

NEWSLETTER

JULY 2002

This month's FRONT PAGE CONTRIBUTION

A CREATIVE DATE

The 2nd March 2002 dawned bright and dry to the relief of all those who had signed up to participate in a day of creativity; they knew they would not have to dodge the showers as they moved between the Croydon Parish Church and its Hall where the day's activities were to be centred.

In all thirty-five people took part, either as workshop participants or leaders, several people taking both roles during the day. Some who came were experienced artists, poets and musicians, others with little claim to skill or knowledge made up for this lack with enthusiasm. Some experienced artists tried their hand at unfamiliar disciplines.

Participants included some who had previously taken part in APCMH creative workshops and chaplaincy events and others who were new to this experience, but all were drawn into the group and felt supported and empowered.

The day started with coffee in the hall where participants chose their activity for the morning. Some dispersed to the Church for creative writing, some to the small hall to explore creative spirituality through three dimensional pictures and others to the bigger hall for a choral workshop.

Lunch was served in the hall. The delicious sandwich and fruit lunch was purchased from an organisation that offers employment to people who use mental health services. Over lunch the experiences of the morning were shared and choices made for the afternoon.

In the afternoon there was an opportunity to try Circle dancing with the Parish Church Circle dance group, more creative writing, a meditative session using Clay and a Rock music Jam Session. Efforts had been made to put some distance between these last two and, true to prediction, they remained somewhat incompatible. A painting workshop was also made available.

In church, led by Father Andrew the groups shared their experiences and showed some of their work. At the end of the day the memories were of shared activity, laughter, friendship and a group experience that was loving and affirming, a source of spiritual strength.

It will be no surprise to find that the participants are demanding another similar event. The people who came were very conscious that there are many who find it difficult to risk coming to this kind of activity though those present thought that even so, they would enjoy the experience if they did. The group were all concerned to find ways of encouraging and supporting others to join in next time.

APCMH Croydon would like to thank all the group leaders for their inspiring contributions, Croydon Parish Church for allowing us to use their beautiful church and premises, the London Borough of Croydon for contributing to the costs and the Trustees of Bethlem Hospital for their financial support.

We are all looking forward to the next time!

Mary Hillier- APCMH (Croydon)

TO BE A MENTAL PATIENT....

To be a mental patient is to be stigmatised, ostracised, marginalized, patronised, psychiatrised.

To be a mental patient is to have everyone controlling your life but you. You are watched by your shrink, your social worker, your friends, your family – and then you are diagnosed as paranoid.

To be a mental patient is to live with the constant threat and possibility of being locked up at any time for almost any reason.

To be a mental patient is to subsist on state benefits which won't give you enough to buy Kleenex to dry your tears – and to watch your shrink come back from lunch driving a Mercedes Benz.

To be a mental patient is to be prescribed drugs that dull your mind, deaden your senses, make you jitter and drool – and then you're prescribed more drugs to lessen then "side-effects".

To be a mental patient is to apply for jobs and lie about how you have spent the last few months or years, because you have been in the hospital – and then you don't get the job anyway, because you have been a "mental patient".

To be a mental patient is to watch TV and see shows about how violent and dangerous and stupid and incompetent and crazy you are.

To be a mental patient is not to matter.

To be a mental patient is to be a statistic.

To be a mental patient is to have a label put upon you, a label that never goes away, a label that says little about what you are and even less about who you are.

To be a mental patient is to never say what you mean – but to sound like you mean what you say.

To be a mental patient is to tell your psychiatrist he is helping you – even if he isn't.

To be a mental patient is to act glad when you are sad and calm when you are angry.

To be a mental patient is to participate in stupid groups that call themselves 'therapy'. Music isn't music – it's therapy. Volleyball isn't a sport – it's therapy. Sewing is therapy, washing dishes is therapy. Even the air you breathe is therapy – and that's called 'the milieu'.

To be a mental patient is not to die – even if you want to – and not cry, and not hurt, and not be scared, and not be angry, and not be vulnerable, and not to laugh too loud ... because if you do, you only prove that you are a "mental patient" – even if you aren't.

And so you become a no-thing in a no-world and you are not.

Adapted, slightly, from the work of an American "mental patient"

CHRISTINE'S STORY

I was helped by many people during my years of psychosis, and not least by those who did not judge me, but accepted me as an equal, but as one who was vulnerable and in need of support.

The lesson I've learnt is that there is a child inside each of us that is hurt, angry and rejected, but is also so full of fear that sound judgements cannot be made. One has to heal this frightened child, before healing can take place, and the adult is free to walk in the world without fear, anger or judgement of others.

