Summer, 2000

In A NutShell

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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 Most psychiatric medications are powerful drugs and should be withdrawn from gradually under the care of a physician or other health practitioner.

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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

Part 2 of 2 Parts — A Continuing Chapter Overview

Chapter 3 — The Fall and Rise of Homosexuality

"...reform efforts to depathologize diagnoses...almost always come from outside organized psychiatry. Few reforms of any kind come from within a profession (even though there may be many powerful and sympathetic insiders) unless they involve struggles for power." — p. 87.

Nowhere, perhaps, was this more graphically demonstrated than in how the homosexuality issue was used by biologically and scientistically oriented research psychiatrists to outmaneuver and displace the traditional power of the psychoanalysts in the field. Thus:

" A major objective of the research-oriented psychiatrists who were revamping DSM during the 70s was to eliminate psychoanalytical influences from the manual, and the fight about homosexuality was the opening salvo in the battle." -p. 64.

Further:

"The declassification of the diagnosis of homosexuality should be understood in the context of the broader debate within the A.P.A. about eliminating psychoanalytical assumptions from the theoretical formulation of the concept of mental illness." -p .65.

"... the homosexuality controversy illustrates one of our major themes, namely, that science is often not central to the decision to include or exclude a diagnosis from DSM. The dispute over the inclusion of homosexuality in DSM was not about research findings. It was a 20-year debate about beliefs and values. Although the professionals who formulated diagnosis couched their arguements in the language of science, the actual influence of empirical data was negligible. More often than not, the issues were settled by political compromise that promoted personal interests." — p. 56.

"The head of the council (The Council on Research and Development of the A.P.A.— B.F.) rejected the suggestion of a survey as 'ridiculous', saying 'You don't devise a nomenclature through a vote. ' Ultimately, of course, this is precisely what the A.P.A. did." — p. 71.

"None of the psychiatrists involved in the controversy had done studies that could pass muster as definitive scientific research, but before a decision could be made, each side had to couch its arguments in terms of scientific standards. " – p. 73.

"It is necessary to recognize that the issue was not how the public felt about AIDS or homosexuality but about the public's faith in psychiatric diagnosis." — p. 88.

"Everyone on all sides of the debate concedes that there is no satisfactory explanation at this time of the way that genetics or other biological factors contribute to the determination of sexual orientation or gender identity." — p. 96.

"We have witnessed a rush to publicize new findings about the genetics of alcoholism, schizophrenia, and manic depression, many of which were later retracted... . Although many have been retracted, the reports

about the inheritability of mental disorders are the scaffolding for the current discussion of the biogenetics of homosexuality." — p. 98.
"Throughout the entire struggle over the inclusion or exclusion of homosexuality from DSM, the minor role played by scientific research has been striking." — p. 99.

Chapter 4 — Bringing The War Back To DSM
"Those who were most likely to suffer from PTSD were those who suffered from battle fatigue, but military psychiatrists, far from identifying combat fatigue as an early warning, were involved in exactly the opposite strategy, namely, minimizing the seriousness of complaints and pushing soldiers back into combat as quickly as possible." - p. 107.

"...but other types of persistent everyday events can be very disturbing, such as persistent... harassment on the job. In such cases, there is no single incident that adequately qualifies as a trigger... but when harassment occurs day-after-day, the cumulative effect can be traumautic. For those reasons, the diagnosis of PTSD was revised to include many ordinary events that can precipitate stress reactions." — p. 118.

"Although it is important to recognize the suffering of these victims, it is a major leap to identify characteristic reactions to assaults, abuse, and harassment as symptoms of mental disorder; this practice leads to the complaint that psychiatrists and other mental health workers are blaming the victim." — pp. 121-122.

In other words, what's so "wrong", abnormal, "ill" or even "dysfunctional" about having a severe reaction to some traumatic life-experience? (In this connection, the authors of the pathbreaking 1999 Research and Policy study from the B.C. Centre of Excellence for Women's Health, **Hearing Women's Voices: Mental Health Care for Women,** Marina Morrow and Monika Chappell write: "In this report we have chosen to replace the term 'disorder' which medicalizes and pathologizes women, with the term 'response' which reflects the recognition that many of the behaviors/symptoms that are diagnosed as mental illnesses can be understood as responses, to traumatic life events. We would like to thank Sasha McInnes for suggesting this shift in language." Note 14, p.78).

"Ziskin too, observes that 'it can be difficult to say whether reactions to purportedly stressful events are most appropriately identified as healthy or unhealthy'." — p. 125.

"Do mental health professionals need to make a diagnosis in order to understand that victims need all the help they can get ? It is a disservice to victims to give them a diagnosis because they are suffering the aftereffects of trauma. Evidence indicates that although they may be very troubled and deserve all available help, few of them are suffering from a mental disorder..." — p. 125.

Here we should just briefly note what Kutchins and Kirk's definition of a "mental disorder" is; they state that:
"A list of characteristics merely decribes a type of behavior. For a behavior to constitue a disorder, a particular mental dysfunction must be identified and it must be established that significant harm exists as a result." - p. 134.

"Harm" here, we are given to understand, means not just — or **even** — the experience, **or avoidance**, of "emotional pain" – which may be very healthy and/or functional. And, again, the emphasis on understanding that natural responses to temporary "overwhelm" do not imply that people are "sick", "diseased", "labile", or organically "pathological" is a distinction vital to prescribing and advocating for safe and effective treatment options.

"By adopting a new diagnosis to identify the severe emotional problems suffered by Vietnam veterans, the developers of DSM opened a Pandora's box. Veterans fought hard for the inclusion of PTSD in DSM not because they were enthusiastic about identifying their problems as a mental disorder, but because they needed recognition of the fact that war had done bad things to them and they needed help in overcoming it's aftereffects. The price they paid was to be identified as mentally ill." – p. 125.

"PTSD has become the label for identifying the impact of adverse events on ordinary people. This means that normal responses to catastrophic events often have been interpreted as mental disorders. Moreover, people must demonstrate how 'sick' they are in order to get help; that is, assistance is offered to victims only after they demonstrate how mentally ill they have become. DSM is the vehicle for establishing this sickness. The diagnostic process makes it harder for victims to overcome problems they have not created and are trying to resolve." –p. 125.

Chapter 5—The Defeat of Masochistic Personality Disorder.

