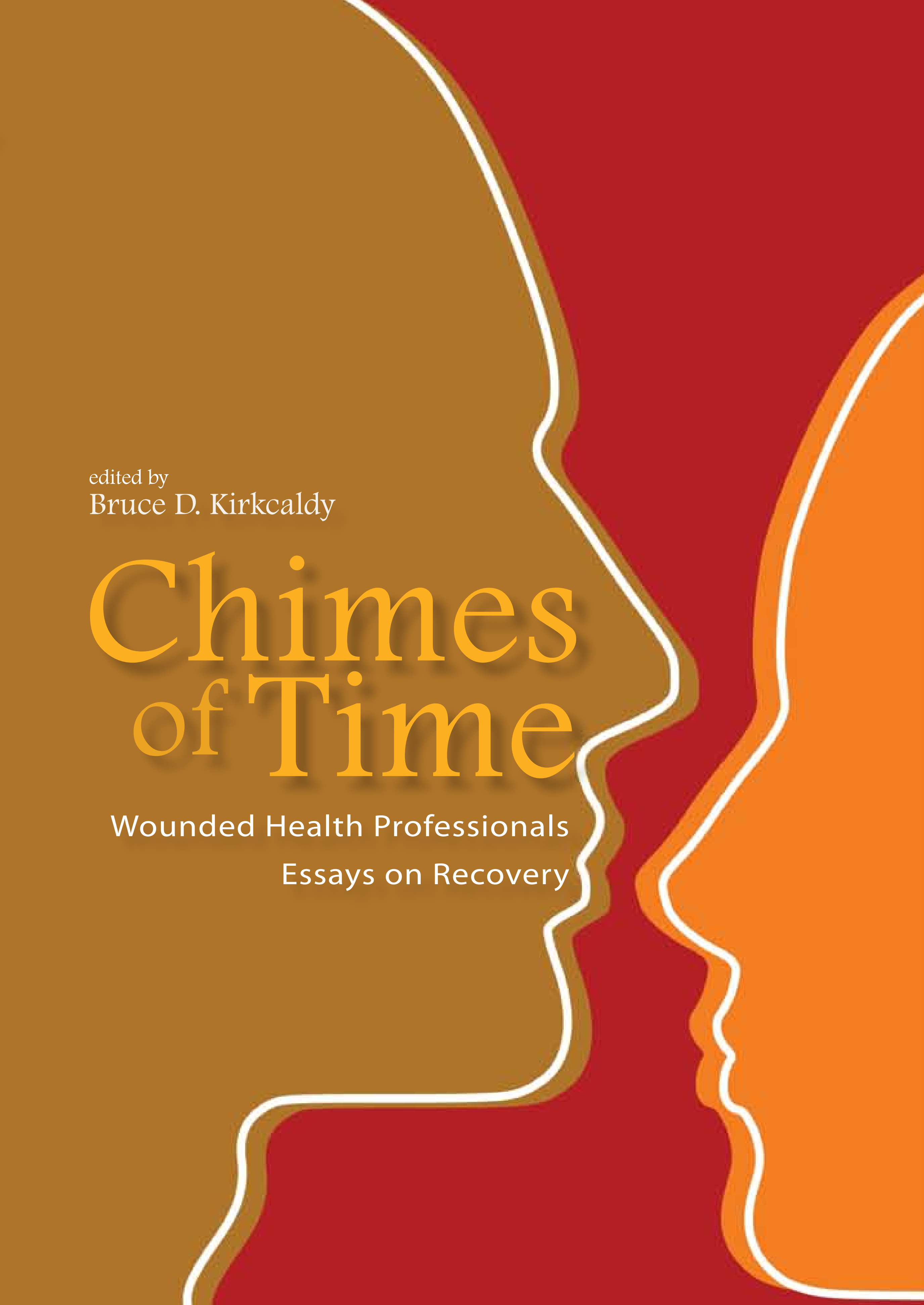

edited by
Bruce D. Kirkcaldy

Chimes of Time

Wounded Health Professionals
Essays on Recovery

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Sidestone Press

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Düsseldorf, 2013

Chapter 1

INTRODUCTION: WHEN, WHY AND HOW HEALERS CAN PROFIT FROM THEIR OWN VULNERABILITY?

Bruce Kirkcaldy

> *"Healing stories give people hope, teach them empathy, and encourage action."*
>
> (Mary Pipher, 2006)

There are many reasons to examine the topic of wounded healers. Not least because it may be useful to know whether health professionals are better or worse in their professions when they themselves have been injured, whether physically or psychologically. Medical statistics frequently suggest that physicians and allied health professionals are often susceptible to ill-health; perhaps this is quite the opposite of what one may expect of the healing occupations. It appears that the chores of diagnostic and therapy with persons suffering either somatically or psychologically, represent a source of stress for health professionals. This stress results in increased psychological morbidity, with higher rates of anxiety, depression and substance abuse (alcohol and chemical dependence and nicotine consumption), as well as susceptibility to job burnout (hopelessness, helplessness and chronic fatigue), negative self-evaluation, and increased self-destructive behavior and suicide (Kirkcaldy, Trimpop, & Martin, 2011). Rinpoche and Shlim (2006) have argued that this may arise as a result of a "*lack of overt compassion*", and paradoxically at a time when there are major advances in medical treatment including antibiotics, minimal invasive surgical techniques, immunization against a variety of diseases, kidney dialysis, etc. They further claim that *"Doctors fear that if they open themselves up to the emotions of their patients, they will be overwhelmed. They feel that they need to distance themselves from the pain, loneliness, and fear that many patients are suffering. If they identify too closely with their patients, they run the risk of emotional exhaustion*." (p. 4). But health care is much complex than it first appears, and indeed there are arguments for a theory that wounded healers may be able to 'capitalize' on their weaknesses and injuries in their work as physicians or therapists.

Carl Jung had earlier addressed the issue of the wounded healer. He wanted to draw attention to the hazard inherent among psychotherapists and presumably other health professionals in being exposed to the potential pain and injury of a patient, which will likely activate negative cognitions associated with one's own emotional vulnerability and hurting. Conversely, he asserted that effective healing requires a repertoire of strengths and resources. Jung's concept was derived from Greek mythology, the legend of the centaur Chiron (abandoned as a child and adopted and raised by Apollo) who had accidentally penetrated his skin with a stray arrow delivered from Hercules's bow. Chiron did not die because like the Gods he was immortal, and consequently would suffer eternally with agonizing pain. He prayed incessantly that he could relinquish his immortality and die. He had to cope with a lifelong struggle of the pain associated with parental rejection and the enduring physical torment of his injury. Life was a life-long quest for a possible cure for his wounds and in the process he acquired a wealth of knowledge and skills especially regarding herbal remedies. The central source of his healing abilities developed more from his sensitivity and empathy acquired in helping others and the adoption of a compassionate attitude than his focus on his own personal injuries.

Stoneham (2008) elaborated in suggesting "*One of the legacies left by the analytical psychologist Carl Jung was the idea that in our psyche we all share deep inherited and unconscious ideas and images together known as our 'collective unconscious'.*" This collective unconscious, Jung said, is made up of different recognizable human models or archetypes. He saw in the Greek myth of Chiron a reflection of the archetypal Wounded Healer of the indigenous medicine man or shaman, first recorded in the earliest known hunting and fishing communities of Siberia and Sub Arctic North America. In fact it was probably from the language of a small group of hunters and reindeer herders from the Arctic Tungus that the name shaman comes, meaning 'he who knows' (Stoneham, 2008).

In understanding the concept of 'woundedness', I am reminded of another 'ancient' sacred story concerning a woman Kisa Gotami, whose only child had died in infancy. Kisa was resistant to accept the child's death, and continued to carry the corpse with her in search of appropriate medicine that would rekindle his life. The villagers were dismayed by her activity and felt she had lost her senses in denying the death of her son. Eventually someone suggested that she seek a physician, the Buddha who could cure her on this malady. The Buddha offered to help her in curing the child and she had simply to bring him a handful of mustard seeds. She agreed in haste, and his only condition was that the mustard seed must originate from a household which had not experienced loss of a child, spouse, parent or close friend. After bitter searching she was unable to find a home that had not experienced personal grief. She returned exhausted and demoralized, and in the late evening towards dusk, she recognized that her selfishness in attachment to her child had blinded her to the universality of death and grief. She was then sufficiently enlightened to bury her son in the nearby forests, feeling emancipated from the 'arrow of lamentation and grief'.

The belief that health professionals may be especially prone to the life stressors, invites the question whether there is a predisposition to select more 'emotionally taxing' occupations that in some sense compensate for emotional crises in ones childhood and upbringing, and/or is due to the consequences of daily confrontation with suffering and ailments, and the inevitable 'meeting with illness and death'. This leads to the underlying question as to what factors motivate helping professionals to gravitate into those careers. Overall, I spent much of the first half of my adult career examining these questions using empirical data and review studies. Around the age of 40, I embarked on the second and current half of my career and shifted towards psychotherapy, establishing a practice for clinical psychology and psychotherapy. During the last 18 years I have devoted considerable, and rewarding time listening to the stories of afflicted individuals with expectations that I could help them unravel the knots (emotional and otherwise) that had brought their lives to a standstill.

Over these years I've gradually felt less inclined towards the medical model of illness and increasingly surmised that watching theatre and reading literature had more to do with what takes place in the social context and dynamics of therapy. As a cognitive behavioral therapist, the cognitive aspects including autobiographical history have become a central feature in my daily practice. In essence, teasing out and understanding the personal narratives that influence the subjective perceptions of my clients, enables me to more clearly identify specific features of a person's life that may have thwarted further personal growth. I use the analogy of 'getting stuck' at a chapter, and not being able to continue with the natural 'flow' of life.

> *"Rather than asking a person to explain his or her experiences to us, we are asking him or her to share … experiences with us: to tell us stories about his or her life as he or she lived it. The role of a participant in a phenomenological study is therefore that of autobiographical storyteller … interested in narratives that capture the flow of experience over time in the lives of each person. …we are more likely to find useful concepts derived from literature and drama, such as plot and role, than we are to find concepts derived from the physical sciences such as causality… The art of storytelling, after all, is not so much in plot or character development as it is in the sensuous rendering of descriptive detail. Stories cannot be told in the abstract, only in the particular. And it is through the particular, through the specific, intimate details of each person's concrete everyday life, that we are able to approach the universal."* (Davidson, 2003, p. 63)

During these many hours, and in excess of a thousand patients, I have observed that the autobiographical histories, the description of the social context and the subjective interpretations of their illnesses, that is, the subjective reporting, was much more akin to the observation of a theater play than the reports and writing in a medical textbook. This idiosyncratic vita, the person history and the crises in trying to find meaning in one's life, corresponds closer to the literary works of Shakespeare, Goethe or Schiller. And nowhere was this most apparent than in the more extremes of psychological impairment such as psychoses, schizoaffective disorders, and/or confrontation with life-threatening physical illnesses.

So that was the background which motivated me to embrace all the empirical studies I had written to date, in combination with the clinical work with my clients. The rationale underlining the motives for compiling such an edited book was to address the issue of 'confessional' health professionals and clinicians and academics, and the possibility of 'therapeutic advantages' of personal injury. To offer a series of essays that best reflected the 'ingredients of therapy' and the process of healing. A unique aspect was the attempt to integrate persons mainly from mental health professions to openly express how they had coped with either a major physical or psychological ailment, and yet had managed to endure and 'recover' and been able to lead healthy and creative lives without the adverse effects of medicalization and/or stigmatization. I began to focus on producing a book featuring essays of (afflicted and non-afflicted) individuals able to portray what it means to experience the torments and insecurities linked with existential fears and anxieties. This 'emotional distancing' and analytical observation enabled me to try and find out what it was that enabled us/others to cope with potentially disabling illnesses and yet 'recover' to the extent that we could continue to experience a colorful and creative private and occupational life. Handicaps may be obstacles but didn't require 'cure' to emulate them and continue our life travels.

A distinction can be made as to whether therapists/health professionals are stressed as a result of their *heightened sensitivity* which 'predisposes' them to select 'healing' professions ('mission'). Another explanation is that the tasks of dealing with illness and the associative emotional demands generate stress among healers. And then a third alternative in this book is the hypothesis, involving the health professional's confrontation and personal coping with an ailment – whether physical or psychological – an illness resulting by chance e.g. cancer, aids, and psychosis, or associated with a job-related risk e.g. brain injury through electrocution, mental ill-health.

Frank (1995) in his Wounded Storyteller commented:

> *"Illness has always threatened the intactness of mind and body, but in postmodern times this threat takes the particular form … embodied paranoia … people fear for their bodies not only from natural threats such as storms or disease and from social threats such as crime or war. People are also threatened by institutions ostensibly designed to help them. Becoming a victim of medicine is a recurring theme in illness stories. The incompetence of individual physicians is sometimes an issue, but more often physicians are understood as fronting a bureaucratic administrative system that colonizes the body by making it into its 'case'. People feel victimized when decisions about them are made by strangers. The sick role is no longer understood as a release from normal obligations; instead it becomes a vulnerability to extended institutional colonization."* (p. 172)

Writing about oneself has a therapeutic effect – for the patient. And writing about oneself and daily crises may have a protective value for the therapist (Kershaw, 2009).

Over the years of my own clinical practice, it has become apparent that there is great value in understanding and sharing the subjective meaning our patients attach to their ailment. By encouraging such self-reflection and personal insight, the health professional will deeply understand the predicament the patient finds him- or herself in. One way of facilitating this is using writing. Pennebakker (2012) has been instrumental in introducing expressive writing in clinical practice. The process of expressive writing about one's emotional upheavals can enhance both physical and psychological health. He suggests writing on 4 or 5 consecutive days at least 15 minutes per day, uninterrupted and edited (write continuously and ignore spelling and grammar). The individual should focus on events or situations that are causing him or her excessive worry, or something he or she may be avoiding recently or have an unhealthy influence on their current life. Furthermore, one could concentrate on the cognitions and emotions associated with a deeply distressing life event. This may be a traumatic experience or a series of conflict-laden experiences. It can be written about in the framework of one's family of origin (parents or those one has loved), and/or how this relates to one's ideal self, or as it has been in the past or is in the present. Such an exercise has been demonstrated to have powerful therapeutic effects.

In much the same way, a couple of centuries earlier, Wolfgang Goethe reflected on what may help the individual manage the hassles and turmoil of daily living and these words are perhaps even more important today in a culture lopsided (with an emphasis on digitalization, oversaturated media presentation, etc) and characterized by a sense of urgency for quick (medical) solutions. Sometimes I feel that there is something magical in putting words to paper; it is more strenuous, time-consuming, and hence reflective in writing our thoughts as opposed to automatic 'thinking' in a frenetic fashion. This may be in the form of writing 'as if' the problem is resolved and exploring what would be different in one's life (Kelly, 1955). The majority if not all, the chapters in this book are personal accounts involving a shift in belief patterns, coupled with an increased feelings on personal control and self-efficacy. Perhaps this is what Goethe meant when he had written "*Magic is believing in yourself, if you can do that, you can make anything happen*".

More recently, Joan Didion expressed the potentially powerful tool of writing in discovering and appreciating our deepest thoughts and moods "*I write entirely to find out what I'm thinking, what I'm looking at, what I see and what it means. What I want and what I fear.*" In reviewing the work on narrative therapy and medicine, Skelton (2012) suggests:

> *"People's lives and relationships, then, are shaped by the narratives they tell themselves as a way of giving meaning to their lives and experiences. These stories become the basis of the self. If I lack a sense of self-worth, then the stories I tell myself will tend to confirm this self-perception. The aim of narrative therapy is to separate the 'problem' from the 'person'. As and when this is done there is opportunity for new stories to emerge: There is, that it is to say, the opportunity for (part of the title of the well-known text on the subject) 'the social construction of preferred realities' (Freedman & Combs, 1996). In particular, narrative therapy aims to see problems as being individual – of course – but also as existing in a particular society, a particular framework which consistent of a socioeconomic context, a set of cultural preconceptions, for example, about sexuality, or the expectations of social class and so on."* (p. 321)

In one of Yalom's chapters in his book, *The Gift of Therapy*, 'Sharing the shade of the shadow', he appreciates the self-disclosure of his analyst in sharing the 'ubiquity of certain feelings and impulses', and thus normalize the shadowy side of human nature (I call this exploring the undergrowths of the deep forest of the patient's mind, and recognizing the commonality of our personal jungles). Yalom underlines the value of being able to share our own shadows and thus prevent our patients from "*flagellating themselves for their own real or imaginary transgressions*". Yalom in using this metaphor underlines the 'shared' fragility and fallibility of being human. In an earlier chapter in the same book, Yalom asserts that both patient and therapist are "*destined to experience not only the exhilaration of life, but also its inevitable darkness: disillusionment, aging, illness, isolation, loss,* *meaninglessness, painful choices, and death*" (Yalom, 2002, p.6). Interestingly, one of the chapters in this book actually uses the construct of 'shadow' in its title. It conveys a cogent visual message, and perhaps the notion of 'outing' (disclosing long-held secrets) among health clinicians or academics liberates one from the burden of our biographical history and well as serving for a model of 'imitation' for our patients.

I didn't want to address purely psychological disorders, neither did I want to confine inclusion in the book to persons who were necessarily afflicted with a physical injury themselves, but cover a spectrum of life stresses among diverse occupational groups, men and women, and of different cultures and ages. There are a myriad of self-help books and many more technical medical books offering varying degrees of "helpful" ideas. The rational for editing this book was somewhat different, that is, I wanted persons who had often had long-standing 'secrets' which they wished to disclose as a form of closure and in order to facilitate growth and development among others. And these people were selected because they could offer more 'optimistic', 'health promoting' and 'recovery-oriented' models of disorders, without the stigmatization so commonly felt and a more optimistic message to encourage others to work through their personal problems, emerging out of a tunnel of darkness into the bright sunlight beyond.

The structure of this book was such that a section was dedicated predominantly towards physical illnesses such as cancer, aids, and physical disability, and another towards psychological impairments quite often from psychotic phases or schizoaffective disorders, but also including post-traumatic stress disorders. I also chose to feature several non self-confessional chapters by academics and clinicians with an outstanding record of writing within the more liberal and creative sphere of healing, views which may challenge existent ideas of medical illness.

The opening chapter represents one of the less self-confessional accounts, and one not from a purely medical perspective. In order to better understand the problem of illness and dying, I was very fortunate to draw on one of the leading experts in the area of literature and medicine. Arnold Weinstein explores the literary testimony regarding doctors which itself can be tough medicine. From Sophocles' view of Oedipus as the 'doctor' of the ailing Thebes (expected to cure the polis, but revealed as the source of the disease) on to representations of doctors in Molière and on to 19th and 20th century literature, we see that physicians are awash in problems, disorders and crises of their own. At times, these works speak to us of the private vulnerability of healers; at other moments, they tell us something about the broader cultural story where medical interventions become deeply problematic as such. In considering texts by Söderberg, Kafka, Fitzgerald, Selzer and Barker, we will encounter depictions of the *healer* that radically challenge any cozy view of physicians-as-intact and authoritative. Such literary encounters should be seen as tonic, rather than distressing, for they remind us that the practice of medicine is, and has always been, a human endeavor with its intrinsic limits as well as aspirations. A recurrent theme in this book is the idea that we are not alone and share the precious emotions, cognitions and behaviors of being human. The sense of alienation and separation, which is to a large extent illusory and causes increased suffering in our lives, can be alleviated and through self-disclosure we can experience increased psychological well-being. This may distinguish literature from the health sciences. Modern medicine has been increasingly distancing ourselves from our mind and bodies, all variations and deviations perceived as abnormalities. Art and literature may help us rebalance this 'asymmetry' by offering 'pathways to emotions and feelings'.

Peter Chadwick, another British colleague, contributes a chapter in a 'from-the-inside' narrative looking, in part, at the strengths and weaknesses of his pre-psychotic schizoid personality and how this metamorphosed into schizophrenia. The chapter also catalogues and discusses the positive after-effects of psychosis as well as showing how positive features of the pre-psychotic personality were utilized in the aftermath of the crisis. The narrative is predicated on a bio-psycho-social-spiritual model of psychosis and hence emphasizes the many levels of description that are necessary for representing madness and recovery from it. Peter considers not only the downsides of psychosis, but also potential positive features of such a psychological state. Peter has devoted much of his working life researching and writing about his own 'susceptibility to woundedness'. He underlines the core topic of extreme subjectivity of thought which is so characteristic of psychosis: "*hence narrative approaches … have a valuable part to play in achieving anything like adequate understanding … (and) we cannot afford any longer the luxury of ignoring the story from within in the interests of being only objective scientists. Too much material is being wasted in this way. The Man/Machine analogy, after all, empties life of its spiritual content. The scientific psychologist likes to use instruments to find facts guided by theories. The artist or spiritual quester likes to understand things via what he or she is, guided by feeling.*" At the same time, Peter is a leading scientific researcher in his domain and recognizes the subtle blend of medicine requiring art *and* science : His chapter manages to fuse scientific constructs with a blend of creative and emotional concepts of psychological disorders.

David Luckoff provides a chapter with a detailed autobiographical account of the confrontation with a psychosis and the author's methods of coping and personal meaning of that episode. In 1971, David experimented with LSD for the first time. This experience catapulted him into a two-month psychotic episode during which he believed himself to be a reincarnation of Buddha and Christ. In this altered state he had set out feverishly to write a 'Holy Book' that would create a new world religion. He weathered this episode without medication or hospitalization, yet it was not an experience he wanted ever to repeat, even though he now considers it to have been his personal spiritual awakening and to have led him into his professional career as a psychologist. David perceives his psychotic episode as taking place in a non-shamanic cultural and psychological context, and yet he feel it bears a distinct relationship to a shaman's initiation in that "*it contained thematic and imagistic parallels to the initiatory crises of professional shaman; it served as my calling to the mental health profession just as the shaman's crisis calls him/her to the role, and it was integrated with the aid of traditional shamans and their practices.*" He suggests that shamanistic calling was influential in drawing him into the mental health profession believing that "*my crisis awakened certain healing abilities that contribute to my work with psychotic patients. For example, it is relatively easy and rewarding for me to empathically enter the delusional reality of* *psychotic patients. Most mental health professionals seem to find an 'abyss of difference' (as Jaspers, one of the fathers of modern psychopathology, described it) between the 'normal' and the psychotic mind. Through my psychotic experience, I became aware that psychotic patients have needs beyond pharmacologically-based treatments*." David argues that he knows of many health professionals who gravitated towards the health professions after a psychotic or depressive episode.

