felt different to me. After the darkness, comes light. I could not keep my eyes off the sky. Everything was intensified. My senses were sharper than I had felt in years and I was in awe.

To conclude, I want to encourage the significance of self love. It is an inside out revolution. Start there and see how quickly your life can change. I am not there yet, but I am on my way, grateful for the wonderful people I am letting in and I am no longer afraid of the pain. I know that I have a long road ahead of me but the fact that I was able to access emotion, even if it hurt, left me with hope. ■

# MY YEAR OF SUICIDE

**Mark Peterson**

In 2010 I spent the year in and out of in-patient behavioural care, culminating in a suicide attempt in August. I was admitted to four different hospitals and became familiar with the quality of each unit. There were two things I noticed that varied greatly from institution to institution. It is my hope that my observations will be of some help to practitioners in in-patient facilities.

## Meatball Therapy

In spite of the fact that I had been seeing a competent therapist for several years, in-patient providers couldn't help from engaging in what I have termed meatball therapy. While I have narcissistic tendencies when I am in the depths of depression and seeking help, I am not narcissistic. Three of the four providers diagnosed me as narcissistic, and followed their diagnosis with such ridiculous treatment as providing me with the *DSM* pages on borderline personalities or a book on how to deal with narcissists. This had the effect of plunging me into deeper depression as I had doubts not only about myself but about the quality of the treatment I had been receiving from my long-term therapist. It was immediately following one such hospitalization that I chose to take my life. As a final act, I bought the book on narcissism that I had been asked to read in the hospital and mailed it with commentary to my attorney. I had hoped that in my death some action against the therapist would be taken.

These meatball diagnoses were reckless. Instead of asking me about what issues I was having or why I was

seeing a therapist, they ignored my then 27 years of seeking treatment and simply engaged their own agenda. How easy it would have been to ask me the questions or call my therapist so as to create a more accurate plan for short-term treatment.

## Reading Materials

Following my suicide attempt I was in the behavioural unit at McKay-Dee in Ogden, Utah, where the reading materials for patients were abundant and of high quality. Yes there were novels for leisure reading, yet more importantly there were books such as *The Four Agreements*, *Man's Search for Meaning*, *7 Habits of Highly Effective People*, and *The Power of Positive Thinking*.

In one hospital there were no books on self-enhancement at all, but stacks of *People* magazine and volumes of *Reader's Digest* abridgements. TV and this kind of reading material offer little opportunity for study and self-reflection, ignoring patients' needs to fill their time with useful pursuits. The library available to patients in a behavioural unit should offer options for exploration of self and encouragement for the future.

I am sure that my lack of intimate knowledge about the field of in-patient behavioural care is evident in these observations. But note that I did not just fall off the turnip truck, nor am I so lacking in education as to fail to notice these obvious flaws in the approaches to treatment. I have great respect for almost all of the providers that have cared for me in these thirty years, and I remain committed to my treatment by continuing to receive weekly therapy. ■

*Mark Peterson, PhD, is a retired school administrator and lives in Orem, Utah.*

# Mental disorder is more than a chemical imbalance

Kate Kennedy

It has become popular in recent years to describe mental disorder as a chemical imbalance in the brain, a neural jumble that needs sorting out. The idea that the catatonic, crippling, world-shattering forms of anxiety, depression and OCD can be attributed to a simple failure in the body's homeostasis is comforting and affirming for many people. It is seductive, too, in its reductionism. Mental disorder is always messy, and thinking about it as a neural mishap helps us to reclaim some power over it: 'My disorder is not me, it is a misfiring in my brain.'

It was Hippocrates, a physician and contemporary of Socrates, who first thought that our bodies being a bit out of whack could have serious consequences for our health. He hypothesised that all illnesses were the result of an imbalance of the four elements or 'humours' that make up a human being: blood, phlegm, yellow bile and black bile. Too much blood, and you were prone to rousing angrily; too little blood, and you were likely to succumb to cowardice.

This line of thought was maintained for the next couple of thousand years – medical practice continued to be informed by it until well into the 19th century. Our modern

approach to medicine is based on a much more complex model, but relics of Hippocrates' hypothesis can still be seen today in the discourse about mental disorder. (The idea of chemical imbalance is also used in pseudo-science and homeopathy.)

Whilst it is worth acknowledging the usefulness of reducing something as complex as mental disorder, we must be careful that we don't leave out something essential in the process.

It is useful for me to know that the feelings I get around my partner are because of chemicals like dopamine and oxytocin circulating my brain, but taking this view does not help me identify how it *feels* to be in love. It removes *me* from the picture. The same happens when my depression is described as a lack of serotonin in my brain – I become a passive observer of a process that might as well not be happening to me, because I don't *feel like* a serotonin deficiency. I feel like me, in a world that has become slow and grey.

The reason why the comparison fails is for the same reason that figuring out the problem of consciousness is

so tricky: our subjective experiences are always tied to a particular point of view. We don't have experiences *along-side* our mental disorder. Our experience *is* our mental disorder – it filters our perception of the world.

Thinking of our mental disorder as a chemical imbalance makes it somehow not us. In the same way that somebody who has diabetes must endure the consequences of a faulty pancreas, somebody who has depression must endure the consequences of a faulty brain. This makes sense – the brain is the epicentre of our thoughts and feelings. But thinking in this way results in a short-sighted view of what it is really like to be depressed.

Mental disorder doesn't just affect one particular, medically identifiable, function of the body. And whilst it may reside in the brain, it doesn't only produce physical symptoms like those produced by other, physical illnesses.

Mental disorder hijacks our whole sense of self: the speed at which time seems to pass, how far in to the future we can project ourselves, what things in the world we care about – mental disorder changes all of these in the most radical way. And it doesn't just affect the function of a particular body-part, it changes the very conditions that make it possible for us to live a meaningful life.

The language that we use in our current discourse on mental disorder is, in many ways, fitting. We now have medicines that can effectively help thousands of people to manage and, in some cases, overcome their mental disorder. But in focusing our discourse on the chemical aspect of mental disorder we blinker ourselves from the real power of mental disorder – the power to change what it means to be human. That is something that can't be reduced. ■

## EVERYTHING IS A SYMPTOM & A SYMPTOM IS EVERYTHING

**Sonia Soans**

When I started work in an addiction rehabilitation clinic in India, nearly ten years ago, I had just finished my masters degree in clinical psychology. The thrill of wearing a white coat and putting theory into practice was incomparable. I would be helping people, people who were misfits. I had the envious task of unlocking their traumas and setting them free. Textbooks had taught us that some people suffered from a trauma and all they needed was a kind therapist to set things right.

Little or nothing of this was true when it came down to everyday therapy sessions. The day was filled with making notes, filling-in forms and updating records. The clients were another story. Some didn't see why their addiction was a problem – after all, they could fund their habit. You see this was not a place built for poverty-stricken addicts who sniffed glue to assuage hunger or trauma. Then, of course, there were the women addicts who were seen as more debased than their male counterparts, and less than feminine. Gender still has a hold on the way we view addiction.

What we observe of a client is almost always in relation to us and them. They, being on the wrong side of the therapy room, are a mass of symptoms. Both men and women showed these symptoms, indicative of a deeper pathology. Addiction to illegal drugs and alcohol were only on the surface: something more diabolical lay deeper. For years I had learnt that observation was a neutral activity, that as a trained professional my gaze would be neutral. But it was anything but neutral. Symptoms of pathology were to be found everywhere. They were to be found in compliance, defiance, indifference and even in the mundane.

As one of the few women working in a mainly male environment I got to work closely with the women. The link between women and madness is not new, however. Some disorders are almost exclusively thought of as feminine and others as masculine. Addiction was most certainly seen as masculine. Women are often thought of as too feminine

to use alcohol and drugs, which is seen as a masculine pursuit. When a woman crosses this gender boundary her pathology is assumed to be more serious than her male counterparts. Of course, this was India where women are not expected to drink, much less take drugs. The stereotype of the female addict was a brash, westernised, promiscuous young woman. Boring housewives in Indian clothes never entered our imagination. Not fitting into our worldview, their reasons for inebriation were assumed to be more dangerous – perhaps they were bad mothers, terrible wives, negligent home-makers with squalid homes. Maybe their carefully constructed image hid the truth – that westernisation had caused their downfall. The contradiction was too much to comprehend: how could someone who looked like the ideal Indian woman deviate so far?

The clinical process is one whereby every behaviour exhibited by the client is indicative of a symptom. Women clients' demands for makeup, toiletries and more family visits were a means of manipulating the staff. A very real fear gripped us. What if the clients' demands grew to such an extent that they overpowered us? Of course, this was not a therapeutic stance but a power struggle. One where we pre-empt how people who are under our charge will react if we give them power. The idea that mental health professionals overzealously label all aspects of a client's behaviour as pathological is not new. However, it does need restating since those of us who set out to help are caught up in a system based on power. That power expects us to differentiate them from us, sanity from insanity. But sanity is not easily definable, which is why defining insanity is often an arduous task full of mistakes. Finding insanity through the mundane has its benefits: it prevents us from addressing the social context in which madness exists. ■

***Sonia Soans** trained as a psychologist and now, through research, examines issues such as gender, nationalism and media in the production of mental illness and violence.*

# UNKINDEST CUTS

## Reflections on destruction and resilience in LGBTQ community-based mental health support

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**Stephanie Taylor-King**, National Survivor User Network (NSUN)

**Sarah Carr**, Middlesex University, London

**Taz Edwards-White**, METRO Centre, London

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This year, on January 29<sup>th</sup>, the community-led mental health charity Project for Advocacy, Counselling and Education (PACE) closed its doors after thirty-one years serving London's LGBTQ (lesbian, gay, bisexual, trans and queer) communities.