Two essential background works for understanding the context and importance of the struggle over this diagnostic category especially for women are Paula Caplan's **Myth of Women's Masochism** (New York: Signet, 1985) and **They Say You're Crazy: How The World's Most Powerful Psychiatists Decide Who's Normal** (Reading Mass. : Addison -Wesley, 1995). Without going into any detail here, what this category deals with is the virtually perennial notion in the history of male-dominated psychiatry (particularly prominent in Freudian analysis) that women habitually "do it to themselves" in terms of suffering abuse — that they are "injustice collectors" (in pop psychobabble) or, in the more sophisticated thesis of psychiatrist, Richard Simmons, characteristically seek to achieve "victory through defeat". Many would argue that, in fact, since guilt-inducement is a primary female control and dominance stratagem, along with deliberate emotional wounding of men, many women **are** aware of being culpable in precipitating male violence. So many **do** see their "defeat"/subjugation — or masochism — as a type of "victory", indeed, just as was posited by Simmons in his influential 1987 paper on the subject (see pp. 129 -30 and p. 279, note 3).

Kutchins and Kirk's objection to MPD is not that the criteria do not describe real phenomena/ behavior but that the assumption that there is anything "wrong" or "pathological" about this thought and behavior reflects male bias – not a scientifically –based mental disorder. A counter - position (from a feminist perspective, even) might be that this behaviour **does** entail/engender real harm to both the female and male paticipants in the drama/trauma. In any case, here are a few relevant quotes:

"This description (criteria for MPD) does not identify specific mental mechanisms that have failed to function properly." – p. 134.

"The diagnositic criteria for MPD fail to specify the nature of the mental dysfunctions or the significant harms that are required to establish a condition as a mental disorder. They constitue an ad hoc collection of behavours that do not conform with late-20th-century notions of how to relate to others to maximize one's self-interest." –p. 138.

"Where feminists offered social criticism for the predicament of women, the men of DSM offered a psychiatric diagnosis." –pp. 138-139.

"At a meeting convened by the Surgeon-General on violence and public health, a working group on spouse abuse condemned Masochistic Personality Disorder as a victim-blaming diagnosis."–p. 144.
The following is a quote from Claire Fagan, president of the American Orthopsychiatric Association, of March 27, 1986 to Robert Spitzer, head psychiatrist overseeing proposed revisions to DSM - 3:
"If this cluster of traits is added to the DSM - 3 it will be equating culturally induced behavior patterns with a psychiatric diagnosis of mental ilness."—p. 145.

"The psychoanalytic literature on female masochism had come under attack on many grounds: it confused learned behaviors with inherent biological phenomena, mistakenly interpreted women's self-sacrifice as pain seeking, ignored the fact that women often endure pain in order to achieve some later expected gratification (including, some would say, the typical/traditional female dominance 'victory' of punishment/control/vengeance via guilt-inducement – B.F.) and viewed some women's strengths (being nurturing, caring, and altruistic) as signs of personality disorder." –p. 150.

Describing the main study which was proferred to attempt to justify MPD, Kutchins and Kirk state:
"This study (by Spitzer, Kass, and MacKinnon on 'Masochistic Personality: An Empirical Study' – B.F.) is intriguing because it reveals how important issues concerning the nature of mental disorder get transformed by the gatekeepers of DSM into minor issues of the consistency of diagnostic criteria. This transformation is a process the gatekeepers had used before and would use again. It is how they invent diagnosis." – p. 151.

Loosely interpreted, this "process "would seem to entail surveying reliability in terms of some ratio of correlation to "criteria" identified by various (and, in this case, only very **select** and close professionally) practitioners/clinicians without any fundamental enquiry into whether or not the thought/behaviour observed is dysfunctional or even a "disorder" (in the sense of being a harm) in the first place. (Note: the methodology of this study as explained on pages 152 - 157 was totally laughable and incredible and must be read to be believed. As Kutchins and Kirk say, it "was about as scientific as asking born-again Christians if they had ever been born again and then acting surprised by the extent of the positive responses." — p. 154).

To illustrate the essential supposedly "scientific" technique often used by the controlling DSM clique (Spitzer, et. al.) Kutchins and Kirk offer the following graphic analogy: "If the alpha (a common measure of the extent to which a series of characteristics 'hang together' empirically – B.F.) is high, however, the conceptual validity of the phenomena itself is not established. For example, if you asked rabid anti-Semites to rate Jews on characteristics such as clannishness, wealth, communist sympathies and the extent to which they control international finance, you might achieve a high alpha with those traits; they might hang together empirically and have good internal consistency. But that finding would not tell you whether characteristics of Jews were accurately measured; it would merely capture theprejudicial belief system of anti-Semites. Showing that masochistic traits hang together is not a definitive method of determining whether masochism exists or whether it is a mental disorder."
–pp. 154 - 155.

Summing, Kutchins and Kirk say:
"What their study reflects, more accurately, is that if you give psychiatrists a checklist of masochistic traits and ask them to rate their patients using those traits and then ask them which patients may have Masochistic Personality Disorder, there is some association between who they say have the traits and who they say is masochistic. What is robust about the study is not the results themselves — they are hardly surprising – but the manner in which the DSM advisory committees manufactured and used 'scientific' evidence to make diagnoses.

The proponents of MPD used the study to forge ahead with their proposal, data in hand, with very little credible evidence about the validity of the category and virutually no developed argument that it constituted a mental disorder. The latter question was assumed a priori to be true." – p. 157.

" ...they (Pantony and Caplan — B. F.) suggested that before a psychiatrist uses the label Self-Defeating Personality Disorder for a woman, it is important to determine whether the woman is living and coping with a man who suffers from DDPD (Delusional Dominating Personality Disorder)." –p, 171.

"The proposal for DDPD never had a chance, despite the evidence; the proposal for Masochistic Personality Disorder had a good chance, despite the paucity of evidence." — p. 175.

Chapter 6—Border Wars: Borderline Personality Disorder (or, How Patients Seduce Their Therapists).