Robert Miller's chapter begins with a brief account of his own journey, from being a medical student in Britain, to one with a diagnosis of schizophrenia, then to researcher on theory of brain function and its relation to mental illness, and now to community advocate and representative on committees of Royal Australian and New Zealand College of Psychiatrists. The chapter includes an account of how stigma and discrimination played a role in his move to New Zealand in 1977. On the basis of a recent meeting with the CEO of the Terrence Higgins Trust in London, he contrasts emergence of consumer activism in the HIV/AIDS field, and in the mental health area. In the former area it has been possible to achieve much greater unity of purpose than in the latter, and a more fruitful collaboration between consumers, researchers and clinicians is needed. Robert goes on to discuss the reasons for this difference, and to suggest ways in which consumers and family members/care takers can forge more constructive alliances with researchers, psychiatrists and others working in the mental health area.

Robert looks in detail at the interface between consumers, researchers and clinicians in the mental health field. He explores topics such as openness and transparency in mental health care; medical authority as an impediment to rational discourse; overreliance of diagnostic labels; programs aimed at reducing stigma and discrimination, and effectiveness of consumer activists on influencing social policies. Robert is cautious not to discard psychiatric effort for healing prematurely: he underlines that "*If so, the idea of having to choose between biological and psychosocial models of mental disorder becomes absurd. The two always, and necessarily go together. The real problem then is not the very notion of neuroscience or brain science in service of psychiatry, but bad neuroscience bent to this end, bad neurobiology, with simplistic metaphors parading as explanations, turning out to be empty rhetoric when examined in detail. One should also realize that there is also much bad psychosocial research*." Overall, his stance will hopefully often useful insight for sufferers and their families in decision-making processes in medical and psychological treatment.

Another chapter relating to one's reflections on being in recovery from schizophrenia and other psychotic conditions is provided by Fred Frese. Fred stresses various aspects of recovery and attempts to measure it, as well as focusing on assessing dangerousness to others, to self, and particularly dangerousness from others. But perhaps the uniqueness of his contribution is the desire to focus – many years after his first episode – and identify what specific aspects of his childhood, adolescence and/or early adulthood may have displayed tell-tale signs of his later 'disorder'. With hindsight he proposed several factors including excessive shyness – likely being related to the 'hypersensitivity to criticism, or expressed emotion'. This may be associated with an increased fear of social rejection, perhaps in the form of interpersonal or ego threat. Fred further discussed his early obsessive preoccupation with challenging tasks, often accompanied by an extraordinary display of will-power. e.g. developing a method to extract cube roots while in high school and taking on the challenge to learn Japanese language. And such complex self-determined learning at the expense of 'commonsense'.

Other potential early indicators of his developing schizophrenia may have been occasional displays of exacerbation of affect, manifested in the mini-hypomanic episode experienced in college. Another candidate for being a 'prodromal' sign may have been intermittent flaunting of eccentric behavior (shaving his head in high school). This tendency was occasionally accompanied by a preoccupation with religious or spiritual ideation.

A central theme of these chapters on psychological disorders is associated with subjective psychopharmacology. There are two often competing perspectives here. The perspective of the physician and that of the patient. The doctor wants to hear that the medication is being taken (the patient being compliant) and helps reduce symptoms. As doctor you are likely to suppress or worse deny potential negative side-effects. It would generate stress if the doctor felt empathy towards his patient, and recognized the impairments and limitations that the medication imposes on the patient. As patient you are likely to exhibit both hope and disappointment with the medication. Even if you don't feel the adverse effects of medication you are constantly aware – through daily ingestion of pills – of your being 'ill'. And this is most pronounced in instances when the side-effects are severe. This worsens the relationship with the physician prescribing the medication. Over this uncertainty, doctors are likely to 'barricade themselves'. Health professionals should be more open and honest in their interaction with patients, addressing these issues.

My own chapter (Kirkcaldy) is an attempt to understand more fully my own childhood history, educational and career development and meaning and role associated with my function as father and spouse in a new family structure. I mention how I 'brushed shoulders' with disoriented patients including schizophrenics, psychoses, and presumably manic-depressives, and recall several incidences as a child in my home town, wanting to walk next to the people who were behaving bizarrely, wanting to accompany them and understand their world of turmoil. People around were reluctant to communicate with them, preferring to avoid any form of interaction. There would appear to have been a deep-seated curiosity for me to share the inner worlds of this supposedly adult 'aliens'. I suppose looking back, there did appear a sense of proximity, a sense of relatedness with these individuals, a wanting to understand and enter 'their deep forests of impenetrability'. I think it was less fear and more a curiosity towards exploration and understanding that characterized my motives. I believe to some extent my own immediate family was somehow 'dysfunctional', without having the cognitive insight into appreciating the mechanism involved (which presumably came later). Children try and understand their parents, and they don't have any 'standards' to measure their behavior. As adults, and particularly being parents ourselves, we recognize the inherent difficulties of our 'new' roles as expecting to support and nurture our family, and yet we are aware that we display our own peculiarities, our deviancies and insecurities and anxieties with which we generally have limited possibilities of disclosure. This sense of alienation and existential anxiety is probably what fuelled me to want to understand behavior, emotions and our thinking patterns. When we enter adulthood and have our own families, processes are occasionally repeated and we may feel haunted by the 'spirits' of the past, and we are challenged to rethink and re-evaluate our relationship to our own children and our own inner child (of the past). This chapter gave me a chance to unravel some of the mysteries of what I feel are some of the most challenging mysteries of the human condition.

This section ends with a review article, exploring the positive features of psychosis and related disorders. Gordon Claridge and his Spanish colleague Neus Barantes-Vidal suggest that many studies – both experimental and biographical – carried out in the context of the age-old 'madness-creativity debate' have demonstrated beyond any reasonable doubt that there is a genuine connection between the capacity for original thought and the predisposition to psychosis. Their chapter evaluates the evidence for this claim, stressing both the varied expressions of creativity and the varied forms of psychosis – schizophrenia, bipolar disorder, autism etc – to which they relate. Gordon and Neus conclude that although psychosis itself does constitute a serious breakdown of mental function (illness), the personality and cognitive traits underlying it are essentially healthy: variants in naturally occurring and evolved human individual differences of which the psychotic disorders are an aberrant by-product, occurring in a few individuals. This perspective replaces the more pessimistic medical view of 'madness' as a simple case of 'broken brain' without recoverable positive features. They comment "*Ever since, Establishment Psychiatry has continued true to its advances in recent decades in neuroscience and molecular genetics. The reality is, however, that despite an awesome research effort over several decades, no single neurobiological abnormality has been found that is really specific to psychosis or any of its varied manifestations*." The authors offer a paradigm shift in the concept of psychosis. They suggest three main issues which indicate a change, including the recognition that environmental social adversities and risk factors exert a major role in triggering of psychosis. In addition, the unitary model would seem to oppose the oversimplified broken-brain, diseased oriented model of traditional psychiatry, and finally, the dimensional view in which there is a 'continuum between madness and sanity'. The latter theory derived from psychological theories, "*specifically trait theories which see dimensions of personality as having a dual function: describing both healthy individual differences and predispositions to psychological disorders trait anxiety and anxiety disorders are the least controversial examples; but the same principle can be applied, we would argue, to more serious mental illnesses.*" Gordon and Neus use examples from literature and art to show the intimate association between creativity and madness. They remark, "*What we learn from the discussion so far … is that how individuals 'manage' their psychoticism/psychosis, and what sorts of people need to do it, is a question that can be posed right along the trait/symptom spectrum described. In other words, it is not narrowly about someone having to deal with acute, full-blown bouts of insanity; it is as much to do with people channeling the unstable energies of borderline psychotic states, or, in the case of healthy (albeit sensitive) individuals, finding ways to express their creative talents.*"

The next section of the book concerns itself more with life-threatening physical disorders, which in part incorporate psychological pain and anguish.

The first essay is by a UK colleague, Nisha Dogra, who suffered from a major physical ailment in her adolescence and early adult life; she describes her experience of being diagnosed with paraosteal sarcoma and its treatment. As she kept a diary of the events (as a mechanism by which to cope), her personal account contains excerpts from that time as well as reflection many years after the event. Nisha further addresses how being a doctor helped her and hindered the impact of 'being ill'. The responses of friends (most of whom were medical) and colleagues are also described. She attempts to consider how this experience has impacted on her practice as a child psychiatrist and how it influenced the way one tends to view illness and disability. Nisha discusses how individuals might view themselves and how this can be difficult to reconcile with the views that others hold about them. She feels her illness did make her more patient-centered but not in the ways she had perhaps expected. "*I had thought I might be a more sympathetic or more patient doctor and was a little disappointed that cancer treatment did not cure my impatience! However … it was very easy to no longer make assumptions about the meaning of any illness to any particular patient… I had also learnt that there is no single right way of managing an illness, there is no guide book or Holy Grail*." Nisha provides a very moving account of recognizing the value of being incredibly intuitive and doing what felt right for her "*…not to play games with myself whatever else I did with other people. As a doctor … learnt to have no preconceived beliefs on whether the way people manage life events really says anything about them at all. …it may not be until they are through that challenging period that they can effectively reflect and learn for the future. (Moreover) … making sense of experiences is such an individual and personal construct, that I am not surprised by the things that people do to get through. As a doctor, whilst I have my own very clear values and sense of what is right for me, I have no need to share or impose those on my patients … (and) don't need immediate answers or quick results*."

Nisha goes on to describe why she chose and continued to choose not to describe herself as a 'cancer survivor' and how this has influenced her work in diversity education.

The chapter that follows from Thandi Haruperi relates to and analyses her reaction to one of the most traumatic experiences of her life, learning of her HIV diagnosis. Paradoxically, this was an experience that set Thandi on a personal journey that awakened her to her Self and her reason for being. What followed was a period of unanswered questions, bouts of shame, confusion and some deep soul searching. Thandi felt her life was over, until the day she challenged that view about her health condition and the meaning of health.

It has long been acknowledged that living well with a chronic illness, demands a holistic approach that encompasses the physical, mental, emotional, social, spiritual, sexual and financial wellbeing. Most of us to who have had some diagnosis of one sort or another will probably identify with the agonizing questions about whether one could fulfill ones work-life aspirations let alone make a living that would sustain oneself.

In spite of the diagnosis she felt there was still more to her and her health than what she was being made to believe and accept. She began to ask herself why she had been so traumatized, and realized her thoughts were at odds with definitions and labels that defined her, in such a manner that was unhelpful to her wellbeing. The medical model of health that defines health as the absence of disease or illness, and a label that says 'Is HIV positive'. For Thandi, searching and finding schools of thought and positive and social models of health that offered health as a state of well being and not merely the absence of disease and illness was a very liberating and vindicating experience. "*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (WHO 1946). The latter reveals that for over a half a century health authorities worldwide recognized the complexity of health, not limited to physical ailments, but including psychological and social factors.

A Polish contribution follows, provided by Aleksandra Tokarz who looks at self-knowledge and personal resources in coping with traumatic life events. Aleksandra's starting point is a Greek maxim *Gnothi seauton* – to know yourself. The theoretical background is based on the concept of self-knowledge (its development, structure, unction) developed by the Polish psychologist Jozef Kozielecki, and by Hoboll's notion of personal resources. There are two levels of individual experience: Firstly, a situational level, representing the 'here and now' (e.g. feelings of anxiety or bad moods), and secondly, an 'accumulated experience level' across one's life span. She weaves the fabric between her passion for scientific enquiry and the rational methods for resolving problems, and the personal challenge of coping with a health impediment, a life threatening illness, at a later stage of life. The reader gets an insight into the issues associated with being diagnosed with cancer in late middle age, and then idiosyncratic methods of coping drawing from ideas in philosophy and psychology.

Aleksandra lists an array of important factors which helped her cope with the problems related to be 'suddenly' ill, including humor, social connectedness, emotional support, and distraction using scheduled activities or work. She also discussed the issue of anger and frustration in interaction and negotiation with 'abusive and neglectful' medical practitioners. And this had been closely associated with helplessness and fear, and yet helped her to mobilize strategies of dealing with her 'bodily threat'. At first, Aleksandra considers the meaning of positive relationships between each members of a family and the so-called family of friends (McAdam's narrative research on intimate relationships), a bond with a dog (Polish research on pets, based on *grounded theory*) and the central role that arts and music played in her life, that is, listening to music (Oliver Sack's Musicophilia: Tales of Music and the Brain, 2007)**.** Next, she refers to the elaborated self-knowledge, creative attitude towards own life and individual resources. It is also important to consider the issue of conscious vs. unconscious behaviors (as we perceive them from a time perspective), affecting individual's own emotions and goals and the meaning of active and passive attitudes towards difficult/traumatic life events.

There then follows a chapter by Emile Allen, and in his contribution he shares his experiences and insights from surviving a near-death electrocution during surgery as a practicing urologist. This is described as a 'split second in the operating room had taken away the value of all my education and experience'. He describes in detail the injury and the immediate aftermath of the ordeal as it affected him both physically and emotionally. It required 6 months of waiting before he received the cluster of medical diagnoses including traumatic brain injury, petit mal seizures, reflex sympathetic dystrophy, and peripheral neuropathy, and the label of 'depression'. Here he was a young surgeon in a prestigious medical centre in the prime of his career, suddenly reduced to the physical and emotional dependency of a 14 year old and what he labels the 'shame and fear' of having to require psychological aid.

From the perspective of the time of the injury and subsequent healing period, he discusses his long road to recovery, as well as providing reflective views and lessons learned several years after the accident. In this discussion, he expresses the deep emotional trauma that resulted from the debilitating hand and brain injuries. The impact of this trauma essentially turned his life upside down and forced him to accept who he had become and begin the process of reinventing himself. He further focuses on the connection he discovered between depression and grief, and how vital that understanding became in his quest to move forward in his life. Emile then discusses the concepts of acceptance and the physical and emotional scars, and 'letting go'. There is much in this chapter which approaches fought and hope for the healers themselves, and in the process of recovery, finding one's self. He expresses this lucidly, *"I was aware of the loss I had suffered … my identity had been changed forever; however, I only had the questions, not the answers. I had trouble letting go of my past and accepting that my life would be different … grieving the loss of so many things. Acceptance was very difficult for me; nevertheless, it had to be done. I had no choice since I was living in hell and certainly wasn't going to stay."*

In conclusion, drawing on his experiences he shares with the readers how he currently feels in his position. Again, we experience the confessional model upfront. Emile opens up some original ideas that developed during that period suggesting that when individuals experience the significant loss of something – whether it is our career, our life savings, or a loved one, grieving can show up as the physical and emotional signs and symptoms that the medical community calls depression. He feels depression may be the clinical term for very real loss and subsequent grief. The grieving he feels had to be personal and unique. He reaches a turning point, "*Life happens. I could either react as a victim or respond as an empowered individual. I found that life became much more fulfilling and energizing when I chose to respond from a place of self-empowerment.*" Emile concludes by speaking of the transformation from being a surgeon to being a wounded healer "*Helping people heal their metaphoric heart rather than their physical body is now my goal."*

Amanda Ekdawi looks at identification and separation, focusing on her clinical career choice after parental loss during early adolescence. The death of her mother in her early adolescence exerted a strong influence on both her initial and subsequent career choices. In this chapter she explores how her early unconscious identification with her mother led her to follow in her footsteps as an occupational therapist, before retraining as a child and adolescent psychotherapist. She goes on to consider the common threads of bereavement and adolescent processes, in particular new identities and separation and loss. Amanda explores how her personal experience (of the death of a parent in early adolescence) initially appeared to complicate ordinary separation processes, leading to her initial career choice before finding her own professional identity as a child psychotherapist. She speaks in detail of the denial which was so prevalent both at home and in the school *"Looking back it is hard to explain what now seems to be such a denial of an event of such significance. In my later research I have come to link this (non) reaction of mine in part to an adolescent's need to fit in with the peer group."* She draws a parallel with the manic's tendency to deny the truth of psychic reality, and the inhibition of grief among adolescents confronted with parental loss. Perhaps there is a biological mechanism for 'dissociation from reality' in circumstances of potentially painful traumatic experiences.

The chapter also considers how her own experiences might have influenced both her practice with adolescents and her related research interests. Amanda was able to learn much about mourning and coping through her own training in psychoanalytical training *"my research enhanced my clinical work with others who have experienced loss in different and multiple ways… (and) strengthened my opinion that currently young people – sixteen to twenty one age groups – are not well catered for within mental health services. They can be considered too old to embark on long periods of work within children's services but often to not fit the criteria for adult mental health services. Adolescents have particular needs regarding a sense of autonomy and for this reason a unit accepting self referrals would be especially helpful."*

I mentioned that the book is to some extent confessional vs. non-confessional and is also intended to be provocative in its 'questioning', namely what is disorder and what is not? We have discussed how psychological models are often quite different from the medical illness-oriented explanations of mental health disorders. We have seen that the tendency to dichotomize for instance, psychoticism vs. normality, or depression vs. non-depression, may be replaced by underlying 'dimensions' of psychoticism, anxiety, etc. with individuals lying on a continuum of differential expression of one of these traits. So following up on this idea, let us take a look at some areas which we can question whether our concepts of normality and abnormality are valid, or whether we are indeed all to some extent injured individuals. Accordingly, our chapters now shift towards colleagues who disclose their own predilections and challenge to some extent whether this legitimizes their being labeled as 'wounded' or 'ill'.

We begin with Adrian Furnham, recognized as one of the most prolific writers and psychologists in Europe. Some would consider him a workaholic, or is he just passionate about his work? Adrian addresses some important questions which not only focus on issues of work in his own life, but may help others to understand what passionate and perhaps maladaptive style of working is. Is dedication to work a serious, sad, sick affliction or is it adaptive, healthy and productive response? Freud said we had two main issues in life: Arbeit und Lieben… how to work and how to love and how to explore and exploit these two well.

Adrian's chapter considers the literature on workaholism and its different types, and explores a few case studies. He discusses a range of constructs associated with work attitudes including psychological components of the work ethic, measurement of PWE (Protestant Work Ethics) beliefs, work ethic at work, and worklessness, etc.

Adrian provides a contribution half the content is theoretical and a review of the literature, and another half autobiographically confessional… but that ultimately the reader will have to decide whether the author's workaholism is adaptive or not. He explores the motives of addictive work behavior may represent one of several methods of cheating death, the ultimate 'closure'. The list include *"(being) religious and hope for an after-life. A second is to have children and live on through them. A third is to make a lot of money and then establish great foundations baring your name. Fourth, there is the hope of writers and authors that one may live on through the printed word. That is my hope and maybe all this manic effort is part of that hope."*

A quite different story is offered by the British cognitive Psychologist, Michael Eysenck. Michael's chapter deals with the considerable problems involved in building a career as a research psychologist when one's father is probably the best-known and influential psychologist in the United Kingdom. He is almost apologetic in his suggesting that his emotional scarring cannot be compared to those of other contributors to this book. And yet a "*major stressful life situation with which I have had to contend has lasted throughout my life so far and I am sure will continue to do so until the day I die.*" Michael's motivation for contributing is "*First and foremost … I am fascinated by the relationship between psychologists' scientific knowledge of human behavior and their personal lives. In fact, in my own everyday life, I very rarely decide what to do or how to interact with others on the basis of my knowledge of psychology. An important part of the reason for this is that it can be ill-advised to apply generalizations about human behavior to specific situations because of the complexities and idiosyncratic nature of most situations… leaves one in danger of losing one's own individuality and simply acting in a rather mechanical way."*

Michael discusses these problems in his early life and career development which were exacerbated by the rather distant relationship between them. After discussing these problems, Michael goes onto consider general lessons that might be extracted from his personal experience. Of central importance is the need to face up to life's major problems, followed by a systematic attempt to develop a personally satisfying solution. *"Another advantage of writing about … my father's research and our relationship was that it led me to understand somewhat better the reasons behind his lack of warmth and involvement with other people. His childhood was blighted by the unusual circumstances in which he grew up. Neither of his parents wanted to look after him, and so he was entrusted to the care of his grandmother … was an only child (like me) … no one else with whom he had the shared experience of parental rejection. First, he was determined to attract the positive attention he had been unable to do with his parents or his native country. Second, his experiences had an inhibiting effect on his personality and made him excessively defensive in his personal life."*

One of the US advocates for an alternative method of helping psychiatric patients is Peter Breggin. He argues that no one gets through the first decades of life without being 'wounded'-and probably deeply wounded. To speak of the ‘wounded healer’ is in some way misleading, since all human beings suffer, and especially so during the prolonged period of relatively helplessness and dependency during childhood and youth. The problem for all therapists is to accept their vulnerabilities, losses and trauma. It can be especially important to recognize our own particular legacies of pain because if they remain unrecognized, they become precisely those areas in which we will become intolerant and judgmental of others. A great deal of abuse inflicted on patients in the form of drugs, electroshock and even lobotomy has to do with the inability to welcome suffering and to find a loving way to help in healing it. Reacting with guilt, shame, and anxiety in the face of another’s suffering; we reject it, and ‘treat’ it as something alien from us. This is reminiscent of Yalom’s suggestion for teaching empathy in therapeutic settings using the ‘here and now’. Yalom’s remarks on how it is common to ask patients how their (the patients) specific statements or behaviors may influence others, but adds *“I suggest that the therapist include himself in that question.”* (Yalom, 2002, p. 23).

Acknowledging to ourselves, our own earlier and perhaps ongoing suffering, can easily become a justification for feeling depressed about therapy and especially for experiencing so-called burn out. That negative reaction to being a therapist can get rationalized as the inevitable result of being ‘sensitive,’ ‘caring,’ and ‘empathic.’ Instead, it is ‘induced suffering’, a kind of helplessness in the face of inevitable human suffering. True empathy is closely tied to love – and love is a joyful awareness of others. Empathy does not make us the victim of suffering; it allows us to see and share the suffering of others from a loving, rational and ethical perspective, without succumbing to it. That is one of the most essential ingredients of being a healer – approaching those we help from an empathic, loving perspective that welcomes their pain without becoming afflicted by it. This is a large part of what he calls a ‘healing presence.’