Stephanie and Sarah reflect on the closure from the perspective of people who used PACE's mental health services, and Taz from the perspective of someone who provides mental health support to LGBTQ people at a specialist community-based charity.

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### **Stephanie: From a self-destructive lost soul into a good advocate**

Austerity isn't kind to minority groups. Things are so bad that the UN's Committee on the Rights of Persons with Disabilities is looking into 'human rights abuses caused by Tory Government welfare reforms'. Practically every week, disability and other minority groups express their suffering and frustration on social media and public demonstrations because the official media remain frighteningly silent.

I am a member of the suffering, frustrated minorities. I say minorities because I belong to at least two: those branded with a mental health diagnosis, and the LGBTQ community. Being at the receiving end of austerity measures doesn't surprise me. When the coalition government got elected, I knew we 'mad queers' were in for hard times. But I wasn't expecting a long-serving organisation like PACE to be forced to cease operations after thirty-one years of providing amazing support to people like me.

Ironically, PACE closed their doors just after publishing research highlighting the continued need for their services. *The RaRE Report*, published at the end of 2015, clearly states that 'negative reactions from professionals can limit lesbian and bisexual women's engagement with treatment and support, causing them to disengage with treatment altogether'. It also says that 'that discrimination perceived by LGB people may partially explain their greater psychiatric morbidity risk'.

PACE was one of the few places for LGBTQ Londoners of all ages struggling with their mental health. This apparently resilient organization managed to survive the Thatcher era, and its demise may seem surprising for those who are not part of an LGBTQ community. Sadly, PACE is only one of many organisations that are either being destroyed or forced to

severely cut back. Journalist Patrick Strudwick has observed that 'beneath the confetti of same-sex marriage, as the government basks in its headline-grabbing policy completing legal parity for lesbian, gay, bisexual and transgender people, comes the cold reality of how the coalition's cuts are disproportionately affecting this community'.

Local LGBTQ support charities such as Mosaic Youth in Camden, London are seriously threatened with closure, and Broken Rainbow, the UK's only LGBTQ domestic violence charity, finally ceased operations on 2nd June 2016.

Back in 2006, I was recovering from a suicide attempt resulting from a brutal, and very poorly handled, redundancy. I turned to PACE, where staff, offering the unique support atmosphere that can only be found in LGBTQ run services, managed to rebuild my self-confidence. I enrolled on their excellent mental health advocacy training and was transformed from a self-destructive lost soul into a good advocate. It is thanks to PACE that not only did I manage to rebuild my sanity but also found a new career in the mental health sector. Without PACE I would not be making the contributions I do to the service-user and survivor movement. Without PACE I would possibly not even be alive.

As I take this trip down memory lane, I am reminded that I find myself in a precarious situation again: my job at NSUN is shrinking because of reduced funding and increased competition caused by austerity, and I am on the brink of needing support again. But PACE is not there to provide it. Minority groups are being relentlessly bashed by austerity measures and with safe, specialist services like PACE disappearing, the LGBTQ community is losing the vital safety net we've woven for ourselves over the years.

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### **Taz: A safe place to be ourselves**

Government cuts and welfare reforms are having a direct detrimental impact amongst those in situations that make them vulnerable.

In health and social care, the term 'vulnerable adult' was used for someone in need of care services due to disability, age or illness. We all experience varying

mental and physical health. We also have various social and biological identities. But some of these identities are extremely stigmatised by our society, with the risk of people being treated less favorably or with shame associated with a particular characteristic. These things can result in making people vulnerable.



Identifying as LGBTQ, non-heterosexual or expressing ourselves outside of society's gender norms can create vulnerability when accessing statutory mental health services. One can fear and experience homophobic, biphobic and transphobic staff attitudes, as well as left to feel excluded when heterosexist language is used or assumptions made.

Working as a mental health nurse on the wards I experienced daily homophobia, with others telling me that I was sinning or going to hell, or always assuming I had a boyfriend. These attitudes didn't come from the service-users, but from my colleagues. I thought if this is how mental health professionals were treating one another, then what impact were these attitudes having on service-users? The Stonewall *Unhealthy Attitudes* survey found that 'one in ten [of 3000 people surveyed] have witnessed staff within their workplace expressing the belief that someone can be 'cured' of being lesbian, gay or bisexual'.

My own experience of discrimination as mental health service staff led me to find METRO, a health and wellbeing charity specialising in diversity and difference. I started volunteering just to be in a space where I didn't need to monitor what I said – a place where I could be myself. Eventually, I started working at METRO, running the mental health and wellbeing service which provides a weekly social-based peer supportive drop-in. I created a one-to-one crisis support service and an advocacy service

for those who identify as LGBTQ and who feel they are experiencing mental health issues.

From my own experience of working in mainstream mental health services, if you have a stigmatised identity and don't feel comfortable to share that in your surroundings, then for protection it's easier to try to conceal it. If you feel threatened by your environment you will conceal a part of yourself to protect yourself from danger. This concealment is a cognitive burden and the effects of the constant discrimination and stigma can be the direct cause of mental health issues. The more stigmatised identities you have for example being 'a black, gay disabled woman' the more of a heightened risk of illness due to experience of, or the fear of, discrimination.

Sadly, in mainstream mental health services both LGBTQ service users and staff are often forced into concealment and experience considerable psychological stress as a result. This is why mental health support provided by community-sector charities like METRO and PACE are vital in providing a safe, supportive space where LGBTQ service users and staff can be themselves, reducing social isolation, building a strong sense of community solidarity and cohesiveness. The LGBTQ mental health and wellbeing drop-in group helps people to feel safe and safety in accessing LGBTQ counselling services, crisis one to one support and advocacy.

The cuts are affecting local voluntary and community sector mental health support across the UK. Services are being pushed to provide 'courses to wellness and recovery' and to see more people than ever before. Harsh competition with large providers is squeezing out brilliant community-led services that have been providing mental health support and crisis prevention for those who were discharged from their community mental health trusts for being either 'too well', 'not ill enough', 'not treatable' or 'too difficult to engage with'.

Social connectedness and peer support is vital for mental wellbeing. Specialist services for specific groups need to remain open. Local specialist community-led services need all the support possible right now before vast numbers of our people whose identities and status can make them vulnerable fall through the net like never before.

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### **Sarah: The evidence is clear, including our own experiential evidence**

When I was 19, suicidal and self-harming, I sought the help of a therapist. But instead of supporting me through my mental health crisis, he tried to change my sexual orientation. Unsurprisingly, as a result I became very wary of therapists and afraid of what could happen in the isolation of the therapy room. Ten years later I found myself in a similar mental and emotional crisis. I knew I needed to talk and be supported to understand myself and why I got into such terrible states, but going to a therapist again seemed almost too risky.

However PACE enabled me find a lesbian therapist who helped and affirmed me. Never once did I fear being pathologised for my sexual orientation or stigmatized for my distress. By holding a list of therapists approved as safe and supportive for LGBTQ people, PACE eliminated the risk and

vulnerability I felt in trying to find help. Later, I volunteered for PACE as a trustee, and advised on research projects. It was the least I could do after they kept me safe from potential harm. Their approach to mental and emotional support was entirely responsive to the strengths, needs, diversities and complexities of LGBTQ communities and families.

It is well documented that LGBTQ people are at higher risk of developing mental health problems and have a greater risk of suicide and self-harm, and evidence shows the impact of discrimination on LGB&T mental health, including within the mental health services.

LGBTQ young people have an increased risk of discrimination that impacts on their life chances and are at higher risk of becoming homeless or experiencing

mental health problems, most frequently owing to familial rejection or abuse. Older LGBTQ people's mental health-related quality of life is positively affected by having a positive sexual identity, but negatively affected by lifetime victimisation and discrimination.

It is estimated that nearly half a million LGBTQ people from black and minority ethnic (BME) communities in the UK have multiple identities and needs unrecognised by public services that adopt a 'one minority at a time' tick box approach. Intersectional discrimination has been identified as a key concern for LGBTQ people from faith or refugee communities, or those who identify as BME, including within the mental health services.

LGBTQ communities have created community-based mental health projects that are trusted, supportive and safe. They draw on peer support, community networks and specialist knowledge of the complexities involved in LGBTQ mental health. Access to peer support has been

identified as particularly important for LGBTQ people from BME communities

In response to unsafe and inaccessible mainstream mental health services, we have pulled our socks up, got on our bikes and taken care of ourselves and each other. Surely the Tories should approve of and invest in our endeavours?!

