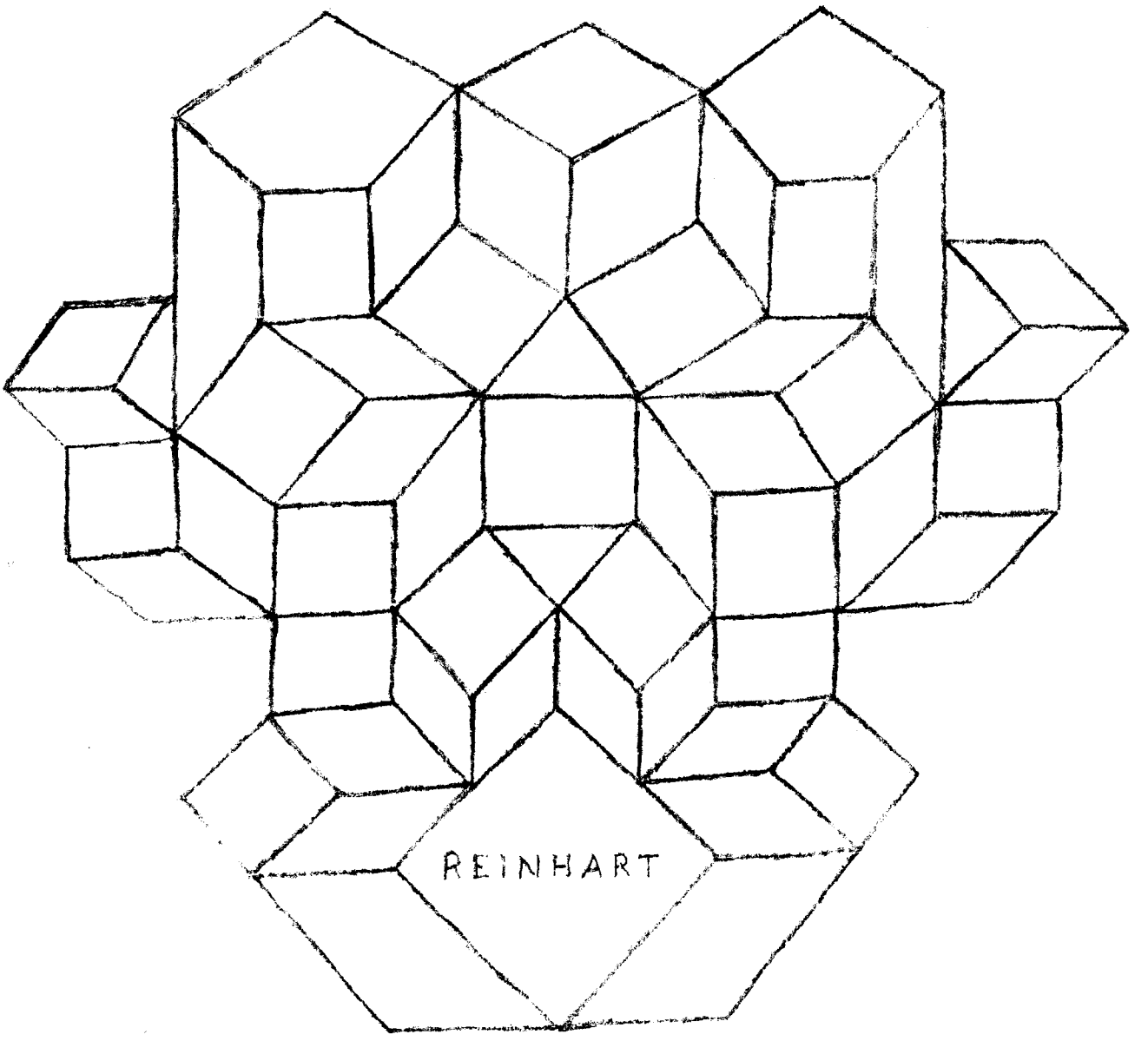
Spring, 2000

In A *NutShell*



In This Issue

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Cover Drawing: by Reinhart

Do not aprubtly stop psychiatric medications! Most psychiatric medications are powerful drugs and should be withdrawn from gradually under the care of a physician or other health practitioner.

'In A NutShell' is a publication of the MPA, #202-1675 W. 4th Ave.,Vancouver,B.C., V6J 1L8, (604) 738-2811. The MPA is a non-profit organization that offers a variety of programs in ADVOCACY, HOUSING, VOCATIONAL, RECREATIONAL, and SOCIAL ACTIVITIES for former mental patients. For more information on any of the above programs or housing waiting lists, please phone the office at 738-2811.
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Making Us Crazy — DSM: The Psychiatric Bible and the Creation of Mental Disorders

(New York: The Free Press/ Simon & Schuster, 1997, 305 pages)

By Herb Kutchins and Stuart A. Kirk

—reviewed by Byron Fraser

(with grateful acknowledgment to Pat Duncan who spent the last of the much-needed grocery money one month to buy us a copy and readily grasped the import of spreading the word about this pioneering conceptual analysis)

"Freud always remained a physician. For all his interest in other fields, he constantly had the clinical picture of neurosis before his mind's eye — the very attitude that **makes** people ill and effectively prevents them from being healthy."

— Carl Jung.

"... DSM– based diagnosis represents a **power-linguistic approach** to categorization, in which patient subjectivity is sacrificed to clinical objectivity. As Kovel (1988) points out, DSM allows for an 'objectifying gaze' rather than an inter-subjective dialogue. Although mental disorders are parts of a system of social relations, DSM makes diagnosis in the abstract by separating persons from their social world....

The entire history of the sociological study of mental health, as well as the tradition of radical critiques of the mental health field, have revolved around this common theme of psychiatry's role in social control. What has not always been clear is that **diagnosis** has been a central component of this social control. **Giving the name** has been the starting point for social labelers. The power to give the name has been a core element in the social control nature of the mental health professionals and institutions.

In one sense the critique of diagnosis **is** the critique of psychiatry, because diagnosis is the **language of psychiatry,** which by extension defines the practice of psychiatry. Diagnosis locates the parameters of normality and abnormality..."[1]

"Although there are many scientific and political threads to the full story (of the problems with the historical development, reliability, and validity of DSM diagnostic categorization – B.F.) ... . Our approach to this story grows out of a sociological tradition that views social problems and social issues as phenomena that are created through collective definition rather than as conditions that objectively exist to be studied and remedied."[2]

Introduction

When I reviewed Professors Kirk and Kutchin's forerunner to **Making Us Crazy, The Selling of DSM: The Rhetoric of Science in Psychiatry**, in 1995, I found it somewhat disappointing. This was because I had fundamentally misconceived the scope of that enterprise as being to (hopefully) render a critical analytical assessment of psychiatric diagnostic categorization practices — or rhetorical "labelling" — when, in fact, it's delimited focus was more exclusively to examine **the rhetoric of science** brought in

[1]Phil Brown in "The Name Game: Toward A Sociology of Diagnosis", **The Journal of Mind and Behaviour,** 1990, Vol.2, Nos.3&4.