Let me complete this introduction with a citation from a recent article by Kearney and Weiniger (2011):

> *“To live as a wounded healer necessitates a high degree of self-knowledge on the part of the clinician. We need to know ourselves well enough to recognize that we have reached that place of powerlessness, to prevent ourselves reacting impulsively, and to consciously respond in the most appropriate way, including the possibility of calling ‘time out’, or choosing to remain compassionately present without acting, despite possibly painful feelings of failure and impotence. For the clinician, the rewards of the path of the wounded healer include finding healing and meaning within his or her empathic connection with patients.”*
> (p. 115)

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Chapter 2

The wounded healer in literature

Arnold Weinstein

The contemporary hullaballoo – if not breakthrough – about 'narrative medicine' as viable and needed construct in medical thinking, and about 'pathography' – the 'story' of one's illness now seen as a means of control over it – as valuable construct for patients' self-understanding, betokens a new discourse and a new kind of authority in assessing medical matters, an authority ascribed to both language and storytelling, hence an authority that stems crucially from a logic other than that of the bio-sciences. *Stories* seem to be moving to the forefront of things: stories about illness, stories about healing, stories about healers. What, however, is to be said – has been said – of the *wounded healer*? What kinds of doctor-stories do we have, where injury might be understood not only as inevitable somatic feature of doctoring, but also – most significantly – as arguable source of strength and insight? How, in particular, does the wounded healer appear in *literature*?

To begin to answer this knotty question, it is worth considering just how 'recent' our contemporary view of doctors as 'intact' and all-powerful actually is. The oldest roots of medicine are located in shamanism, and the more-than-verbal link between doctors and witch-doctors – certain to raise hackles in the profession – is perhaps not as prehistoric as we'd like to think. Surely, older cultures – indeed highly civilized older cultures – often enough regarded doctors as charlatans, as Latin-spouting con-men who were invariably good for a laugh, but rarely successful in ministering to the human body. Here is where the testimony of literature can be tonic. Consider, for a moment, the plays of Molière: following the archetypes of the Commedia del Arte, he succeeds in spoofing medical men in play after play, including in his masterpiece on psychosomatic illness, *Le Malade imaginaire* (1679). (It is instructive, nonetheless, to recall that the aging and sick Molière himself played the hypochondriac Argan on stage, and famously died after one of the performances.) Satire gets you laughs, but it doesn't get you well. Just where do we find representations of poised and successful physicians, confident professionals in white coats who enjoy social prominence, who have heft? The literary reply is: not in many places, not in older texts, and not memorable.

What is memorable is the more problematic view that doctors are as wounded and needy as the people they treat. As far back as Greek tragedy there was a prescient awareness that the healing was the province of the gods, not of mortals. It is no accident that Oedipus is imaged by Sophocles as the *doctor* whom Thebes is calling upon to cure them of the devastating plague killing everyone and everything in sight. We know all too well how ironic the doctor-label turns out to be, since Oedipus is himself the source of the miasma, the rot that is waylaying the kingdom. Kings, in earlier myths, were often regarded as sacrificial figures whose fate hinged on the wellbeing of the populace. Illness itself was a trope for figuring political and moral disorder, as is so visible in Shakespeare's famous line, "*Something is rotten in the state of Denmark*" (Shakespeare, 1992, I, iv, 90), given that Claudius's transgression (murder of his brother, marriage with his sister-in-law) is repeatedly imaged as societal pestilence. Even Hamlet makes use of an orthopedic metaphor when he claims that the "*time is out of joint*" (Shakespeare, 1992, I, v, 187) for him ever to set things right. The 'body politic' seems scarcely a metaphor.

Let me segue backwards once more, to the New Testament this time: Jesus is not infrequently imaged as physician – great crowds came to him, bringing with them 'the lame, the maimed, the blind, the dumb, and many others' – and he *healed* them: the lame walked, the maimed were whole, the dumb spoke and the blind saw. Surely this power is spiritual not 'medical' in any scientific sense, yet I'd also argue that Jesus is not without what theorists term 'the diagnostic gaze.' Christian teachings invariably link the spiritual and the diagnostic – think of *Corinthians 13* and its parable of 'seeing through a glass darkly' – and we would do well to bear in mind how ambiguous such a vision is: it can speak to our [the patient's] greatest longing (to be seen through, to be 'understood'), but it can function as invasion, as take-over, as unwanted and unpreventable violation. Many literary texts highlight this destructive power of doctors: one thinks of the doctor Chillingsworth in Hawthorne's *Scarlet Letter* (1850) whose diagnostic vision seems to eat through the very flesh of the man he studies. (It has been argued that Hawthorne took his cues from the then new science of auscultation and stethoscopes.) The story of the prying invader who sees 'through' you is scarcely limited to the medical field itself, but I think it is purring behind the scene in modern medicine – even if anonymously 'technologized' in today's scientific culture of imaging – and the warnings we know about, concerning excessive radiation, are of a piece with still older warnings of being penetrated, being made visible and legible.

Being penetrated: Jesus-as-doctor bears thinking about in just that light. At the risk of being sensationalist, I'd suggest that his dismembering at the Cross has uncanny (and unwanted) parallels with his diagnostic acumen. Doctors open you up. Anyone who knows Hogarth's brilliant series of engravings, *The Four Stages of Cruelty*, will remember that this allegory of 'evil' is decidedly scientific – indeed medical – in character, as we move from the prying eyes and actions of sadistic children to a final scene at the Royal College of Physicians where the villain, Tom Nero, is a living corpse in the process of being dissected (surrounded by reading, laughing and chatting doctors). Literature is chock-full of bullying doctors: one thinks of Büchner's sadistic physician in his play, *Woyzeck*, of the 1830s, where the doctor outright tortures the poor patient, uses him as scientific experiment for the edification of his students. Büchner himself was a (brilliant) doctor, so I see no bias as such in his caricatural story, but rather a grave warning about the very make-up of doctoring. Or, in a different vein, there is the well-meaning but no less domineering figure of the doctor-husband in Charlotte Perkins Gilman's nightmarish tale, *The Yellow Wallpaper* (1892), in which the female protagonist, subjected to the famous 'rest cure' that was the fashionable response to 'hysteria' in 19th century thinking, becomes visionary/insane in her espial of 'sisters' crawling in the yellow wallpaper of her carceral bedroom. My point in emphasizing the penetrative *power* of doctors is to add some resonance to our term 'the wounded healer'; *healer* has a serene, almost cosy valence, but doctoring is a power-laden activity, and we shall see that stories about injured doctors invariably refer as well to the authority and 'potency' of physicians.

But we also know that many doctors are distressingly without power. 19th century literature offers us as well a number of portraits of impaired doctors, doctors limited in their work, either personally or societally. George Eliot's *Middlemarch* (1874) presents a complex and disturbing portrait of an idealistic and ambitious doctor – Tertius Lydgate – who fails quite significantly in his work. Lydgate comes from a good family, so already the choice to be a doctor is socially damning: physicians ranked very low in terms of prestige in 1830s Britain (when the story takes place). Worse yet, Lydgate's stirring professional agenda – he wants essentially to revolutionize the medical thinking of his time by rethinking signs and symptoms along strictly scientific lines – is a flop: he makes essentially the wrong marriage, he fails to gauge public sentiment, he is unequal to the task. By book's end, he is mired down.

Let me, however, contrast Lydgate with Flaubert's Charles Bovary (country physician in *Madame Bovary* [1857]), and Eliot's doctor looks like a giant. Flaubert's merciless clinical gaze fastens onto the low-profiled, ungainly, hapless country practitioner who manages (catastrophically, it will be seen) to marry the love-starved Emma Bovary. Charles is a decent man with good intentions. He devotedly serves his rural community – communities, in fact, since he moves slightly upward, as the plot progresses – but he is fatefully pushed by the ambitions of his wife to undertake a surgical procedure for which he is woefully unprepared: to 'correct' the club-foot of the sweet young boy Hippolyte (who idolizes Emma). This literary presentation of a botched procedure has got to rank high among (bookish) surgeons' nightmares: the foot swells dreadfully, infection rages, gangrene sets in. At this juncture, the eminent Docteur Larrivet is called in: he immediately sizes up the situation, amputates the foot, and effectively rescues the image of physicians; readers and critics have long felt that Larrivet epitomizes a kind of scientific prestige and dignity that Flaubert deeply respected – it is not for nothing that Flaubert himself is the son and brother of successful doctors – but Larrivet's prowess cannot make us forget the bumbling performance of Charles Bovary. And the limping Hippolyte (outfitted with prosthesis, no less) virtually punctuates the narrative and serves as a constant reminder of the gap between medical ideals and human ineptitude.

Let me close this brief look at stumbling doctors by commenting on Proust's Docteur Cottard. Proust's long opus, *A la recherché du temps perdu* (1913-1927), has room in it for many different kinds of snapshots, and Cottard is seen in distinctly different venues: as a clumsy social figure in the Verdurin *soirées*, as pretentious yet rather likeable figure in his many encounters with the narrator, and as fairly remarkable diagnostician and physician in the long, almost unbearable account of the grandmother's stroke, illness and gradual dying. The bumbling doctor, on whom the text has shown more than a little contempt, rises to the challenge in confronting the old lady's symptoms and distress. Proust refers to him in military terms, as field commander in a battle who must size up his assets, examine lucidly his risks, and ultimately decide when and how to take action. Cottard knows – this is early 20th century France, don't forget – that his toolkit is not only limited, but that each remedy he proposes comes with a price tag. We see this most vividly as the grandmother – Proust's most loveable and refined character in the entire text – desperately seeks to retain her 'personhood' in the wake of each of Cottard's interventions: at one juncture she is blinded, at another deaf, and we watch her seek to offset these deficits, to conceal her real state from the loving family members who witness her rapid decline. Cottard cannot save her – no one could – but one emerges from these pages with a higher respect for this man's limited but real competence as striving helper of last resort.

With these examples in place, we are perhaps ready to take a closer look at a number of 20th century literary renditions of wounded healers. These stories – from the Swedish writer Hjalmar Söderberg, from Franz Kafka, from F. Scott Fitzgerald, from Richard Selzer and from Pat Barker – differ in tone and meaning, yet each, I believe, illustrates the profound ambiguity of our topic: *the doctor as at once powerful and wounded*; and each raises the thorny, perhaps unanswerable question of what 'healing' actually signifies.

Söderberg's (all too unknown) masterpiece, *Doctor Glas*, was published 1905. This is hard to believe. This story of a fin-de-siècle middle-aged Swedish doctor's complex affairs – he falls in love with one of his patients, he ends up murdering her husband (who happens to be a pastor) – is, beyond even the sensationalist plot I've just sketched, larded with some of medicine's most intractable topics, such as abortion and euthanasia. Glas tells us straight-out that the *only* reason he refuses to perform abortions (and he is often beseeched to do so) is his fear of scandal; morally speaking, they do not bother him in the least. Yet, in this arena, as in much else, he plays by social rules he does not believe in. (The book is in the form of a journal, so we have access to his immediate thoughts and musings.) Euthanasia – or physician-aided suicide – he regards as a self-evident moral necessity for any enlightened democratic society, and confidently prophesies that soon all cultures will share in this view. (This makes for interesting reading a century later.) Ahead of his time, you might say.

Glas is, although he never quite says it, a disciple of Nietzsche. His view of the doctor's role in society is at once noble, revolutionary and criminal: the doctor's task is to cut away the rot in society, to cauterize culture's wounds. We are far from Hippocrates's injunction to do no harm. Yet, as I said, he is also complex. For instance, he is, although over 30, still a virgin. And we come to understand that his view of sexuality is at once idealistic, uneasy and slightly disgusted. Why, he asks, should the same organ serve to excrete waste and provide exquisite pleasure? Why, he asks, couldn't the sexual consummation of love be something that takes place in a church with friends and family looking on? Finally, we gather that this man, far from being an *Übermensch*, can experience desire only for impossible women. Hence, he is drawn, emotionally and sexually, towards his patient Helga

Gregorius, but the attraction seems to require not merely that she be 'unavailable,' but that she in fact be in love with another man than her husband. And her husband? He is the thick, gross, pious-yet-hypocritical Pastor Gregorius.

Helga has come to Doctor Glas precisely to seek his help in preventing her ogre-like husband from continued sexual congress with her. Glas senses immediately that her request is somehow 'right,' that this boor should not be mating with this lovely young woman, but how can he do anything to help? Here is where the doctor's power comes in: he can warn Gregorious that sexual activity with Helga is injurious to her health (a lie). He does that; it works only for a few days, and Gregorius is back to his habits. Glas then takes the next step: having sex with Helga is now coded as injurious to *his* – Gregorius's – health (a second lie). This solution is also of short duration; Gregorius cannot refrain from his 'rights.' What remains? Obviously – obviously to a man such as Glas – Gregorius must be stopped … so … Glas decides quite simply to murder him. My account of these matters has left out the quite real libidinal attraction Glas feels for Helga (unreciprocated, of course): he dreams of her naked body beckoning him, he dreams of her assisting his murder of her husband. One begins to realize that this short novel has an allegorical cast to it: it stages the war between doctor and pastor, and it seems crucial to recognize that war for what it is: the doctor in modern society (1905) has effectively replaced the pastor as guide, gate-keeper and power-magnate. Welcome to modernity.

On the other hand, Glas is woefully ill-equipped for his Nietzschean task. He is sexually anxious, he knows that Helga will never be his, he is beset with uncertainties, he fears what nightmares may come if he takes this fateful next (homicidal) step. It is worth mentioning that he is *not* worried about being caught; he has a handy supply of cyanide pills available, if the forces of order catch him. Guilt as such? Not at all. And, lo and behold, he does murder the clergyman. Right out in the open, in one of Stockholm's most charming squares, by slipping a bit of poison in the parson's seltzer water, yet doing so 'openly,' by calling the pill a new German medication that he (Glas) has been trying, and that the pastor will doubtless benefit from. Pastor takes pill, falls out of chair, dies. Nearby waiter confirms an 'accident.' Neatly done. And yet, no happiness will come from this. Helga is pregnant; her lover will abandon her; Glas will not only remain unmarried and uncaught, but he seems to be emptied out entirely by his deed, dried out, en route for further desiccation and entropy. The ending is autumnal. Snow is beginning to fall; we are moving toward the dark.

Söderberg's depiction of Glas is not likely to give much pleasure to physician-readers. I know that. Yet, this book deserves a wider readership because it insistently tells us a nasty little secret about medicine: doctors tend to bodies, doctors have bodies. In this story we realize that Glas's own manifold problems – an unhappy childhood, a tragic early love cut short, a capacity for profound self-contempt that matches his Nietzschean desire for action, a delicate and spiritual view of love that is incompatible with the baser elements of sexuality itself – bear entirely on his professional behavior. He has, it would seem, kept all this at bay until NOW, but in his professional encounter with Helga Gregorius (and, indeed, with her husband the pastor), the whole pot boils over, and we see this doctor utterly mired in his own mess. Not that he is ever uncontrolled or emotional or violent (he is too elegant, too repressed for that, too damn civilized). Outwardly speaking, he would conform beautifully to the ideal of 'equanimitas' that Osler prescribed as the physician's chief virtue. But the story, as the journal-form makes all too clear, is nonetheless one of a ticking bomb, and Söderberg helps us to see just how much awesome *power* even the most wounded doctor can wield over the lives of others, in ways that are entirely sanctioned by society.

My next literary exhibit is my most drastic: Franz Kafka's 5-page story, 'A Country Doctor' (1919). If Charles Bovary was a hard-working country doc, his travails pale considerably when compared to those of Kafka's practitioner. The plot seems simple: doctor needs to get to sick child some 10 miles away; but there is a problem: his horse died the night before, so no wheels. (This is horse-and-buggy time, beginning of 20th century, also a time of house-calls.) Yet the problem is magically solved: standing in front of his 'empty' pig-style, the doctor (accompanied by his maid Rosa) witnesses the emergence of two powerful horses 'buttocking' their way out; they are followed by an animal-like groom who crawls out on all-fours. Rosa's reaction to all this is arguably the most memorable line in the story: '*You never know what you are going to find [available] in your own house*' (Kafka, 1971, p. 221) Yes, indeed. In fact it seems like a pact of sorts; the two magic horses will indeed take the doctor to the sick patient, but there is a price to be paid: the groom plants his teeth into Rosa's cheek, and it is crystal-clear (to the doctor who outright visualizes it) that he (the groom) will break the walls of the house in order to rape Rosa. Tit for tat.

Off to the patient! Doctor arrives in seconds, it seems. Enters the house, sees the family standing around the bed of the sick child, looks at the child, looks then at his instrument bag, thinks about what is happening 'back home,' and sizes up the child's condition: he's not sick at all. This causes the doctor to ponder the vagaries and hardships of his profession, causing him to reflect that it is easy to write prescriptions but hard to come to an understanding, not to mention the sacrifice (of Rosa) that has been made. Just how hard it is, just how real the sacrifice is, is about to be shown, for the doctor now notices that the boy's sister is holding a blood-soaked towel, which prompts a second look at the patient. He is stunned by what he sees: a huge wound. Let me cite Kafka:

> *"In his right side, near the hip, was an open wound as big as the palm of my hand. Rose-red, in many variations of shade, dark in the hollows, lighter at the edges, softly granulated, with irregular clots of blood, open as a surface mine to the daylight. That was how it looked from a distance. But on closer inspection there was another complication. I could not help a low whistle of surprise. Worms, as thick and as long as my little finger, themselves rose-red and blood-spotted as well, were wriggling from their fastness in the interior of the wound toward the light, with small white heads and many little legs"* (Kafka, 1971, p.223).

You never know what you're going to find … What kind of wound is this? Was it even there when the doctor first looked? It is at this point – if not earlier – that the reader fully understands just how treacherous the terrain of this narrative is, just how slippery its words are. Even though I've been told by doctors that such a worm-filled wound is indeed possible, it seems clear that we're dealing with some kind of psychological projection or symbolic utterance. But of what?

Before answering that question, let me quickly summarize the remainder of the tale, since – believe it or not – it actually goes downhill from there. Doctor realizes there is nothing to be done about this wound – a "*blossom in your side*" (Kafka, 1971, p. 223) is how he characterizes it to the child himself – but now the family (and the villagers who are somehow in the room as well; even the horses have thrust their heads into the windows to witness events) play out their little role: they disrobe the doctor, singing an old chant about sacrificing doctors when they fail, and he is made to lie down naked on the bed with his patient. There is the tiniest uptick at the end, as doctor crawls out of bed, looks for his clothes, manages to get to the buggy, finds the horses 'spent,' is stuck in the wintry wilds, bemoans the end of his career (and again the rape of Rosa); and story is over.

Wounded healers is our rubric. Kafka's tale explodes with information about doctors and wounds; or, I should say, it *implodes*. For we can scarcely avoid seeing that the wound itself is somehow related to Rosa (and her fate), given the twice repeated term 'rose-red' for describing the wound. Hence we are led to consider that the boy-with-a-hole just might be a projection of the woman-being-raped. And the worms would appear to convey a measure of sexual repulsion. But we might consider, further, that the animal-like groom who appears out of nowhere just could be the animal-side of the doctor, doing what the doctor has wanted to do. All of these speculations – interpretation of literature can never be more than speculation, unlike scientific analysis – make it tolerably obvious that the wound at the centre of the story is as much the doctor's as the patient's, inasmuch as it seems to stem from the doctor's own libidinal make-up and dilemma. The tale seems outright oneiric, and if it were being told by someone lying on a couch to a psychiatrist, we'd have little trouble seeing its inner logic. Just a dream, we might say. Yet, Shakespeare had it right when he claimed that we are the stuff dreams are made of. Literature as a discourse foregrounds the subjective pulsions that course through all minds, and it thus differs entirely from anything one might term 'empirical evidence.' What might its value be?

My interest in enlisting Kafka's surreal tale has nothing to do with humiliating doctors, although it might read that way. Instead, I'd argue that there is something salutary about this story, and that it possesses a severe logic on the far side of its grisly plot. Let's leave the issue of this doctor's private problems (so much on show) and consider the matter more generically: it shows us a doctor who has lost what doctors most prize: *control* and *authority*. Note that this doctor initiates nothing; he follows, helplessly, the unfurling events: the magic horses, the wound, etc. Life differs from the laboratory in precisely this way. But that is not all. I see something deeply arresting and significant in the spectacle of a doctor lying naked on the bed with his patient. Is Kafka telling us that this is perhaps the only way to understand the wound? Shakespeare reminded us in *Lear* that we are all 'bare fork'd creatures,' and Kafka has taken that creatural logic to the crisis-point where he often takes his stories: metamorphosis. For we cannot fail to see that the story is indeed about *house-calls*: in all senses of the term: the surprising things you are likely to find in your own house, but also the central encounter at the core of medicine itself. Kafka's sepia-story of horse-and-buggy is also ours. No amount of modern technological know-how and shiny medical settings will quite remove this existential meeting which is medicine's *raison d'être*: doctor meets patient. In this hallucinatory narrative, it goes one step further: doctor becomes patient.

As indeed he does in my next installment as well: Fitzgerald's *Tender is the Night* (1934). This long, intricate novel cannot be adequately assessed in a few paragraphs, and its dark tonality leaves few readers with much sense of uplift. Further, Dick Diver, the protagonist whose arc from glittery success to increasing decline and finally complete erasure, has not always been thought credible as doctor. But doctor he is, nonetheless, and brilliant doctor at that: graduate of Hopkins and Yale, positioned the one-to-succeed Freud, Diver is at the apex of his career (in a Swiss psychiatric institute) when he makes the life-altering decision to marry his sick (rich) patient Nicole Warren. Nicole suffers from depression and hallucinations about male attackers, and we soon enough discover the origins of her disorder: an incestuous liaison with her powerful father, not long after the death of her mother. Fitzgerald manages to convey at once the sordid and the beautiful in this relationship: the Warrens see Dick as a prime purchase, a permanent 'in-house' doctor for Nicole, but we also see the tenderness and poetry of their love (nurturing and generous on his side, idolizing and needy on hers). Dick is warned by his Swiss colleague that it cannot end well, and it doesn't. Dick soon enough gives up his practice, in order to be the lynchpin of a dazzling group of moneyed Americans playing and partying on the French Riviera (which is how the reader first encounters Dick).

The reason the novel belongs in this discussion is that Fitzgerald is at great pains to take his incest/injury theme and run with it, so much so that we watch a very strange type of inversion gradually but inexorably take place: Nicole grows stronger and stronger, gradually moving past her earlier lapses into hysteria, whereas Dick moves from confident social animal and lady's man to alcoholic to even worse. The book codes Dick's descent in terms of 'blackness': black heart, black drink, Black Death. One of the most nightmarish episodes entails Dick in Rome, drinking heavily, becoming ever more vulgar, getting beaten up, being suspected even of having raped and slain a five-year old child; the reader 'knows' this charge is false, yet when Dick is pulled away from the angry Italian crowd, he resists: " *'I want to make a speech,' Dick cried. 'I want to explain to these people how I raped a five-year-old girl. Maybe I did --.*" (Fitzgerald, 1962, p. 235). Literally wrong and incredible, yet symbolically on-the-money: the story of the doctor marrying his sick patient now a horror story, written as displaced repetition of the very abuses and sexual violation that made her psychotic in the first place. The novel closes with Nicole moving on to another, tougher lover while Dick, banished, exits the scene, retreats back to an obscure rural practice in upstate New York, and literally shrinks to a vanishing point. Undone.