The evidence is clear, including our own experiential evidence, that LGBTQ mental health outcomes can be improved and lives saved by community-based support services like PACE, Mosaic, Broken Rainbow and METRO. However, during these times of ideological and increasingly brutal austerity, the evidence is ignored when it comes to making counter-productive decisions about where and who to cut. Cutting such support will inevitably lead to cutting short the lives of many LGBTQ people who experience mental and emotional distress. ■

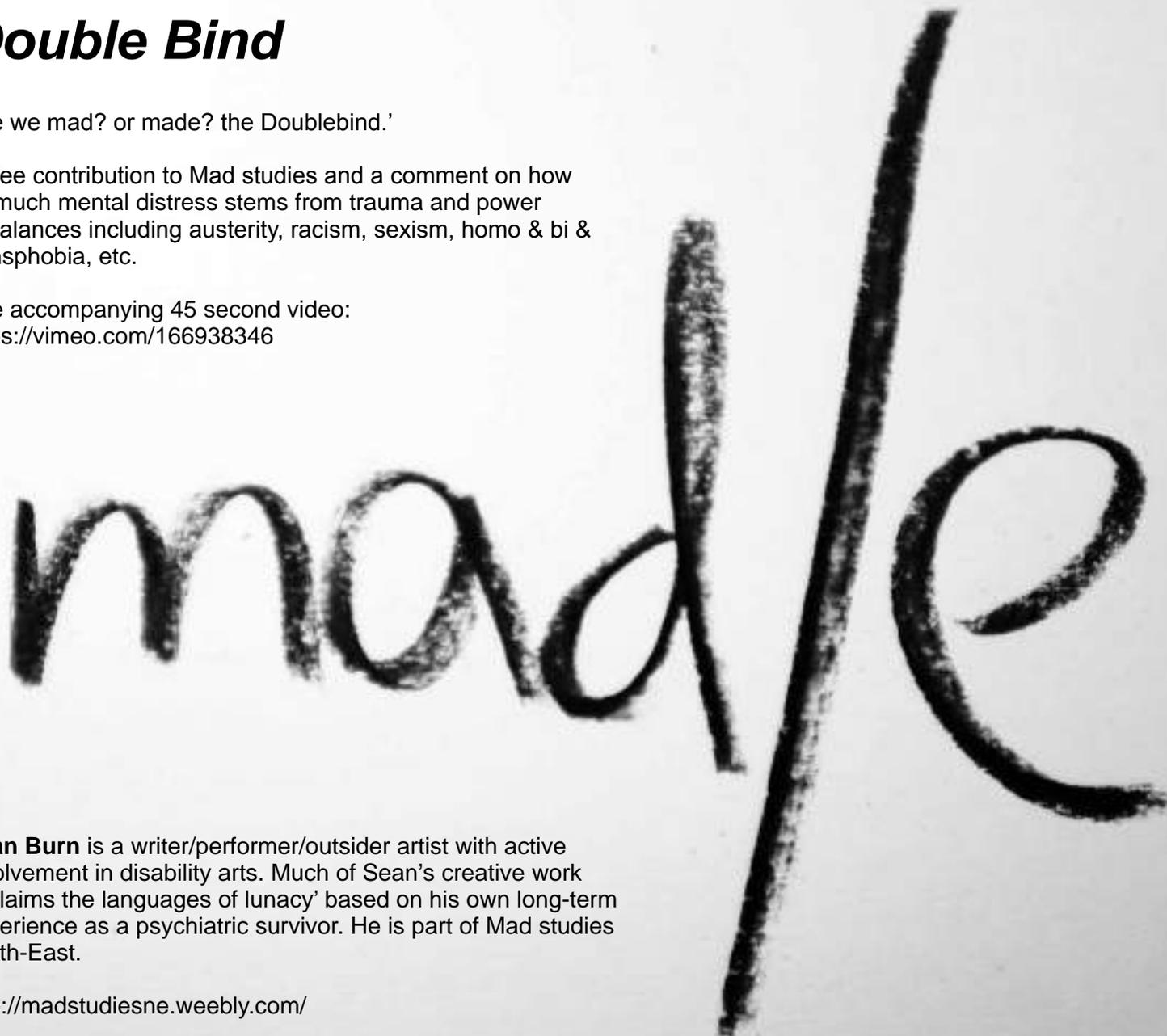
*Full references can be provided by the authors on request*

## **Double Bind**

'Are we mad? or made? the Doublebind.'

A wee contribution to Mad studies and a comment on how so much mental distress stems from trauma and power imbalances including austerity, racism, sexism, homo & bi & transphobia, etc.

See accompanying 45 second video:  
<https://vimeo.com/166938346>



**Sean Burn** is a writer/performer/outsider artist with active involvement in disability arts. Much of Sean's creative work 'reclaims the languages of lunacy' based on his own long-term experience as a psychiatric survivor. He is part of Mad studies North-East.

<http://madstudiesne.weebly.com/>

# LOBOTOMY/ LEUCOTOMY

## Phil Virden

The first attempts at psychosurgery were in 1888, but an apparently reliable and easy method was developed in Portugal during the 1930s – when the country was under a fascist dictatorship. Nearly all psychosurgery has followed the original form of pre-frontal lobotomy (or leucotomy).<sup>1</sup> This involves surgically cutting and destroying brain tissue in which there is no manifest disease or

injury, so as to change the thoughts, feelings or behaviour of a patient who suffers from a functional mental disorder. Psychosurgery has largely fallen into disuse over the last forty years or so. This is due to its cost, ambiguous efficacy and levels of over-damaging or undesirable results – including perhaps a 6% risk of death.<sup>2</sup>

An estimated 50,000 Americans were lobotomised in the years between its introduction in the mid-1930s and decreasing use from the early-1960s. By the late-1970s, each year something between 300 and 1,000 patients were still lobotomised in the USA, but the numbers then sharply declined. It is hard to get statistics for the UK, but by 1960 there had been at least 15,000 leucotomies, and until 1970 operations still ran at about 400 a year.<sup>3</sup> Since 1983 no more than 28 psychosurgical operations were carried out in the UK in any year, and there were none in England between 1999 and 2009; one was performed in 2010.<sup>4</sup> The Brook Hospital in London carried out the largest number of leucotomies in Europe; it performed more than 1,000 operations between 1970 and 1990.<sup>5</sup> Leucotomies are now usually 'modified', i.e., radioactive burning. So as to counteract particularly disabling fears, obsessions and anxieties, some doctors still advocate modified techniques of psychosurgery and electrode implants (which are supposed to target brain tissue more accurately); units in Cardiff and Dundee still carry out a few operations each year.

The effects of psychosurgery are usually more profound than those of drugs or ECT. Throughout the world many more than 100,000 psychiatric patients must have been subjected to the technique, among them children as young as four. It has been used for almost every diagnosis, but almost always to 'quieten down' the patient. Psychosurgery works by cutting cortical connections. In this manner, so as to obviate undesirable symptoms, brain function is disrupted and the whole human being is subdued. There is no research



Image by Bob Sapey

to match the results of lobotomy against placebo or a control group; the little research there is indicates no overall improvement in the quality of life of lobotomised patients compared to patients with similar symptoms but not given a lobotomy. However, there is much anecdotal evidence of serious physical damage and mental deterioration; the latter, as 'quietening down', is actually the desired result of psychosurgery. Because of its highly disproportionate use on women and black people (in the USA), we might suspect the use of psychosurgery as a form of control or oppression. Psychosurgical literature and research reports show no interest in psychodynamics or other aspects of patients' lives and relationships – the demography of the patients, what they think, what their mental disorders might signify, the possible genesis of their mental disorders, etc.

Anti-manic and anti-psychotic drugs and electroconvulsive therapy (ECT) all have lobotomising effects similar to that of psychosurgery, but without such overt risks. ■

### Notes

1. Leucotomy is the preferred term in the UK.
2. Frank, LR (Ed) (1978) *The History of Shock Treatment*. San Francisco: L. R. Frank, p.184. This book is the classic collection of information, from both sides of the debate.
3. Berke, JH (1977) *I Haven't Had To Go Mad Here*. Harmondsworth: Penguin. Chapter 4, pp. 89–114 gives a history and discussion of psychosurgery.
4. Monitoring the use of the Mental Health Act in 2009/10 (2010) London: Care Quality Commission. 93.
5. Remarkably, there was apparently only one death. See Berke, JH, op. cit. (n. 14), pp. 183–4; see also: Verkaik, R (1991) Please doctor, will you give me a lobotomy? *The Independent*. 14 May.

# OBSESSIVE POSTING DISORDER

*Declan Flynn*

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Obsessive Posting Disorder is a serious mental health problem that has recently been identified and studied by mental health professionals and other interested parties. This leaflet is intended to give you a basic grounding in the condition so that you can identify it in your family and friends and thereby empower yourself to offer them support. As always with any serious medical problem, it is best to consult a doctor in order to get the best medical advice.

## What is obsessive posting Disorder (OPD)?

Obsessive Posting Disorder is very common, although it is only recently that the extent of its occurrence has been recognised and individuals successfully diagnosed. OPD is a condition that affects many middle class professionals, but it has been recognised amongst all social classes and groups. Young and middle-aged persons are particularly affected. It seems to be prevalent amongst activists and other persons who have passionate belief systems. The major characteristic of OPD is an excessive desire to communicate thoughts, feelings and acts to relative strangers despite major contra-indications to the appropriateness of such communications. However there is still great controversy about what OPD is, what causes it, and how it may be treated.



## What are the signs of OPD?

Every person with OPD is unique, however it is useful to know what common symptoms to look for which may indicate its presence.

**Characteristic symptoms:** Three or more of the following, each present for a significant portion of time during a one month period.

- 1) Bizarre communication: such as with people the person has no known relationship with, about issues of an idiosyncratic or personal nature which would not normally be suitable for public disclosure. Communication will be incessant and obsessive, and the sufferer will engage in it throughout the day and night.
- 2) Inappropriate communication: insisting on carrying on communicating despite clear evidence of disinterest by the recipients of such information. In particular the fundamental ground of human discourse – acknowledgement of the other – is

frequently lacking. This often manifests as lack of common courtesy and impaired understanding of the other's communications.

3) Disordered cognition and intellectual rigidity: sufferers often display bizarre thought patterns. This can manifest in rigidly held beliefs which are held to be factual; the sufferer holds on to the validity of such ideas when presented with clear evidence from the real world to the contrary.

4) Delusions of grandeur: sufferers sometimes see themselves as important, gifted and perceptive. They believe that their facebook 'friends' are people they have a close personal relationship with, despite never having met them. A frequent delusion is that the sufferer deserves to be trusted and believed by others, prior to expressing any insight which would make such trust appropriate. This can frequently lead to pointless arguments and having your account deleted.