It is now fairly widely recognized that orthodox psychiatrist's standard operating procedure often entails not only conscious attempts to offer their patients various "sickness roles" with implicit **quid pro quos** attached (material and emotional security/support, etc.) but also that the diagnostic labelling repertoire very often serves explicit defense -mechanism functions for psychiatrists and many other mental health "professionals" as well; it is one of the ways they try to maintain pseudo-self-esteem and class/cultural/racial and political biases — their way of "calling their enemies 'niggers' ", in popular parlance. BPD, as Kutchins and Kirk demonstrate, is psychiatry's favourite "n-word" for "difficult (to socially control) women." Specifically, we see where "Borderlines" (3/4 of whom are women) are often said to exhibit symptomatic rage and revenge via false accusations against their psychiatrists. But, of course, when this diagnostic category is used as a defense mechanism **by** psychiatrists, it is designed to protect them, for the most part, from **true** accusations about their indifference to the known and unnecessary harm routinely caused by their institutionalized coercion and common treatment modalities – as well as the usually obvious environmental causes (often physical, emotional, and /or sexual abuse) of their patient's suffering — which they are either oblivious to or in total denial about.

".... If the patient makes an accusation, it is used as evidence that she is a borderline. If she is a borderline, there is a likelihood that she is lying and the accusation is false. For the offending psychiatrist, this is a crafty defense." – p. 198.

"...Borderline Personality Disorder (diagnoses) ... are likely to be women (76% of those who are given a diagnosis of Borderline Personality Disorder are estimated to be women). If a woman is very angry, she is more likely to be borderline. If an angry woman has a history of sexual abuse, the likelihood increases. If she accuses her psychiatrist of improper sexual conduct and seeks revenge by suing her psychiatrist, she must definitely have Borderline Personality Disorder.

The diagnosis of Borderline Personality Disorder has replaced the need for objective evidence and

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Minute Particulars

by Andrew Feldmar

I have been interested in psychedelics since 1967. When these substances are used in a spiritual context, they are referred to as entheogens. Peyote, mushrooms, ayahuasca, cannabis, LSD, MDMA, and 5MeO-DMT are some of the more prominent and widely used entheogens.

Imagine walking up to the altar in a Catholic Church and taking into your mouth the host, the communion wafer, the sacrament. And imagine that you'd actually experience what this common ritual refers to. Well, to know yourself to be a living cell in the body of Christ means to experience yourself as a tiny part of something much more, much greater than yourself. If a cell in my body would start "boasting himself to be somebody" (Acts 5:36), it would suffer from an egomania that might occasion its separating away from the organizing principle of my being. We call such self-willed cells cancerous. If too many of me cells rebelled in this Luciferian, Satanic way, I would die.

The spiritual use of psychedelics is always in search of self-naughting and self-sacrifice. The "self" here means "ego" or "psyche". Since language, thought, the ability to speak are powers of the soul, at the moment of its annihilation, nobody remains to experience and there can be nothing said about it. Leading up to this melt-down feels like dying, reconstituting oneself from nothing feels like re-birth. But the crucial point remains ineffable: it's blinding light, everything; it's total darkness, nothing; "the soul, in hot pursuit of God, becomes absorbed in Him... just as the sun will swallow up and put out the dawn" (Meister Eckhart); it's terrifying; it's bliss...

On this side and leading up to this indescribable moment, one meets oneself, with all one's doubts, pretensions, heroics, defenses, habits, hopes and paranoias. Entheogens, carefully used, in the right setting, in the right frame of mind, teach you compassion. Towards yourself, as well as others. One learns to become more feminine, receptive, relaxed. It is most difficult to learn that there is nothing to be afraid of. Not even fear needs to be feared or avoided. One becomes no longer the victim, but the spectator of one's own fate. One realizes that the only proper function of the will is not to will. Like the Ouroboros, the snake eating its own tail. "Nothing burns in hell but self-will. Therefore it is said, 'Put off thine own will, and there will be no hell.'" (Theologia Germanica) If a trip goes bad, this is where it happens: willing anything other than what is happening precipitates one in hell. An experienced guide or sitter who is unafraid because (s)he is familiar with the territory and has gained the trust of one who struggles, can midwife one into surrender.

On the other side of the unspeakable a warm surprise awaits one. Just as one can never get used to dying, the process of re-birth or re-constituting oneself is always an unexpected blessing. One feels loved and whole and welcome in the world. After all, I could have been killed, and I wasn't. I experience mercy. Whatever guilt or shame made me hide before is burnt away; I have been forgiven. Love and Death are one person. I feel frail, tender, but safe in "the everlasting hand of God".

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UnderDog
In the Mind and Hands of Love
by Jim Gifford

As one with mystical nature, the other evening I was overwhelmed by a profound sense of meaning and unity, all this while waiting for the bus at MacDonald and Broadway in the Kitsilano neighbourhood in Vancouver.

To my core, I felt the divinity of everyone and everything. Persons at the corner, crossing the street, and passing in cars, royal beings one and all, our complex realities united in the simplicity of here and now, the universe streaming in the flow, outward ripples manifesting Truth in endless circles of eternal delight.

Store signs became great vessels of the symbols of language, pouring forth communication, intimating the diversity of verbal communion. Architectural majesty, Gutenberg's imprint on the library, the industrial and technological impact of Ford, Marconi, Bell, and Tesla, in the cars with radios and cellular phones. The streets and avenues, our Appian Ways.

The mystery of money and corporations: the person in Levis, pulling out of the Petro gas station in his Volkswagen, stopping at the Royal Bank, then shopping at Safeway for various and sundry products. Newspapers, wooden benches, and posters, sacrificial blessings to our human life from trees blessed with the Creator's elan vital of earth, sunshine and rain, providing jobs in the lumber industry, in turn raising families and enlivening the economy.

Blossoms in the trees, pigeons foraging for food then winging away, dogs with masters, blades of grass pushing through pavement. Fashion statements: a fellow in jeans with a beard and baseball cap, looking a little scruffy, a made-up elderly woman, dressed to the nines, fighting off old age, a young punk couple replete with tattoos, purple hair and nose and lip rings; cottons, wools, leathers, synthetics, primary and secondary hues of the spectral image of light; sounds, the grinding of cars, caws and chirps of crows and sparrows, and a cacaphony of music, country, rap, jazz, and rock revealing that diversity of man is the spice of life.

In the Inner Silence of Here and Now, within the infinity of space and the eternity of time, in this particular universe, in this galaxy, along the Milky Way, on this small planet we call Earth, circling a small star known as the sun, one of trillions and trillions of stars, at this spot in Vancouver, British Columbia, Canada, returning home at the end of day, cradled in the Mind and Hands of Love.

"I don't develop: I am."