I am unable to derive from Fitzgerald's novel any kind of useful wisdom, but I do see it as a heart-breaking story of vulnerability and alteration. I claimed that Kafka's austere fable tells us of metamorphosis. *Tender is the Night* is no less luminous about the strange figure we cut over a lifetime; the way fate reshapes our designs to its own sometimes horrid ends. And I believe it whispers something unwelcome to us, regarding our belief in professional values: namely that the heart can undo us, not along cardiac lines, but according to its sheer emotional dictates. Look one last time at Dick Diver's liabilities: love, alcohol, vanity, human weakness. Is there any life where these do not loom large?

I want, in my two final discussions, to consider more frontally the thesis that doctoring itself is what wounds healers. And that perhaps this is as it should be. Let me begin with Richard Selzer's haunting story, 'Imelda,' published in 1982. Selzer is among the most fascinating doctor/writers of our time. As a child he was torn between medicine and writing, but when his father – a doctor – died during the boy's teens, the child knew that the decision was made, that he had to do medicine. And he did, leading to a distinguished career culminating as surgeon at Yale Medical School, when he finally realized that he could not say No to writing either; and from that second decision came the remarkable spate of stories about the costs, vistas and rewards of doctoring. 'Imelda' is narrated from the perspective of Selzer-as-medical student, and it focuses on the career of Hugh Franciscus, respected, aloof, brilliant cosmetic surgeon-as-*Übermensch*. And, as we have seen in each story I've discussed, the moment of truth comes where it always comes: in the encounter with a patient.

The patient is Imelda. The place is Honduras. The occasion is the yearly stint undertaken by Franciscus with a team of medical students, to do charity work. The inexperienced Selzer is asked to come because he speaks Spanish and can serve as interpreter. This he does. Yet, as is true of all fine art, the task of interpretation is passed on, live, to readers who must make sense of this riddling tale. The child Imelda, severely deformed by cleft lip and cleft palate, is to be 'made over,' and the surgeon painstakingly maps out (in advance) her face, like an exercise in geometry, but then at operating time, disaster strikes: she dies of malignant hypothermia while being prepped for the procedure. The operation could not take place. Yet, the next day, Selzer is stunned by Imelda's mother's reaction that even though the child died, she went to heaven restored to her beauty. How can this be? Then Selzer imagines the unimaginable (and impermissible): that Franciscus went down into the very bowels of the old building where Imelda's (still disfigured) corpse lay, and that he proceeded to operate on her by candlelight, dead though she was, as if to carry out his end of the contract no matter what. At story's close, Selzer is operating the slide projector for displaying to an audience the before-after photos taken from the Honduras mission, and he then comes upon the before-image of Imelda; he looks intently at the face of the inscrutable Franciscus, and elects to move the slide out of the projector. There seems to be an unarticulated mutual consent on the part of surgeon and student. The final words of the story inform us that the case of Imelda was a turning point in Franciscus's life and career, that he cut back (as it were) on surgery, did less and less of it, gradually withdrew, finally retired. Too much blood, too much cutting, the medical student reasons.

Critics have seen in the story a rebuke to the surgeon. He over-reached, it is claimed, by operating on the dead child; it was a breach of medical ethics. All this is true. Still truer, perhaps, is the deeper rebuke concerning surgery itself, concerning the entire medical project of altering bodies. Perhaps nature will not allow it. Perhaps even the world-class scalpel-wielder comes to find that he cannot forever reshape flesh to his design. And perhaps Imelda was an inevitable waystation for Franciscus, indeed for the young Selzer himself. Not that one should put away one's instruments and retire, but that one should sense one's limits, that a lifetime of cutting flesh must at some point cease, because one will have reached one's fill, have come to see one's own interventions as arriving at their end. Time to stop. All careers, including those of literary critics, have their internal clocks, I am inclined to believe. But surgery is arguably the most Faustian of medical projects, the one where one bids, over and over, to repair nature, to refashion her. How long can it be done? How long should it be done?

Let me close this essay by discussing a hybrid text, Pat Barker's novel, *Regeneration* (1991, first narrative of a trilogy), which approaches documentary fiction by revisiting the real life and career of W.H.R. Rivers, distinguished anthropologist and neurologist, during his stint at Craiglockhart Hospital in Scotland in the last years of the Great War. Barker's book is based on considerable archival research: not only is Rivers fully and richly present, but so too are other major medical and intellectual figures, including Louis Yealland, Robert Graves, Bertrand Russell, and of course the two 'star' patients (from our perspective) at Craiglockhart: Wilfred Owen and Siegfried Sassoon, great 'war poets' each. To this mix, Barker adds her own remarkable group of figures, most notably Billy Prior (bisexual, feisty, officer yet from modest background, initially mute because of major trauma, destined to be the leading protagonist of the trilogy itself), Sarah Lump (saucy, straight-talking, 'of the people,' doing work in munitions, drawn to Prior), but also including a spectrum of 'shell-shocked' officers who've been sent from the trenches in France to the hospital in Scotland so that they can be 'cured' by the gentle and fatherly Rivers. And then sent back, if the medical-military judgment so deems.

Barker's book seems especially suggestive to me, if we think back to *Tender is the Night*, because each has a distinct Freudian coloration, the early book because Freud and psychoanalysis themselves were so much in the air in the 20's, and the latter book as historical recreation on Barker's part. Rivers is not a card-carrying Freudian, but his major therapeutic principles enshrine much that is familiar: to work with these traumatized officers in such a way that they can move past their current array of decimating symptoms: nightmares, paralysis, hallucinations, muteness, and the like. Often enough, this entails making one's way back to the scene of the crime. The book doesn't pull its punches, in depicting these psychic injuries, along with their causes. Willard, for instance, is utterly persuaded he cannot walk, even though his spine is entirely intact; no amount of 'talk' will convince him otherwise. More disturbing still is the case of Anderson who now vomits at the sight of blood; I call this especially disturbing because Anderson is a doctor, and hence his impairment cuts deep. But most unforgettable, in my view, is young Burns whose injury is described in this way:

> *"He'd been thrown into the air by the explosion of a shell and had landed, head-first, on a German corpse, whose gas-filled belly had ruptured on impact. Before Burns lost consciousness, he'd had time to realize that what filled his nose and mouth was decomposing human flesh."* (Barker, 1993, p. 19)

Against a real-life backdrop of this sort, Kafka's tale of a wound with worms in it seems less fanciful and exaggerated. The hospital is packed to the gills with damaged people who are each agonizing over the fate that awaits them: continued hospitalization and derangement? Being found sufficiently intact to be sent back to France? Rivers is the man who ministers to this suffering population, and we clearly see that he serves as a father to them, because he *listens*, because his is the very voice of sweet and tender reason, and ultimately because he *cares*. The moral core of the novel, in my view, consists of Rivers the doctor ever deepening his own diagnosis of what is happening, and has happened. One installment in this education concerns Burns whom Rivers visits at his family home and whom Rivers now sees with ever more clarity as permanently impaired, how even the marshland setting of his home causes him to re-enact the horror of the gas-filled trenches, to collapse. Seeing this up close, beyond hospital walls, Rivers then asks the ultimate question: what can justify suffering and injury of this stripe?

That question has to be what Barker most wanted to emphasize in her account of these shell-shocked victims and their kind doctor. Her strategy for shedding maximum light on this moral quandary is to focus at length on two of Rivers's most complicated and recalcitrant patients: Siegfried Sassoon and Billy Prior. Sassoon is of course the famous figure who wrote and published his Declaration against the War as senseless slaughter, and whose presence at Craiglockhart is riddled with ideological as well as medical challenges. He is a man of great presence and integrity, but he is prey to visions of the dead who visit him regularly, and much of his poetry gives voice to these living ghosts who will not die, who will not be silenced about the carnage they encountered and incorporate. He and Rivers are both gnawed by the impending decision that must be made: either claim that Sassoon is mentally deranged (and thereby take all the force out of his Declaration) or determine that he is still capable of returning to duty (which would allow the Declaration to stand, but enable Sassoon himself to be redeemed (in his own eyes, as well as those of official Britain, for Sassoon is a 'natural' warrior, much adored by his men). This is an either/or that both parties recognize as hideous, distorting and coercive.

And then there is the elusive, feisty, steely, and often hilarious Billy Prior, the consumptive commoner-who-became-officer (and thereby became a class-traitor in the eyes of his bullying father), the man who, in his conversations with Rivers, deconstructs a great deal of war-myth and soldiering. Those conversations follow a bout of hypnosis ministered to Prior by Rivers, enabling the young officer to re-experience the founding trauma that made him mute and got him sent back home to be hospitalized. It is a stunning literary moment, reminiscent of Faulknerian 'recreation' of the past, but now medicalized, and it allows Prior to relive the horror: the mortar explosion that ripped apart his two men was a site of such chaos and destruction that officer Prior, reaching into the mess of limbs and blood and tissue, pulled out of it an *eye*, and that eye was too much; he crashed; speech disappeared; he was shipped off. But now, finally seeing (via hypnosis) what actually transpired, Prior is *relieved* to find that at least he himself did not fault. (We are meant to see that it is the old Kipling code still in place.) And, with that reassurance, he can begin the work of moving on.

I think the novel wants us to be forever under the gaze of the eye that Prior held in his hands. Prior himself makes progress, and he goes a far piece in conveying to Rivers the class warfare that is routine in the army, the quasi-systematic ordering of British foot-soldiers to serve as human fodder for the German mortars. Barker also has a significant gender card to play here: life-in-the-trenches, we come to see, is the utter reversal of all Kiplingesque heroic views of warfare; on the contrary, it is utter confinement (such as women have been subjected to, forever), and it leads inexorably to *breakdown*, to tears and collapse (also coded forever as feminine behavior). In short, an entire masculine Gestalt is being decimated in this war, and Rivers begins to realize that his job consists, in part, in helping this young injured officer to accept the soft, vulnerable and emotive side of themselves, to see that this is humanity, not weakness.

Where is the wounded healer in all this? You may ask. I want to propose two answers to that question, which will perhaps serve as a conclusion to this entire essay. First of all, Rivers is an older man under remarkable stress and strain in his role as military doctor. We note that he seems increasingly vulnerable to somatic disorders as the book – and its parade of damaged victims – progresses: he sleeps poorly, he has chills and fever, he has major chest pain, he is ordered to go on leave for rest. One can of course regard this as routine for overworked doctors, but I think Barker wants us to go further. In some hard-to-prove fashion, Rivers is catching the diseases of his patients; he is suffering, in his own way, their disorders. This is hard to prove but the novel is deeply invested in issues of *expression*, and Rivers's ailments express his growing understanding of the nature of the illnesses he is dealing with at Craiglockhart. It is not for nothing that Rivers has a significant *stutter*, and it is Prior who points out to the gentle doctor that his stuttering is a form of somatic boycott, that his stuttering is proof that his body wants to say something that his will cannot sanction. Freudian analysis? Be that as it may, we are to learn that Rivers himself came from a stern family – his father was both a man of the cloth and also a speech therapist – and Rivers's lifelong problems with stuttering have everything to do with issues of authority. One begins to see just how resonant these matters are, when one factors in Rivers's own beloved fatherly role in the hospital. What might he be repressing? The novel is obsessed with symptomology, with the translation of power into body language.

But it goes still further. In one important episode, Rivers, musing over the brutal price of this Great War, examines the stain-glass window in his own village church, and he is struck by the horrible eloquence of the Biblical story it presents: Abraham's willingness to sacrifice his son Isaac. Rivers then comes to a chilling perception: fathers sacrificing sons is the oldest covenant in culture, and it is still playing, as the old men of British Parliament send out the young in droves to be sacrificed in trenches in France. Something very large is coming into visibility. The doctor realizes ever more clearly his own role in these power arrangements. In one of the most hallucinatory moments of the novel, he has a nightmarish vision of himself forcing a horse's bit into the mouths of his patients (as was done to 'uppity' slaves in the American South), performing a kind of violent oral rape on them. Now we readers know that the tender Rivers treats his patients with utmost gentleness – we've seen it on page after page – yet the hallucinatory image has its awful truth: the job of this doctor is precisely to heal his patients exactly enough to send them back to France. He, Rivers, is inextricably part of the machinery of slaughter whose price-tag is on exhibit every day in all the corridors of Craiglockhart. The entire chorus of wounded and 'stuttering' bodies is moving towards utterance. And it is damning.

The wounded healer? W.H.R. Rivers stands for most of us as a hero. His own patients invariably see him exactly that way. But Pat Barker's sights go beyond physician-kindness, so as to illuminate the wider socio-ethical arena where medicine exists, and where both sickness and healing take on their broader meanings. Rivers has come to the fateful understanding of his complicity in a system-wide regime of rot and disease, and that his healing efforts are a cog in the machine. (Something is rotten in the state of England?) I do not think that Barker intends anything programmatic all. No one expects the distinguished neurologist-anthropologist to go on the barricades or to exit Britain. (Documentary evidence shows he didn't. But can documentary evidence show what he felt?) Hence, we are nonetheless left with an almost intolerably wide view of the doctor's responsibilities: wide because the novelist has pushed the customary boundaries of patient-care beyond the individualist-frame we're accustomed to, and has shown us that medicine, like all other human and professional endeavors, is inscribed within still larger parameters of human meaning and action, well beyond anything ever taught or dreamed of in medical school. The *wounded healer* may well express the tensions and conflicts of an entire Age. At its best, I believe that literature helps us towards perceptions of this scale.

How, it may well be asked, does this survey of literature's portrayal of wounded healers help any of us: you, me, readers to come? In the spirit of this volume devoted to the difficult question of wounds' *legacy*, wounds' impact on our future work and lives, let me say that the sometimes harsh findings I've discussed here are, in the last analysis, tonic rather than dispiriting. Freud always claimed that the great writers and artists 'got there before he did,' and I'd like to adapt that claim here: Sophocles and Shakespeare and Kafka and Pat Barker chart for us the perhaps truer (if darker) contours of the human spirit. They illuminate, often enough, the Abyss. Reading them scarcely cheers one up, but it does offer us company in our pain, and it helps us towards a more balanced view of our own troubles. Perhaps I can go further: literary depictions of wounded healers may possess a cathartic dimension: they may show us that doctors are human, and that the frailties of both body and mind are part of the human condition (rather than scourges 'visited' upon us by alien forces). We may – may – emerge from such texts, stronger than we were. I will not claim that the writers under discussion here have ever lifted me out of depression or saved my life, but I do believe they've given me a more generous and resilient picture of the human condition. They have expanded my picture of life, and that gift is no less than a powerful medication in itself.

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Chapter 3

BEFORE AND AFTER PSYCHOSIS: IS THERE ANYTHING POSITIVE TO BE GAINED FROM THE EXPERIENCE?

Peter K. Chadwick

Introduction

Experimental psychologists traditionally consider that the qualitative study of subjective experience lies outside the scope of scientific psychology. In my own research field, psychosis, this has led me to think that to obtain an adequate characterisation of psychosis it is necessary to go outside of positivistic, empirical psychology and to also seek artistic and spiritual approaches to knowledge (Chadwick, 2011).

This particularly is acute in psychosis as psychotic patients are known for their extreme subjectivity of thought (Claridge, Pryor & Watkins, 1990, 236-239). Hence narrative approaches (amongst others) have a valuable part to play in achieving anything like adequate understanding (Strauss, 1994).We cannot afford any longer the luxury of ignoring the story from within in the interests of being only objective scientists. Too much material is being wasted in this way. The Man/Machine analogy, after all, empties life of its spiritual content.

The scientific psychologist likes to use instruments to find facts guided by theories. The artist or spiritual quester likes to understand things via what he or she is, guided by feeling. Whilst spirituality is not a structure imposed on the mind but an expression of an integral part of the mind which predates reason. The combination of knowledge and insight from these three endeavours does however cast a wider net which more fully captures the reality of the psychotic experience and recovery from it than does empiricist fact-finding alone.

Artistic techniques such as dramatherapy and playwriting are apposite because, as Oscar Wilde once said, one may discover what one thinks and believes by putting words in *other people's* mouths – and I might add, even if these mouths are those of God and Satan. The music of a person's personality and their spiritual resonance often comes through also in their poetry, if they write, or can be encouraged to write poetry. Group work, prose poetry, painting, clay modelling, dance and song writing are all especially helpful as one can avoid solipsism by sharing experiences and can transform a closed private world into an expressed, communicated and hence public world. Clearly, seeing psychology as a blend of science, art and spirituality multiplies the approaches one feels that it is legitimate to use (Chadwick, 2009).

My own battle as an investigator has been intertwined with my own experience of psychosis (in 1979), an experience which shifted me from cognitive neuroscience to abnormal psychology as a preferred speciality. As I was qualified in psychology before the episode, the shift in mentality that psychosis brought about was reflected in the kind of work I preferred to do once I'd recovered. My previous experience, however, did give me a respect for the biochemical, physiological and cognitive side of psychology whilst my shift in mentality also encouraged me to blend these levels with the benefits to be gained from research at the higher levels of description. In doing this I stretched the meaning of *scientia* to include knowledge-seeking not only of a positivistic kind but of artistic and spiritual kinds (Chadwick, 2001, 2002, 2004).

Sadly one of the limitations of traditional positivistic research on psychosis is that it says little or nothing about what patients actually get out of the psychotic experience to nourish them on the rest of their journey through life. The emphasis is on the more easily measurable and classifiable disorders, deficits and dysfunctions (Gergen, 1990).This makes patients feel that they have no strengths to strengthen further, no positive capacities to utilise, all they are is a mass of biases and errors to be 'corrected'. A valuable counterweight to this, however, is the work of Cordle, Fradgely, Carson et al. (2011) who ask patients to reflect on their psychotic experience and report specifically what they did get out of it to help them and give them hope for the future. This proved a very enlightening exercise in which people reported a spectrum of benefits ranging from no longer seeing money as the most important thing in life to increased humility and consideration for other people to a closer and deeper relationship with God.

Positivism has little interest in spirituality other than to relate such experiences to brain processes – so as to reduce them to 'a thing' or 'a fact', in this case a particular pattern of right hemisphere neural firing (Fenwick, 2010). But if one instead takes the experience itself seriously, one's thinking goes in different directions. Indeed if one becomes more at peace within oneself with reference to the pivotal point or zenith of human experience, whether one calls it 'The Divine', or 'God' or the 'Higher Self' or 'Overself' or whatever, it is likely that this will bring harmony to lower level processes and operations. If one sees the spiritual experience as one of being open to forces from beyond oneself (however one construes this) – actually a Jungian definition – it is clear that such experiences can uplift, and stabilise or indeed disrupt the entire Self. It would be crass not to incorporate the study of them *as experiences* within *scientia*.

Since we have evolved within the cosmos, the brain-mind system is nature precipitated and so it is a microcosm of the universe. Wordsworth used to say that "*the external world is fitted to the mind*". But if indeed the brain-mind system is nature precipitated, on this argument one can hardly be surprised at the belief of Asian culture that knowledge comes from within – as opposed to the attitude of Anglo-American culture which, following Aristotle, sees knowledge eventuating from the observation and measurement of the natural world.

Even within Western culture there is a similar opposition. We have knowledge from 'Being' (Kierkegaard) and knowledge from 'analysing, criticising and measuring' (the Positivists and Refutationists). In the first edition of my text *Schizophrenia – The Positive Perspective* (Chadwick, 1997) I tried to show, however, that one could use both approaches to supplement one another and so to reach firmer and, in a deeper sense, more satisfying conclusions.

Rather than pre-emptive experimentation, the above implies that one also should stand in defence of the single case and the story and insights from within so as to reach more nourishing understanding. This chapter is written in this spirit.

At the present time the *Gold Standard* in positivistic psychopathology research is the meta-analysis. But even meta-analyses only reveal interventions that are helpful 'on average'. Some individualised tailoring of the approach will still be needed and in some instances a rationale that works only on average may have to be dispensed with altogether. On the other hand the more ideographic, artistic avenues available, from re-storying one's life to clay modelling are usually presented in the literature at single case level. Conservative critics usually react to these as being too specific and lacking needed generalisability. However they do present ideas, anecdotes and a potpourri of possible hints, actions and strategies that – in this case – psychosis sufferers can learn from, be inspired by and use.

A number of very recent publications (Basset & Stickley, 2010; Cordle, Fradgely, Carson et al., 2011; Davies, Wakely, Morgan & Carson, 2011) have presented such stories from within at the individual level specifically to give other service users such hints and insights which they can consider in terms of their value to them in their own particular case. In my own work (Chadwick, 1992, 1997, 2009) I have presented a number of biographical sketches of individual people both on the edges of psychosis and who have succumbed to it so as to show how they have coped, prevented pathology worsening and turned their lives into meaningful and fulfilling ones. This clearly is valuable as *scientia* in addition to the endeavour of 'finding facts'.

In the rest of this chapter I will present my own experience of the pre-psychotic, psychotic and post-psychotic states to show the relations between them and also to show how I thus turned my life around after 1979 and moved on to a creative and fulfilling future. In this chapter I touch on the *causes* of my psychosis, something writers on their recovery virtually never do. My approach, however, to my psychosis was that if I could understand how it happened I could make things so that it would never happen again. And it worked. The study of causes helped me to avoid similar factors in the future and showed me my own part in bringing about my crisis. Hence such investigations helped me to take more *responsibility* for my own mental illness and health (Chadwick, 2010a).

Subjective Experience

To what extent is your 'Self' a reflection of what you're really like and to what extent is it a reflection of the social world you grew up in? I found that I could hold back what I was for a time but eventually one just has to be oneself. Rogers, of course, always maintained that continual frustration of the 'Real Self' is what leads to psychopathology but Winnicott (1965) also adduced that the 'False Self' can be a 'Caretaker Self' that one wears until it is safe for the 'Real Self' to emerge.

I remember well that in the old days, before my psychotic illness, I found it virtually impossible to receive love. It was as if I was saying, "*Don't love what I'm not!*". That was the internal sentence beneath all my relationships. My mother had always brought me up to feel that I was "*no good*" and *"never good enough*" in myself as a person. It wasn't a good start for giving and receiving love. I remember that I could be easily infatuated, but underneath it all I knew it wasn't love. Occasionally I would push the feeling of infatuation higher and higher in the hope that eventually it would 'click over' to some other dimension of feeling and I would feel genuine love – but it never happened. There's not much love at high dopaminergic activity levels, just thrills, excitement and infatuation.