5) Grossly disorganised behaviour: as the desire to communicate comes to dominate, the sufferer's everyday duties, patterns of behaviour and structures are impaired.

6) Formal sleep disorder: the sufferer may lose sleep, staying up late or rising early in order to keep up with the latest post.

7) Dependency: an excessive need to be confirmed by the other in their sense of self-regard.

8) Negative transference and projection: commonly sufferers are unable to distinguish their own beliefs from those of the people they are attempting to relate to. This is assumed to be why they sometimes 'act out' this confusion by behaving in ways which provoke anger in other people, and then punitively call this anger a sign of pathology in the other.

**Social/occupational dysfunction:** for a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset.

**Duration:** continuous signs of the disturbance for at least six months. This six months must include at least one month of symptoms that meet criterion A.

**Mood disorder exclusion:** a differential diagnosis has ruled out mood disorder because no depressive or manic

or mixed episodes have occurred with active phase symptoms, or their duration has been brief.

**Substance/general medical condition exclusion:** the disturbance is not due to the direct physiological effects of a substance or a general medical condition.

**Relationship or a pervasive developmental disorder:** if there is a history of autistic disorder or another pervasive developmental disorder, the additional diagnosis of obsessive posting disorder is made only if prominent delusions of grandeur or grossly disorganised behaviour are also present for a least one month.



## What causes OPD?

This is a matter of debate, especially amongst the mental health service-users and survivors who were the first to notice the condition. As usual, they struggled to be heard amidst the usual stigma and discrimination they suffer, but lately mental health professionals have listened and are now taking the condition seriously. Undoubtedly much of its symptomatology becomes deeply ingrained in sufferers' behaviour patterns as a result of negative socialisation. Sufferers tend to isolate themselves from regular human relations thus leading to an increased tendency to show signs of the disorder.

Others, however, believe that these environmental factors merely mask a severe underlying disorder which is almost certainly genetically determined (although the precise mechanism of this organic fault has not yet been fully determined). Most researchers today would work from a stress/vulnerability model recognising environmental triggers but concentrating on how to treat the underlying disorder.



## Notable sufferers.

Today its most prominent manifestation is through internet forums. But this should not confuse us – it is just the post-modern manifestation of the disorder. In previous eras it has taken, and to some extent still does take, the forms of serial letter-writing, graffiti, pamphleteering and posting, amongst others.

It has been noted that many venerable persons from history have shown signs of the disorder and are believed to have been sufferers. This should be a great solace to sufferers, since there is no need to think that sufferers cannot go on to live productive lives if medical science is able to identify protective factors.

Some noted sufferers were the novelist Henry James, former US president Ronald Reagan, Jane Austen, Napoleon Bonaparte, Jackie Kennedy Onassis, and the noted physicist Albert Einstein. They all manifested the disorder by writing large amounts of correspondence. The artist Jean Michel Basquiat, famous in the 1980's for his 'graffiti art', is also thought to have been a sufferer.

It is not yet determined if Ronald Reagan's OPD influenced his politics, but it alerts us to the fact that some sufferers may rise to positions of public prominence or power. This should alert us to the need for a vigorous public information campaign so that the public is fully informed.



## How can OPD be treated?

Several barriers to treatment have been identified.

- Most sufferers do not, or are unable to recognise that they have a problem. Lack of insight is a major stumbling block to treatment.
- Much of the sufferers' disturbed behaviour is positively reinforced by the surroundings they develop for themselves: they tend eventually to come to restrict their relations to other sufferers.
- The main harm caused by OPD is not experienced by the actual sufferer but by those around them. This limits the motivation to change.

In spite of the above, treatment is being tried. At present the core of therapy seeks to find the right balance between support and challenge, so as to try to bring the above problems to the sufferer's consciousness.

To date, results are mixed. There have been some successes. However, the people administering the therapy (largely other posters) are becoming frustrated at the painfully slow rate of progress achieved through this approach.

Unfortunately, the prevalence of the disorder also reinforces it. As more and more individuals develop the full-blown disorder and don't answer their phones or socialise in regular ways, others become vulnerable. This isolation leads them to depend on communication by irregular means, thus making them vulnerable to develop a positive symptomatology.

Ultimately, it may be that OPD only responds to individual therapy to a limited degree, and that an approach based on structural change will need to be tried. It may be tempting to simply ask sufferers out for a pint. However, while this may distract them for a while, due to the widespread use of smartphones it won't dissuade them, and in fact the disinhibitory effects of alcohol may provoke a crisis of all-night posting. ■

# ONE FLEW OVER THE DRAGON'S DEN

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## No\_Label\_Dave

The movie *One Flew Over The Cuckoo's Nest* uncovered life in a 1970s asylum in America. The lead anti-hero, RP McMurphy (played by Jack Nicholson), pleads insanity rather than endure hard labour in the state penitentiary. Arriving at the asylum he witnesses the power wielded by Nurse Ratched, and we hear the now infamous cry 'Medication time!' burst forth from her lips.

Coincidentally, McMurphy's initials, RP, are used to designate if one falls under part 2 of The Mental Health Measure (Wales) Act, 2010. Here RP means relevant patient. In my opinion, when one gets to Part 3 of The Measure one might become a responsible person. McMurphy would have liked that, had he not accidentally managed to gain a lobotomy whilst interned in the asylum! Oopsy!!!

During times past, people like us have been embraced by some cultures and denied by others. As a result some of us are now in hiding whilst others merely conform to today's norms.

If you happen to be a conformist you will have gained many a 'pat-on-the-back' from those who chose to patronize you. This reward may have been 'earned' by taking medication or attending an appointment at a psychiatrist's bidding. If you've been really fortunate (sic) you may have been sent to a psychologist for talking therapies. If so, you are in a class of your own.

My question to you, the reader, is: 'What has helped most?'

I'm guessing that amongst the readership of this magazine there are a myriad of decent people in search of personal truths. We don't mind sharing such truth when we find it, but it must work for us. My personal truths might not work for you in their entirety, but some small fraction of them might.

I am in the final year of my third decade and started receiving treatment for what is commonly known as mental illness when I was sixteen. Later, at twenty-two, I was treated for serious mental illness. What happened?

Sometimes we ask questions out of curiosity or because we are just plain nosy. The medical profession seem to want to supply answers first and ask questions later.

Unfortunately they provided an answer to me in the form of a tablet. Initially this seemed to work on the mind of a sixteen-year-old boy, and had some efficacy on the racing mind of a twenty-two-year-old man. The shaming detail is that whatever I received in my humble beginnings of mental illness has

been shown to have no foundation in any research evidence. Scientists studying the theory of chemical imbalances in the brain have long since shown that serotonin does not need a SSRI to correct its course in the individual brain. That theory has been proven to be bunkum! What else will science show in the next twenty years regarding psychiatry and how we treat the minds of others?

Another more sinister truth that is now well documented is the harm caused by anti-psychotics used to alter thinking. Yes, we can agree that most have the desired effect of slowing-down thoughts or restoring peace to an unquiet mind, but is that all they do? I'm not referring here to the known side-effects which are acknowledged in the bumf you get with your tablets. What I am saying is that researchers can now link the use of anti-psychotic medication with organic brain illnesses in later life. Just how much anti-psychotics and in what dosages and over how much time is unsure, but the research shows strong linkage to Alzheimer's, dementia and other similar conditions.

The balanced person would question his or her need to meddle with his or her own brain chemistry purely on the basis of a GP's say-so. Then again who is balanced? A GP is almost always doing his job in a 'paint-by-numbers' fashion. They do their best! Quite often it is their practice which is thirty years out of date. Do they even read anymore? Most reach for a prescription pad within ten minutes.

I'm not advocating a drug-free regime for anyone. At the moment I'm reassessing the value of taking lithium as a supplement. I should be at therapeutic level by the time this article is published. I have taken small quantities of a popular anti-psychotic so as to gain balance before mood stabilisation. I have also smoked approximately twenty cigarettes a day, drunk a lot of good cappuccinos and consumed a moderate amount of alcohol. Life has been tough but manageable. I have had to deal with the unwarranted attentions of mental health professionals who have on more than one occasion in the last six months sought to section me. More fool them!

Life can be hard, given our 'giftedness', but it is how we are treated by others which either helps or hinders. The best piece of advice I can leave you with is what I once heard from a leading mental health professional in Wales. When talking about how to help people recover from serious mental illness he prescribed two words: 'Be nice!' ■

# ‘Stigma’ and Mental Illness

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## Harold A Maio

The term ‘stigma’ has but one purpose: to *direct* prejudice, to make it appear that something is wrong with the person *at whom* it is directed, not with the person directing it. It matters not who employs it, or how they interpret it: its purpose is to prejudice.

‘The stigma of mental illness’ is today a popular usage. Other uses have diminished or disappeared, history having proven they were purposefully designed to prejudice, that the term and phraseology itself was an act of discrimination. For example, ‘the stigma of rape’ was employed to disguise the prejudice directed at the survivor; it directed attention *away from* the perpetrator and onto the victim. Its usage was so powerful that victims took it onto themselves and taught it generation after generation to others who might become victims. The stigma of rape was primarily assigned by word of mouth – it required no government funding, no government support.

Support for ‘the stigma of mental illness’, on the other hand, survives not only by word of mouth but through funding by universities, governments, charities and mental health professionals, as well as by the victims themselves, ourselves: we are as likely to internalize and teach it as any other segment of society. One of the most successful results of teaching a prejudice is that the victims assume it onto themselves, becoming themselves its teacher.