Pablo Picasso

Pink Floyd Proles

by Ron Carten

A few nights back, the radio was playing Pink Floyd's "Wish You Were Here" when I remembered three neighbours of mine in a cheap apartment block in Toronto's Parkdale fifteen years ago. They were sitting on the floor of my bug-ridden bachelor apartment strumming a guitar and singing that very song in 1985. We were passing time on a weekday, and I may have been rolling a cigarette while listening to them, when it crossed my mind that they were singing it to me. That transitory conceit underlined a class division I instinctively felt existed between them and me. In Canada, in 1985, class lines were something that were never directly mentioned in any conversation that I can recall, outside of a meeting of Trotskyites.

Bobby, the one strumming the guitar, was twenty-two, had a grade seven education, a hard-bitten, hard drinking father, who was a country musician, and Bobby had a new-found love of the guitar, a love I shared with him. With him was Kim, in her black satin nightie, a native Indian, pregnant, unmarried, and mother of a three-year-old girl named Tascha. The third in the trio may have been Andre, Kim's present boyfriend, father to the unborn child, like Bobby, undereducated, and again like Bobby, all too familiar with the local youth detention centre. His father was an untrained handyman and Andre was following in his footsteps.

Or perhaps the third person was the mousey, blonde girl from down the hall, who, weeks later, in the midst of a quarrel with her boyfriend, appeared at my door, her pink sweat suit spattered with blood. Later, there was talk of a pair of scissors, but she moved from our building and never returned.

That third person was not the flat-chested junkie who came to the apartment door one day, asking for a cigarette, and, leaning on the doorframe, promptly fell asleep on her feet. I mention her only to flesh out more completely the picture of the kind of people found in an apartment block in Toronto's Parkdale in 1985.

Class lines. I had come from a summer job on a tobacco farm the previous autumn, out of college, but due to return, and travelling by thumb around the country. I had bought a used Smith-Corona to write stories, maybe the big novel, but about that I was hopelessly naive. Suffice it to say it kept me busy and provided some mental exercise. Yes, I was looking forward to a happy, free, and prosperous future.

To my shame, I was collecting welfare benefits in Ontario, which in 1985 topped six hundred dollars a month. British Columbia in 2000, with an NDP government offers a mere five hundred. Ontario, since the Harris "common sense revolution", offers no more. Hence, the proliferation of panhandling.

But, to the point. I believed I had a future. Bobby and Kim knew their present station was more or less permanent, as it had been since they were old enough to remember. Here is where we find the class lines, lines that fifteen years later are etched into our brows. Still, we were neighbours and friends, and shared a common enthusiasm for rock and folk music.

Such good friends were we that on an auspicious Friday evening, when someone brought the cocaine, a needle was passed around among six or seven of us (this was before the AIDS scare), and it was thoughtfully offered to me. Despite the offer, which I declined, and the greed with which my refusal was accepted, I remained with them strumming on my guitar. Someone asked me if I was playing "The Needle and the Damage Done", but I was not. After shooting up, Bobby and Andre went outside, vomited in the back lot and returned to the party, energized and wild-eyed.

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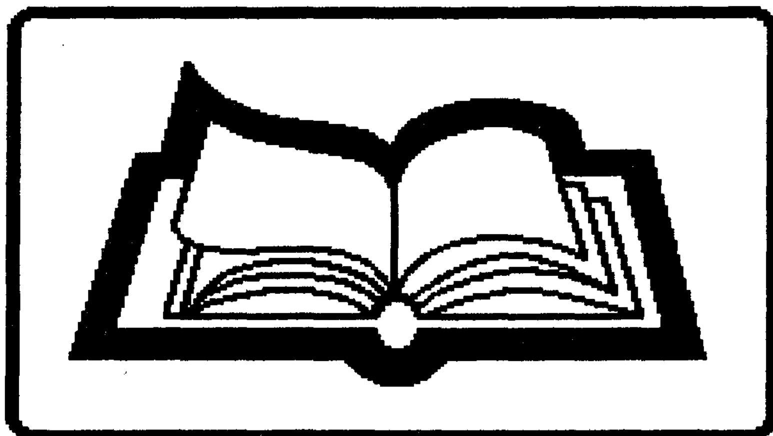
BookWorm

A Defense of Masochism

by Anita Phillips
St. Martin's Press, 1998

Reviewed by Andrew Feldmar

I think it's time to realize that each of us, if the truth be known, is an incurable deviant. Our desires are various, our tastes individual, our experiences forever private. Those in power tend to select certain desires as undesirable, declaring them perversions. As power shifts so does the dividing line between normal and sick. Anita Phillips argues for erotic anarchy, a tolerance for all non-transgressive, non-coercive sexual desire. It takes great courage to come out with one's own unpopular desires. Phillips, smiling and blushing, bravely ushers us into her world of sexual fantasy. By the time you finish this brilliant book, you can't help feeling that you are missing out on a whole realm of pleasure and excitement.



Contrary to popular belief, the best partner for a masochist is another masochist, not a sadist. Masochists want to find a playmate and they are invested in each other's enhanced pleasure. No one wants to play with a sadist because sadism "is characterized by a sullen, resentful apathy punctuated by bursts of self-pitying rage". Sadists seek victims they can bully and hurt. Masochism is an intelligent, imaginative, literary, theatrical enterprise.

Since sexual pleasure is the aim, the roles of torturer and victim are taken on as in a psycho-drama. The discovery that painful feelings can spill over into ecstasy reveal pleasure as a very complex alchemy. The satisfaction of desire can be distinctly unpleasant, and encountering resistances can increase arousal. Anita Phillips writes, "I have heard of a group of feminist psychoanalysts suggesting that lesbian writer Pat Califia was into sado-masochism because her stepfather beat her; her sexual practices, they suggested, were a pathological attempt at mastery. But S/M practices are nothing like real violence — nobody is beaten up, for example, there is no question of a repetition of the original scene. In consensual sado-masochism the idea is to control pain for sexual purposes, to stop when it goes beyond the limit. To equate the two is like comparing traffic noise to a sonata. On the contrary Califia, like many women who have been the target of male violence, is dramatizing it for her own purposes, rewriting oppression as pleasure , and using it to have a great sex life".