[2]Herb Kutchins and Stuart A. Kirk in **The Selling of DSM: The Rhetoric of Science in Psychiatry**, 1992.

and incorporated (mainly in DSM -3 , circa 1980) in psychiatric diagnosis to attempt to solve the glaring and outstanding on-going reliability problems in the field. This meant going into a good deal of dry and technical (though eminently scholarly) analysis of such esoterica as the **kappa** statistic, the multi - axial — or 5 basic dimensions or "axes" of behavior — classification system, the field studies which show no greater degree of reliability for DSM -3 and DSM -3-R labelling categories than was evident with DSM - 1 and DSM -2, and so on. Nevertheless, that book did touch on quite a few other issues of historical import and interest such as a fairly extensive exposé of the political machinations and economic motivations involved in the professional and corporate/governmental bureaucracy - building endeavors entailed in the behind-the-scenes formulation of the DSM largely by a rather small and exclusive clique within the A.P.A., the famous/ "infamous" 1974 A.P.A. referendum on whether or not homosexuality is a scientifically proven "mental illness", and the American Psychological Association's successful battle to have the American Psychiatric Association delete language claiming that psychiatry was a **medical** undertaking.And, although the authors nowhere actually challenged the use of the term "mental **illness**" or the notion that there can be a "psychiatric **nosology**" in the sense of nosology as "the medical science that deals with the classification of **diseases**" (**Webster's** — emphasis mine — B.F.) a la Thomas Szasz, the latter had this to say about the book:

"**The Selling of DSM** is a well-documented exposé of the pretense that psychiatric diagnosis are the names of genuine diseases and of the authentification of this fraud by an unholy alliance of the media, the government, and psychiatry. I recommend this book to anyone concerned about the catastrophic economic and moral consequences of psychiatrizing the human predicament."

Ultimately, I concluded — vis-a-vis this previous book —: "...the definitive critique of the DSM remains to be written." Happily, I can now report that, with the publication of **Making Us Crazy** (and by a major — not merely academic or obscure — publisher in a very handsome and suitably lengthy edition with fully 27 pages of substantiating notes no less!), such a definitive (though not **exhaustive**) critique has arrived.

In describing their transition to this broader-scoped, more popularly-styled — yet tightly reasoned and backed with a wealth of scholarly references — treatment, the masterful culmination of close to two decades of specialized collaborative work in this field of expertise, the authors have this to say:

"In an earlier book, **The Selling of DSM: The Rhetoric of Science in Psychiatry**, we examined the making and marketing of the third edition of DSM by focusing on the most salient scientific problem of the 1970s, diagnostic reliability, and on how the developers of DSM created, managed, and used that scientifc problem in the service of reforming the official diagnostic manual. In this book, we move well beyond that territory to examine in detail the politics and scientific basis of specific diagnostic categories that have created controversy. In telling these stories, we attempt to reveal how professional biases can sweep seemingly normal behavior into categories of mental illness, how definitions of mental illness often mask gender and racial bias, and how the interpretation of scientifc data is often distorted to serve the purposes of powerful profesional groups."[3]

So what we have in this newer work is a lively but essential summary of all the relevant findings from the previous book — but without the more difficult and tedious technical scientistic convolutions — **plus** a thoroughgoing conceptual analysis of prevailing fallacious assumptions underlying major DSM categories and procedures, illustrated via abundant historical examples, which sums to a devastating indictment of current diagnostic practice virutally **in toto**. In short, precisely what many of us had

[3] **Making Us Crazy**, Chapter 1, under the subsection "A Preview of the Book" p.17

"intuited" was sorely needed and had been looking for.

Perhaps equally significant is the very topical (if possibly pandering overly much to "political correctness", in the view of some persons) treatment of what has come to be known as the "psychopolitics" aspect of psychiatric diagnosis. For instance, Professors Kirk and Kutchins argue very persuasively in many places, with a variety of examples, that DSM is regularly "used to assassinate character and slander the opposition, often for political or monetary gain." Another dimension of this treatment is succintly capsulized in their preface as follows:

"...There is a growing tendency in our society to medicalize problems that are not medical, to find psychopathology where there is only pathos, and to pretend to understand phenomena by merely giving them a label and a code number. There may, indeed, be comfort to be gained by these maneuvers — and money to be made — but in this book we question the legitimacy of this tendency and describe its risks."[4]

And, as a last prefatory remark before proceeding to a chapter overview by way of some select and related quotes and commentary, I should just say a couple of words about the essential problem under examination, what the theoretical core-issue of the subject-matter considered, here is — i.e.,what is "at stake" on the most fundamental level. Setting aside the political and economic ramifications, then, for a moment (which, of course, are not inconsequential, by any means), and highlighting the matter with undue brevity, here are a couple of apropos quotes:

"an unreliable classification system, whether for research or for practice, is an **invalid** one." — p. 49, **MUC** (emphasis mine).

"In fact, if reliability is not good, the practical validity of the constructs that DSM embodies, that is, the diagnoses, is called into question. If DSM is unreliable, it cannot be used to distinguish mental disorders from other human problems." — p. 50, **MUC.**

So there you have it: nothing less than the credibility of the entire legal/medical underpinnings of the psychiatric professional establishment — as currently constituted—hinges on the scientific conlusions of this and like inquiries.

What follows are some passages which basically "speak for themselves" and are meant to stimulate reader interest by giving a "flavour" of some of the significant subject- matter treated of, in lieu of any attempt at a comprehensive restatement of all the exposition in shorthand, which would be impossible, and a disservice to the finely-crafted whole, which it is my fond hope that interested readers of these excerpts will make time to consult.

(Stuart A. Kirk holds the Marjorie Crump Chair in the School of Public Policy andSocial Research at UCLA and was formerly Dean of the School of Social Welfare at SUNY-Albany. Herb Kutchins is a professor in the School of Health and Human Services at California State University, Sacramento. Together they have authored dozens of articles on labelling in mental health, deinstitutionalization, research utilization, social service delivery, advocacy, psychotropic medication, and issues involving law, medicine, and social reform).