On a daily basis I follow ‘the lesson’ in the news – not only who employs it, but through whom. Seldom is a victim empowered to teach it in print, victimizers are often so empowered. Seldom does a reporter or editor recognize the prejudice inherent in repeating the term in its specific usage. Making a prejudice customary by rote repetition is a powerful way of raising it to the appearance of truth. It suggests people have the right to employ it, and that right is widely accepted.

To end that right, victims have to take back the power of naming. We have not done so, but many women did refuse such a stigma.

As part of the Women’s Movement, women rejected ‘the stigma of rape’. They told everyone directly and powerfully to terminate that association. Raising their voice above ours, above custom, we stopped. We stopped precipitously. I was there; the end was for most people almost immediate. The usage by governments, universities, by advocates did stop immediately.

As part of the Women’s Movement, women took back the right to name, to respect. Through

their activism, we set up specific rules for address, codified them, and quite literally enforced them. The rights of women expanded. Women have not achieved complete equality, but the power of naming is changing the way both we and women themselves define things.

As yet we have taken little interest in positive linguistic representation. We address the negatives as they appear, but do not offer any organized positives: We do not say stop! We do not ourselves stop.

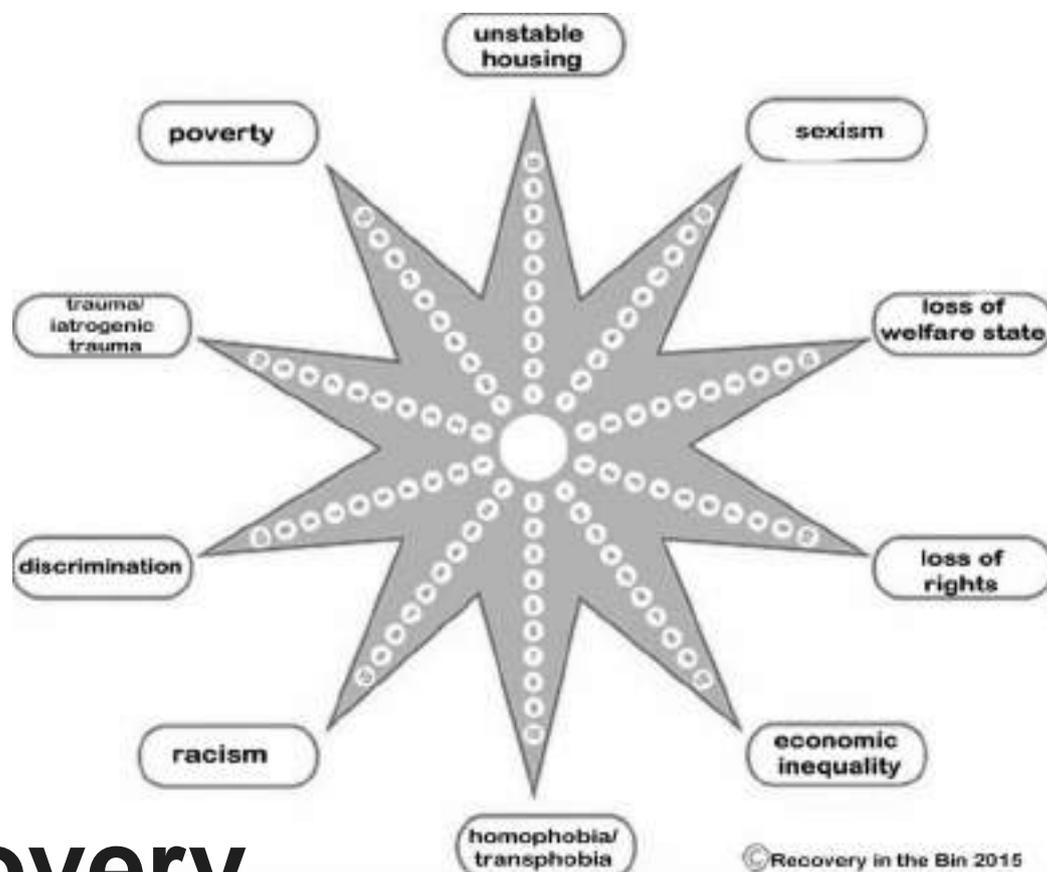
Each day I go to my computer and address the negatives directed at individuals dealing with a mental illness, at the illnesses themselves, at me. Each and every day, first a cup of coffee, and then to the computer.

I search in the news for representations, first the caricature: ‘the mentally ill’, recognizing it as identical to earlier broad social uses: ‘the Jews’, ‘the Blacks’. This usage has permeated even the US Supreme court, has entered law. I encounter it from universities, from governments, from charities, from well-educated and not so well-educated people.

Once a group has been diminished to ‘the’ this or that, further prejudices follow. There is no longer any need to see the individual, only an entertaining caricature – entertaining, that is, to all but the group diminished. Members of the diminished group begin to diminish themselves. I know I did.

Released from a mental institution, my prevailing thought was to hide. A year later, I hid no more, knowing that what had been done to me was far more important than my mere presence in an institution. From that moment I became an advocate. I have not stopped.

Forty years later I still have not stopped. I will not tolerate ‘the mentally ill’, mentally ill ‘stigma’, mental illness ‘stigma’ and mental health ‘stigma’. Deliberately or not, to say ‘the mentally ill’ disregards that fact that we earn millions, hold every university degree, and every professional, white-, and blue-collar job. The term ‘stigma’, no matter who directs it and no matter against whom, intends only prejudice, and to permit whatever discrimination ensues. I do not intend to participate in that discrimination nor, by the way I speak, teach others that they should. As with women’s empowerment, victim, university, government and advocate have to reform their language if equality is ever to result. ■



# The UnRecovery Star

The 'UnRecovery Star' was developed directly from open discussions in the Survivor-led facebook group, Recovery in the Bin. We talked of wanting an alternative to the 'Recovery Star', which seemed a redundant, unhelpful and blunt tool for narrowly judging how someone should be expected to 'recover'.

In contrast, the UnRecovery Star may be described as a tool for social justice. It highlights the reasons why we go Mad, but also what can maintain our distress and hinder our 'recovery'. We really mean it when we say that some of us will never feel 'recovered' due to the social and economic conditions we experience, because they frame everything. Therefore, the UnRecovery Star is political as well as personal – for many of us, both are intrinsically linked.

The UnRecovery Star is a powerful teaching device which highlights prominent social inequalities and helps students see the links to the causes of mental distress. The UnRecovery Star clarifies the fact that people's problems are not merely rooted in something wrong with the individual, such as a faulty brain, a genetic abnormality or a faulty personality. Instead, the UnRecovery Star clearly indicates that humans are social beings, and that the determinants of distress are to be found in families, communities, the wider society and social policies. The value of the UnRecovery Star is that it demonstrates that we not only need to pay attention to the distressed person but must deal with the problems that exist in communities and wider society – that mental health is a profoundly political issue.

As Survivors and allies we can also use the UnRecovery Star as a means of campaigning for greater social

equality, and for protesting against the pharmacogenetic psychiatry and psychocompulsion which dominates mental health treatment and welfare in the UK. We need social and political solutions for the social problems which the UnRecovery Star simply and clearly identifies. The UnRecovery Star is intended to encourage students and practitioners to consider these issues through CPD and activism with people with first-hand experience. Examples of this work are seen in Psychologists Against Austerity, WalktheTalk, the forthcoming Manchester conference 'Psychologists and the benefits system', Mental Health Resistance Network, films such as psychocompulsion: <https://vimeo.com/157125824>, the work of Lynne Friedli and Robert Stearn <http://mh.bmj.com/content/41/1/40> full, and RITB <https://recoveryinthebin.org/2016/04/23/yippee/>

Furthermore, Survivors can take their MH professionals to task by demanding what are they going to do as an intervention in 'the therapeutic relationship', with regard to issues raised by the UnRecovery Star? In other words, Survivors can use this 'social justice tool' as a means of advocacy, so as to try to address any unmet needs, i.e., housing/welfare (both in and out of work) advocacy/professional reports.

Some may feel that the language of 'UnRecovery' is backwards and regressive, but we believe that the word 'recovery' has been co-opted and colonised from its more radical roots. We consider that the language of 'recovery' is no longer a helpful word to describe the outcomes that MH services now expect of us. ■



# Literature Portraying Mental Illness

**Jhilmil Breckenridge**

If you say you have diabetes, people engage, ask about your medication, and say, 'Oh you should not be eating rice, or potatoes', and so it goes. But if you say you have schizophrenia, for example, there will be an uncomfortable hush, as though you have just said something unmentionable. The reason is the stigma behind mental health issues, and the fact that people are just not comfortable with knowing or acknowledging that people can suffer from issues of the mind. Is it because they don't know enough? Or the fact that it could happen to them, too? Or the fact that it may be inside the brain, still a largely unknown commodity, and they can't view it on the outside, like a fracture or a wound?

People who suffer from mental health issues like depression, bipolar disorder, anxiety, depression, schizophrenia, PTSD and others, are stigmatised simply because society is not comfortable with these issues. According to the UK's leading mental health charity, MIND, each year 1 in 4 people in the UK will experience a mental health problem. And because of the stigma surrounding mental health, sufferers may take longer to seek professional health or support from their peers or well-wishers. If there are more fictional or real life accounts with protagonists with mental health issues, perhaps readers can identify with characters in books or films, and feel they are not alone.

*It's a Kind of Funny Story* by Ned Vizzini is a novel inspired by the author's struggles with depression. Vizzini uses humour to describe the protagonist's hospitalisation for depression, and though Vizzini later went on to commit suicide, this book is a testimony to his struggle and is one of the most realist portrayals of depression ever written.