Fr Shay Cullen of the Philippines, who was nominated for the Nobel Peace Prize, has a sanctuary for child prostitutes, and he, like me, agrees that 'the children must be set free from fear to love' so that they might grow up to lead fruitful lives. There is much good being done in my Church, but the primitive ideas on sex, also, if believed, can do a lot of damage. Those who teach that sex is evil need help too. This disabling knowledge seems to be passed on from generation to generation with disastrous outcomes for those who live with this knowledge as truth. The rape of my body at seven, made me phobic of men, angry and tormented by their desire to use my body without kindness or love. But this frightened child had to learn trust, and I had to learn that not all men were rapists.

I wonder why psychiatrists don't understand this universal pattern in schizophrenics, and use better therapy to heal these phobias. In each schizophrenic there is an adult mind that can understand reason, but the child is so powerful and reacts only to love and kindness in a positive way. Every time that child is spoken to with reason, he or she does not understand; but once out of reach of people, the adult regurgitates this knowledge, and does understand.

The child in us is only a part of what we are. It is the child driven mad by fear that causes us to run or fight, and the child needs healing before it can integrate with the whole psyche.

The drugs I was first given only served to kill my feelings of fear and love, so I could reason but was apathetic. The present drugs ease my fears but do not stop them altogether, and still allow me to love and empathise with others. A person who can only reason and not love is sick also, and in fact, is a psychopath, but apathy stops such people from offending.

We all have a soul that is growing and changing and learning by experience and we all have to grow in understanding.

Jesus taught us not to judge others, but to show all people kindness and love, and to worship none but God our Father and Creator.

An excerpt from a letter to The National APCMH Secretary by Christine Sheehan

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My teaching career started in a draughty classroom, opening onto the school hall. While writing on the blackboard one day I heard a child come in and, leaving the door wide open, sit down. "And who was born in a barn?" I enquired loudly. Quick as a flash came the reply, "Jesus, Sir!"

***From St Stephen by Saltash Parish News***

## THE LOST CAUSE OF RETICENCE

Is there any other extremely reticent service user out there, thoroughly disgusted with the failure of the Mental Health Service to provide for our special needs due to its tendency to focus its attention predominantly upon our more assertive counterparts, on the basis of, "She or He who shouts loudest wins" ?

During my childhood, the type of continual domestic strife against which many youngsters unquestioningly rebel, consistently eclipsed my status in the family. However, due to my own innate predisposition to evading hostile situations, I instinctively withdrew from this one by escaping into a fantasy world of imaginative reverie. At the age of ten, when the tendency to daydream had abated somewhat, I experienced an extreme identity crisis in the form of a continual struggle to maintain an adequate sense of personal presence. Within the next few years, I unfortunately lost my pugnacious battle against capitulation to anonymity, thereafter being irrevocably condemned to a vicarious mode of being which has proved consistently unpopular with others.

The 'Swinging Sixties' era of my youth ushered in the global and enduring cult of enhancement of the attribute of self-assertion, together with its attendant assurances of being attainable by all. Yet I have found to my cost that this is not the case for the occasional vulnerable, existential being, devoid of an empowering social interface. Indeed, I have learned on the basis of considerable experience that the anonymous person's efforts to emerge from obscurity are inevitably frustrated, whether by accident or design, by others possessing a more influential persona. Consequently, I have reached the conclusion that there appears to be a natural selection process whereby the person of indefinite and insecure presence is ultimately obliged to yield to others endowed with the biochemistry of manipulation, even in cases wherein the latter is moderate or subtle rather than overpowering.

Hence, far from being an equaliser, the quality of self-confidence is very much a divisive element in contemporary society. Indeed, the widening differential in status between, either those with substantial, or those with negligible, endowments of this attribute is causing increasing numbers of low scorers in this respect to sequester on the periphery of mainstream life. Consequently, these disenfranchised outsiders either become voluntary Mental Health Service users or independent self-helpers.

If the Mental Health Service seriously intends to rehabilitate the socially challenged, it should enlist the services of a more evaluative breed of therapists in order to curb its traditional practice of disapproving judgementalism of perceived social inadequacies liable to further demoralise the client. In fact, I believe that present forms of analysis should be replaced by customised lifestyle therapies, taking account of each service user's assets and liabilities. Furthermore, in order that this facility should be available to all, the type of client liable to become inhibited and inarticulate in the consulting room situation should be assigned to practitioners with reasonable tolerance of this phenomenon.