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[4] **Making Us Crazy**. Preface p. X

Chapter Overview

There are 8 chapters in **Making Us Crazy** titled as follows:

1) Doubting Thomas: Psychiatric Diagnosis and the Anita Hill Controversy
2) Pathologizing Everyday Behavior
3) The Fall and Rise of Homosexuality
4) Bringing the War Back to DSM
5) The Defeat of Masochistic Personality Disorder
6) Border Wars: Borderline Personality Disorder (or, How Patients Seduce Their Therapists)
7) The Enduring Legacy of Racism in the Diagnosis of Mental Disorders
8) Diagnosing the Psychiatric Bible

Chapter 1 — Doubting Thomas: Psychiatric Diagnosis and the Anita Hill Controversy

The introductory chapter begins with a very enlightening exposé of DSM-based "psychopolitics" as illustrated by an analysis of the Anita Hill/Clarence Thomas case and moves on to a brief summary of other issues in diagnostic categorization, why they are relevant, and how they will be treated.On the first:

"In her story one sees the enormous discretion that DSM permits in placing people in mental illness categories and how... new categories can rapidly be pressed into political service. We showed how leading psychiatrists were used as hired guns or eager volunteers ready to quickly draw DSM from their holsters to defend or attack a person's character and veracity and how the psychiatric establishment obsessed over the proper diagnosis for the woman while it completley ignored the equally significant question about the mental health of her tormentor. Hidden biases about gender and race are embedded in DSM, and they are important elements in the diagnostic pot-shots fired at Anita Hill." – p. 240.

Three major themes to be emphasized in the book are described as follows:

1) The increasing "pathologizing" of everyday behavior.
2) The fragility of science in the face of political advocacy.
3) How DSM can be an instrument that pathologizes those in our society who are undesireable and/or powerless.

Some quotes from the subsection, "The Importance of the Psychiatric Bible", are:

"DSM is a claim for professional jurisdiction by the A.P.A. The broadness of this claim provides justification for the scope of psychiatric expertise and a basis for requests for governmental and private support. But it does more: it proposes how we as a society should think about our troubles." — p. 11.

"DSM is the psychotherapists' password for insurance reimbursement." — p. 12.

"... Because of the financial incentives structured into the development and use of DSM, decisions about which human problems get included as mental disorders in DSM and who qualifies for the reimbursable diagnostic label are vulnerable to pressure and advocacy groups, professional associations, and corporations.

The pharmaceutical companies, for one, have a big stake in psychiatric diagnosis. It is well known that drug companies provide substantial funding for the American Psychiatric Association's conventions and major scientific journals and reap enormous profits from the expanding market for psychiatric medications. It is less well known that some pharmaceutical companies have contributed directly to the development of DSM. The companies have a direct financial interest in expanding the number of people who can be defined as having a mental disorder and who then might be treated with their chemical products. For this reason, drug companies are disturbed by the findings of many surveys that have found that a majority of the people whom DSM would label neither define their own problems as mental illness nor seek psychiatric help for them. For drug companies, these unlabeled masses are a vast untapped market, the virgin Alaskan oil fields of mental disorder." — pp. 12-13.

"Although the conventional view claims that science and hard evidence underlie the decisions about DSM, we find that political negotiation and advocacy — as well as personal interest — are just as, and often more, important in determining whether a mental disorder is created." — p. 16.

"... status, reputation, and turf are the dominant considerations." –p. 18.

Chapter 2 — Pathologizing Everyday Behavior

"First, you must appreciate that the notion of mental disorder is what social scientists call a construct. Constructs are abstract concepts of something that is not real in the physical sense.... Mental illness is a construct, a shared abstract idea. " — p. 23.

"The constant revising provides the illusion that knowledge is changing rapidly (it is not) and that more specific categories are likely to be more valid and used more reliably (which is also not necessarily the case...) ." –p. 25.

Further to this point:

"(Zimmerman) questioned whether constant revisions really improved diagnostic reliability or validity, the ability of researchers to study these matters, or the quality of psychiatric care provided to patients and asked whether the constant revisions might have more to do with financial considerations of the A.P.A." — p. 48.

"DSM is a book of tentatively assembled agreements. Agreements don't always make sense, nor do they always reflect reality. You can have agreements among experts without validity." — p. 28.

Speaking emphatically to the same issue, here is Phil Brown in "The Name Game: Toward a Sociology of Diagnosis":

"The psychiatric literature is full of DSM reliability studies on countless numbers of diagnoses on all the axes. Yet hardly any research addresses validity. Anyone can achieve interrater reliability by teaching all the people the 'wrong' material, and getting them to all agree on it. Chang and Bidder (1985, p.202) put the problem this way:

At the current stage of psychiatric knowledge, grouping patients according to selected properties rather

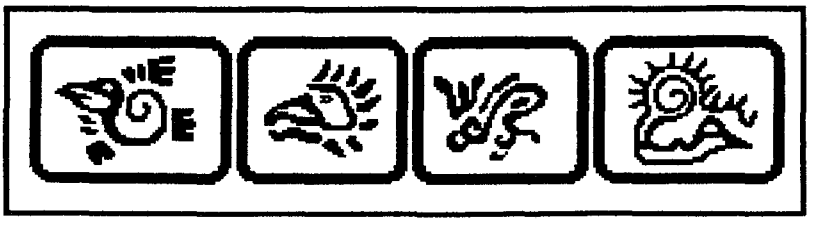
(Continued on pg. 12)

Minute Particulars

by Andrew Feldmar

Greater Vancouver Mental Health Services Society (GVMHS) invited me to be one quarter of their afternoon program on their Annual Education Day at the Radisson Hotel Burnaby. As there were three other presenters offering their wares concurrently, the partitions between rooms were for make-sound-space. The title of my seminar was **Awakening to Love**, appearing very soppy and sentimental and soft-headed, especially in comparison with the medical-technical-scientific topics of my fellow presenters: Carol Ann Fried spoke of 'lateral thinking techniques', Marshall Wilensky was introducing the effective technique of EMDR (Eye Movement Desensitization and Reprocessing), and Gabor Mate was to speak on the recently invented 'Attention Deficit Disorder'. Soon all the chairs in the room assigned to me were taken and Lindsay from the Art Studios introduced me. So, I'll tell you what I was on about, and also how it was received.