A good companion volume, a rich illustration of Phillips' book is Bob Flanagan's **Supermasochist**, a Re/Search Publication (1993). Flanagan just died recently, a complex and fascinating performance artist and a poet. He was a master of transforming shame through creative exposure into art, and pain into pleasure through a "stark clear existential acceptance of his desires, his body and his impending death". He was born with cystic fibrosis, and managed to become one of the oldest sur-

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A Secret Crime

by Reinhart

Where, where did you come from
Where, where have you been
How long have you been here
How did you get in.
Have the two of us met
Have you been here before
Was I busy and stupid
Was there something more.
Do you know me or something
Did I ever get through
When she was in bed
Did I ever reach you.
Have you always been watching
And listening too
Assembling the evidence
Waiting to move.

Did I waste your time
For the sake of a rhyme
Was my love really
A secret crime.
Did I miss my cues
Did I think too much
Did I borrow her body
Was I cold to touch.
Show me the victim
Where's the defence
Am I breaking the rules
Of the laws of romance.
Is this what you're after
And is now the moment
Have you waited enough
To execute judgement.

And she, can she ever return
Is she banished or freed
Was she guilty too
For harbouring me.
Did she fake, hide, did she lie
Was it not meant to be
Was she sentenced to die
For collaborating with
For collaborating with
The enemy.
Is it over now
And is this your show
Is it over now
Are you ready to go.

And is it over now
Are you ready to go.

Thoughts From The Interior

by D. Strad

Internally turning and yearning
outside the frame of named illness
brings me back to the core and,
more than existed before,
there are now lattices woven through the interior rooms -
realms where distinct treasure is stored.
So why now decry your sorry state or contemplate
on matters gloomy, less roomy
than all that interior store?
Let outward blessed become inward more
and lay down lines of communication at every station,
allowing elation to take hold
of your inner spaces with traces of love,
imbibed and arrived at through travel,
unravelling knots of miscommunication
to become - ah- who knows or can predict the directions that destiny allows,
never frowning upon the bold soul
or withholding reward from the proud doer.
Dream-doing,
human becoming is more becoming than being when seeing
is refreshed and challenges channelled
into meaningful status-action satisfaction
not for self alone but cheerfully imbibed
with others - it bubbles up from below -
below the level of mere mind to find
like-minded souls in chorus bending and bonding
into never-ending, freed-from-longing crescendo.

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reasoned argument. As with so many entries in DSM, this diagnostic label is inappropriately used as an explanation for behavior — when, in fact, it can carry no such burden. **The causes of most mental disorders are unknown. Psychiatric diagnostic labels do not explain why people behave the way they do. A label is simply an attempt to identify a cluster of behaviors, yet it is accepted as a claim that those behaviors constitute a mental disorder. Consequently, using a diagnosis as an explanation of behavior is circular. For example, we don't increase our understanding one iota by saying that someone is sad because he or she is depressed. Similarly, if impulsivity is used as a criterion for BPD, it gets us nowhere to say that a person is impulsive because he or she has Borderline Personality Disorder."** - p. 198. (Emphasis mine —B.F.)
"Regardless of the label adopted or how the criteria were chosen, once BPD became ensconced in DSM, psychiatrists found many uses for it, although many of its applications were not for their patients." –p. 181.

"Psychiatrists claim to be experts on identifying the boundaries where normal behavior shades into pathological behaviour. One of the important tasks of psychotherapists is to help patients recognize and respect those boundaries. Patients with BPD are often viewed by clinicians as difficult patients to treat precisely because they are said to have many problems with boundaries in interpersonal relationships. In fact patients with BPD have been accused of inducing boundary violations in other people, including their psychotherapists." - p. 182.

"We usually refer to sexual intercourse under these circumstances as sexual abuse or rape, but Guthiel only goes so far as to argue that therapists are the vicitms of their abusive patients." —p.183.

"They (critics of Guthiels thesis: 'Boundary Violations and Patient-Therapist Sex: Medicolegal Pitfalls', **American Journal of Psychiatry**, 1989, Thomas Guthiel) feared that Guthiel's thesis would be used by male psychiatrists to justify their own misbehavior and that the BPD diagnosis would be used to suggest that female patients are partially to blame for their psychiatrist's misdeeds." —p. 185.
"...there is evidence that patients often consider sexual relations with their therapists to be exploitive and harmful."–p.193.

"According to Guthiel, patients who induce their therapists to have sex with them probably have Borderline Pesonality Disorder, and borderlines are likely to make false accusations against therapists. Thus an accused therapist can label the patient as borderline and, by doing so, can undermine her credibility. " –p. 197.
"As one therapist has summarized the situation to us: 'Borderline is a wastebasket diagnosis; the diagnosis is given to patients who therapists don't like, or are troublesome or are hard to diagnose and treat. Many of those who are diagnosed as Borderline have histories of sexual abuse and incest.' **Borderline** is a code word for trouble for the therapist. Instead of dealing with the real source of trauma, it is easier to talk about the patient's pathology and make a diagnosis of Borderline Personality Disorder.

Diagnosis with shaky empirical support and vague, flexible boundaries lend themselves easily to distortion and misuse. In the case of the creation of Borderline Personality Disorder, there were no inside or outside advocacy groups questioning the evidence or identifying the misuses or harms that might stem from a diagnosis used primarily as a label for patients, particularly women, who can be difficult to treat." – p. 199.

Chapter 7 – The Enduring Legacy of Racism in the Diagnosis of Mental Disorders.

There is a great deal of general interest in this chapter which must be left to those who have time for a more in-depth read, however, for review purposes, there is one section of priceless black humour (if one may so speak) which is a highlight of the book's historical vignettes, really "speaks for itself", and bears repeating here. Under their subsection on "The Mental Disorders of Slaves" (pp. 209-211), Kutchins and Kirk relate how, in 1851, one Samuel Cartwright, a prominent southern physician,

"...published an essay in the prestigious **New Orleans Medical and Surgical Journal** on two new mental disorders peculiar to Negros. One was drapetomania and the other was dyaesthesia aethiopis. Cartwright minted the term **drapetomania** from **drapetes**, the latin word for 'runaway slave', and **mania**, meaning 'mad' or 'crazy'. He observed that the disease was previously unknown to medical authorities although' its diagnostic symptom, the absconding from service, is well known to our planters and overseers.' He concluded that what 'induces the Negro to run away is as much a disease of the mind as any other species of mental alienation, and much more curable.' The measure he recommended to prevent slaves from developing the disease was 'whipping the devil out of them.' He cautioned owners that patients should be 'treated like children, with care, kindness, attention and dignity.' He warned that overly severe whipping **or** too lenient treatment would induce drapetomania; brutality and permissiveness both had to be avoided. He assured his readers, 'With the advantages of proper medical advice strictly followed, this troublesome practice that many Negroes have of running away can be almost entirely prevented, although the slaves be located on the borders of a free state, within a stone's throw of the abolitionists.'