Nevertheless, these proposed reforms, need to be complemented by a social package. Therefore, some politically influential figure should persuade both employers and providers of leisure pursuits to minimally adapt their current structure in order to admit the occasional person with chronic communication disabilities and make them feel a valued member of the community. Please note at this juncture that I, as an afflicted individual, am not an idealist claiming that my counterparts and I are equal to any and every situation, but that our condition should be somewhat better tolerated and accommodated within mainstream society than at present.

Indeed, on the basis of commonsense rather than idealism, why should not the condition of reticence, hitherto the traditional target of unfettered exploitation causing untold grief, ultimately become an equality issue?

*Margaret Selby*

## ***DOES "DOCTOR KNOW BEST" ?***

Tell Rufus May that "doctor knows best" and he would have a few words to say about it. When he was just eighteen a psychiatrist diagnosed him with paranoid schizophrenia and told him he would have to take medication for the rest of his life. May was admitted to a psychiatric hospital suffering from delusions. After a while he stopped taking his medication upset by its disabling sedative effects. When he refused the experienced psychiatry's powers of compulsory treatment, six nurses pinned him to the ground and injected him with tranquillisers. May was traumatised and unable to trust his doctors. So after his discharge, and against all advice, he never returned to hospital. Instead he lived in a squat and, despite his confused state of mind, came off all medication. He eventually got a job as a night security guard.

Thirteen years on May has not taken anti-psychotic medication since. His recovery is one that few patients – let alone mental health professionals – would go through. Yet May is now a clinical psychologist. He uses his experience as a psychiatric patient to challenge the traditional medical model for those diagnosed with severe mental illness. "When I was a patient I felt misunderstood and written off", he says, "I thought I was treated cruelly. When I was forcibly treated and injected, it felt like rape".

May still suffers nightmares of being readmitted to hospital and being compulsorily medicated. He channels his anger productively, arguing that as long as psychiatry's medical model continues to understand severe distress as rooted in biology, rather than experience, thousands of patients will be denied a fair chance of recovery. With psychiatry's compulsory treatment powers and a tendency to confuse withdrawal effects of medication with symptoms, May fears vulnerable patients quickly become dependants. He believes the mental health service often handles patients inappropriately from the beginning.

Before admittance to hospital, May had been living in a daydream fantasy world, "to escape a dull job". When referred to two psychiatrists, they listened to his perception of the world but did not question him about his views. May was in and out of hospital for the next seven months, he felt treated like a "Social, moral and genetic outsider". On the other hand he could share his bizarre thought with the squatters without being seen as relapsing. He came off his medication without professional help and managed to see through the surges of mania and restlessness, which accompany withdrawal. Too afraid to return to his psychiatrist he used friends and those he met at community centres and churches to slowly rediscover his social and confidence. After casual jobs he started a psychology degree and in what became a remarkable recovery, trained as a clinical psychologist at university. Yet during six years of study he never revealed his past diagnosis. It was only when May qualified that he "came out" to his colleagues about his diagnosis.

May is now in his second year of working as a clinical psychologist in London. He prefers a more "collaborative" approach when treating those with psychotic illness. The first thing he does is simply to talk openly with patients. "When I was a patient it was believed that talking openly about psychosis made it worse", he says, "but I prefer making sense with a person about their experience." May believes that his illness was a severe identity crisis triggered by the breakdown of a relationship. He thinks that the quickest route to the restoration of his good mental health would have been time, rest, low-levels of short-term medication and discussion of his experiences.

May believes that professionals should redefine their relationships with patients. He says, "It is not right to say, "doctor knows best." These professionals have expertise, but treatment will fail if they do not engage with clients who have an expertise about their own life. Treatment of clients should involve agreement rather than just imposition. "Often compulsory treatment is not necessary, it just drives people away from asking for help, and that can be dangerous".

***From an article in Kent & Canterbury Mental Health Carers Newsletter***

## **BE STILL AND KNOW:.....**

**The Reverend Dr Denis Duncan President of the Guild of Health writes .....**

To be able to be still is to have found the secret success in the struggle against the strains and stresses of this noisy, raucous and demanding world. It is a capacity made incarnate in the life of our Lord. When faced, as he often was, by criticism, hostility, opposition and, in the end, crucifixion, Jesus never lost his serenity and tranquillity. Even in his darkest hours, Jesus knew how **to be still and know** that God, his Father, was with him in that darkness.