Sanctuaries, asylums, safe-house which I have visited, known, worked in, are all attempts to create environments that could hold people in extreme distress without interfering with them, without anyone presuming knowledge of what's going on superior to that of those who are suffering. No drugs are depended on to force guests to stop feeling or acting distraught. To label the residents' confusion as paranoia is a very effective way to get rid of our responsibilities and deny the confusion we help to create. Mental illness is thought to do with relationships—past and present. Students in these environments struggled with omnipotent defense structures of feeling one had to **provide everything**, before realizing that one just had to continue being oneself. Joe Berke, Mary Barnes' therapist at Kingsley Hall, thought that mental illness was not an illness or sickness at all, but reflected what was happening in a disturbed and disturbing group of people. Berke also felt that schizophrenia was an expertise in producing disquiet in others when an altered state of reality is culturally unacceptable and inadvertently upsetting. In other words, it is often against the social rules to have certain experiences or manifest certain behaviour. Mary Barnes, for instance, transgressed a taboo: she chose not to regard her shit as separate from herself, as something to be removed, but a something to 'stay with'. At Kingsley Hall this transgression was met, without drugs, without coercion, until Mary moved on from smearing shit on the walls to putting paint on canvas. The work of Nancy Waxler is thought provoking regarding how important it is **how** we meet 'mental disorder' once it has occurred. I met Nancy at the sociology Department of UBC, where we wondered about why psychiatry was blind and deaf to facts that challenged its premises. For over 20 years now, we've known that in traditional, pre-industrial societies (Sri Lanka, India, Ceylon, Africa and Mauritius for example) the rate of mental disorder and the tolerance of degrees of deviance are not at variance with societies such as Great Britain, Denmark, U.S.A., or Russia, for instance. Yet there is a 60 - 70% recovery rate with no re-admissions in the first set of societies compared to a 30 - 35% rate in western countries. The traditional treatments in peasant societies are highly ritualized and reintegrate those



(Continued on pg. 19)

UnderDog Cosmic Paradox

by Jim Gifford

(Previously published in Vancouver Richmond Mental Health Network's ***Bulletin)***

We often hear of people "falling through the cracks" of the Mental Health System. Fortunately, such was not my fate. In my particular case, the "fall" was of a different context, manifesting itself in two distinct ways.

Firstly, my experience included entering into cosmic consciousness, a descent into the centre of the soul. Misinterpreted by the powers that be, I descended again, on this occasion into the world of the mental patient, quite traumatizing in itself, but accentuated by the fact that it was a free fall from a life of affluence and respectability. For I came from a prominent old family of outstanding athletes, successful businessmen and career politicians, pillars of The Establishment in my local community.

Allow me to elucidate. A fourth-generation member of a distinguished New Westminster family, it was natural and fitting of me to feel a sense of high expectations. Among my relatives were an Olympian, Lacrosse Hall of Famers, a Mayor of the Royal City (my father), a Member of Parliament, and executives of lumber, deepsea shipping and engineering firms. My roots were deep and solid in accomplishment and achievement. It was, as they say, "a hard act to follow."

As for me, my ego was well-developed. Graduating from high school on the Honour Roll, I then attended the University of British Columbia, where I received a Bachelor of Arts Degree in Canadian History and, in 1970, was a first-year Law student at UBC. Then, suddenly, my world collapsed.

An ecstatic mystical breakthrough was diagnosed as a manic-psychotic episode. I had fallen through a "crack in the cosmic egg," my egoic conventional reality shattered as I succumbed and surrendered into the Spiritual Abyss of the Universe. Almost immediately, I tumbled into the world of asylums, psychiatrists, medications (legal drugs), halfway houses, drop-in centres, and street people. Although I never received Electro-Convulsive Therapy, the sudden change in my circumstances was a devastating form of shock treatment to my psyche. Ostracized, ridiculed and ignored by some, and deserted by "fair-weather" friends, my disease had made me unemployable and, put on a handicapped pension, I fell to the bottom of the financial ladder. Had I been cursed? Soon I realized the hidden blessings in my dilemma. I saw the suffering and misfortune as opportunities in disguise, and I re-evaluated my life and grew in meaningful ways.

I was freed from the rat race, slowed down, no longer hurried along by thoughts of ambition and success. I had a fresh outlook on things; I had little money, but plenty of time. My intellectual pursuits became a great delight to me, works of metaphysics, philosophy, psychology and poetry. I developed a deeper and broader view of life and my place in the scheme of things. I pursued journalism and creative writing. And came to embrace "voluntary simplicity."

Like other ex-mental patients, I was among the ranks of the poor. I found the "solution in the problem" by joining the likes of Diogenes, St. Francis of Assisi, and Henry David Thoreau in singing the praises of "Lady Poverty."

My life had been turned topsy-turvy, transforming as new

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Success/Excess

by Reinhart

Overpopulation, starvation, foreign aid dependency, greenhouse effect, climatic changes, drought, flood, famine, third world plagues and diseases, global soil erosion and depletion, desertification, deforestation, wildlife extinction, food-chain poisoning, depletion of natural resources, oil spills, air/water/land pollution, toxic waste, radiation contamination, carcinogens, poison preservatives/pesticides/herbicides and fertilizes, overproduction, unemployment, national debt, economic collapse, political instability, global warming, drug resistant super viruses and bacteria, poverty, homelessness, drug addiction, commercial exploitation, child labour, ecological destruction, crime, violence, racial and ethnic strife and discrimination, terrorism, war, AIDS etc., etc.

You don't have to be a religious fanatic or doomsday enthusiast to admit that the world's present and future looks bad. Things deep rolling on. The world turns, people buy their satisfactions, and the troubles become more pronounced, more pervasive and more entrenched. Some are temporarily resolved only to reappear again in another guise. All are due to come to a head at some unknown time in the future — but not in our lifetime. We find our lives acceptable and convince ourselves that it will all work out somehow. We have too much invested in our lifestyles to admit the truth, even to ourselves. A crisis in the future — my fault — no way!

We buy a car, spew out tons of fumes into the atmosphere — hell, we buy two or three cars if we can afford it — we go to work and support all the industries that derive their profits at the expense of the poor and the environment; and then we buy the tons of manufactured shit to oppress and pollute some more. And the more damage we are responsible for, the greater our success. Our societies are diseased, our institutions self-serving and onerous, our families broken, and our world is dying.

But it seldom occurs to us to question the core of our values. Competition, capitalism, market economies, continuous growth and consumerism are taken for granted. We may complain a lot but we console ourselves with trite and familiar old aphorisms like, "It's not perfect, but it's the best possible system we have." The poor poets, prophets, and philosophers who see a different vision — who yearn for the brotherhood of man, who ache for harmony with nature, who are sick to see man, beast and earth exploited in the name of profit - these poor sons a bitches, when they act out due to frustration, anguish and distress, are singled out, rounded up and taken away. They are declared insane and dangerous and put behind bars. Their hopes and dreams for liberty, fraternity and equality become delusions. Their visions of peace, love and good will toward men are hallucinations. Their fear of "The Man" is paranoia. They are treated in "re-education centers", commonly called insane asylums, until they learn the errors of their ways and recant their "abnormal" inclinations. Once they "see the light", they are considered for release.

As for the rest of us: we graduate from high school or college, fully programmed by teacher, media and public, and immediately begin to scurry about like rodents seeking to build a cozy little nest. We accept the status quo, we accept a dysfunctional world, and we start sniffing for our share of the pie. The ladder of success stands amidst a pile of garbage, but with a little bit of cash we can by a shiny new trinket. Up we climb. Of course it's a scramble; and the bigger share of goodies are at the top. Stepping over, on top, and pushing down those in our way is part of the pile. It's the "American Dream". The one with the biggest pile when he dies wins. The more crap you own, the more successful you are. A model citizen: so get it while you can we say, the sky's the limit. We forget that the sky is yellow now instead of blue.