This inner vacancy within for relating to people in a loving way was a great source of guilt. I felt that I just *"didn't have something for people*".

The culture in which I was brought up gave me nothing to stimulate what was within and hence my 'Real Self' was starved and paralysed. There was no encouragement of sensitivity or protectiveness feelings, at least in men, no sense of encouragement to be responsive to the gentle things in life. What I was had to remain asleep behind this silly mask of tough, hard-faced masculine pride. Looking back on it, it was all so revolting and sick, I hated being young. My whole 'Self' was deformed into a parody. Probably the nearest diagnosis was schizoid personality. I knew at 13 that something was definitely wrong.

Getting away from home and going to university, at first in Wales, did help. At 20 I started to rebel privately at the mask I'd been forced, or conned into, wearing. It was mixing with women and reading psychology that helped me to do this, even though, at that time, my subject at university was geology. But it seemed to me at that time that my personality was going to have to be self created. My home and home culture environment would give no sustenance to it. All that mattered there was a lantern-jawed hard-facedness. Breaking away from what my mother and home culture demanded I be involved in endless screaming rows. It was horrible. When my mother died in 1971 when I was 25 I was glad to see the back of her. I was glad she was dead. I'd come to hate my mother and everything she stood for.

By the time I was 25 my life was indeed filled with hate. I hated my home town, my school, my home environment, my mother, my local community. I hated and felt hated. The only thing that kept me going was my talent as a research man. At least in that department of life I was being myself. My father had died in 1954 of heart failure when I was seven. It became obvious to me that I was going to have to be my own father as traditional role models for men that were, in a sense, 'on sale' socially at that time were all inappropriate for me.

What I desperately wanted to get away from was machismo. Even my hard-faced mother had encouraged it and so too my father in my very early years. I wasn't homosexual but my sexual orientation was transvestism. It was the one area of my blunt, monochrome life where colour, femininity and the gentle things of life could come through. Psychotherapy I had for it in 1967-'68 had had no effect, I decided instead that *this* was a tiny outcrop of my real personality and needed to be indulged rather than cauterised away as abnormal. I was right.

My psychotherapist had said, in 1967, that my transvestism was 'obviously abnormal' but by 1973 I had come to see it as one of the most precious aspects of my personality and a signpost for where to move next. That year I gave up geology and started a second BSc course in psychology, hoping to get away from the intellectual machismo of earth and physical science. Alas by 1977 I realised that the field I was then in, experimental psychology, was as pervaded by intellectual machismo as anything in the physical sciences. It had been a frying pan to fire transition. By then my working life had shrunk to a straitjacket of logic and rationalism which crippled my liberty and stultified my imagination.

I resigned a university lecturing post in cognition in 1977 and came down to London in 1978 basically to try out new possibilities for my life and mind in which transvestism would not clash. In the end this did work out but the transition period between 1978 and 1982 turned out psychologically to be a 'Perfect Storm' in the middle of which I lost my sanity for a time.

What I was looking for was a broader conception of psychology, not much on sale to the empirical English. I wanted a feeling for detail and individuality and a sense of the momentary – not 'average findings' and the 'We're tough' ideology of physical and behavioural science. The nuance was irrelevant to these people, as it is to a politician, but to me it was the life's blood of the subject.

My mentality was, and had always been, that of what Guilford (1959) would call a cognitive and emotional introvert. Unlike, say, an investment banker, a current affairs reporter, geographer or physical scientist (all cognitive extraverts) I liked to think and feel about things *inside* myself not outside of myself. In geology I had spent years, eleven years in fact, way outside of my comfort zone. But I had found that behavioural science was also pretty cognitively extraverted, it just wasn't my scene – and hurt and deformed my mind.

The psychotic episode, in 1979 when I was 33, had mainly been precipitated by the scorn I had received for my transvestism. But in my delusional madness, in the hot steamy atmosphere of private psychotic thought in the mad hot summer of 1979 I did find a new freedom and suppleness of mind. I was breaking away from the 'extraversion fascism' of English empirical science and English provincial social life and releasing a latent fiction-making ability within. Since the episode I have written over a dozen short stories, something I could never have done with the cramped mentality I had before it.

Paranoid madness is, in its own sick way, exciting and to feel that one is at the centre of a persecutory plot means that one is at least a person of consequence. One has to wonder if these cryptic searches for pleasure and enhanced self esteem are not a camouflage for depression as argued by Zigler and Glick (1988).Underneath all the larger-than-life confusion and bizarrity of it all was a man, myself, who had given up all hope of being good, useful to the world or indeed able to be himself in a positive, valued way. The empirical English had presented me with nothing but Kandinsky's 'Nightmare of Materialism' – and incredibly psychology, supposedly the study of the soul, was eagerly going along with it. After a suicide attempt under the wheels of a double-decker London bus I lay in Casualty and when the local vicar came to see me I wailed to him in despair, 'Is there any HOPE??!' As a cognitively introverted 'soul psychologist' known to the mob as a transvestic pervert I was, surely, a waste of space?

Getting in to psychosis and out again is a life process. I do not believe the latter can ever be pinned down by 'a science of recovery' even if science can help. Designing a new model of a car is a science, running a nuclear power station is a science, but living is not a science and there are very few people who ever want it to be. I was only outrightly psychotic for a couple of months and once the medication went into me I was bounced out of it very quickly and never went back. But the *shock* of the psychosis was something I had to deal with and make sure it never happened again.

I wearied of cross-dressing by September 1980 and met and married a woman who thought it was 'a laugh'. It didn't bother her. This was in stark contrast to the sickenly scornful attitudes of people I had mixed with before the episode. In 1982 I restarted teaching and researching in psychology and embarked on a second PhD at what was then Bedford College. I taught at the Open University, at the City Literary Institute and at Birkbeck College. I changed my specialities away from perception and cognition to personality and abnormal psychology and, teaching adult students, it at last became possible for me to talk about *feelings* at the individual level!

Because I could express my femininity and sensitivity in the work that I did, transvestism was no longer necessary but it had indeed been a signpost to my 'Real Self'. Commensurately I was able to now give and receive love with my wife Jill and we have been happily together now for 30 years.

The medication I eventually was put on (and, to this day, still take) a small dose of haloperidol, reduced my terrible anxiety levels, widened my attentional beam allowing me to make better use of context and gist and helped me regulate my emotions a lot better. Importantly it also helped me a lot to *integrate* thought and feeling better. I no longer have a schizoid personality.

But living is bigger than reason and minds are more concerned with transformation than with adaptation. Now with the worst out of the way and feeling more my Real Self than I ever had before, it was time, at last, and at 35, to *have a life*. Looking back I thank London people for helping me just to be who I organismically am. My life has been like a journey from the South coast to Edinburgh but via New York. My early life set me off on completely the wrong direction and I had to fight my way back from this enormous detour so as to be able to have a settled and fulfilling life.

There were probably *genetic factors*. My brother George, 28 years my senior, was a classic case of what used to be called hebephrenic schizophrenia and my mother was so deeply disturbed from her own upbringing – she'd had a violent abusive alcoholic father – that doubtless she helped to bring out psychosis in both of us. But even in the old days I sensed, in me, that there was a normal, stable and healthy personality lying dormant and latent if it could just be given the chance to emerge. In the culture of my upbringing that had proved impossible.

There are a lot of negative things said by vocal patients about medication. But I find that well targeted medication doesn't turn you into someone you're not, it instead helps to remove the barriers that were preventing you from being who you are. There's no doubt that science can help recovery and that medication can make a positive difference. I decided to take as little as possible so as to avoid lethargy and sluggishness but occasionally take a little more if I felt I needed it. So I was on a variable dose regime and this was really helpful. The rest of the work however had to be done by, most of all, love and a kind of psychology-in-life NOT psychology-in-the-lab'. Every branch of psychology proved helpful to me, particularly humanistic, psychodynamic and cognitive approaches but my spiritual life also was vitally important to me so I had many valuable talks with vicars. I had had a particularly savage view of God put there by numerous Old Testament readings at school and also by doorstep Jehovah's Witnesses in the 1960s.Even my view of God, like almost everything about me, had been deformed.

Ironically one has to be in the mood for reason but sadly the scientific treatises on psychosis never seem to make one hear a single note of the tragic music they describe. This is the value of service user volumes where patients speak for themselves and don't have psychiatrists or psychoanalysts speaking for them. However empiricists and positivists might well see even my present personality as off-centre and perhaps diagnosable. Certainly they see my belief that psychosis does involve an amplification of the genuinely uncanny as 'pathological' or at best as 'hippy 1960s talk'. But as Richard Hurd said back in 1762, *"When an architect examines a Gothic* structure *by Grecian rules, he finds nothing but deformity*" (Honour, 1991, p.157). Blake used to describe Greek architecture as 'mathematical' but Gothic as 'living' form. For someone like myself who tries to blend empirical science with art and spirituality in both his life and work (e.g. Chadwick, 1997) such a fluid, Romantic personality will present problems for people relentlessly scanning with fixed, narrow categories and a materialistic atheistic outlook on life.

Aftermath and Conclusions

For me, life has been better, not worse, since psychosis. My mother and I didn't have a relationship but a collision. And the outcome wasn't love but combustion. To this day my attitude to her is ambivalent but I do see that she really needed help. Meeting my wife Jill put genuine love in my life that, given the way I was, could never have been there before. No-one can overestimate the importance of love to recovery particularly since one of the reasons for my existential fragility before the episode was my total incapacity to love.

With my changed mentality came an increased sense of consideration for other people; a calmer (rather than hypomanic) reaction to and enjoyment of pleasurable things; a disappearance totally of the strange and horrific callous streak in my pre-psychotic personality and a capacity to view things in full perspective. In the past I'd had to regard everything with analytical tunnel vision and that can lead, especially socially, to more blunders than it solves.

Before the episode I was basically a nomad having no commitments to anyone or anything – except the life of the mind. After the episode my commitments to my wife, my jobs and my friends were total and gave me the settled life I needed to really thrive.

Of course one has to see all this in the context of increasing age. As I said earlier I hated being young and, unlike Oscar Wilde, who mourned every birthday and understated his age, I celebrate every birthday and feel better in myself the older I become. But, somehow, the way I used to be… I don't think, without the 1979 crisis, that I would ever have grown up. There was a terrible juvenility about me that I noticed and of which I could not rid myself. When I once asked my mother if she loved me she shouted, *"There's nothing to love!"*. All I was, was an analytical reasoner shunted into *"the contracted country of the head", a*s Sylvia Plath would put it. A loner, detached, distant, a nomad… 'nothing to love'.

Perhaps I would eventually have attempted suicide anyway, without the psychosis. In the summer of 1968 I asked a girlfriend, Barbara, if she loved me and she threw back, independently, exactly what my mother had said, *"There's nothing to love!"*. So I asked her why she was still hanging around and she said, "*I don't know, there's something*". But that was my life: unable to love, unable to *be* loved. How long can anyone last like that? A life of reason and analysis might satisfy an autistic or Aspergers person but for me I felt I was drifting on a road to nowhere. The anguish was always there.

The reader might ask, *"surely your family could have helped?"*. But after my father died in 1954 the Chadwick family shot off over the horizon like cheetahs chasing a deer. My mother's family were all either dead, dispersed or in alcoholic oblivion. My brother died when I was 20 of acromegaly, when my mother died, at 69, I was alone with my dog Penny. So I had to face all the above *alone*. In many ways Penny's devotion did help me to keep going but in 1980 I had to part with her to a loving family because in London I could not get anywhere decent to live with a dog. Those were the rules in those days.

One of the delights of my post-episode life was a complete change of luck in that I started to meet so many cognitive introverts in London! Before my life had been almost totally bereft of them! This really helped to light up what was within and gave me many new friends that I could relate to deeply.

The writings of Oscar Wilde (Wilde, 1994) have always been an inspiration to me and as he was horrifically scorned for his off-centre sexuality, as I was, he has always been someone with whom I could identify. He and his clan have, for me, been 'friends across time'.

My transvestism and slight bisexuality are now both dead and have been for over 20 years. I am 66 now, retired but certainly able to look back on an eventful life! I didn't really begin to *be* as I was in any way whatsoever until I was 23 and started research for my first PhD, in geology, at Liverpool in 1969. And, of course as we have seen, I didn't fully come into my own until 1982 when I started teaching, particularly for Birkbeck, at 36. So in some ways I spent a lot of time drifting. Because of this I have described myself as *'The Man from Nowhere'* (Chadwick, 2010b, p.13), a man not brought alive at all by his upbringing, but living in some kind of inner suspended animation. I would say that the 1978-

1981 crisis period accelerated my maturation by 15 years. On reflection perhaps it is important to FAIL? If one keeps succeeding along tracks that are ‘not you’ then the whole exercise is, in a way, futile and wasteful. The shock of a severe and unqualified *failure* can seriously wake one up, clear the decks and enable one to make a totally fresh start. That essentially is what happened to me. But for all the adulation we give to great reasoners and to great money-makers, this really is cow-towing to the values of *men*, particularly young competitive men. As I found myself, the whole fabric of life will still fall to pieces – and it is sobering to realise this – in the total absence of love.

In closing I would say in summary that medication has always been immensely helpful to me but my recovery also massively benefitted from the love of my wife, close friends and students. Having a satisfying and fulfilling job, good accommodation and a decent income also gave me the scaffolding to thrive and move forward. I always tried to avoid guilt-inducing and over talkative people and macho types as they reminded me too much of the past and I found them emotionally overwhelming. I also avoided people who only stressed the intellect at the total expense of feeling and stressed only materialism and atheism at the total expense of the subjective and soulful approach to life. It is clear that my recovery has taken me far away from materialism – which I detest – and much closer to a blend of science, art and spirituality as the way forward for psychology and for myself.

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Chapter 4

STEPS TOWARDS BETTER COLLABORATION BETWEEN STAKEHOLDERS TO PROMOTE MENTAL HEALTH AND TO ALLEVIATE DISABLEMENT DUE TO MENTAL ILLNESS

Robert Miller

The 'Wind of Change' in Today's Psychiatry

In February 1960, the British conservative Prime Minister Harold Macmillan gave a speech in Cape Town to the South African Parliament. It included the following sentences: "*The wind of change is blowing through this continent. Whether we like it or not, this growth of national consciousness is a political fact.*"

He was of course speaking about colonialism and apartheid. It is a singularly appropriate metaphor for what is happening in psychiatry today. Suddenly there is public realization of the depth of discrimination and prejudice which has dogged mental illness from time immemorial. At last, the tectonic plates are shifting. In the past, the lives of many affected by mental illness have been blighted by insensitive, demeaning and alienating public attitudes and mental health services. Today the aspirations of such people, which hitherto lay hidden beyond the horizon, are coming centre stage. The Wind of Change which is now blowing in psychiatry, though not yet by any means global, is becoming quite international. These are heady days for those involved. At last we have some influence, even some power; but we should not overplay our hand. We need wisdom to go with that power.

Some of my own Story

Let me say a bit about my own background, as context for what comes next. I was born in Sheffield, an industrial city in the north of England in 1943. At grammar school, I went into the science stream and in my last year at school, in the school library, I found a book by J.Z. Young, professor of anatomy at University College London, a leading British biologist of that era, called *Doubt and Certainty in Science* – the published version of his 1954 Reith lecture series. At age 17, I was introduced to the idea that all the impressions which flit through our minds, moment by moment, were linked to mechanisms in our brain, which might be comprehensible. I was 'hooked' – no other word will do; and I've been thinking about that ever since.

In 1961 I enrolled as a medical student at Oxford University, and was becoming very interested in research on the brain; and by 1965 was doing my first research study, recording from single nerve cells in the brains of anaesthetised animals. However, other things were happening. Even in my school days I had been a moody youth, and at Oxford I suffered a remarkable succession of mood swings. Before going to the clinical part of the medical course I acquired a B.A. degree in physiology. How I managed it, considering my health at the time, I don't know. I found myself at University College Hospital, London, in 1966, trying to be a clinical medical student, but badly disabled by psychiatric symptoms. After some complex events which need not be described I was prescribed tricyclic antidepressant medicines and went home to Sheffield while they took effect. Two weeks later, suddenly, I became floridly psychotic, and was committed to the mental hospital in Sheffield, under the authority of Erwin Stengel,[1] then professor of psychiatry there, and two years from retirement. I have no hard feelings about Stengel. He himself knew what it was like to be a refugee, and I now regard him as a man of solid integrity, and a real pioneer in some areas of psychiatry.

It was late November when I was committed. The day after I arrived in hospital, I heard that snow was forecast. I explored the hospital grounds, saw the front gate open, so I bolted, I did a runner, as they say – or as the euphemism has it – I eloped. (Unfortunately, I had no-one to elope with!). I could move fast in those days, headed home, collected by tramping boots and an anorak, and set off for Australia. I didn't get there of course on that occasion, but I legged it about 30 miles over hill country in the Peak district, overnight, during which there *was* a snow storm. This *was* in part a suicide bid; but the fact that I covered such a long distance on foot also has a pharmacological side – was it mania, a not uncommon side effect of tricyclic antidepressant drugs? Was it akathisia caused by

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[1] A few details about Stengel may interest readers: He was born in Vienna in 1902, and graduated in medicine there in 1926. He got to know Sigmund Freud around this time. In 1933 Hitler came to power in Germany, and in 1938 moved to annex Austria. At that time Stengel was working under Julius Wagner-Jauregg, who had received the Nobel prize for his idea of treating tertiary syphilis by giving people malaria. In 1938 Wagner-Jauregg joined the Nazi party, and later was involved in the sterilization program for supposed genetic disorders. Stengel was Jewish, and didn't like what was happening, so, as a refugee, he fled to England. He was interned on the Isle of Man during the war, and then had to repeat his medical qualifications to practice in Britain. Later he became founding Professor of Psychiatry in Sheffield. In the 1950s he translated various works of Sigmund Freud into English, including the latter's book on aphasia. He was interested in the history of psychiatry, and wrote on the *origin* of Freud's ideas (especially their debt to the British neurologist John Hughlings Jackson). Working for the World Health Organization in the 1950s he contributed to improvements in classification, and insisted on the use of operational definitions, to make diagnoses more reliable. He was a pioneer in making the topic of suicide an acceptable subject for research in Britain, and wrote a book for the general reader on how to cope with suicide or attempted suicide in a relative. (Until 1961, it was against the criminal law in Britain to attempt suicide.) He died in 1973.

antipsychotic drugs? (I had been given a hefty whack of chlorpromazine by now). Eventually, I phoned home on a frosty morning, and my father met me and took me back in the car. The upshot was that I consented to go back to hospital, not as an in-patient, but as a day patient, where I was for the next six months.

I was out of action for several years. Eventually I retrained as a scientist, at Glasgow University in Scotland, in the Department of Zoology. Then, as a post-doc back in Oxford, I began to specialise in brain science. In 1973 I had another brief spell in hospital, as a result of stopping my medications, in the course of which I was actually told the diagnosis – schizophrenia, as I could have guessed anyway – and was shown it written in the case notes, so that there could be no misunderstanding. After that, about 1974, the idea took hold of actually researching psychotic disorders. I emigrated to New Zealand in 1977, to a job in the Anatomy Department in Otago University, and apart from teaching, pursued my research there for many years. My objective was to bring together my understanding of how the brain works, with personal experience of psychotic illness. This was almost entirely theoretical work, based around academic libraries. However, I resigned my job in Otago in 1999, to continue research work in a freelance capacity. As a result, I was able to complete my big book on the theory of schizophrenia (Miller, 2008). I am now aged 68, and moved north to a rural region of the North Island of New Zealand, called 'the Wairarapa' three years ago.

Since I moved north, I have become involved in psychiatric politics in a way I could never have anticipated. I was invited as a community representative on to committees of the Royal Australian and New Zealand College of Psychiatry. It is a privilege to sit on those committees. It allows me something never possible when I was in academia, where I was always a square peg in a round hole – the chance to influence matters related to psychiatry on which I care deeply. It has also stimulated me to formulate views on many issues which previously were beyond dreaming. However, while I pay a big compliment to the Royal College for its courage in inviting mavericks such as myself on to its committees, when I'm there, my job is to say it how I see it, and how it is conveyed to me by the many people I meet; and if that happens to be challenging, even on fundamental issues, that too is part of the job.

How I landed up in New Zealand

Let me back-track to explain how I came to New Zealand. In the early 1970s, when I got out of hospital the second time, and started to form the ambition of doing research on psychotic disorders, I knew I had a significant health problem. I realised what public attitudes were like, and that I would face discrimination, especially in getting a job. So, I decided, very deliberately, to play the issue with a dead straight bat. No concealment, complete transparency. There were three reasons for this: (i) If I was to be taken seriously as a researcher, I never wanted to be compromised, on the grounds that I had hidden things about myself. (ii) By being completely open, it would force discrimination out into the open, when it would be easier to deal with. (iii) In seeking employment, if I did land a reasonable job, it was likely to be with a boss who had some appreciation of the personal issues I faced. Friends in Britain at the time were worried about the line I was taking. Forty years later they say: ‘You were right Robert, and we were wrong.’ But here, I’m not trying to give general advice. Everyone in this situation must take their own decisions and play their own game, mindful of the social context in which they take their decisions.

As a post-doc in Oxford, I had to consider options for a secure job. After discussion in my department, I was directed towards a prominent researcher in another department. I was not impressed by what was on offer, partly because I really wanted to focus on library-based theoretical research, rather than what I foresaw as the treadmill of experimental research. So, I applied for another post-doc position in a different university. The underlying reason to move from Oxford, more of an instinct than a conscious choice, was different. In Oxford, of course there were top-class researchers, better than I would have found elsewhere – but I needed space for personal growth. Like a delicate sapling in a forest of tall trees, in Oxford I would never be able to grow into who I might become. When I told my Head of Department that I was thinking of moving away, he was not pleased. His words were quite revealing. He said: “*Morally speaking, who is responsible for this decision?*” I replied (of course) “*I am*”. That line … (‘Morally speaking, who is responsible?’ …); it conveys the effortless sense of superiority of some Oxford professors (not all, I should say. Some helped me greatly). In effect he was saying “*You’re in a dodgy situation. You’ll never get a job anywhere else. We offered you protection, and you rejected it.* “And when, predictably, I said “*I am responsible*” he could then wash his hands, and wait to say, “*I told you so*.” Well, of course it didn’t work out the way he expected. He implied a lot in that remark, but wouldn’t say it openly. He concealed his tracks. That’s not so nice.