There were times when Jesus' inner peace was severely challenged. In the garden of Gethsemane, as he sweated blood over the appalling events that faced him; on Calvary, where those events became reality and he was strained to the limit to hold on to his faith and his peace. But he did. The disciple can never emulate the extraordinary spiritual strength of the Master, but the example remains to help us find our peace. We need, like Jesus, to be able, under great pressure, **"to be still and know that He is God"** (Psalm 46:10)

To develop his **"still centre"**, Jesus went to quiet place. The Mount of Olives, the seashore, the desert/oasis place is the sanctuary we create *wherever* we are, the place where we can meet God. It may be in the quiet of a church. It may be somewhere in the garden. Perhaps we cannot go anywhere at all through physical limitation, so a corner of a room can be our sanctuary. There, selected symbols will speak to us of spiritual things. It may be simple or splendid, small or large. It is of no importance. "The desert place" is where we meet God in the stillness and know that God is there.

The desert place is also the place where we meet ourselves, where we face the pain of our weakness and our separation from God. It is here, however, that a miracle takes place. It is at the very time when we face ourselves, like the Prodigal Son, that we know that God is already there, forgiving, redeeming, assuring, renewing. It is in this experience of a loving God that we find the stillness we so eagerly seek and desperately need.

True serenity comes from knowing God as a living, loving presence. Equipped with such peace, we can face life, a day at a time, with calmness and confidence. Aware of our weakness, physically, emotionally, spiritually, we become the more sure that the divine strength is flowing through our whole being. Such stillness is not of our making, ***It is God's gift to us and it is on offer to all people.***

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Say **"Yes"**

To a love that will drag you through the depths,
Scour your every feeling,
Scar and heal your heart,
Lift you to the heights.

Jim Cotter

Protest – Empowerment and Spiritual Care

Notes on a Conference held at Rampton Hospital

Part ONE of two parts

On April 9, Sister Teresa Pountney and I attended a conference at Rampton Hospital on the themes of Protest – Empowerment and Spiritual Care. The main questions being considered were:

- 1) How do we protest effectively about mental health issues?
- 2) How are we empowered to “keep on” in difficult situations?
- 3) Where does our spirituality fit in to all this?

The first speaker, Phil Barker, Professor of Psychiatric Nursing at Newcastle University, was truly inspirational. He has been a psychiatric nurse for over 30 years and for the last 20 has been primarily involved in psychotherapy and the development of recovery models in mental health. He has been visiting professor at several universities abroad and has written a number of books.

He described that the patient who was mad was isolated and ostracised by a frightened society – an outside experience. It was essential to have an encounter with a person as opposed to an engagement with a patient.

In order to help one had to:

- Acknowledge distress
- Develop a true relationship
- Address problems of living
- Develop a view of the immediate future
- Inspire hope. Hope is the ultimate protest.
- Have lots of options
- Have self determination – not compliance
- Risk, and accept the right to failure
- Recognise that medication is only one tool amongst many
- Value their peer group and its support and self-help
- Have as much information as possible
- and,
- There has to be Community integration.

He quoted the experiences of many well known people who had suffered, and had achieved a great deal, such as Charles Dickens and Cole Porter.

Madness is an existential crisis – who am I? What am I doing here?

True love suffers alongside and holds out hope.

Julia Giles, a writer and survivor, told us about successful workshops she had held at the hospital using some of her poetry as a basis. One can see how the themes of empowerment protests and spirituality come into her work.

Pam Freeman

A SEMINAR ON PSYCHIATRIC RESEARCH

at the

Institute of Psychiatry

De Crespigny Park, Denmark Hill, London SE5 8AF

on

4th SEPTEMBER 2002

10.00 am to 3.30 pm

The speakers will include:

Professor Sir David Goldberg

Dr Raj Persaud

Dr Peter Fenwick

Dr David Ball

Dr Isobel Heyman

The topics covered will include:

ALCOHOLISM

SLEEP DISORDERS

OCD IN CHILDREN

EPILEPSY

etc.

To: The Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF

I would like to attend the Psychiatry Research Trust Seminar on 4 September 2002

NAME Telephone No. :

ADDRESS

..... Post Code

I will be bringing (number) of guests

I enclose cheque for (£20 per person) £ (payable to the PSYCHIATRY RESEARCH TRUST)

ALL READERS PLEASE NOTE

The editors NEW Email address is now: johnrawson@blueyonder.co.uk

THE ASSOCIATION FOR PASTORAL CARE IN MENTAL HEALTH

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The views expressed in the Newsletter are not necessarily those of the Association

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