BookWorm

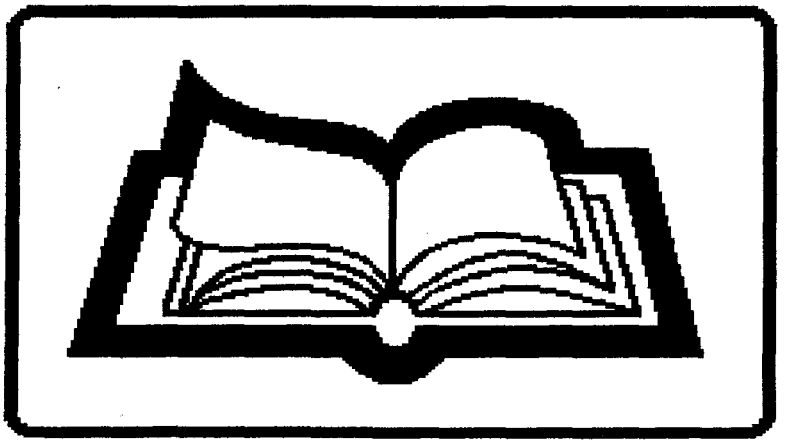
Dangerous Emotions

by Alphonso Lingis
University of California Press, 2000
Reviewed by Andrew Feldmar

On Friday, August 26, 1994, Al Lingus read a paper, entitled **Dangerous Emotions**, in the lecture-theater of Vancouver's Planetarium. I invited him here, to help me reframe the practice and theory of psychotherapy in terms of ethics and politics. He is Professor of Philosophy at the Pennsylvania State University. I first met him on October 26, 1990, in London, England, where at a conference he dazzled and annoyed the participants by reading a paper called **Lust**. By facing the beast within himself and daring to talk about it, he challenged everyone to face the horror and fear of acknowledging one's own lechery, lasciviousness, craving and desire.

The paper he wrote for his appearance with me at the Planetarium, you can now read, with some modifications, as Chapter 5, **Blessings and Curses**, of the book under review. The weak, reactive emotions are named contentment and resentment; they contrast with the dangerous emotions of laughing and crying and blessing and cursing. The fetish we make of understanding and certainty reduces our lives to irrelevance, emptiness and boredom. True autonomy means a life-sentence of risk and insecurity laced with the erotics of doubt.

Lingis is one of the most autonomous humans I have ever met. His travels have taken him to every continent. He is at home in the world and he wants to know and enjoy every dark corner no matter how remote, hidden or threatening. He makes you feel that you must save up for years, if necessary, and take off at least a few days "and fly to France just to see the Mona Lisa, fly to Japan just to spend a morning in the Ryongi Zen sand garden in Kyoto, fly to Peru just to spend, if that were all that was possible, a day in Machu Picchu". He sends you to admire the giant sequoias, the baobabs in Africa and the banyans of India. Then go and experience the "Rheims cathedral in France, the Hagia Sophia in Istanbul, the temples of Khajuraho in India, Teotihuacán in Mexico, and Borobadur in Java". Unless you've been there and done all of that, you begin to feel like an agoraphobic, lily-livered coward. Lingis has a tendency to evoke envy or admiration depending on the reader's proclivities.



Chapter 11, **Gifts**, leaves you wondering whether you've ever really given or received a gift. "It is not gift-giving", Lingis writes, "unless what you give will come into the life and heart of the recipient as a grandeur. It is the extravagant and passionate heart that can recognize and receive a gift". He wants us to give up our self-assurance and self-satisfaction which constricts us into refusing many transcendent gifts this world is full of. Lingis dares you to surmount what frightens you and face it squarely. We exist in constant fear of ourselves,

(Continued on pg. 19)

Sigmundane Fraud
by Jim Gifford (1983)

breakup?
break in?
breakout?
breakdown?
breakthrough?

welcome to the loony bin
welcome to the funny farm
welcome to the nut house
welcome to fruitcake city
welcome to the freak show
welcome to the compromised land of sigmundane fraud

the patient bumbles stumbles tumbles crumbles

diagnosis: a frantic-receptive

mystical mania of uncritical fantasia

planted in a putrid reality
of the soul's welts and abrasions
a castrated cadaver in a closet-case corner
shielded from the sun-son
chlorpromazine burns baby burns

a scar is born
a star is scorned
a dream is torn
a gleam is worn

enter the strained brain contagion of shrinks
rushing toward the hallowed hellish realm of slobotomy
sifting through pills, banalysis and defrocked treatment
in the charade masquerade
cackling tackling
rendering offending glib globs of gloating
sterile legions
dissecting manipulating multilating manouvering
whim-wham ways
in cahoots like a coyote prowling scowling
for ba ba black sheep

Therapist/The-Rapist

by Jim Gifford (1983)

Therapist/ The-Rapist adores lawn order of conformist
straight-jackets, abhors spawning corridors
of performers elated jokettes

Therapist/The-Rapist glows and restrains you, chalking
up normal joes and janes, stalking you with
a pose so profane, balking at letting a rose
be a rose.

Therapist/The-Rapist strives to make you well. He
connives to pigeonhole you in his own little
hell. He tells you avoidance of a void dance
is the right path. He doesn't understand the
ushers of his way are pushers of wrath, powers
scowering to make you pay for the contraband of
plight. Don't they know how to play?

Therapist/The-Rapist inflames your amazing need to be freed
of the close-minded decrees bequething your
savage integrity into average banality.

Therapist/The-Rapist hates a crazy little critter soaring
in a jungle of mother-nature's doing, accepting
the bitter with the sweet and the mature wooing
of each moment's beat, teaching there are no
opponents, only you and me and us and we, wild
rebels revelling in the limitless bliss-blast of
fun that we've already won.

(Continued from pg. 5)

than in terms of their total phenomenology is analogous to classifying a car by observing any four of the following eight properties: wheels, motors, headlights, radio, seats, body, windshield wipers, and exhaust systems. While an object with four of these properties might well be a car, it might also be an airplane, a helicopter, a derrick, or a tunnel driller.

Put otherwise, witch trials showed a much higher degree of interrater reliability than any DSM category (Kovel, 1988), yet we would not impute any validity to those social diagnoses." —p. 393, **JMB,** 1990, Vol.11, Nos. 3 & 4.

"Having an operational procedure for determining whether a phenomena belongs in a class, such as the checklist of symptoms in DSM, does not substantiate what that construct or class is." —p. 28.

Here is the DSM - 4 (- i.e., "current", released in 1994) definition of mental disorder:

"... a... syndrome or pattern that occurs **in an individual**... a symptom of dysfunction in the individual... " — pp. 30-31.