A couple of years later, in the mid-1970s, I was applying for lecturing jobs. In my applications I mentioned the gap of several years in my CV, due to psychiatric illness. At one interview, in front of a large panel, I was asked “*What was the nature of your illness?*” I replied: “*It was a schizophrenic illness*”. I was offered a temporary lectureship. Six months later, after another application, I got a cable from a far-away place called Otago, New Zealand, offering me a job there. I went to see my then Head of Department, and asked: “*Should I accept the job?*” He replied, very straightforwardly. “*Yes you should. With your health record, you don’t stand a chance of a permanent academic job in this country*”. I went out of his office and down the road to the post-office and cabled a reply to Otago, accepting the job; and that’s how I came to be here, the best decision I ever took, I should say. Compare that remark with the curly remark I have just described: Which was easier to deal with? Actually the second was more wholesome and honest, and helped me to make a key decision, although it reflected a terrible state of affairs at the time.

A Recent Meeting

Jump forwards to 2011, and my current political activity. Consumer involvement in the health industries has grown rapidly in the last twenty years, and is now a major force in many countries and many medical specialties. This has been propelled from many quarters. One field where the alliance between consumers, researchers and clinicians made particularly notable achievements is HIV/AIDS. The current strong alliance in that field was forged in the 1980s and early 1990s, ahead of consumer movements in other areas of medicine. In Britain, a key figure at this time was Nick Partridge (now Sir Nick Partridge, CEO of the Terrence Higgins Trust [THT][2]). More recently, he has been using his experience in organizations concerned with community involvement in the health services and health research generally, outside the area of his initial commitment.[3] On 7th November, 2011, I was privileged to meet him and learn of his experiences at the offices of the THT on Gray's Inn Road, London. I particularly wanted to make this contact, to learn what I could of relevance to Mental Health Consumer Groups in New Zealand, Australia and elsewhere.

The field of HIV/AIDS has a number of similarities to the mental health area, which make comparison interesting, but also significant differences. *Similarities* include the following: (i) In both areas, there has been a 'culture of denial'. Vicious circles of fear and ignorance amongst the public have hindered the mounting of effective health programs. In the mental health area readers of this chapter will be familiar with this point. In the HIV/AIDS area, there have been powerful taboos over open discussion of sexually transmitted disease, homosexuality, and sexuality as such. (ii) Both specialties have been regarded as 'Cinderella areas' of medicine. (iii) In both areas there has been unhelpful (and sometimes scurrilous and sensational) reporting in print media. (iv) Both areas have attracted their share of dangerous activists, using media outlets with considerable skill to promote agendas which are either simplistic or, in terms of scientific evidence, manifestly incorrect. Sometimes they use their illness-experience for self-promotion, or to convey a sense of their own embattled victimhood or martyr status. (v) In both areas community activists have had to break through resistance of senior clinicians and researchers reluctant to work alongside community spokespersons, sitting, as equals, on the same committees. (Nick Partridge described his experiences in the 1980s, as the sole community voice, on committees full of eminent professors). (vi) Nevertheless, in both areas persistence has paid off. It is now realised that fresh viewpoints from community people may highlight weaknesses in current research or practice, such as expensive research that is going nowhere, or the inability of experts to integrate other areas of valuable expertise into their own thinking.

Differences include the following: (i) Mental Disorders only sometimes become matters of life and death; HIV/AIDs from 1980 up to the late 1990s *was* such a matter, and on a large scale. (ii) HIV/AIDS is a more discrete and precisely defined condition in terms of medical science than are most mental

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[2] www.tht.org.uk.

[3] One of these in called INVOLVE (www.invo.org.uk *"National advisory group to the Department of Health, established in 1996, part of the National Institute for Health Research. Supports and encourages active involvement of the public (e.g. patients, carers, service users) in NHS, public health and social care research."*) Nick Partridge is also involved with the JAMES LIND ALLIANCE. (www.lindalliance.org *"To increase the focus of research on questions and priorities shared by patients and clinicians about the effects of treatments in which there is no commercial interest; To promote working partnerships between patients and clinicians, to identify their shared priorities for research; To ensure that important questions are not overlooked because of emphasis on chronic but not acute health problems; severe but not common health problems; and disease-specific but not cross-cutting issues, such as social support."*)

illnesses. Community activism related to HIV/AIDS could therefore focus on research, and especially on decisive clinical trials, in the hope of finding a cure, or at least an effective treatment. In the mental health area, disorders are more diverse, more difficult to define, and more complex conceptually. Fundamental research from which effective treatment or cure of mental disorders might emerge inherently has a slower tempo. Community activism has therefore tended to focus on service delivery, or the relative merits of established clinical approaches or strategies of treatment. (iii) Psychiatry both historically and today has been split by a deep philosophical division, between the '*somatikers*' and the '*psychikers*' in the nineteenth century German-speaking world, and its equivalent today of bio-genetic versus psychosocial views on causation and treatment. There *have* been such splits in the HIV/AIDS area, for instance by those who deny the viral aetiology, but in most countries this is now mainly confined to fringe groups. Divisions are by no means as old and deep-rooted as those within psychiatry.[4] (iv) In psychiatry, but not in the HIV/AIDS field, psychiatrists have had the power to commit patients involuntarily,[5] which has made it more difficult for consumers and psychiatrists to work together. Even when committal is not the issue, the relationship between doctor and patient is fundamentally different from that in any other area of medicine: A psychiatrist very often finds he has to protect a patient from him/herself. (v) HIV/AIDS is definitely an unmitigated illness. In contrast, many mental illnesses combine, in an inseparable mixture, definite (sometimes severe) impairment in one area of psychological function with unusual, (even outstanding) talent in other areas.

Several things combined in the HIV/AIDS area, leading to a fruitful collaboration of consumers, clinicians and researchers. The sexual liberation of the 1960s and 1970s, which led to increased openness about sexual matters, set the scene for this. Without that, the collaboration might not have developed. Amongst the gay communities in North America this led to emergence of a vigorous political force. In the mid-to-late 1980s, as the nature of HIV/AIDS became clear, there was a growing sense of apprehension and urgency, shared jointly amongst groups themselves at risk, clinicians and researchers. No-one knew how big the problem would become. Amongst consumers, there were many young, articulate and energetic activists. These included Terrence Higgins himself, one of the first in Britain to grasp the size of the problem represented by AIDS, and who died from AIDS. These developments produced a social context

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[4] Another parallel in the field of infectious disease is relevant here: *Myalgic encephalomyelitis* (ME: 'Chronic fatigue syndrome'). This has been variously regarded as a psychiatric disorder (perhaps a form of depression), or as a viral disorder. Interestingly, the passionate insistence of consumers is that ME *does* have a biological basis, not a psychological one, an emphasis exactly the opposite of that which often prevails amongst consumers of mental health services.

[5] In modern times, in many jurisdictions, it is not the psychiatrist him/herself who has this power, since initial reports by psychiatrists are subject to routine legal review. It also needs to be said that, in today's world, the occasions when these powers are needed involve a small minority of patients, mainly those with psychotic disorders, compared to a generation ago. Nevertheless, the memory of the past lingers on in the public mind. (Acknowledgements to Professor Rob Kydd for drawing my attention to these points).

where researchers and clinicians in the neglected fields of STD and infectious diseases knew they were on the frontline of a very important battle. If they were to respond adequately, they had to join forces with community people in pushing through their research agenda. Nevertheless there were stormy scenes at large international AIDS conferences in the late 80s and early 90s. There was tension between consumer groups and researchers, with mass demonstrations in Bethesda, Maryland outside NIH, and outside Wellcome and MRC head-quarters in London. The consumers' role proved decisive in the politics and science at big research meetings, by pointing out that much research was irrelevant: They shaped the course of much subsequent research. The hardest group of professionals to bring on board were those, excessively concerned about rigour of research, who wanted absolute proof before turning lab findings into clinical trials or clinical trials into routine treatment (an unfortunate consequence of the thalidomide disaster in the 1960s). However, by the mid-1990s, with the Terrence Higgins Trust playing a leading role, research studies were conducted involving close collaboration with researchers, on trial design, recruitment, and rapid dissemination of results. By 1996 highly effective antiretroviral drugs were available, which by now have reduced the death rate by 70%.[6]

The Interface between Consumers, Researchers and Clinicians in Mental Health

Emergence of the consumer movement in the mental health area has a rather different history, and is not yet as coherent a force as developed earlier in the HIV/AIDS field. (i) Early community pioneers in the mental health area, starting in the 1970s, were not consumers themselves, but rather family members in bodies like the National Schizophrenia Fellowship in the UK, and similar organizations in New Zealand, Australia and elsewhere. Activism amongst consumers came later, probably because it took some time for them to overcome their own fears, related to the climate of stigma and discrimination. When this happened, separate organizations tended to emerge for consumers and family members, naturally enough since there are genuine differences of interest between the two. There were antagonisms between the respective groups, and also between consumers and psychiatrists. This is still true to some extent. There *is* however some coming together of the different stakeholders, and, amongst community consumer groups in the mental health area, there *is* now a body of vigorous, articulate activists, keenly interesting in being better-informed, and willing to challenge orthodoxy. However, there is far from a united front amongst consumer groups on basic

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[6] It should also be said that, in the crisis of the AIDS epidemic, the stringency of usual FDA procedures for ethical scrutiny of new medicines was relaxed and approval of new medicines thereby expedited. The campaign to persuade FDA to relax its usual procedures was led by a community activist, Martin Delaney, and has since been extended to anti-cancer drugs.

(For details see: http://www.fda.gov/ForConsumers/ByAudience/ForPatientAdvocates/HIVandAIDSActivities/ucm134331.htm#.T-vs2o5VA5Y.email). (Acknowledgments to Professor Tim Peto).

philosophy. Few activists are able to assimilate biogenetic and psychosocial models of mental disorder into a coherent viewpoint. (The same can of course be said about researchers.) There is no unanimity on respective roles of psychotherapies versus biology-based treatments. (ii) Psychiatrists in most countries have been reluctant to engage with consumers. International conferences on fundamental aspects of psychiatric research have been slow (compared to AIDS conferences), in bringing consumers into their midst. The reasons are discussed later in this chapter. (iii) There has never been the sense of urgency in the mental health field, seen in the early years of the HIV/AIDS emergency. However, some psychiatrists now fear that the 'metabolic syndrome' linked with some new antipsychotic drugs constitutes a 'time bomb', which may soon lead to a major epidemic, and feel that urgent response is needed now. (iv) The ingrained scepticism of some researchers may parallel that in the HIV/AIDS field (for instance when absolute proof is demanded that early intervention improves long term outcome, before such programs are implemented). (v) Fundamental research on the biological mechanisms of mental illness is unlikely to attract a high level of enthusiasm from consumer groups (much though such research may be needed), partly because it seems so far removed from their own daily struggles.

Compared with the HIV/AIDS field, in the mental health area, active collaboration between consumers, clinicians and researchers lags far behind. How can active collaboration be brought about in the field of mental illness? There are lessons to be learned from the history of collaboration in the HIV area.[7] In the next three sections I discuss changes that I believe are needed. These comments are addressed partly to mental health professionals. Although I am not really one of them, I meet them often as friends, and often try to put myself in their position and imagine the pressures they are under. The comments are also addressed partly to researchers, of which I definitely am one, but with a background different from the vast majority of such. I devote more space to addressing the approaches to be adopted by consumers and other community people. Here I *am* to some extent one of them, but with a different background from most of them. Finally, I make some comments addressed to all these groups on the nature of the interactions from which may grow real partnership.

A Challenge to Mental Health Professionals (Clinical and Research Staff)

The unwillingness of mental health professionals to embark on true partnership and collaboration with community-based activists is true of some, but by no means all such professionals. While many psychiatrists are open to collaboration, there *is* a need for a shift in the attitudes of many mental health professionals. When there is unwillingness (in my view) it is partly because psychiatrists (and others in mental health professions) do not yet recognise that their patients can be intelligent commentators on the issues involved, and perhaps also because those professionals are at some level aware that their own research concerns are far

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[7] I hear also that in the Alzheimer's field, there is also quite fruitful interaction between families and researchers/clinicians.

removed from those of the consumers (whose interests research *should* be serving). Sometimes it is because consumer organizations have been poorly informed, and poorly led by those held up as spokespersons, a point discussed further in the next section. It has then been difficult for psychiatrists and others who *do* want to engage with community groups to recognise the activists in these groups who *are* well informed and fully aware of the complexity of mental disorders and their treatment. I offer the following comments about areas where a change of approach by professionals might help the coming-together of the different stakeholders.

Openness and Transparency

At the interface between community activists and mental health professionals, several factors may hinder the development of true partnership. *First,* clinicians are used to dealing with patients in a clinical encounter, but the interaction with community activists is not a clinical encounter, and different guidelines apply. In a clinical encounter, there may be a tendency for clinicians to refrain from responding, but (inwardly) to interpreting what is said in terms of psychiatric disorder. However, in committee, or in public meetings, service users may feel free to disclose personal stories, which they would not expect to be made public, were it a clinical encounter. They would appreciate, and are likely to respond positively, if such openness were to be reciprocated – for instance if clinicians or researchers were somehow to take the community people into their confidence. This may be difficult for professionals who somehow think they are crossing professional boundaries; but if it *were* possible, it would lead to freer discourse all round, from which all would benefit. If openness is *not* reciprocated, consumer activists may conclude that a clinician has something to hide. Who can blame them?

Second, and perhaps more important, in the research field, and perhaps even more in the clinical field, people are not used to being really open with their own colleagues, except within the bounds of their professional relationship, because of the social dynamics and styles of training in their own field: These may be dominated by competition and hierarchy of relationships, which do not favour open communication across political frontiers. If service users can effectively challenge such a constrained approach to relationships, more power to their elbow (in my view); and they may even be able to introduce those clinicians to a more open style of social dynamics.

Third, there is always the implication that 'we are too busy' to respond openly to all and sundry. It is certainly true that consultant psychiatrists usually *are* very busy people; and yet this does not explain the systematic brush-offs one might get at times (such as international conferences) when the pressure is less. Clinicians and researchers are reminded of what their real mission is, to help their patients; and in the days when community psychiatry is becoming the main interface with patients, psychiatrists should not ignore opportunities for exchange of views with people who come to the subject in a quite different way. Indeed, when, as is often the case, there are not enough psychiatrists for the demands placed on them, and the workload seem impossible, one strategy is for you – as a professional – to take those concerned community people into your confidence, give them some training, and invite them to join you as collaborators in the areas where they can help, perhaps in a voluntary capacity. They may be eager to join with you on such a basis. It may be hard at first, but will pay off handsomely down the track. I have seen this principle applied in Hong Kong, where the number of psychiatrists per head of population is far less favourable then in most Western countries, and there is little other alternative. It is also my experience that some of the really big figures in psychiatry, who are probably busier than anyone, *do* somehow manage to build up those many contacts, although necessarily they may be rather brief in their communications.

Fourth, there may be a rejection of statements of service users because they have political import (thereby betraying the 'ivory tower' attitude often fostered in academia). This is a cop-out. It is likely that the issues really *are* political, and should be discussed in that context. You cannot keep politics out of psychiatry.

Last, in some mental health services, there appears to be knee-jerk attitude of negativism to any positive suggestion. This may be a continuation of attitudes prevalent in the days of the large mental institutions. A more up-beat approach is needed if the full benefits of community engagement are to be realised.

Medical Authority as an Impediment to Rational Discourse

Some consumers may be intimidated by medical authority, and this is not helpful. Others have the courage, tenacity and knowledge-base to be more challenging. However, the *only* basis on which true partnership can develop across the frontier is that of rational discourse; and the *only* authorities which can be assumed in such discourse are abstract principles – sound evidence, sounds reasoning, and sound ethics. Personal or institutional authority, or the authority of a discipline have no role. The starting point for interaction between different stakeholders, must then be one of equality of status and rank. If experts are to be treated as authorities, their authority has to be earned, in interaction with each person individually, not to be taken as a given; and of course it is not only the professionals who are experts: Those with lived experience of mental illness also have their own expertise.

Technical Detail and Jargon

People from the wider community who happen to be users of psychiatric services or caregivers of impaired relatives, may object to impenetrable technical jargon which they do not understand, and which appears to be impersonal, denying the drama and the trauma of their own lives. Sometimes, to be fair, opaque language is used so that lay people can *not* understand, or even as a cloak to hide the fact that the speaker him- or her-self doesn't understand either. As far as possible, therefore, opaque language *should* be avoided. In such situations for a professional to say 'I do not know', may inspire more confidence in other areas, than to try to pull the wool over the eyes of consumers (who of course soon see through the ploy). If an expert has anything worth saying it should be possible to explain it to an audience of intelligent lay people, in a way that the audience not only understands, but on which it can offer constructive criticism – and at the interface between community activists and mental health professionals, you *are* dealing with intelligent lay people. It is vital that you, as professionals, can somehow expose yourself to the possibility of intelligent, constructive criticism from outside your own field.

Strife about Diagnostic Labels

Diagnoses have a different role in general medicine from psychiatry. Historically diagnoses do not start off as scientifically precise concepts, but as names for syndromes – the coming-together of various symptoms – and it is only slowly that these are refined to become precise concepts, corresponding to disorders with known causes. In general medicine, diagnoses are often more precise than in psychiatry, reflecting the fact that the disease entities there are usually better understood. In general medicine, diagnoses are important for the researcher and the clinician – to guide treatment, to indicate prognosis, and as a focus for public health measures – but also for the general public, potential patients, for whom a clear diagnosis provides a basis for understanding and self-education. This is especially the case for disorders where the diagnosis is precise and clear, for instance for relatively rare genetic conditions. In psychiatry diagnoses are important for researchers and clinicians, although for clinicians I suspect that broad categories are often more important than fine distinctions; and, once the broad categories are decided, treatment is judged more on an empirical try-it-and-see basis, than by reasoning from fine diagnostic distinctions. For patients – those who experience mental illness – diagnoses may be less important than in general medicine. This is partly because, as just indicated, concepts of mental disorder are at present far from well-established. Future research *might* resolve such issues – I hope so – but it won't happen quickly. Another reason for questioning of diagnoses in psychiatry is a more permanent one: In psychiatry, the unique personal characteristics of each individual, their personality, are of far greater importance than in any other area of medicine, except perhaps general practice. Diagnosis may indeed be *inherently* stigmatizing; many consumers think it so. One can sum this up by stating that medical practice deploys the traditions both of the natural sciences, and their tendency to be objective and impersonal, and also the traditions of the humanities which have more of a focus on the individual and his or her unique history, in all its complexity; but in psychiatry the balance is shifted somewhat towards the latter, while not ignoring the contribution of the natural sciences. So diagnostic terms have different roles for different stakeholders – the scientists, the clinicians, the direct consumers, their family members, the statisticians, those who consider finance of health care, and the medico-legal experts. It does not help, therefore, when documents like DSM in its various editions, provide systems for diagnosis that are used to serve all stakeholders equally.

Challenging Behaviour and Challenging Words from Community Activists

This may be based on genuine, unresolved anger, perhaps of long standing. Given the complexity of mental health care, and the pressures on staff, there are bound to be areas of unresolved hurt for some ex-patients, as well as areas where service users have a lot to be grateful for. Challenging behaviour by consumer activists may also be a deliberate attempt to test the mettle of those with whom they are dealing. This is fair enough: If anyone should be adept at de-fusing unresolved anger, it is the psychiatrists or other experts in psychological medicine. Part of the interchange with professionals may then be for service users to test whether this is actually the case.

Speaking personally, I know how to challenge psychiatrists, aiming to 'encourage' (and sometimes provoke) them to move closer towards true partnership. Although I have no tangible victories yet, I know I am being at least partially effective, when I listen not so much to what is being said, but to the silences, the times when psychiatrists can come up with no immediate answer. However, silences are not what I want – which is open, robust and rational discussion of issues at stake. Then, in the market place of ideas, I say firmly, 'may the best arguments prevail'. I also hope that I can accept with good grace convincing arguments against my own views, put forward by people who have expertise and experience beyond my own; but let's *hear* those arguments. Silences, or ignoring views which are difficult to assimilate with one's own, are not rational strategies. On the other hand, to say openly and honestly 'that is difficult for me to accept' *is* a rational strategy, since it opens the door to mutual exploration of contentious issues. Even open expression of anger by professionals, as their last defence, is preferable to being ignored.

A Challenge to Mental Health Consumers and Family Members/Carers

Here, I want to challenge service users and carers, my aim being similar to that of the last section, to foster true partnership with the other stakeholders.

Philosophical Polarization

There is, in my view, a need for service users and others, in their role as mental health activists and advocates, *to be better informed.* First of all there is need for better understanding at the philosophical level. All cultures have to wrestle with issues about the relation between body and spirit (or soul), or equivalently between brain and mind. In the areas of mental health and mental illness, this becomes the contemporary debate between bio-genetic versus psychosocial concepts of causation, and their respective application to treatment of mental disorders. Sometimes consumer advocates strike a decidedly ideological stance, strongly favouring psychosocial models, and rejecting biogenetic ones. They may see themselves as pitted against an army of faceless advocates of a pure biogenetic philosophy in the psychiatric professions and their researchers, aided and abetted by the pharmaceutical giants. As a result, such voices may force sharp polarization upon the debate, which is unhelpful. It may be fuelled by headline-hungry news media, who like to present the polarization between advocates of biogenetic and psychosocial approaches to psychiatry as primarily a political struggle. This may sell newspapers, and activists may use dubious ploys to win short-term political advantage. I admit that on occasion the relation between consumer activists and mental health professions *may* to some extent become a political struggle, where the real issue is one of power imbalance; but the consumer activist movement won't gain any ground in the long term unless it is based on more balanced arguments, and on the most solid science, whether biological, psychological, social, or preferably on research which assimilates all three. The reality is of course that psychiatrists come in many shapes and sizes, with many philosophical shades. They do not fit the stereotype just described: Many earnestly search for the complex middle ground, where biogenetic and psychosocial models of mental disorder are fully integrated with each other. Most of the above comments also apply to divisions between different professional groups involved in mental health. These divisions (for instance between clinical psychologists and psychiatrists in some countries) become ideological battlegrounds, which, when it occurs, is also not helpful.

There are several reasons why this philosophical polarization emerges, and why consumers and mental health professionals are (or appear to be) on opposite sides of the divide: Possibly these polarized attitudes reflect a throw-back to the dualism of the classical Greek philosopher, Plato, carried forwards two thousand years later in ideas of the French philosopher, René Descartes. In this dualism, brain and mind (a.k.a. 'body' and 'soul'), were held to be so completely separate that they could each be effective as independent causes influencing one another. In the nineteenth century German-speaking world, where battles raged become the *somatikers* and the *psychikers* on the right way to conceive mental illness, protagonists on both sides of the debate based their arguments on mind/brain dualism (Beer, 1995). Belief in such a strict separation is not widely held nowadays, either by philosophers or by scientists, whether they work as neuroscientists studying brain mechanisms, or as research psychologists studying functions of the intact brain in terms of behaviour or subjective experience. In addition, polarisation and rivalry between professional groups involved in mental health may arise in part from the way different disciplines are defined within universities, which hinders the much-needed integration of obviously-related fields.