Escaping slavery was not the only behaviour attributable to a mental disorder. 'Paying no attention to property,' which led a slave to destroy things; 'breaking the tools he works with'; and self-indulgence leading to 'idleness and sloth' were symptoms of dyaesthesia aethiopis. Cartwright expressed less respect for the views of plantation managers in regard to this disease: 'The term rascality when given to this disease by overseers, is founded on an erroneous hypothesis and leads to an incorrect empirical treatment which seldom or never cures it.'

Cartwright believed that dysaesthesia aethiopis, which was 'peculiar to Negros,' resulted from respiratory weakness that led to a lack of oxygen in the system and that the remedy was to stimulate the liver, skin, and kidneys in order to assist in decarbonizing the blood. To do this, Cartwright prescibed hard work in fresh air — chopping wood, splitting rails, sawing, and lifting and carrying heavy weights — in order to expand the lungs and increase breathing: 'The cumpulsory power of the white man, by making the slothful Negro take active exercise, puts into active play the lungs, through whose agency the vitalized blood is sent to the brain, to give liberty to the mind.'...

Cartwright's diagnostic formulations of the mental illness of Negros were publicized throughout the English - speaking world. His 'discoveries' ... received international acclaim when they were publicized by Daniel Tuke, whose famous English family established the York Retreat, a 19th - century model for moral treatment in asylums."

Chapter 8 – Diagnosing The Psychiatric Bible

By way of concluding, here are just a few more brief select quotes from the final chapter:
"The purpose of revising DSM was ostensibly to take mental illness out ot the realm of superstition, opinion, and ideology and placed it firmly in the antiseptic medical world of science. The earlier chapters of this book

provide a rich array of examples of how and where DSM has failed to accomplish this." – p. 239.

"The relative ease with which prominent psychiatrists could manufacture a diagnosis out of a few uncritical assumptions about the 'pathology' of what may be adaptive or culturally sanctioned behaviors was... a warning about the potential expandability and... bias of DSM." – p. 241.

"... A diagnostic category, once enshrined in DSM, offers therapists and others considerable discretion in deciding how it should be applied. And often the applications proposed are astounding... a diagnosis can be not just a shorthand rubric for identifying mental disorders but an elaborate justification for unethical conduct by professionals." – p. 242

"DSM is used to directly affect national health policy and priorities by inflating the proportion of the population that is defined as 'mentally disordered'." —p. 243.

"Americans may be told that 20% of adults in this country currently have mental disorders, but they are not warned that the figure is based on outdated criteria, on methods of untested accuracy and reliability, on a selective choice of disorders, on wavering definitions of **age of onset**, and on an inflated concept of what an active case of disorder is. What will be most enduring about the ECA (Epidemiologic Catchment Area— 1991) study in the future will not be the numbers it provides about mental disorders in America but what it reveals about the state of diagnosis in American psychiatry. And what it reveals, in part, is how psychiatry has been captured by the illusions of science provided by the psychiatric bible." —p. 246.

"... clinicians are forced to make extraordinarily complex, contingent causal inferences. In the absence of any guidelines or comprehensive knowledge about how to make those inferences, it is understandable that clinicians have plenty of room to arrive at different conclusions. Diagnostic criteria, some 900 pages of them (covering over 300 supposed mental disorders — B.F.) do not prevent clinicians from making conflicting, often contradictory, diagnosis..." — pp. 253 - 254.

"The limited evidence suggests that individuals are given DSM diagnosis when family, marital, and social interrelationships are clearly the problem; that treatments are shaped to adhere to what is reimbursable, rather than what is needed; and that troubled individuals are getting more severe diagnoses than may be warranted. And it is in this context that (many, many, people) might receive a psychiatric label when none is justified." – p. 260.

"We are not selling some alternative diagnostic system, nor are we suggesting that diagnosis in psychiatry is without redeeming value. But we have suggested throughout the book that DSM is seriously flawed and that those flaws are largely ignored by the American Psychiatric Association and are unrecognized by DSM's diverse users." —p. 263 - 264.

"It is not that there are no such phenomena as mental disorders, that their existence is all a myth or psychiatric hoax. The point is that mental disorders constitute a small part of what is described in the current **Diagnostic and Statistical Manual of Mental Disorders**. Clearly, as we have shown in this book, psychiatrists and other mental helath professionals benefit from DSM's unrelenting expansion of domain, its attempts to sweep all manner of personal troubles under the medical umbrella and to rationalize those moves on the basis of research and science. The public at large may gain false comfort from a diagnostic psychiatric manual that encourages belief in the illusion that the harshness, brutality , and pain in their lives and in their communities can be explained by a psychiatric label and eradicated by a pill. Certainly, there are plenty of problems that we all have and a myriad of peculiar ways that we

struggle, often ineffectively, to cope with them. But could life be any different? Far too often, the psychiatric bible has been making us crazy — when we are just human."
— pp. 264 - 265.

Afterthought Esoterica:
"For instance, to make a diagnosis of Schizophrenia, Catatonic Type, **five** additional criteria must be evaluated after the **23** basic ones for schizophrenia are considered." —p. 44.

(**Making Us Crazy** can be ordered through ODIN BOOKS –Mental Health Educational Resources – for approximately $47.00. 739-8804 or 1-800-223-6346).

Two Vital Information Sources for Consumers/Survivors/Ex-Mental Patients

Two sister publications of **In A NutShell** which are invaluable in terms of resource information (websites, literature, and affiliated groups, etc.), as well as great articles and news items on current issues on the mental health scene, are:

The Key
National Mental Health Consumer's
Self-Help Clearinghouse
1211 Chestnut Street, Suite 1207,
Philadelphia, PA 19107
(800) 553-4KEY
www.mhselfhelp.org
info@mhselfhelp.org
(4 quaterly issues, Free to low-income status consumers/ survivors. Otherwise $15 U.S. check or money order payable to: N.M.H.C.S.H.C.)

Dendron
Support Coalition International
454 Willamette, Suite 216,
P.O. Box 11284
Euegene, OR 97440-3484
To order or join: 1-877-623-7743
(541) 345-9106
Fax: (541) 345-3737
www. mindfreedom.org
office@mindfreedom. org
(Latest issue — Summer 2000, #43, 64 pages — available for $3 U.S. Great discounts on bulk orders. $25 U.S. donation for Support Coalition membership also covers subscription for 4 issues and discounts on all books and video materials, etc. Checks or money orders payable to: SCI).