"...the definition implies that something within the individual has gone wrong, that there is a dysfunction. By defining disorder as a dysfunction, it tries to include some notion of internal pathology that causes symptomatic behaviors. The problem with defining disorder in terms of dysfunction, however, is that dysfunction itself requires a definition and DSM does not provide one." –p. 31.

Not only this but "madness may not be a dysfunctional stratagem" at all, as Dr. Thomas Szasz has so succinctly put the matter. Or, alternatively, there are many who would agree with the following statements from Dr. Ty C. Colbert's 1996 book, **Broken Brains or Wounded Hearts: What Causes Mental Illness**, which informs us not only that no internal biologically-based causal pathology for any DSM category has ever been proven, but also that what the prevailing medical/disease model calls "mental **illness**" is, for the most part, probably a quite sensible (at some level) reaction to overwhelming, predominantly **external**, circumstances. Thus:

"To date, however, not one proven biological cause for mental illness has been found. Even though biological psychiatry assumes a physiological cause for all major emotional disorders, there is still no proven cause-and-effect relationship between any specific disorder and any specific physical defect."

"In fact, I believe that even the most so-called severe mental illnesses – schizophrenia, depression, and mania – are not biologically based, but a reflection of a person's emotional woundedness. These symptoms are defenses and strategies developed by a person to cope with emotional pain."

"It is important to realize that when overloaded with emotional pain, the mind begins to act 'crazy' in the process of splitting off that pain."

"All emotional or so-called 'mental' disorders, whether they be schizophrenia, depression, mania, panic attacks, or compulsive behaviours, are defence mechanisms that the mind creates to deal with an overload of pain. This is the central difference between the medical model and the emotional pain model. The medical model presents the brain as broken or defective. The emotional pain model declares that nothing is wrong with the brain and, in fact, shows that the brain is often working **brilliantly** as it helps create strategies to deal with the emotional pain of an investing heart."

Under the subheading of "The Failures of DSM's Definition" (of "mental disorder"), Professors Kirk and Kutchins list four broad categories under which it is assailable:

1) Expectability
2) Impairment
3) The notion that "it" originates "in the individual."
4) The notion that "it" is a "dysfunction."

"... the definition avoids any requirement that the etiology or cause of the disorder is identified or that the disorder be understood through the lens of some theoretical system of explanation. Eschewing etiology allows the DSM's developers to claim that the manual is descriptive and atheoretical and avoids the many controversies in mental health that swirl around the murky topic of causation." —p. 32.

Along similar lines:

"But psychiatry was slow to become enamored with diagnostic classification, in part because psychiatrists recognized that any classification of disease based on symptomatology rather than etiology presented formidable problems." –p.269, note 20.

The crucial distinction to be aware of relative to this context, for the uninitiated, is of course that between functional disorder and organic pathology . And **why** this is so important, again, is that, if the psychiatric establishment loses it's claim to specia l expertise of a traditional **medical** sort due to the supposed organic causal component of abnormal thought and behavior – just like any other bona fide disease –, then there goes also their claim to State-legislated monopolistic privileges which have been worth literally billions to them, and their drug-company cohorts (et. al.), for many, many years.

There is an interesting related paragraph on page 44 on the battle to exclude the psychoanalytical term "neurosis" from DSM-3 ostensibly because, as a term for a disorder presumably resulting from intrapsychic conflict or "psychodynamics", it implied a cause (or etiology) and was presumably not merely atheoretical and descriptive. The paradox is that (as Von Mises points out in **Theory and History**) Freudian psychodynamics probably presumes more of a non-materialistic basis for mental phenomena (despite Freud's sometime speculations about the ultimate basis of mind in "impermeable neurons" and such) than the "new psychiatry"/biopsychiatric categories of DSM 3 & 4 – which are virtually always framed and applied on the underlying assumption of a materialist reductionist paradigm. The point, of course, is to avoid the issue of primary causation, all the while working with the implicit assumptions of materialist reductionism on which the prestige and presumed expertise of medical science has traditionally been based (and upon which the lucrative psychiatric professional monoply, by extension, is predicated), but which, as famed psychiatrist Stanislav Grof said at a recent lecture in Vancouver (Oct. 22, 1999), is essentially **the reverse** of what all cutting-edge science – and especially quantum physics – has been telling us about the fundamental (in philosophical terms, "idealist") basis of reality and causation for at least 30 to 50 years now (see especially, in this regard, **The Self Aware Universe: How Consciousness Creates The Material World**, 1993, by quantum physicist, Amit Goswami, for an extremely lucid update). The obvious implications of the impending paradigm shift overthrow of "the superstition of materialism" are, of course, also what is feared most.

"Mental conditions frequently mediate between environmental stresses and resulting impairments. Thus, the issue is not simply whether the disorder is 'in the individual' or how it was caused but whether it represents a **mental dysfunction**." —p. 34.

"...in terms of offering a conceptually valid framework, the definition fails because it neglects to provide a systematic analysis of the concept of dysfunction, a concept on which most discussions of disorder are grounded." — p. 34.

"Thus, the everyday behaviors that DSM uses as criteria of mental disorders do not necessarily indicate any mental dysfunction at all! "— p. 35.

"The manual has no consistent requirement that the everyday behaviors used as diagnostic criteria actually be the result of mental disorders and not the result of other life experiences." — pp. 36 - 37.

"And since the final product, incorporating hundreds of minor and major changes, is never directly tied through citations to research articles, the claims of science-at-work are difficult to verify or dispute." – p. 38.

"This cycle of denigration, enthusiasm, and denigration makes an old system appear antiquated and a new system necessary, a marketing strategy (popularly known as 'planned obsolescence' — B.F.) pioneered by the automobile industry." — p. 38.

"... in order to obtain approval from the federal government to sell a new medication, the drug industry must conduct clinical trials with the new product and document its effectivenes for individuals with specific, defined disorders. If psychiatric diagnoses cannot be made reliably, it is difficult to determine for whom a drug may be effective." — p. 42.

"... DSM- 3 became a moving target for all those who had criticisms. By presenting the manual as provisional, not final, ... the A.P.A. muted the force of criticism and offered opponents future opportunities for change." — p. 46.

"As we have shown in great detail elsewhere, the reliability problem did not get much better with DSM-3. In fact, no study of DSM as a whole in a regular clinical setting has shown uniformly high reliability. And most studies, including the DSM field trials themselves, provide little evidence that reliability has markedly improved, much less been 'solved' as a problem." — p. 52.