Psycho-social ways of comprehending mental disorders *do* seem easier to understand and *are* closer to common sense than ones based on brain science. Neuroscience is very technical. Competent researchers in this area need extensive education and training, and there are many sub-specialities, each requiring their own expertise and knowledge base. This area may offer the most fundamental understanding of mental disorders, but its impact is necessarily in the long term. Mental health consumers often have had breaks of several years at critical stages in their lives. This is likely to have made such extensive higher education and training difficult to acquire. Thus, few community activists in the mental health area can be expected to be 'up-to-speed' on such a technical area. Even under the most favourable circumstances, consumers can be expected to grasp the detail in only a few areas of neuroscience. With such an imbalance in requisite knowledge (and therefore in power) between researchers and consumers, it is hardly surprising that there is a degree of polarization between the two, favouring polemics rather than mutual understanding. Therefore, the hard question must be asked: How can one reach a situation of equality of knowledge in the discourse between consumer activists and researchers? I address this question shortly.

Underneath all the scientific technicalities, there *may* be a deep but unstated clash at a philosophical level. Behind the impenetrable jargon of the neuroscientist, there may seem to lie attitudes which appear to dehumanise us all, to reduce human nature to no more than a slight upgrade of a purpose-bred laboratory rat, or to the status of a deterministic machine which denies anything like freewill. Much 'brain talk' we hear is a simplistic, insulting caricature of human nature. It is seemingly a deliberate assault on our sensibilities, by virtue not so much of the technicalities, but of its underlying philosophy. So, brain science, as commonly purveyed, is inherently frightening to many people. This depends a good deal on the world view of each scientist, and each community person with whom they interact. It may then be at this level, rather than at the level of technicalities, where lies the real challenge from biological psychiatry, as perceived by consumers. Yet the focus, as presented by researchers, usually tends to be on technicalities, and on glossy false-colour images from brain scanners (and many similar show-piece displays), rather than underlying concepts.

There are many things to be said here. *First,* the fact that psychosocial approaches to understanding mental illness seem closer to common sense does not mean that such approaches bring one closer to underlying realities. Those realities may be complex, requiring much subtlety before they are properly grasped; and it is undoubtedly the case that many of experiences with which psychiatrists deal are very far from common sense. If neuroscience approaches seem frightening, so also, if truth be told, are some of the realities of mental illness, until we grow familiar with the details, and how they relate to one another.

More fundamentally, can one really support the notion that 'psychosocial approaches are good; neuroscience is bad'. It is an easy slogan to repeat, like the sheep in George Orwell's *Animal Farm*, forever bleating "*Four legs good; two legs bad!*"; but is it really helpful? For myself, I think we need both, and consumers as well as researchers and clinicians need to explore the intellectual territory where both are simultaneously under scrutiny and in interaction. To coin a phrase, 'Mind without brain: It's a 'no brainer'!'

Why is it a no-brainer? I answer with truisms. We *are* made up of mind and spirit, but we are also made up of flesh and blood, and also of neurones. I venture to assert that even the most vehement denier of biological psychiatry, the most ardent ideologue of psychological approaches, might have just a little bit of electricity, even a little bit of chemistry in their heads, as well as the aesthetic, emotional, cognitive, and moral sensibilities embodied by such physical processes. This 'duality' is accepted in most cultures. I use the word 'duality' here, to distinguish it from the 'dualism' of Plato and Descartes, in the same way as does Harold Turner (1998). For the Maori of New Zealand it is part of the foundation of their metaphysics, which actually is more complex than duality: For them, the metaphor for health is a table with four legs, physical, psychological, spiritual, and lastly, social (or ancestral), all part of a single and indivisible functional unity. It is only in the western, and particularly the Anglo-Saxon world, with its tendency to dichotomise all issues into polar opposites, that we artificially make a split between two things that obviously go together as inseparable parts of a single organic unity – ourselves.

How then *do* the two go together? The most fundamental science is physics. That is where the natural science tradition started, and where scientific explanation becomes most rigorous. The primary language of the natural sciences now extends well beyond physics, but so far is only just beginning to incorporate psychology and psychiatry into its common language. By saying this, I am in no way trying to belittle these disciplines, just putting them in historical perspective, implying that these are the contemporary growing points of the scientific enterprise. In physics, a form of reasoning grew which I call *'cross-level explanation'.* Arguments are presented by which phenomena known at a 'higher level' are accounted for by premises at a lower level. Often these premises are quite hypothetical initially, because their examination is far beyond techniques currently available. An obvious example (but there are many more) is the relation between the gas laws at an 'upper level' (relating pressure, volume and temperature of a gas) and their explanation in terms of movement and collision of molecules (a concept which was initially entirely hypothetical).

For me, the relation between mind (=psychology) and brain (or neurobiology) is like that: Things to be explained at the upper level may be any of: psychological or behavioural findings, symptoms and signs, and, with some qualifications, first person accounts of a person's own experiences. Premises at the lower level, on the basis of which explanations might be made, are about functioning of nerve cells, their electrophysiology, the dynamics of their transmitter substances, and the interactions emerging in networks of nerve cells. I *do* believe such cross-level explanations are possible in psychiatry, and have ventured to propose some such myself. If so, the idea of having to choose between biological and psychosocial models of mental disorder becomes absurd. The two always, and necessarily go together. The real problem then is not the very notion of neuroscience or brain science in service of psychiatry, but *bad* neuroscience bent to this end, bad neurobiology, with simplistic metaphors parading as explanations, turning out to be empty rhetoric when examined in detail. One should also realise that there is also much bad psychosocial research. That also should be exposed.

There are good reasons, which might appeal to consumers, for supporting a continuation of fundamental neuroscience research directed at the understanding of mental illnesses. Quite apart from the possibility that this might lead to better treatment, it is likely that, at rock bottom, the reason why callous treatment, and sometimes frank abuse has often flourished in mental institutions, is in part because the staff there have a truly profound lack of understanding. This may also touch those staff in a very personal way, since serious mental illness challenges our basic ideas of what a person is or can be. Better fundamental understanding would be one way to help prevent those abusive environments from developing.

Even many of the most esteemed researchers are, in my view, to a degree floundering, or trying to impress by their use of impenetrable jargon. They may try to convey a sense of their own confidence and importance, way beyond what can be justified by the fine print. This may be to avoid revealing their lack of real understanding, their failure to provide real explanations (as exemplified in physics), or so that they can gloss over the big issues – which are philosophical, rather than in the realm of scientific technicality. This shallow behaviour is also a response to the pressure many of them are under to raise research funds for their institution. An emphasis on simplistic metaphors for mental disorders (such as 'chemical imbalances') rather than more difficult and subtle concepts may also be promoted by the pharmaceutical industry to promote sales, or use of medications in larger doses than necessary. (Note here that I am not categorically opposed to the pharmaceutical industry, and in a small way do sometimes seek pharmaceutical company sponsorship for scientific meetings. I do not stereotype drug companies by assuming that 'they are all the same'. They are not all the same. Some companies have very reputable, indeed impressive company histories, others not so.)

What is needed is *good* biological science in aid of psychiatry, neurobiology which is rigorous on its own terms, in terms of its evidence and reasoning, and not transgressing ethical norms. It should be capable of being presented to mixed audiences including consumer spokespersons and family members as well as researchers and clinicians, neither talking down to the former or offending them in terms of philosophy, nor appearing naive and unscientific to the latter. Today such presentations are rare, but are not impossible. Traditions need to be developed to make them possible more often.

Of course there are also general questions of philosophy, not to be confused with those answerable within traditions of the natural sciences. These include the question of whether the behaviour of the physical world (including each of our own brains) is *really* subject in finest detail to the remorseless determinism of causal laws. I do not think this is an answerable question, although, in decisions of our day-to-day affairs, we all take our choices on the issue from time to time, as items of faith (but not always in a consistent fashion). The other question is on the general relationship between subjective and objective worlds, the view 'from within' and 'from without'; but again I think that to be a metaphysical question beyond anything answerable within science. Nevertheless, in the mental health area, we ignore either of these perspectives at our peril.

Let us return to the question posed above: How can one reach a situation of equality of knowledge for discourse between researchers or clinicians and consumer activists? Is it possible that, as in the AIDS area, consumers can effectively challenge the paradigms of research? Here are a few suggestions:

Technical Terms and Jargon

Neuroscience, as admitted, is a technical and difficult area for non-specialists. Can consumers get an overview which helps them make meaningful contributions to dialogues with biological researchers in psychiatry? There are several issues here. Perhaps there is a need for training courses, with plenty of opportunity for discussion, involving consumers as both learners, and as teachers or facilitators. However, this is at best only a partial remedy, and there are many other areas where consumers and carers can have influence without this. Suppose, however, that you find yourself in a forum which does allow extended discourse. (At present, in my experience, this happens rarely, but it might become more common in the future as the need for such discourse becomes more widely recognised.) If this happens, you may be bamboozled by technical jargon. Do not be fobbed off by claims of expertise and authority. Point out, politely, yet firmly, that the language is opaque; but be fair! Technical language develops in any profession, a necessary shorthand for conciseness and precision, like texting for young people, and equally incomprehensible to those who aren't into it. Whatever its motives, it arouses suspicion from the so-called 'ignorant' public with whom that profession has to deal, just as does text lingo for many adults. Nevertheless gentle pressure may encourage the use of more transparent language. This may be a way to 'level the playing field', to improve communication between different stakeholders, and, at the same time, to improve your own education on research topics. If however, you seem to be getting nowhere, and a gentle approach fails to shift prevailing professional attitudes of superiority and authority, it may be the time to use your considerable collective power. The history of activism in the HIV/AIDS area shows that this can move mountains, when rational arguments fail.

The Context of Neuroscience Research

If one then gets to the stage where cutting-edge science is presented in relatively plain language, the next step would be to examine its place in a broader context. If several presentations are given on related matters and seem to be based on quite different perspectives and assumptions, the various speakers might be challenged to assimilate each other's findings. This might be possible for you, even if you don't follow the fine details, and it may encourage some cross-fertilization between disciplines. In addition you might ask about how results relate to broader theories of whatever is being studied, using a wide variety of methods. Researchers in biological psychiatry need such challenges because they are not encouraged by styles of research administration to think more broadly about large-scale theories. In addition, in biological psychiatry, most conclusions are based on correlations, not reasoned explanations as they might be in physics. A fair line of questioning is then to ask how the evidence presented *explains* symptoms or other aspects of the mental disorder referred to. This approach may stop those over-confident researchers dead in their tracks.

Diagnostic Labels

For mental health research a central area of concern is the role and status of diagnostic labels. Here you may be on secure ground, because, from your own experience you may well have received a variety of different diagnoses from different psychiatrists for the same illness. More technically, the research literature shows most official psychiatric diagnoses to confer risk of another such diagnosis – so-called 'co-morbidity'. Not to stretch the point too far, one might suggest that the strongest risk factor for any psychiatric diagnosis, is already to have another one! More seriously, the extent of co-morbidity, and the lack of reproducibility of many diagnoses suggests there is something fundamentally flawed about the concepts from which official psychiatric diagnoses flow. I have written elsewhere at greater length on this topic (Miller, 2011, 2012a,b). Here, all I need to add is that a little personal recall of your own experiences with psychiatric diagnosis may open up the dialogue. Psychiatric diagnoses at present are almost ways based on ‘conventions of wise men’, not on proper scientific reasoning. I am not categorically denying their usefulness, but they need considerable refinement, perhaps to come in future years.

Practical Relevance of Biological Research in Psychiatry

Next one might ask about the relevance of research to matters of practical concern. I have already suggested that neuroscience research may offer the most fundamental understanding of mental disorders, but, since its tempo is slow, the pay-off is likely to be in the long term. Unfortunately this argument is used to justify inordinate expenses for *any* research, with little attempt to balance expenses against likely outcomes. So, one could ask researchers: ‘How much did it all cost?’ and to explain and justify the costs of their research. If it is very expensive, and only for the distant future, you might want challenge its relevance, or suggest that the money could be better spent, or even that it is mainly done to promote the career of the researcher and his team. Since you may know the inadequacies of mental health services, due to their underfunding, you may be able speak straight from the heart. A line worth remembering comes from John Maynard Keynes, the economist who contributed greatly to understanding the causes of the great depression of the 1930s. He was writing about classical economic theory, but his line is also relevant to much of today’s research. His line was ‘In the long term we are all dead!’ In other words, he pointed out that some of our problems may be so urgent and immediate that what happens in the long term is quite irrelevant.

Addressing the Underlying Philosophical Issues

If one has reached a stage of genuine discourse on scientific issues, the door may be open to debate bigger issues of philosophy, already mentioned. Here you may be on stronger ground than most scientists. Personal experience of major mental disorder puts you in a privileged position in discussing the relation between mind and brain, and also on the much more problematic question of determinism. You are likely to see these issues (particularly the second) as stark realities at the coal face, not as academic niceties for professional philosophers. If you have thought through your own experiences well, and can express yourselves thoughtfully, you may be able to force some rethinking of basic attitudes amongst the researchers you interact with.

For these areas where your influence can be exerted, any movement you produce will necessarily be slow. However, it is not only in areas of science and underlying philosophy where extended discourse is needed. There are other areas where progress can occur on a much faster tempo, and where your contribution may be quite critical.

Service Delivery

Here you have a vital role to play, in drawing attention (for instance) to crises which were handled badly, lack of coordination between different parts of mental heath services, and gaps in the services. Thankfully, this is an area where in many countries, consumers and carers already play an important role. Active collaboration in shaping modern mental health services is in full swing in many places. Since the partnership is often working well, there is little more to say; and you will no doubt be aware that most mental health services are underfunded, and their staff overworked. While research studies often have a slower tempo than in the HIV/AIDS area, this is an area where relatively rapid improvement may be expected from engagement of service users in policy development for mental health services. Related to service delivery issues, a more strategic area where a coalition of clinicians, researchers, consumers and family members *might* emerge is to use their collective influence to encourage a stronger *research culture* in clinical services. This might then increase the possibility that what is known to work well in the best services is emulated more widely.

Programs to Reduce Stigma and Discrimination

Here again you have a vital role to play. While public anti-stigma campaigns using the broadcast media influence many people, the more personal messages told by people with lived experience of mental illness, in smaller forums, are likely to have a more profound impact on those who hear these stories, even though they affect a smaller number of people. As a public health program, both are needed. A similar comment can be made in relation to youth suicide: Carefully planned community-based public health campaigns have been implemented in some places, which considerably reduce suicides and attempted suicides. There too, personal accounts from people who have been on the brink, and have come back to lead rich and fulfilled lives may be very influential (Hatim, 2005a,b). Like public health measures to combat infectious disease (especially building and maintaining proper drains and sewage systems), these initiatives are never-completed works, not one-off jobs. They need to be maintained year after year, decade after decade.

Social Policies which Impinge on Mental Health

Here we get into central areas of political debate. While emphasis often focuses on shortcomings of personal mental health care, there is a largely unexplored territory which might be called ‘public mental health’, or ‘mental health of a society’. It is easy to argue that most national policies on social and economic issues, for better or worse, have impact on mental health. Examples include policies which widen the income inequality in a society; which, in the name of ‘efficiency’ force through policies for fulfilling targets, as though employees are mere cogs in a state or business machine; excessive competition and certain management styles in public institutions and businesses; noise pollution in public places, and excessive noise levels at public events; legislation related to the gambling industry; school education which over-emphasises academic success at the expense of emotional development and ‘life education’; the widening currency of violent imagery in entertainment and video-game industries, as precursors to real-life violence; failure to recognise psychological and cognitive diversity in educational establishments, business and other workplaces; social welfare policies which limit earnings for those on sickness or invalid’s benefits, which results in people being caught in a ‘dependency trap’. The list could easily be extended. On many of these issues it is likely that community voices added to those of the professionals can bring about change at political levels which the professionals by themselves, however well-intentioned, cannot achieve; and make no mistake, it *does* mean that the combined voices of consumers, carers and mental health professionals enter central debates of any nation's politics.

Help in Recruiting Participants for Research Studies

This is mentioned last, not first, because, it is not likely to be very successful until other strategies have been successfully deployed. However, research *is* a fundamental way from which future improvement in health services will come, and much research requires active, willing, well-informed participation by those who might benefit most, indirectly if not directly. Consumer and carer advocates have an important role in bringing service users, family members and others as potential research participants (including comparison groups) together with the researchers themselves, who are keen to explore new ideas about cause and treatment of mental disorders. A longer account of this area was recently written (Miller, 2010). To highlight just one area, clinical trials of new medications and other innovative treatments, *may* produce important advances; and clinical trials *might* be possible without involving major pharmaceutical companies, and at a faster pace than most drug development (as happened in the HIV area). However, this would depend on forming a solid coalition between consumers and researchers, with shared perspectives and common purpose over-riding philosophical splits of the past.

Other Issues for Consumer Activists Working at the Interface

Look after your own Health as 'Number One' Priority

You may be vulnerable; and political activity of any sort can be cruel and unforgiving, especially when dealing with big issues. So choose carefully when and how to become involved, and develop your personal support networks. It is easier to be strong, and unshaken by public criticism in political debate when you know the people whose views you are representing. *They* give you strength. It also helps you to stay cool if you understand your opponents' perspective and manner of thinking.

How to handle Anger from the Past

Anger *should* be expressed, and in public. Unless it *is* expressed it will fester to become a perennial running sore. The lines from William Blake's poem '*The Poison Tree*' sum it up excellently:

> *"I was angry with my friend*
> *I told my wrath; my wrath did end.*
> *I was angry with my foe.*
> *I told it not; my wrath did grow."*

However, if you express anger, do it thoughtfully, with full understanding of your own feelings. As when declaring your love for another person, unless you understand your own emotions, it will appear incoherent and ineffective. But if we do understand our own emotions, and reason and emotion become well coordinated, the combination may be an unstoppable force. The aim is then certainly to *convey* anger, but without being inwardly consumed by it, and even to speak from a position of inner calm. If that can be achieved, it means that, when listeners start to respond positively to the message you deliver, it is emotionally easy for you to change tack, and reciprocate with a positive message which invites collaboration.

Don't make a career out of anger. A story from a previous generation is relevant here. During World War II, Wilhelm Furtwängler was conductor of Germany's most prestigious orchestra, the Berlin Philharmonic. He was in disfavour in the immediate post-war period, because he was thought (wrongly) to have been an active Nazi collaborator. As with many people of integrity, he found himself in an impossible and very ambiguous situation in that regime. The violinist Yehudi Menuhin worked hard to rehabilitate Furtwangler in immediate post-war years, which itself aroused criticism. On one occasion, Menuhin found himself playing to survivors from Belsen concentration camp. A heckler in the audience shouted angrily: 'Go on, play for the murderers!' Menuhin responded with a brief speech, including the following words: 'I cannot blame anyone for his bitterness. You have suffered too much; you have lost parents, children, brothers and sisters. I have been spared this torture. And still I do say that you simply cannot rebuild your life upon your suffering.' (Burton, 2000). His eloquence carried the day, and he was received with rapturous applause. Issues within today's mental health sector are by no means as grim as those to which Menuhin was responding, but the principle is the same.

Don't personalise the anger. The forces at work, as psychiatry emerges from the asylum era, are larger than any individual, as were those which set up the asylum policy 200 years ago. Mental health staff of former years, almost as much as the inmates of those asylums, can be seen as victims of a policy they had no hope of challenging. All of those involved should be included as potential participants in the process of healing (even if they do not want to join in it). We may be swept along by the exciting times where at last we see long-sought change emerging; but we should always think strategically, with long-term focus, rather than just seeking immediate victories, including personalised victories.

Discourse within Consumer Groups

Within activist groups, get used to listening to opposing viewpoints, and to the disciplines of democratic process. Learn about the discipline needed in committees, committee procedures, and don't let other activists get away with anything less. There is also, I believe, a need for more unity amongst consumer groups, with less knee-jerk oppositional politics by service users pitting themselves against the psychiatric profession and the pharmaceutical industry. In saying this, I am not saying that either of these are beyond criticism, but criticism should be fair, balanced, well-informed and rational. Don't over-emphasise minor issues, and don't look to consumer or family groups for your little slice of power in the group. There are bigger issues at stake, where the common purpose should be of paramount importance.

Build Bridges, foster Useful Alliances

These may be between any of the following: service users, family members, researchers, media people, politicians, commercial enterprises and activists in other health- or disability-related areas, or social advocacy groups in the wider community.

Sometimes there is antagonism between community groups which needs to be healed. One of the sharper splits within community groups interested in mental health is between people with lived experience of mental illness, and their own families. As already noted, there *are* legitimate differences of interest here, but also there are areas of common interest. The differences are sharpest on matters of privacy and control. Service users (and I am one) are usually adults, wanting to run our own lives, and take our own decisions. We need no protection. We all make mistakes; but we want to learn from *our own* mistakes. We cannot learn from those of other people made on our behalf, including those of our parents.

Parents, on the other hand (and I am one), want the best for our offspring. We may be able to see trouble brewing for them, and want to advise, warn and protect against real dangers. We may have heard about over-protective parents, in areas of mental health and disability – and a protective reaction is quite natural, although not necessarily the wisest. Looking at the history of medicine, there are also plenty of precedents where medical professionals adopted over-protective attitudes to patients; and they too had to learn the hard way about how to do it better. So, a word of advice to parents – never offer advice! … *but,* be prepared with wise words when they are asked for; and also realise that each person's world of disability is one you can never fully know. Each disabled person has to work out for themselves the best strategy, but perhaps with support and gentle guidance along the way.

Some of the more intractable problems created by mental illness are unresolved issues within families. Apart from issues of privacy and control, there may be ones arising from times of crisis. Because parents may have been involved at very critical times of committal to a psychiatric hospital they continue to harbour unresolved guilt feelings. Such times of crisis may have a bad impact on family relationships for years to come, because, at the time, they were so frightening and intense that no-one subsequently can find ways to talk about them. In addition, because the world of each individual's disability cannot be fully grasped by anyone else, those with the disability may get angry that no-one else understands their situation. This also can lead to rifts between parents and offspring. Mental health professionals, or a skilled facilitator with another background may have a special role in helping to bring together family members, where events such this have led to separation and estrangement, the aim being to resolve the anxiety, guilt and misunderstanding surrounding those events. I suspect it rarely happens, and this may be one of the factors making it difficult for groups (respectively) of consumer activists and family members to work together on the policy issues where they have common cause.