The Fresh Air Camps of My Boyhood

by Sam Roddan

The "fresh air" camps of my boyhood wee summer hang-outs for the rough and ready lads of the East End. For me, the camps were based on endurance, goodwill, self-discovery. Everything sprang from the cult of the leader, the mulch of campfire culture. We lived by credos such as: Be strong. Be Brave. Be pure. Follow the gleam.

Many of our leaders were imported from he "outside". Places like Shaughnessy Heights, Dunbar, Kerrisdale. These were well-fed lads with positive outlooks. Non-smokers. Clean livers. Beefy Christian young men with reputations for "doing good deeds". On weekends they received huge "care packages" from their mothers. Buns, candy bars,clean underwear. Allsorts and jelly beans to share with their "followers". Sometimes, if we were lucky, our leaders handed out a jelly bean for doing an extra chore.

One day, the boys in our cabin climbed a mountain on Gambier... Darkness overtook us... Gravel sounds drifted past the rocky ledges. Our leader made a compass of his Pocket Ben, checked trees where the moss grew on the north side, asked us to be silent and pray for guidance. Then he lost his Pocket Ben over the ledge, suddenly went bonkers, fell apart at the seams (later we discovered, in his prayer session, he had eaten our emergency ration, a Sweet Marie). We felt betrayed.

One of our climbers was a poet. Kids snickered but inside he burned with a secret flame. We called him Spunk. In his packsack he had a book of poems by a fellow called Carl Sandburg. On the side of the mountain he read to us by a flickering candle. In the gloom and darkness, we forgot our tears, grew strong on laughter.

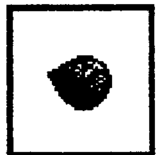
"Put on your hat (he read) here comes a woodpecker... the turnip looked big until the pumpkin walked in... some men eat nails, others break their teeth on apple sauce... what are the smallest things mentioned in the Bible?... the widow's mite... the wicked flee...".

At dawn, we stumbled back to Camp. For a day our leader sulked in his cabin. At campfire that night, Spunk read more Sandburg:

"Hopeful as a rain-washed hill of moonlit pines...every blade of grass has its share of dew... an old man's love is like a flower in winter... painted roses never smell... stars make no noise... God is a bridge over deep waters... ."

Today, anxious parents are busy shipping their kids off to computer camps. The idea is to give them a head start in bytes, key procedures, all about the internet... hands on experience with digital cameras.

Ah, my friends... little time in these days for the "fresh air" camps of my youth, moonlit pines, the Milky way, Sandburg, guys with a soul like Spunk... All gone now, but still, at this late hour, I am grateful for an epiphany of memories that toll like silver bells in the dusk.



Mystery

"One always learns one's mystery at the price of one's innocence."

Robertson Davies
Fifth Business

A Fellow Sufferer

by Frank G. Sterle, Jr.

Whenever the effects of my mental illness torment me — and they very frequently do so — in my daily life, I recall what one adult told me when I was about 14 years old, which was about six years before I was first diagnosed with psychoses and chronic depression: "When you get older, you'll see life will be hell — sheer hell".

Perhaps he was just referring to adult responsibilities and obligations; or, perhaps he could tell that I had serious mental/psychological problems below my surface which I'd have to deal with all my life , and perhaps he also knew that those problems would get worse. (Sometimes I even wonder is he had hexed me or something.)

Nonetheless, he was right. Life has indeed become a hell, in which, as one then-friend had told me would happen, I am "riddled with (mental) problems" (although he was wrong in predicting that, "I can't see you living to 30 [years of age]").

And common sense tells me that most, or at lease much of the mental illness with which I've been (for lack of a more accurate verb) cursed, are the — of course, unintentional — result of a very dysfunctional upbringing of my parents (but particularly my father), and perhaps of their parents before them, left them as victims of mental illness before me.

As such, I've decided that I must not pass down the suffering for which I was destined — both genetically and environmentally — when my parents conceived me. And, thus, I have promised myself that I will not procreate, that my misery stops with me; for I believe that if I did have children, I'd very likely pass my curse on to them, genetically and/or environmentally, albeit unintentionally and likely unaware.

As a tragic result of such an inheritance, many caring parents witness the torment of their mentally-ill offspring and feel guilty about having given life to their children. But potential parents concerned about their future offspring's acquisition of mental illness need not completely deny themselves procreation. Instead they can, and definitely should, educate themselves as extensively as possible — before they have children — about how to rear their offspring in a mentally-functional environment; and although people planning to be parents cannot control the genetic traits which may be passed on to their children, new parents definitely can control the emotional surroundings of their children's family life and upbringing. For example, it's crucial that parents, without a single exception, keep any and all disagreements between themselves confined to be settled but between themselves — without their offspring being utilized as political pawns or focal points at which the disgruntled parents can release their spousal frustrations.

And be not mistaken: it is too easy to ever-so-slightly treat one's infant in a psychologically-incorrect manner without even realizing the fact and thus to leave the infant susceptible to developing, for example, a dysfunctional thought process, which can remain with him/her for life.

For example, if my parents knew what incredible suffering their allowing of my witness to their incessant worrying would do to me as a little boy and as an adult, they would very likely have altered their behaviour in my proximity. For as a result of their dysfunctional behaviour, every day not only do I, because of my tortuorusly-chronic worrying, cross most of my bridges before I reach them, I knock many of them down before I even know of their existence.

These are compelling reasons why mental health resources should be applied to include mental illness and dysfunction prevention as well as awareness and treatment.

Having said that, however, if a child, for whatever reason, develops a mental illness, he becomes a part of the mental health "consumer" community; and once there, he'll realize how difficult life as such can be and how unfair "normal" society can treat them. (Which is why I prefer to mostly stay in the closet.)

Mental illness is like any other form of illness, yet "normal" people who have not been directly or indirectly affected by such too often tend to reactively perceive it as not a real illness but rather something you can snap out of if your mind is adequately

(Continued page over)

A Fellow Sufferer

(Continued from previous page)

disciplined; for it involves the mind, and if your character is strong-willed enough, you should be able to will it away.