Kutchins and Kirk summarize the findings of a major study (by J. B. Williams, et. al., in **Archives of General Psychiatry** 49, 1992, pp. 630-36) on reliability and other recent studies as follows:

"Because of the great care that was involved with this study, it should have produced the highest diagnostic reliability possible in a supervised research setting. We would expect that diagnostic agreement would be considerably lower in normal clinical settings, where the staff is not knowingly involved in an international research project. The findings of this elaborate reliability study were disappointing even to the investigators. The kappa values (the statistical measures of reliability) were not that different from those statistics achieved in the 1950s and 1960s — **and in some cases were worse.** What this study demonstrated was that even when experienced clinicians with special training and supervision are asked to use DSM and make a diagnosis, they frequently disagree, even though the standards for defining agreement are very generous....

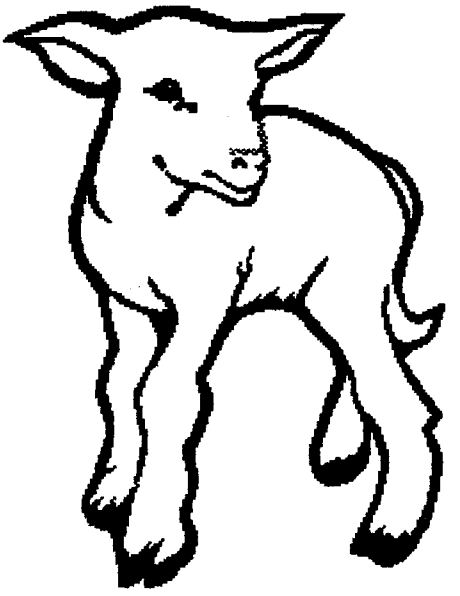
Twenty years after the reliability problem became the central scientific focus of DSM, there is still not a single major study showing that DSM (any version) is routinely used with high reliability by regular mental health clinicians. Nor is there any credible evidence that any version of the manual has greatly increased its reliability beyond the previous version. The DSM revolution in reliability has been a revolution in rhetoric, not in reality. Despite the scientific claims of great success, reliability appears to have improved very little..." — pp. 52-53.

Concluding their chapter on "Pathologizing Everyday Behavior", Kutchins and Kirk state that: "The unreliability of DSM is a chronic problem that the psychiatric establishment tried unsuccessfully to solve and would now rather ignore." — p. 54.

Finally, if somewhat ironically, many are now pointing out that this is exactly the result you would/should expect given the inherent methodological fallacies operative in typical psychiatric diagnostic schema. As Phil Brown says ("The Name Game", p. 394):

"By criticizing the existing attempts at 'objective' measurement in psychiatry, I do not mean to imply that these can be sufficiently refined to the point that they offer a very valid picture. Indeed, my point is that psychiatry is approaching the problem incorrectly by examining patients and their symptoms as discrete phenomena without context.... Thus, methodological and measurement refinements will not be likely to increase the validity of psychiatric diagnosis... ."

(This is the first part of Byron Fraser's Review which will be concluded in the next issue of "In A NutShell")



I Paint What I See

by Sam Roddan

It takes a lifetime to find your way around. Sort out the signposts, get past the detours. In my day (now a young and perky 85) I have done much back-tracking, picking up lost trails, unearthing old friends.

But most of my ancient friends are now gone, names in OBITS, leaping alive only in some restless dream, or an aside in an encounter on the street, or a fugitive memory in the bustle of a day.

Sometimes I yearn briefly for Housman's "YON FAR COUNTRY"... "blue remembered hills... spires... farms... happy highways..." but for me, fortunately the "rue" is always short lived.

The ever-present fear of old age is that you will lose your way... not be able to find your way back... not recognize familiar landmarks.

But I'm very lucky.... The streets and lanes of the Downtown Eastside are still familiar to me. In the early 30's I could spend hours around the North Van Ferry dock at the foot of Columbia, watching the No. 5 bumping into the wharf or straining to see the Empress of Japan or the Aorangi moving slowly through the Narrows.

Or I could be in the Museum in the Carnegie Library checking out the Egyptian mummies, the Indian masks, carvings of West Coast Indians.

But today my memories are often clouded with contradictions. They are like whispers, asides, eaves droppings, parings, the stuff of the distant past... And to quote Housman for the last time...

"This is the land of lost content,
I see it shining plain,
The happy highways where I went
And cannot come again."

But all is not lost.

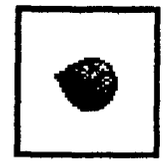
Over the past few years I have worked hard to become a painter... A kind of Grandpa Moses, an old folks Toulouse-Lautrec. But most of my subject matter is the streets and corners that I knew best as a boy. Main and Hastings, the Carnegie Library, the Cozy Corner at Columbia (now closed down), the old Mission Church at Gore and Hastings, Powell Street Grounds.

I am a regular contributor of sketches and paintings to the Carnegie Newsletter. I put words to rough work and paint what I see and feel. I am a poor draftsman, but I go for the heart.

Through my paintings, I have rediscovered much goodness in Downtown Eastside. And apart from the hard core of the "sick and disabled" who hang around lanes and street corners, there are many brave and resolute characters who are citizens of this community.

I don't need a camera to help me in my painting. My own memory bank stands me in good stead. And I see the same faces I knew so well as a boy. And I see the unloved and the lost, as I did seventy years ago, hurting, stumbling, shuffling by, in pain and loneliness.

One of the functions of art is the education of the heart. And what I have tried to paint most are brothers and sisters who go about their daily living undaunted by bad luck and misfortune. And best of all surviving with great spirit even when all hell seems to threaten their every footstep.



Things

"Things are in the saddle and ride mankind."

Ralph Waldo Emerson

Riverview Hospital Mental Health Week and 2nd Annual Patients' Conference Schedule of Events (May 2 -5)

Many of our MPA staff and broader membership and readership of this newsletter have close ties to the Riverview Hospital community so we are listing the following events as a service to "our constituency", as it were, but it should be noted that the events are not all open to the general public (for more specific information on any of them, please phone Phil Bell, Accreditation Co-ordinator, at 524-7688 or our MPA Hospital-wide Advocacy staff, Judy Shirley or Bev Percival, who are co-ordinating the May 4th "Healing Our Spirit" Patients' Conference, at 524-7379).

Phil Bell who has been a co-ordinator of Mental Health Week events for some 10 years now, will also be known to many as the former Co-ordinator of Patinet relations and co-developer with Jill Stainsby of the **Guidebook of the Charter of Patient Rights.** He has more recently been involved as co-editor and content expert on the CD-ROM Interactive component of The Charter.

Events: (Open to members of the Hospital Community, Patients, Staff, Community.Partners, Clubhouse Members, etc.,)

Tues. May 2:

10:10 A.M. Opening Remarks – Helen Connolly, Chair of Board of Trustees
– 10th annual Gold Mile Walk/Run (approx. 800 participants)
– Snacks & music at Penn Hall

11:30 - 2:00 Vocational Services Plant Sale (Westside of Eastlawn – outside pharmacy)

Wed. May 3:

10:00 - 11:30 – Fun Olympics – Penn Hall

1:00 – Finnies Garden Tour and Tree Walk – meet at Library entrance to H.E.Y. building (RV Horticultrual Society).