*I work. And I think about work, and I freak out about work, and I think about how much I think about work, and I freak out about how much I think about how much I think about work, and I think about how freaked out I get about how much I think about how much I think about work*

*Crazy* by Amy Reed, another YA (young adult) novel, looks at bipolar disorder. Izzy and Connor meet as

summer school counselors, and as Izzy spirals into the highs and lows of bipolar, the story is told in chapters alternating between Izzy's and Connor's voices.

*Even though I'm sleeping again, everything still feels a little rickety, like I'm here but not quite here, like I'm just a stand-in for my real self, like someone could just reach over and pinch me and I'd deflate. I thought I was feeling better, but I don't know anymore.*

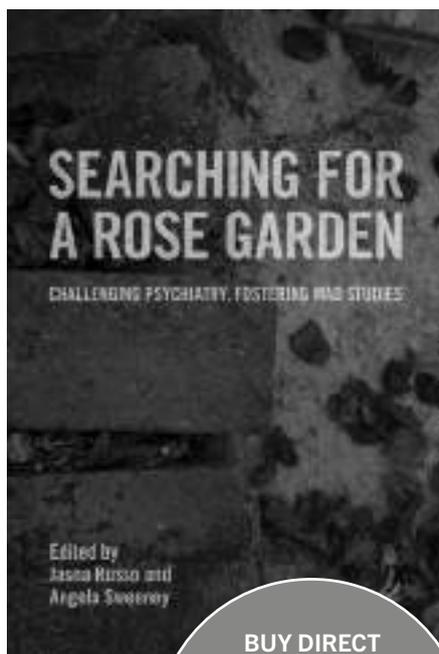
*Will Grayson, Will Grayson*, written by award winning authors John Green (*The Fault in Our Stars*) and David Levithan (*Boy Meets Boy*) is a funny, rude and – according to the New York Times Book Review – original account of a character who battles with depression. Told alternatively by the two authors, they describe Will Grayson's struggles with depression. This book also offers a perspective on how the way society deals with terms like 'depressed' or 'mental health' – that it is not at all helpful for those diagnosed or labeled with a mental illness.

I think the idea of a 'mental health day' is something completely invented by people who have no clue what it's like to have bad mental health. The idea that your mind can be aired out in twenty-four hours is kind of like saying heart disease can be cured if you eat the right breakfast cereal.

*Mrs. Dalloway* by Virginia Woolf, written way back in 1925, is inspired by the author's own struggles with bipolar disorder. Set just over a day in the life of socialite, Clarissa Dalloway, the novel examines the character of Septimus Warren Smith, whose madness escalates as he nears suicide.

*A thing there was that mattered; a thing, wreathed about with chatter, defaced, obscured in her own life, let drop every day in corruption, lies, chatter. This he had preserved. Death was defiance. Death was an attempt to communicate; people feeling the impossibility of reaching the centre which, mystically,*





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Challenging psychiatry, fostering mad studies

Edited by Jasna Russo and Angela Sweeney

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# PHOTOGRAPHS

by Scott Michael



*Anonymous on a street*



*Anonymous on a beach*

P  
O  
E  
M  
S

**TWO FOREIGN LANDS**  
*Julia Garcia*

I can feel your hurting,  
And it's like our souls could hold hands,  
Breaking through walls of body and skin,  
Is the meeting of two foreign lands.

**MISOPHONIA**  
**(THE HATRED OF SOUND)**

*Stephen Plant*

Our the 4 SSSS  
Selective-Sound-Sensitivity-Syndrome  
Sniffers-Slippers-Screamers-Suckers  
Chewing gum slob  
High heels on flags  
Even flip-flops  
My worst trigger  
Is noisy eaters  
When on the bus  
I sometimes have to get off before my stop  
With their cans of special brew  
And big Macs  
Smacking their chops  
And getting the one with verbal diarrhoea  
Always sat near  
I don't want pills  
Though my troubles grow  
As I could cheerfully  
Close their windpipe  
That would let them know?  
Because I suffer from  
Misophonia  
Don't you know?  
Oh please just white noise  
Slipknot  
Stripes of white  
Soul asylum  
And I'll be all right  
Sisters of mercy  
They release me  
Bit daft really  
Cuss they're very loud  
But it's my little cloud  
Where the screamers at Sainsbury's  
Cannot get to me  
With such a pitch  
They should ear defend on the door  
Because I suffer from  
Misophonia  
That's for sure?

## **A HUNDRED TASTES OF ME**

***Jhilmil Breckenridge***

I am the whisper of a leaf in the breeze  
 I am the flutter of a butterfly against the white honeysuckle so sweet  
 I am the gurgle of the flowing river  
 I am the wind in the willows  
 I am the waitress picking up coffee cups in the cafe  
 I am the old woman reading a newspaper against the window  
 I am the siren of the police car as it drives by  
 I am the laughter of an old man who twirls his moustache  
 I am the chatter of a young child  
 I am the taste of sugar on your tongue  
 I am the scent of a hundred roses in your nose  
 I am the sound of plaintive notes on a flute in a land far away  
 I am the smell of candles and incense in a wooden church  
 I am the flavour of Marmite on hot buttered toast  
 I am the feel of the cool granite table against my wrist  
 I am the refugee who hides in subway tunnels  
 I am the man who cheers for Arsenal  
 I am the woman buying anti ageing creams  
 I am the child kicking stones on the path  
 I am the smell of rain  
 I am the taste of freedom  
 I am the sun upon your skin  
 I am the honeyed kiss of your lover on the inside of your wrist  
 I am the taste of violence upon your lips  
 I am the woman in the red dress and the ebony skin dancing  
 I am the poet on Speaker's Corner  
 I am the woman licking her fingers as she eats  
 I am the autumn leaves that rustle under your feet  
 I am the man checking his phone  
 I am you and you are me and we are a hundred other things  
 And we are all unseen, forgotten, experienced, reviled, overlooked, and replaceable  
 And the music plays, the clock ticks, and we look away

## **REFLECT**

***Julia Garcia***

We sit become here, look – the worlds in action.  
 Shining lights, shouting, sirens, attractions,  
 And we become awash with passion;

Grateful, suffocated by our own subtraction.  
 How did we get here? When so much has proceeded this?  
 We burst, we ooze, we drip this disbelief, this pain, this beauty, this bliss,  
 We drift into the jaws of this deep abyss.

How can we be here, among the sounds and smells of normality?  
 When we started all this was just the fantasy,  
 Sometimes gratitude weighs, like cement, cracking, its reached maximum capacity.

Adoration for those we love; the urgency grips like corsets fastening.  
 When all around are normal happenings,  
 Here we are, what we experience is enlightening,  
 But how can enlightenment have an air that's troubling?

Are we drowning in the waves and depths of the sea?  
 I'm scared of no we and instead just me.

# Driving Somewhere Beautiful



Photograph: Looking towards the Wye Valley, by Sam Taylor

## **Mike Snelle**

A friend once told me that the only sensible way to tell whether a philosopher is worth reading or not is to look at a photograph of them. Wittgenstein yes, Heidegger no – that kind of thing. Karl Popper had a lovely face. Google him if you don't believe me. He didn't have Wittgenstein's intense stare or Nietzsche's ridiculous moustache. Popper looked more like a kind old grandfather from a children's story, wise and generous and thoughtful. He had the sort of face I am intuitively inclined to trust.

Popper was an influential philosopher of science.

He claimed that one of the key tenets of science is that any theory, to be considered scientific, must be inherently falsifiable. He was not saying that ideas which fall outside of this test are not interesting, or valuable, or part of what it means to have a rich and complex understanding of the universe. He was just saying that those ideas are not scientific. A belief in God, for example, is not falsifiable, so too theories about an afterlife. These are matters of faith and, according to Popper, fall outside the scope of scientific enquiry.

In 1973 the academic journal *Science* published the article 'On Being Sane in Insane Places'. It documented the findings of an experiment by psychologist David Rosenhan designed to test the validity of psychiatric diagnosis. The first part of Rosenhan's study involved eight 'sane' people feigning auditory hallucinations to see if they could get committed into various psychiatric institutions. What is interesting about the experiment is not the ease with which the participants successfully feigned mental illness but, once inside the system, the difficulty they had with proving themselves sane. Although none of the participants showed any further symptoms it took anything up to 52 days for them to be released, and even then only when they would accept the diagnosis of an irreversible lifelong condition such as schizophrenia.

So what? That's pretty much what I thought, until I got diagnosed with bipolar.

As a teenager, I had a two-year-long psychotic episode. It was terrifying. School became impossible and I left, a week after my fifteenth birthday, with no qualifications. Although I have had no subsequent break with reality I have, for the past seventeen years, experienced episodes of debilitating depression alongside moods so good that my thoughts crackled with electricity and made my skin prickle with excitement. I am tempted to write about how it feels to be on a mental high, how the grace and fluidity of my own thoughts gives me an erection. I'm tempted to write it down because it's a feeling so good that even the memory of it allows me a tiny fraction of the experience. But my involvement with the mental health system didn't arise because of the highs.

The best explanation I have ever heard of suicidal depression is by the writer David Foster Wallace. 'The so-called "psychotically depressed" person who tries to kill herself doesn't do so out of quote "hopelessness" or any abstract conviction that life's assets and debits do not square. And surely not because death seems suddenly appealing. The person in whom its invisible agony reaches a certain unendurable level will kill herself the same way a trapped person will eventually jump from the window of a burning high-rise. Make no mistake about people who leap from burning windows. Their terror of falling from a great height is still just as great as it would be for you or me standing speculatively at the same window just checking out the view; i.e. the fear of falling remains a constant. The variable here is the other terror, the fire's flames: when the flames get close enough, falling to death becomes the slightly less terrible of two terrors. It's not desiring the fall; it's terror of the flames. And yet nobody down on the sidewalk, looking up and yelling "Don't!" and "Hang on!" can understand the jump. Not really. You'd have to have personally been trapped and felt flames to really understand a terror way beyond falling.'