Even at a time when society has established Mental Health Week (May 1-7), it is still, contrary to some people's assertions, implicitly socially acceptable to stereotype the mentally ill as being more potentially-violent than the average person, although the opposite is true. Furthermore, mentally ill persons' opinions are not taken as seriously as those of the "normal" population; and the media's on-and-off insensitive use of the term "schizophrenic" to describe, for example, inconsistency in a politician's election policy, usually reveals how much consideration they have for the victims (including caring family members) of such illness.

Furthermore, many mentally ill persons, although officially considered "disabled", are still perceived by some in the "normal" community as not really warranting social assistance; after all, they could be digging ditches, right? But speaking for myself, I always put in 110 percent effort when I'm doing my volunteer job (or any kind of job); even though, according to prevalent societal thinking, since I do not "earn" a regular/"normal" paycheck for doing regular/"normal" work, I am not actually working.

As for the political interests of the mental health "consumer" community, there's a large enough mentally ill segment of the population, that if they concentrated their voting power instead of continuing their typical non-voting nature, they could actually attain all of the rights which they, like the "normal" population, so deserve. But as long as the mentally ill persons' wheel fails to squeak, they'll get no grease. Their pension cheques, at best, will barely take into consideration inflation levels; hospital bed numbers will inadequately deal with seriously mentally ill persons, and those people will instead be left to the mean streets or jail. Or suicide. Their suffering is indeed that great; and it's only worsened by the fact that their mental illness cannot be measured in a physically-tangible manner, like skin cancer or AIDS, and these poor souls are sometimes left to languish in a private, Hell-like, internal torture chamber of the mind.

Although I do think about taking my own life, I do not actually contemplate (there is a difference) such a drastic, selfish measure — because of both fear and divine punishment and (mostly) the intolerable fact that I, by my suicide, would leave behind my loved-ones to grieve. But always remember, mentally ill people do not want to die or kill themselves; rather, they simply want their mental anguish to cease. Which is often the only consolation that suffering, mentally ill people have in life is the knowledge that each day they endure and survive will not have to be repeated — for every day's end is one (albeit small) step closer to that permanent, blissful sleep and peace.

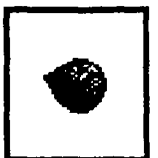
Minute Particulars

(Continued from pg. 6)

This sequence of dying—death (or nothingness)— re-birth is a universal pattern called initiation. The secret of initiation remains inviolable by its very nature; it cannot be betrayed because it cannot be expressed.

The worst trauma is betrayal. I have been betrayed and I have betrayed. Each time it happens we contract, tense up, and defend ourselves from further let-downs. And we begin to die of our defenses.

The use of entheogens in the safe container of psychotherapy can heal this wound both in patient and in therapist. Together one can find the Way "from privation to plenty, darkness to light, and death to immortality" (Coomaraswamy). Sounds crazy? Well, in that case we better stick with anti-depressants, tranquillizers and lithium.



Pink Floyd Proles

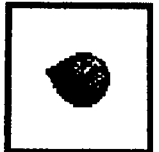
(Continued from pg. 8)

Bobby kept repeating, "Where can we get some more?"

Bobby was not a junkie then, and I hope dimly that he did not become one. Some time before the coke party he had said outright that he hated junkies, but at the time I wasn't sure of his reasons. I think now that it was because nothing is secure when IV drug users are around. If they don't have jobs, they need to steal to support their compulsive habit, and in the process they become criminalized, an unwanted underclass.

Bobby and Andre and Kim were not far from that underclass. I wasn't anywhere near it. I never felt the anger or frustration or recklessness that brings people to stick needles in their arms to get high. A hundred years ago my inclinations and industrious habits would have been called breeding. Today, as in 1985, the differences that existed between my neighbours and me were so embedded that I think of them as class lines.

When Bobby and Kim sang "Wish You Were Here", I felt the need, the duty to practice solidarity, to believe in it. Was I really "there" for them? This was what crossed my mind in my bug-ridden bachelor suite in 1985. As the well-documented gap between rich and poor widens in this country, it strikes me that solidarity has never been needed more than it is in 2000. Do the broken dreams, and broken wills, the lost years and the barriers to success of the psychiatrized qualify us as an underclass? I think so. And who can really be "there" for us?



BookWorm

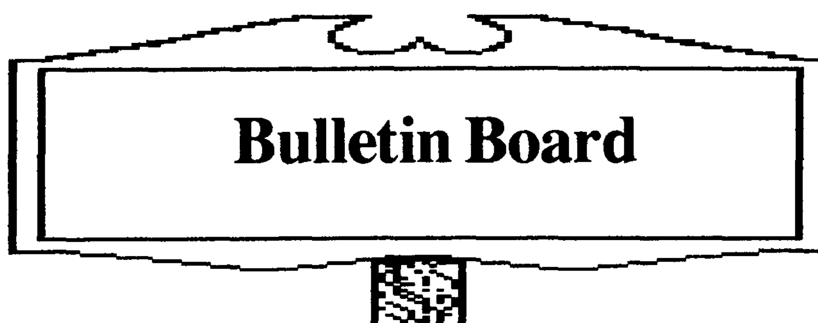
(Continued from pg. 9)

vivors. Masochism means endurance. Flanagan found a way, not unlike a meditation process, to enjoy pain and discomfort. He could will himself into an altered state of consciousness. with humour and irony, he survived the most potentially humiliating experiences. Through S/M practices he made fun of what he <u>had</u> to do.

Researchers who are exploring how to alleviate the suffering of those with chronic pain, ought to study seriously Bob Flanagan's achievement. When he, in a public gallery, ejaculated while driving a nail through the glans of his penis, he showed what was humanly possible. He made the best of a very bad thing.

Phillips also sparkles with wit and humour. "Sado-masochism and the wearing of Birkenstocks are thoroughly incompatible," she observes. "Any kind of real enjoyment enables a temporary forgetting of the self, whether it is gazing at a Giotto fresco or betting on the dogs". She can make important distinctions succinctly: "It is a difficult task to get sexual dominance right — go too far and your partner feels devastated, not far enough and they feel short-changed. Domination is less popular than is generally imagined — it carries too many responsibilities".

Both Phillips and Flanagan address themselves to the more general question, "What is the best way to handle suffering?" Who can afford to ignore them? I want to quote one more sentence from Anita Phillips: "Life itself is exceptional, not moderate, to live moderately is to trivialize and waste it".



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 Co-ordinator 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.