Thurs. May 4: – "Healing Our Spirit" Patients' Conference at Henry Esson Young Building.

9:00 A.M. – Registration, Coffee

9:45 – Opening Remarks by Coquitlam Band Chief Marvin Joe
– Dance Troupe "The Gathering of Young Eagles"

10:30 – Introduction of Workshop Presenters

11:00 -12:00 – Workshops:

1) Therapeutic Story-telling – Sue Cohene
2) Relaxation Therapy – Jennifer White
3) Healing Circle – Cyril Sinclair
4) Self-Esteem Building – Penny Keene
5) Reiki – with Kahadeja

12:00 – LUNCH WITH NORA THE CLOWN

1:00 – Dianne MacFarlane/Advocacy Award Presentation to Robin Loxton

1:15 – Forum / Open to all / Keynote Speaker: April Porter, recipient of "The Courage To Come Back" award.

Fri. May 5:

9:00 -10:00 A.M. – Demonstration of Patients' Charter of Rights CD - ROM with Phil Bell (Auditorium B, HEY building)

1:00 – Arboretum Tour & Tree Walk (meet at front entrance of HEY building)

1:30 -3:00 – Karoake Contest at Penn Hall

5:00 - 7:00 – Bowling Banquet at Penn Hall

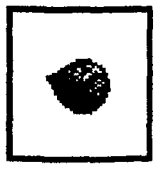
The MPA **Mental Heath Empowerment Advocates Program** (MHEAP) which helps people with applications for Disability Benefits, income assistance appeals procedures, and accessing community resources now has a new toll-free number: 1-877-536-4327.

UnderDog

(Continued from pg. 7)

values and unique insights emerged. My family and I struggled with the drastic changes, but love is the energy, power and essence of the Universe, and in unison with our loyalty to one another, we survived those troubled times, and in the process, matured in compassion and understanding.

Now, in retrospect, I see the long and winding road that is "jim gifford" as a cosmic paradox — both a curse and a blessing.



Minute Particulars

(Continued from pg. 6)

who suffer, whereas in western societies treatment alienates, stigmatizes and locks people into the chronic role of 'mental patient'.

I also spoke of the writings of Jay Neugeboren, who in two books so far, has told the story of his schizophrenic brother, Robert, who's been treated unsuccessfully for almost forty years now. **Imagining Robert** and **Transforming Madness** pose many difficult questions. Why do mental health professionals disagree so strongly with one another that they tend to viciously attack each other? Therapy versus drugs, which matters more? If the drug works, why does it appear to stop working on the departure of a social worker Robert grew to like?

I defined **love** as a manner of living and relating that allows the other person to emerge as a **legitimate** other in co-existence. This excludes any coercion, persuasion, or pressure to conform. If you wake up to this, if you realize this, the other, even if labeled 'schizophrenic' or 'depressed' or 'mentally ill' will remain **legitimate**, deserving respect, conversation, and conviviality.

Read Emily Dickenson who wrote in 1862, "Much madness is divinest Sense —/ To a discerning eye —/ Much Sense — the starkest Madness —/ 'Tis the Majority / In this, as All, prevail —/ Assent — and you are sane —/ Demur — you're straightway dangerous —/ And handled with a Chain —"

When I finished, people applauded, and the questions weren't hostile. GVMHS operates on the Medical Model. Perhaps there is hope of change.

BookWorm

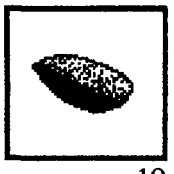
(Continued from pg. 9)

others and the world. Yet, when you consider how easily the unique you that you are might never have been born, you might be moved from fear to gratitude for your mere existence. Out of this gratitude then flows all the enjoyment that will leave no time for fear once you learn to cultivate it.

In Chapter 7, **Innocence**, Lingis speaks of the possibility of awakening. "Awakening is a bound, not weighted down with the past that inculpates the present and demands compensation from the future, a bound out of the drunkenness of remorse and resentment. Awakening is a commencement. It is a point of departure... Awakening is a birth." How eloquently put: **the drunkenness of remorse and resentment**. A most difficult intoxication to quit.

Georges Bataille in **Erotism: death and sensuality**, wrote that "the pinnacle of being stands revealed in its entirety only through the movements of transgression in which, though founded on the development of awareness through work, at last transcends work in the knowledge that it cannot be subordinate to it". **Dangerous Emotions** is a book filled with transgressions. How unusual to read that "language came into existence to speak of what we laugh and weep over together". Or "Ugliness is often the mark of fatigue and exhaustion". Or: "Most of what anyone says is daft; most of what humanity has written is fudge".

This book will stir up dangerous emotions of your own. For me, the book is the ultimate gift: Lingis gives his life. A dozen photographs by the author are the icing on the cake of his illuminating ideas and generous flow of eloquence.



Bulletin Board

Mothers In Transition Support Group

Mothers who have lost custody of their offspring due to mental illness meet other moms of like mind and situation. We share experiences and interests. We hope in unison to lessen the burden of living without our offspring. We create friendship. For more information contact Dawn at 871-0151

Alternative Healing

Health Action Network Society supports natural healing methods for mental illness. Ph 1-888-432-4267. Their local address is #202-5262 Rumble St., Burnaby B.C.

Vancouver Women's Health Collective has peer counselling and makes referrals to support services, groups, and does advocacy work in health care reform. Their address is 219 - 1675 W. 8th Ave., Vancouver, V6J 1V2. Info by phoning (604) 736 -5262

Freedom of Choice in Health Care, B.C. Chapter can be reached by phoning (604) 685-7835

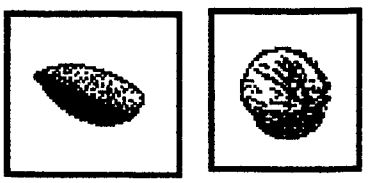
Tzu-Chi Institute for Complimentary and Alternative Medicine is at 715 W. 12th Ave., Vancouver, They do research, have a clinic, resource centre, and library . They can be reached by phoning (604) 875-4767.

Vancouver/Richmond Mental Health Network sponsors many self-help groups including a Women's circle. Their address is #109 - 96 E. Broadway, Vancouver, V5T 4N9 and the Director of the Network, Helen Turbett may be reached at 733-5570.

The Gaia Garden Herbal Apothecary at 2672 W. Broadway, Vancouver, V6K 2G3, can help with transition therapy for people with psychiatric problems going from orthodox medication to herbs. Their phone number is 734-4372.

Freebies:

For those in need: Free clothing; Dishes
Choose from a variety of donations
At Community Resource Centre, 1731 W. 4th Ave., Monday to Friday, 9 am to 9 pm on request.



Lavender

750