During a particularly brutal and extended bout of depression I phoned the Samaritans. As good a service as they offer, it's still an excruciating and pride-swallowing experience to realise that your desperation has exceeded your dignity. On a particularly dark night I was grateful to

a generous stranger for picking up the phone. I called in the hope that this most fragile thread of human connection would be enough to stop me from killing myself. And it was. I decided then to seek help.

And so I found myself first at the GP and then, via an assessment with a psychiatric nurse, in the office of a consultant psychiatrist who had massive hands. Not just big but huge – the sort of hands that could crush apples or tear a phone book in half. It had taken six weeks to get an 'emergency referral' but it took only 45 minutes for her to diagnose me with bipolar disorder and prescribe the mood stabiliser Lamotrigine. I'd be lying if I said I hadn't expected it. I'd read Kay Redfield Jamison and knew by heart the relevant sections of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

I had always resisted pressure to seek medical help for what I saw as my uniqueness. I preferred to believe that my moods were an essential and perhaps defining characteristic of my personality. My depressive phases were emotionally painful but I believed they allowed me a privileged access to a kind of truth too difficult for most people to bear. My heightened moods were the best of me, concentrated and distilled into a point so fine it could pierce the membrane separating me from the outside world and allow me to connect with the universe in ways that felt almost supernatural.

The psychiatrist with the gargantuan hands told me – within the space of a few minutes – both that medication 'would make you a different person' and that 'medication will not make you a different person'. I was perplexed and began to ask some questions. Before long I found myself expressing my anxieties about accepting a diagnosis. What if my mood swings were due to a traumatic childhood with an emotionally turbulent mother? Was it still accurate to diagnose me with a serious mental illness or was I merely reacting normally to a prolonged period of childhood trauma? Could I get better? Was it possible that one day the diagnosis would no longer fit? And anyway, how did these mood stabilizers even work?

Her explanation was that bipolar is like diabetes. There is a genetic predisposition that may or may not be triggered by environmental factors (emotional abuse and too much sugar, respectively) but that once triggered it is a lifelong diagnosis that needs to be treated medically. She said that similarly to a diabetic it is possible to make lifestyle changes to help minimize the episodes and manage the symptoms, but that the illness was something to learn to live with rather than hope to be free from. Managing the symptoms mostly involves avoiding the triggers. This is all very convincing until you realise that the triggers are most of the experiences that involve participating fully in human life.

When I expressed concern and doubt about accepting a lifetime of avoiding stressful or emotionally-charged environments and experiences she replied that this was a normal response of someone with bipolar disorder. And when I suggested that in time I thought I would be able to change and grow and get past the diagnosis she said that rejecting the facts was a common symptom of

the illness. It seems that once a diagnosis is made, any normal human response can be interpreted as a symptom of the illness.

The problem runs deep. Accepting a psychiatric diagnosis seems to rob you of the validity of your own thoughts. They become symptoms of an illness, which is exactly the fear that prevented me from seeking support in the first place. Because what anyone who is struggling really wants is compassion, understanding and support. At least, that's what I had always assumed until, on getting a diagnosis, I looked in on some forums for fellow bipolar sufferers. It seems that a diagnosis is not only a licence for the medical profession to invalidate genuine thoughts and concerns: it's also an opportunity for those diagnosed to excuse their behaviour under the guise of mental illness. 'My wife doesn't understand why I lose my temper, or hate her friends, or occasionally smack her about. She doesn't understand my illness.' I'm exaggerating, but you get the picture.

I want to be held accountable for my actions and thoughts, even those I wish I did not have and struggle to control. I think it's a key component of being able to have meaningful human relationships based on mutual respect and equality. I believe it's possible to change unwanted behaviour and even thought patterns by understanding the underlying distress which causes them.

My point here is that, once diagnosed, there is no legitimate thought or concern I could have which could not be interpreted as a symptom of the diagnosis. This is dehumanizing. But more than that, if Popper is to be believed, and he had a trustworthy face, it's not even scientific.

Back in the psychiatrist's office the doctor explained to me that there had been numerous studies that proved that bipolar disorder has a genetic element. It is possible for trauma to be the trigger, she said, but not the cause. Usually where there is one family member with bipolar there are others, whether diagnosed or not. And anyway there are plenty of people who had a happy upbringing who develop the illness.

Perhaps I'm ill-informed. I'm certainly not an expert. But I find that this kind of reductive argument is usually an oversimplification. Take for instance, the idea that CT scans show that the brain of someone with bipolar is functioning differently on a neurochemical level than someone who doesn't have it. This seems at first to be irrefutable evidence of the fact that bipolar is caused by a physical phenomenon, perhaps a lack of some chemical or other in the brain, and hence should be treated by adjusting the level of that chemical using medication. But this argument requires a whole universe of assumptions, none of which are falsifiable. For instance, reducing mind states to brain states does nothing to illuminate the causal relation between the two. To say that the tendency towards extreme emotional states runs in families and that this is evidence of a genetic component to bipolar is to ignore a more obvious explanation.

It is well documented that those who have experienced trauma act out that trauma on the people around them.

Abuse begets abuse. There are wildly varying statistics about the percentage of the prison population who have been abused, sexually or otherwise. Some studies record up to 83% of inmates having been abused as children. Those damaged children then go on to develop their own distorted ways of interacting, and end up in prison, or in the case of bipolar sufferers, unable to regulate their own moods in a way that is healthy. Of course it runs in families. Trauma always does, sometimes passed down countless generations, each struggling to cope with the emotional inheritance left by the last.

A child whose parent cannot regulate her own needs and emotions (perhaps because of her own traumatic childhood) and as a result fails to create a safe and stable environment in which that child can develop healthily, will himself struggle to self-regulate his feelings as an adult. It is often cited that when one sibling suffers from bipolar there is a far higher likelihood that the others will too. When they grew up in the same house, that's hardly a surprise.

But what of the people who had a stable, happy upbringing and still end up developing the symptoms and being diagnosed? The psychiatrist posed the question as if it were a trump card – with a relish that made me wonder if I hadn't accidentally strayed into hostile territory. It didn't feel like a clinician's emotionally detached explanation. It made me wonder why people choose to become psychiatrists, what personal reasons they might have, and how much self-worth might be wrapped up in their belief in the system.

How about this? Just as some people can sing in tune better than others, or have better physical coordination, some people are more sensitive than others. And some of those people find the world a difficult place, even if they had an idyllic childhood. Turn on the news. Walk down a city street. There is terrible inequality, an inhumane value system which promotes wealth, fame and power as the ultimate human achievements. There is the relentless advertising on billboards, television, magazines and the internet which tells us a thousand times a day that to buy more is to be more. There is the worldwide economic crisis caused by a society which idolises the rich and fuelled by a belief that money and power are the ultimate symbols of personal meaning and value. And all this in a world where people are starving and children die every day because they don't have clean water, or food, or medicine.

Following the diagnosis by my apple-crushing psychiatrist I bought a book about living with bipolar. I bought it hurriedly and with a stab of shame that reminded me of getting caught masturbating over the lingerie section of the Littlewood's catalogue, when I was thirteen. I failed to notice that it was intended for the partners of people with bipolar. It contained lists of common signs that your partner may be in either a manic or a depressive phase. The manic list included 'Wanting to take a really long drive just to see something beautiful.'

There is something terribly sad about a diagnosis which treats being willing to travel to see something beautiful as a symptom. Thank fuck for Karl Popper and his lovely face. ■

# NEWS & FINDINGS

## 28% OF CHILD REFERRALS DENIED MH SUPPORT

The Children's Commissioner reports that in 2015 28% of the children referred to the English mental health services received no help. The CC's review also found that 13% with life-threatening conditions were not given specialist support.

Data from 48 of England's 60 child and adolescent mental health service trusts revealed the numbers denied specialist treatment – mostly on the grounds that their condition was not serious enough. However, included were children who had attempted suicide and serious self-harm, and those with psychosis and anorexia nervosa.

The CC's research also found that those who did secure treatment nearly always faced lengthy delays: an average waiting time of more than 100 days. The average waiting time for support ranged from 14 days in a trust in North-West England to 200 days at one in the West Midlands. Bizarrely, 35% of the trusts said they restricted access to services for children who missed appointments.

Children's Commissioner Anne Longfield said that she had heard from 'a constant stream of children, parents and professionals' about their inability to get help when they really need it. They go to their GP who refers them to specialists, but the specialists then say their conditions are not serious enough.

Sarah Brennan, from the charity Young Minds, said: 'Services have been cut and young people had nowhere to go. They are then more ill when they get help, so services have become overwhelmed... Six months for a young person is huge and in that time most young people are becoming more ill.'

Natasha Devon, formerly the government's Mental Health Champion for Schools (See *Asylum* 23(2), p. 30 for news item about her sacking) said that in order to identify problems in the early stages, it was necessary to look at the root causes. 'Anxiety, for example, is the fastest growing illness in under-21s, and we need to look at what's happening to young people – the culture and the society they live in, the pressures that are on them.'

In March, the Mental Health Network, which represents MH trusts, said it had seen 'no significant investment' in psychiatric services for children in England. It suspected that some of the funds the government promised to CAMHS had been used for other NHS services instead.

Mental health support 'denied to children' (2016) *BBC News*. 28 May

## ANTIDEPRESSANTS DOUBLED IN TEN YEARS

For England in 2005 there were just under 30million prescriptions for antidepressants. According to the Health and Social Care Information Centre, by last year this had more than doubled to 61m. And during 2014–2015 the rise continued at about 8% p.a. - 3.9m more prescriptions. According to the Health and Social Care Information Centre, which published the data, it is the greatest numeric rise of any drug class in the last year.

Although this represents more than one prescription for every person, of course most patients get more than one prescription in a year. If they seem to work, NICE advises people should stay on them for at least six months.

Rethink points out that one person in 10 will experience depression, and that austerity, job losses and increased homelessness is on the increase. Most prescriptions are written by GPs. Counselling is not immediately available everywhere, in spite of the government programme Improving Access to Psychological Therapies (IAPT) designed to attract and train new counsellors. When they don't have therapists to refer people to straight away, many GPs simply write an antidepressant prescription. There is often no time to talk through the patient's underlying concerns and work out other ways to help, and sometimes it might seem a dangerous option to send somebody home empty-handed.

Boseley, B (2016). Why have antidepressant prescriptions doubled in the last decade? *The Guardian*, 8 July.

## CHILCOT: BLIAR & CO RISKED TROOPS' MENTAL HEALTH

Amongst all the other evidence of chicanery and carelessness, Sir John Chilcot's *Iraq War Inquiry* exposes how the MoD and ministers risked the mental health of thousands of troops by breaching strict guidelines designed to protect military personnel from excessive deployment and overstretch.

On behalf of families of those killed, injured or who suffered post-traumatic stress, lawyers are now looking to see if civil claims for compensation might be pursued as a result of evidence of negligence or other illegalities. The Chilcot Report exposes the way the MoD and ministers ignored the 'harmony guidelines' – strict controls on the frequency and length of operational tours of duty, designed to protect the mental and physical health of troops.

Chilcot states: 'The government's decision to contribute a military force to a US-led invasion of Iraq inevitably

increased the risk that more service personnel would be put in breach of the harmony guidelines. The issue of the potential pressure on service personnel was not a consideration in the decision... In January 2006 the government boosted the number of British troops in Afghanistan, and there were further breaches of the guidelines as the military worked at full stretch. Figures released to the inquiry by the Ministry of Defence reveal that thousands of troops were exposed to mental and physical pressures deemed to be beyond harmony limits, putting them at risk of post traumatic stress disorder (PTSD).'

The MoD admits that in 2004 the guidelines were breached for 18% of the 28,000 army troops in Iraq – more than 5,000 soldiers. Breaches continued each year, dropping to 10% in 2009. Between 2002 and 2009 the RAF also breached the rules for between 2% and 10% of its 7,000 personnel.

Christopher Dandeker, a former professor of military sociology at King's College London and co-director of the King's Centre for Military Health Research told the House of Commons: 'The evidence suggests that if you stay within the harmony guidelines [service personnel] do not suffer; if you go beyond them there is a 20%-50% likelihood that they will suffer in terms of PTSD.'

Chilcot reveals that some military chiefs objected to the risks their troops were being put under but the government said it had no alternative as Iraq had to be dealt with. In August 2006 Sir Richard Dannatt, then commander-in-chief at UK land command, wrote to Des Browne, the defence secretary, setting out his serious concerns about the impact on troops. He wrote: 'As an army, we are running hot, and our operational deployments are well above planned levels set out in current defence planning assumptions ... you should be aware that, in my opinion, the demands of the organisation are currently greater than our ability to provide satisfactorily for the needs of the individuals. Quite properly, we often talk about an implied contract – the "military covenant" - that as an army we have with our soldiers and their families and I fear that it is somewhat out of balance.'

When challenged about the risks to the mental health of troops by the breaches of harmony, Adam Ingram, armed forces minister between 2001 and 2007, told the inquiry that the government knew the invasion of Iraq would put additional strain on the harmony guidelines. He said: 'We had been involved in both Iraq and Afghanistan, still engaged in Northern Ireland, still having people in Cyprus, still having people in Sierra Leone and other parts of sub-Saharan Africa, and still having a significant lay-down in the Falklands. All of that made it very difficult to meet harmony guidelines, although it varied between the services – the army under most strain. They would be under quite considerable stretch. So [were] medics, engineers, a raft of people who were under very significant strain. We knew that. However, what was the solution? That [Iraq] was then something we then had to attend to.'

Ingram visited Iraq in September 2006 where he was faced with concerns from the military about the impact

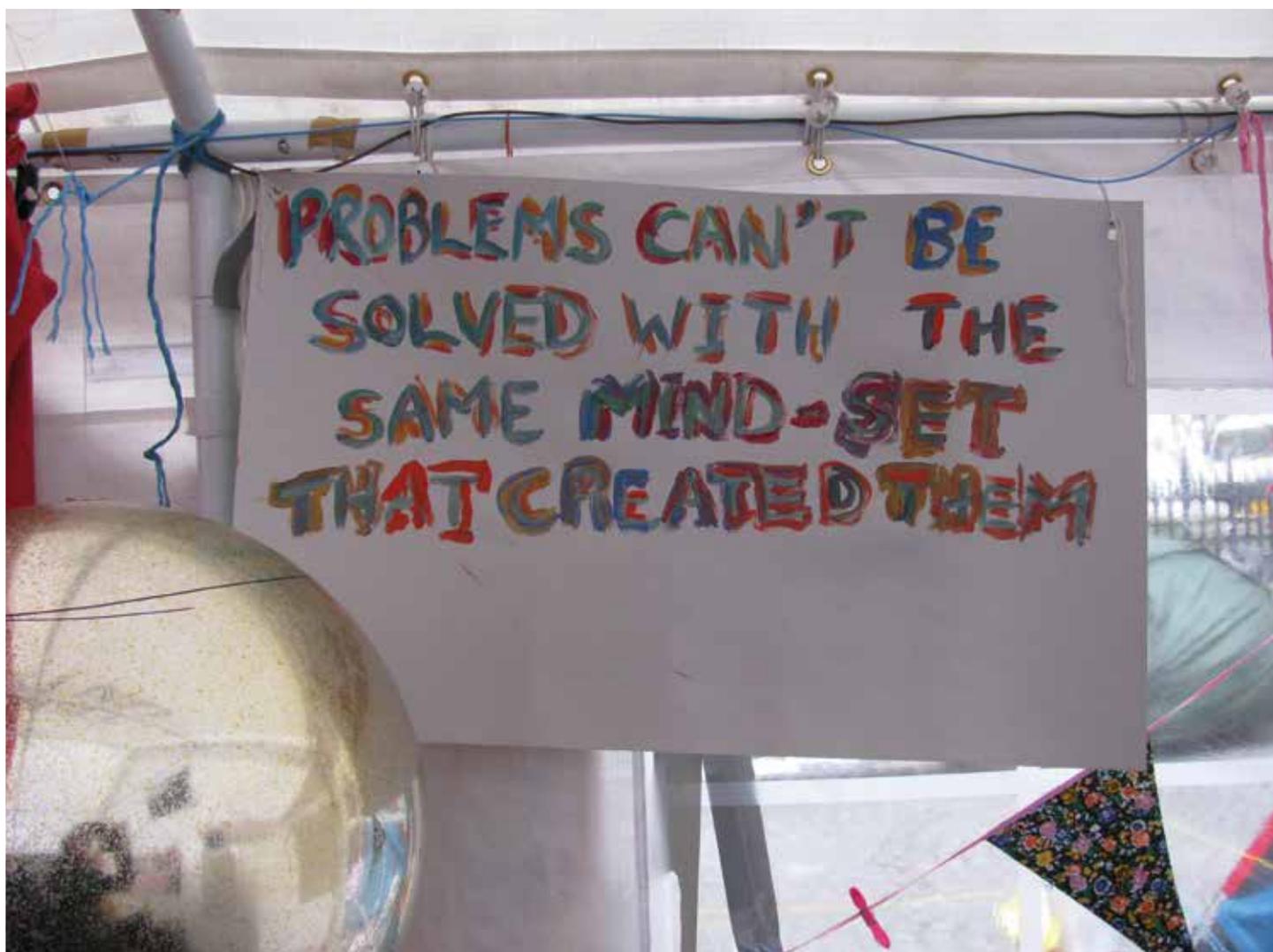
on the mental health of the troops from the pressure of deployments. Ingram was told: 'There was an apparent upward trend (if not surge) in the number of people requiring support in the second half of six-month tours. The US provided "significantly more in-theatre welfare/counselling support" than the UK, and personnel evacuated back to the UK to receive treatment at the Priory had, from their unit's perspective, been "lost" for weeks at a time.'

In 2006, research from the King's Centre study into the physical and psychological health of personnel deployed in Iraq found there had been no substantial increase in symptomatic ill-health among members of the regular armed forces who had taken part in the invasion of Iraq, but alcohol misuse was a common problem. But it found evidence of a clinically and statistically significant effect on the health of reservists in relation to PTSD symptoms, multiple physical symptoms, and general health.

The charity Combat Stress supports veterans, and has dealt with several thousand veterans from Iraq suffering from severe post traumatic stress. It currently supports 1,317 veterans of the Afghanistan conflict and 1,486 from the Iraq War. 'We expect to help many more over the coming years,' said Sue Freeth, the charity's chief executive. 'The Harmony Guidelines place important limitations on the length and regularity of deployments to protect the physical and mental wellbeing of serving personnel. Research shows there is a clear correlation between serving more than the guidelines recommend, and an increased likelihood of experiencing PTSD.'

Laville, S (2016). Government risked mental health of troops, Chilcot report reveals. *The Guardian*, 7 July.





PICTURE TAKEN BY ASYLUM COLLECTIVE  
OF BANNER AT OCCUPY'S TENT,  
CITY UNIVERSITY, LONDON, ST PAUL'S, 2012

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