Challenges addressed equally to Professionals and Community Activists

As already noted, the relationship between psychiatrists (and other mental health staff) and patients is different from that in any other area of medicine. Even with the most conscientious attention to ethical principles, there *is* a power imbalance. However, when it comes to collaboration between *former* patients, now acting as consumer activists, and mental health professionals, the game is different. The power imbalance which existed formerly *is* an inevitable source of tension; but it is certainly possible to get beyond this tension. This requires movement on both sides of the divide. The professionals need to radically shift the approach they adopt in dealing with actual patients, inviting their former patients to adopt stronger positions, as respected partners of equal status. I know from my many friends in mental health professions that this is possible. To the consumers (former patients), I say: 'Go easy on the shrinks!' They have a difficult job to do, easily misunderstood, often in the face of much public misunderstanding, and they are overworked. Try to see things from their point of view as well as your own.

The Need for an Extended, Disciplined Process of Dialogue

It is to be hoped that the different stakeholders, despite vast differences in life experiences, can get to know each other as friends, colleagues, and (I would like to say), comrades in arms, fighting on a different front perhaps, but in the same campaign. To bring this about, what is needed is a prolonged, thoughtful, and carefully considered process of dialogue, so that, despite the differences in perspective, the communality of cause becomes the dominant factor, and all can start to work together. Especially when there is the possibility of conflict, such dialogue may need skilled facilitation by mediators knowledgeable about the field, but not identifiable with any particular viewpoints or factions within it. The aim would then be for concerns to be expressed calmly and rationally, looking for rational responses, and with willingness to ask questions if responses seem excessively defensive, or not rational. Everyone should strive to be fair in their criticism. Consumers should try to put themselves in the role of a busy psychiatrist, trying to make wise decisions in the face of considerable uncertainty, large workloads, and the possibility of public criticism or worse. In such dialogue, it may be needed to go over the same ground repeatedly, so that active reflection on issues already discussed can lead to more constructive solutions. If people on both sides of the divide *can* move towards each other, and develop a shared perspective of the whole field, I believe that, in psychological terms, it may mean profound healing for all participants.

Conferences

Apart from small informal meetings, the times when a lot of networking, and 'meeting of minds' takes place is at conferences of various sorts. Their focus may be on medical science and research, or on professional matters or health politics. Medical or research conferences are usually large, the program full, registration fees substantial. The environment is often crowded and noisy, and in plenary sessions presentations are often to some extent showpieces, with little chance of real discussion. In the mental health area, if the real objective is to build bridges between professionals and community spokespersons with very different life experiences, this is usually a most unsatisfactory format for meetings. The registration fee is likely to be right outside the budget of service users, aimed at people with medical salaries, or institutional backing. The program is rarely set up for extensive discussion to reconcile opposing viewpoints. If the meeting is large, with most participants being professionals, it is likely to be intimidating for service users, who will make up only a small minority of participants. Since many consumers have perceptual problems, such as noise sensitivity, it may be physically unpleasant, and therefore, for a four- or five-day conference, quite exhausting. In other words it is far from the best environment for service users to show their strengths, and may be the worst possible environment.

Here, for consideration, are some alternative guidelines to make research meetings more user-friendly for service users.

- Aim for small inexpensive conferences, perhaps one- or two-day meetings, with no more than fifty or sixty participants. The meetings can however occur more often, and with more specialised focus than at the large international gatherings. Small meetings are anyway easier to organise, and financially less risky.
- Small meetings will also minimise the noise and overstimulation of big meetings, which effectively silence any consumers who, against all odds, manage to be there.
- In promoting such meetings it is important to encourage a roughly equal mix of consumers, family members, researchers and clinicians, perhaps along with mental health administrators, case managers, and others influential in engineering research partnership between service users and researchers.
- If a large proportion of participants are scheduled as speakers (which is easy to arrange in small meetings), this encourages the 'meeting of minds'.
- With this aim also in mind, a relatively 'open' program, with ample time for discussion of each paper, and plenty of time between sessions for people to get to know one another is also recommended.

Conclusions

The times we live in are ones of historic change for psychiatry and other mental health professions. The past was dominated by the asylum era which stretched from the early 1800s (in Britain) to the second half of last century. The legacy of that period is still with us, and, in some sense, will be with us for a long time to come (just as, in the UK, the legacy of the workhouses, set up in the years after 1834, and phased out between 1930 and 1948, has barely faded from public consciousness). At present however the psychiatric profession in many countries is attempting fundamental recasting of its social role, reaching out to communities and hoping for continual and fruitful dialogue and partnership. Part of that shift, aided in part by availability of medications with far fewer unpleasant side effects than in the past, is that the relation between psychiatrist and patient is changing. It can now, as in other areas of medicine, be based on genuine trust and collaboration.

A stumbling block in the transformation, which prevents the profession gaining the respect and trust needed in the process, is the emotional legacy from the past. Criticism of psychiatric services and mental health professions may then be based not on styles of practice now emerging, but on folk memories and lay understanding about large mental institutions of the past, and professional attitudes which sometimes flourished in those environments, perhaps rehearsed unhelpfully by the entertainment industry and other media outlets. There are ways to address, and move beyond the legacy inherited from those times, which will hasten the day when those memories are consigned to history, and are no longer influential and of practical importance. In the process of 'letting go' of the past, it may be necessary to hear the truth about those times, told openly in forums where there is no thought of retribution or litigation. There are many stakeholders whose voices will need to be heard. The transition will occur gradually over decades. If we are all aware of the historical shift now in progress, and its probable time scale, the transition can be expected to go ahead more smoothly, more rapidly and in a more wholly positive way.

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Chapter 5

A CONTEMPORARY SHAMANISTIC INITIATORY CRISIS

David Lukoff

> *"The future shaman sometimes takes the risk of being mistaken for a 'madman' … but his 'madness' fulfills a mystic function; it reveals certain aspects of reality to him that are inaccessible to other mortals, and it is only after having experienced and entered into these hidden dimensions of reality that the 'madman' becomes a 'shaman'."*
>
> (Eliade, 1951, p. 107)

Mircea Eliade found that a psychotic episode has served as the initiatory crisis marking, for some shamans, a call to the healing profession. For example, the Siberian shaman Kyzaslov entered a state of 'madness' lasting for seven years which resulted in his initiation as a shaman. He reported that during those years he had been beaten up several times, taken to many strange places including the top of a sacred mountain, chopped into pieces and boiled in a kettle, met the spirits of sickness, and acquired the drum and garment of a dead shaman. Being 'tormented' by spirits, babbling confused words, displaying curious eating habits, singing continuously, and dancing wildly are other common elements in initiatory crises; in our society today these experiences would be considered evidence of a psychotic disorder and could possibly result in hospitalization. Yet when Kyzaslov recuperated, he reported that, "*the shamans declared, 'You are the sort of man who may become a shaman; you should become a shaman. You must begin to shamanize*" (Halifax, 1979, p. 50).

All mental and physical illnesses, accidents, and other ordeals, by creating psychospiritual crises, open the door to the shamanic world of spirits and nonordinary reality. In contemporary society, psychotic states of consciousness retain their power to awaken shamanic tendencies and talents. It proved to be so in my case, and for others whom I have met, worked with as a psychologist and written case studies about. My psychotic episode took place in a non-shamanic cultural and psychological context, but it bears a distinct relationship to a shaman's initiation: 1) it contained thematic and imagistic parallels to the initiatory crises of professional shaman; 2) it served as my calling to the mental health profession just as the shaman's crisis calls him/her to the role of healer; 3) it was integrated with the aid of traditional shamans and their practices.

Since I live in a contemporary Western society which does not recognize the social role of an ecstatic healer who cavorts with spirits, my psychotic episode did not initiate me as a shaman. I have devised the term 'shamanistic initiatory crisis' to describe my experience. As anthropologist Ruth-Inge Heinz noted, "*The term 'shamanistic' is used for shaman-like activities, e.g., activities which may be carried out by somebody other than a shaman, while the term 'shamanic' indicates that these activities are carried out by somebody who actually is a shaman*" (Heinz, 1984, p. vi). Therefore, shamanistic is the appropriate term.

My psychotic crisis occurred 41 years ago. After coming to the conclusion that, at 23 years of age, I had lived a very sheltered life and did not know my own self, I dropped out of the doctoral program in social anthropology at Harvard University. I gave away all of my possessions, from bed to books, that would not fit into my backpack. I started travelling – hitchhiking across the country, up into Canada and down into Mexico. In San Francisco six months later someone offered me a tab of LSD. I took it thinking this was another chance to try out new things I'd never done in my life before. The day went well with some wonderful visual effects but I didn't notice that anything seemed transformative or life changing. However the next day, while reading Suzuki's book *Zen Buddhism*, I felt for the first time I had solved the riddle of Zen teachings and become 'enlightened.'

Then 4 days later, I awoke just after midnight and walked over to the bathroom in an apartment near San Francisco that I was crashing at. I stopped in front of the mirror and gazed at my reflection. Suddenly I noticed that my right hand was glowing, giving off a white light. My thumb was touching my forefinger in the ancient *mudra* position of the meditating Buddha. Immediately the meaning of this sign was clear to me: I had been Buddha in a previous life. Then another thought came: I was also a reincarnation of Jesus Christ. Now, in this moment, the luminous image in the mirror was awakening me to my true purpose: to once again bring the human race out of its decline. My new mission was to create a new 'Holy Book' which would unite all people around the common tenets of a single belief system. Instead of unifying just one social group, as Buddha and Christ had, I would write a book that would create a new worldwide society free of conflict and full of loving relationships.

I had been trained well. Undergraduate studies in ancient civilizations at the University of Chicago and a Master's degree in social anthropology at Harvard had provided me with a comprehensive and scientific understanding of the way societies function and change. This knowledge, added to the wisdom inherited from my previous incarnations, prepared me for my sacred mission. Due to my enlightenment, I was now freed from dependence on society's rigid norms and narrow perceptions of reality. I had acquired the intellectual freedom and creativity of an enlightened being. In addition, I had unraveled the mysterious process by which the Zen Master creates the enlightenment experience in others. Thus, I deemed myself fully prepared to design a cultural revolution in which everyone would become enlightened.

Now that my life's mission had been communicated to me during this single glance in the bathroom mirror, I headed for the table where my journal, now to be a 'Holy Book,' lay open. Over the next five days and nights, I worked with only short breaks for meals and naps. I found I could contact the 'spirits' of eminent thinkers in the social sciences and humanities to help me with the task of writing the new 'Bible.' As I reflected on their relevance for my work, I would 'become' these people of wisdom, and 'think their thoughts with them.' I had discussions with contemporary people including Ronald D. Laing, Margaret Mead, and Claude Levi-Straus. To give me insight into how to take my work into the popular culture, I sought out the advice of Bob Dylan and Cat Stevens. People who were no longer living were also communicated with: Durkheim, Locke, Hobbes, Rousseau, Mead, Voltaire, Adam Smith, Jefferson, Freud, Jung, and, of course, Buddha and Christ. At times during the writing, the clarity of my thoughts and the beauty of my vision for the future brought tears to my eyes. Initially I assumed a penname 'The Scholar' to allude to the erudite origins of this project, and I soon realized that 'The Scholar' was my new reincarnated identity.

After five days of writing, the book was finished. Its 47 pages contained a combination of parables, poems and instructions on how to organize the new society. I concluded that Berkeley was the New Jerusalem for 1971 and that Cody's bookstore was the centre of a communication vortex of hippies and freaks, who would be first to herald my new Bible and circulate it to others. So I went in front of Cody's in Berkeley, and passed out copies of my new book. I mailed other copies to friends and family, wanting those closest to me to be the first ones to learn about this new way of living.

Over the next 2 months, I awaited the response. To my surprise, most people I mailed it to or gave it to did not respond. No one reported becoming immediately enlightened; no one expressed a desire to join my mission to change the world. Nevertheless, I was sure that the revolution I was to lead would materialize. I was so preoccupied with my mission that I didn't work to earn money. I crashed at many friends' homes. They were compassionate and generous in supporting me, both financially and psychologically. None of them ever treated me as though they thought I was crazy. They gave me food and shelter and let me read their books. They listened to my new ideas and talked to me about religion and life.

My sense of being the reincarnation of Buddha and Christ slowly dissipated over the next two months. There was not a specific moment when this belief dissipated. I just thought about myself less and less as a new messiah. Although I began to realize that it was not to be a new 'Bible,' I still believed that it contained many brilliant and novel ideas and syntheses of previous thought. I would publish it as a best-selling book.

In early spring of the next year, I went to live by myself in my parent's summer cottage in Cape Cod. I continued working on my book; however, my health rapidly deteriorated. It began with headaches and insomnia; my head felt as though it would burst with pain after an hour of reading and many nights I could not sleep. I felt miserable and depressed. Then I had a recurrence of an illness I had suffered 10 years earlier, Crohn's disease, a serious condition affecting the intestines producing severe cramping and internal bleeding. I forced myself to keep reading as I was discovering the works of Jung and Joseph Campbell for the first time and they seemed to speak directly to my experiences.

At the same time that it was becoming physically difficult for me to read, it was also becoming more imperative. In giving up my grandiose identity as a prophet, I now turned my attention to becoming a renowned author. However, my research led me to many books on religion and social change that showed me my ideas were not so original. While reading Roszak's *The Making of a Counterculture*, I realized that my 'vision for a new society' was a stock '60's' Utopian plan that had led to the founding of numerous communes.

I became embarrassed at the thought of having sent a semi-incoherent 'Holy Book' to all my closest friends and family. Now I questioned whether I had anything worthwhile to say in the book, which had been my *raison d'être* for the previous several months. I felt totally lost and confused. I was still quite sick physically with Crohn's symptoms, headaches, and insomnia fuelled by horrific hypnogogic images of angry faces and the image of my skeleton hovering over me on sleepless nights. I was even considering the possibility of committing suicide with an overdose of pain medications.

Two months after moving to Cape Cod to be alone, I was walking near the bay, ruminating about the events of the last several months and feeling depressed. Suddenly I heard a voice speaking to me. I was startled. The voice distinctly said, 'Become a healer.' At that time, lost in self-recriminations about the past, I did not think of myself as even having a future! However, this voice – the only one I've ever heard emanating from outside of myself – set a whole new train of events in motion. Although the voice was not accompanied by the ecstatic emotion of my first rebirth, it initiated my path toward a new lifestyle and profession.

I decided to leave Cape Cod and go to my parents' home in New Jersey to recuperate. There I took classes in yoga and herbs, and participated in encounter groups. Then I joined a program at a personal growth centre and trained in a multitude of healing practices including gestalt therapy, transactional analysis, primal therapy, bioenergetics, massage and psychodrama. Eventually I became a group facilitator at the Forest Hospital Growth Center outside of Chicago.

After working as an encounter and growth group leader for 3 years, I entered a doctoral clinical psychology program and learned that my experience would have been diagnosed as a schizophrenic episode. Taking LSD four days before the episode began had probably triggered its onset. In the current diagnostic nomenclature it could be considered a 'Hallucinogen Delusional Disorder' even though the extraordinary events started days after the LSD was out of my system. The LSD had initiated a train of mental events which were amplified over the next four days by intensive reading of books on Zen, introverted journal writing, social withdrawal and little sleep. These preoccupations and behaviors culminated four days later in the event in front of the mirror, and my life did not return to normal until six months later.

Although this level of understanding sheds some light on what happened, nothing in my training as a psychologist encouraged me to explore this psychotic episode further. From the medical model perspective, psychosis brings no potential for transformation, only the risk of recurrence. The new 'holy book' and all my copious notes sat in a sealed box that moved with me from one living abode to another but was never opened – physically, mentally or spiritually.

Some 7 years after this episode, during my psychology internship at Camarillo State Hospital in California, I entered into Jungian analysis. Soon after starting therapy, I had a dream in which a large red book appeared. My analyst, Dr Margaret Johnson, asked for my associations about the book. Memories of my 'Holy Book' leaped into my consciousness. I had not discussed my psychotic episode with anyone, and my heart raced at the prospect of having to share my story with someone in my own profession. Recognizing therapy as a sacred place where one can safely tell secrets, I blurted out the details of my experience – being a reincarnation of Buddha and Christ whose mission was to save the world by writing the new 'Bible' but to show that I was now a sane member of the psychology profession, I described these as 'grandiose delusions' and 'visual hallucinations.' She said, "*Well, I don't think that's craziness. Sounds like something important was happening to you on a deep level.*" She invited me to bring the book to the next session. The sealed box would soon be reopened – physically and mentally.

While the next two sessions focused on this phase of my life, my lingering discomfort with its grandiosity and inflated identity kept me from delving very deeply into the experience. However, James Hillman (1983) pointed out, "*Recovery means recovering the divine from within the disorder, seeing that its contents are authentically religious*" (p. 10). After that therapy session, I began my own process of 'recovering the divine.' I realized that my book and the events that had surrounded its writing could be analyzed like a dream, examining personal and universal symbols. True to my 'scholar' nature, I began research on psychotic episodes and their parallels to various myths. I turned to writing case studies such as the '*Myths in Mental Illness*' which were published in *Journal of Transpersonal Psychology* (Lukoff & Everest, 1985). My Jungian analysis and scholarly work provided me with a 'dictionary' of symbols for interpreting my own experience. When I did begin to reflect on my experiences in therapy, I realized that I had very little knowledge of Christ or Buddha at the time I assumed their identity. These experiences led me to explore Christianity, Buddhism, and other forms of spirituality for the first time in my life. Perry (1998) noted that after a psychotic episode, "*What remains … is an ideal model and a sense of direction which one can use to complete the transformation through his own purposeful methods*" (pp. 34-35). I now view my own experience of having 'been' Buddha and Christ as revealing ideal models for my spiritual life as well as my spiritual awakening.

However, the spiritual potential inherent in my experience lay dormant until contact with shamanic teachers enabled me to connect with that dimension. Upon finishing my doctorate in psychology in 1980, I became a faculty member in the Clinical Research Center for Schizophrenia at the UCLA Neuropsychiatric Institute. At the same time, I became a staff member of The Ojai Foundation, a new educational retreat centre north of Los Angeles. In this semi-wilderness location, the first structure we erected on the land was a teepee. A sweat lodge was soon added. This hospitable and appropriate setting for training in shamanic practices was created by medical anthropologist Joan Halifax, an author and expert on shamanism (now the Roshi of the Upaya Zen Center). Daily life included chanting; drumming was a frequent activity. Pipe ceremonies marked special events and frequently were held at sunrise. The New Year's Celebrations were ceremonies modeled after the Peyote Ceremony with a water drum and singing stick passed around the circle throughout the night.

The Ojai Foundation was host to many traditional shamans and Native American medicine people who held retreats where they shared ceremonial healing techniques. During the next few years, I attended programs by Wallace Black Elk and Grace Spotted Eagle, Prem Das, Sun Bear and Wabun, Hyemeyohsts Storm, Oh Shinnah, Grandfather Semu Huaute, Rolling Thunder, Harley Swiftdeer, Thomas Banyacya, Evelyn Eaton, Adam Fortunate Eagle, and Elie Hien. Their extended visits after the retreats enabled those of us living on the land to get to know them more intimately and to participate in private ceremonies, prayer sessions and sweats.

In the altered states of consciousness induced by these shamanistic practices, I re-experienced, for the first time since my psychotic episode, a feeling of oneness with the universe. Once again, I was communicating with divine spirits, and comprehending the meaning of life itself. Instead of repressing these ecstatic experiences which had brought painful memories, I was now learning to trust them again. Such experiences are a major component of shamanic life: "*Shamans do not differ from other members of the collectivity by their quest for the sacred – which is normal and universal human behavior – but by their capacity for ecstatic experience*" (Eliade, 1951, p. 107).

Shamanistic practices enabled me to reclaim a culturally-disapproved and repressed dimension of my being that psychosis had revealed: my capacity for ecstasy – the union with higher forces and understanding. However, these teachers and my daily shamanistic practices taught me how to exercise voluntary control over entry into and out of ecstatic states, and how to keep them contained within appropriate social contexts.

During these years, I learned about power animals and discovered some of my own, including the owl, the coyote and the lizard. Times of solitude and spiritual reflection in wilderness settings taught me how to follow my inner voices. For instance, a dream in which my file cabinets appeared covered with beads and feathers made me aware that these tools for academic work are my power objects. One morning bicycling to work, I came across a dead barn owl. This connection with my first power animal reminded me of my dream. I spent nearly an hour intently working to sever its wings and claws using a sharp stone. I had the claw beaded and that beaded owl claw still hangs in my office. These spirit teachers along with more traditional teachers helped me create a personal mythology based upon my inner life.

Parallels between Psychosis and Shamanic Initiation

The key themes in shamanic initiation are ascent into the upper world, descent into the lower world, dismemberment and rebirth (Eliade, 1951). These four themes were present in my experience. First, I ascended into a kind of heaven where I felt myself to be chosen for a mission to change the world and 'became' the gods Christ and Buddha. Then I descended into a hellish realm which represented my dismemberment – constant headaches, insomnia, intense abdominal cramps and internal bleeding – during which I envisioned my death. At the end of my experience I felt reborn through an audible call to become a healer. Thus, the story of my psychotic experience follows the classic four-part thematic structure characteristic of shamanic initiatory crises.

Many images that appeared in my experience also parallel the symbolism of shamanic initiations. Shamans frequently have experiences, as I had, of becoming enlightened and being enveloped in light. Referring to 'the disciple's 'lighting' or 'enlightenment,' Eliade writes: "*the experience of inner light that determines the career of the Iglulik shaman is familiar to a number of higher mysticisms*" (p. 117). He mentions similar occurrences in the Upanishads, the Tibetan Book of the Dead and Christian mysticism. Another common initiatory motif which was part of my crisis is discussed at length by Eliade in his book in a section on "*Contemplating one's own skeleton.*" Lastly, the theme of rebirth also occurs in many traditions. Joseph Campbell (1972, p. 237) wrote: "*The inward journey of the mythological hero, the shaman, the mystic and the schizophrenic are in principle the same; and when the return or remission occurs, it is experienced as a rebirth.*"

Of course a key difference between my psychotic episode and the shaman's initiatory crisis is the way it is viewed by our respective societies. From the contemporary Western perspective, it would be considered a psychotic illness. However, in shamanic societies, such experiences often mark an individual as an ecstatic healer. Another difference relates to the type of divine figures encountered. The shaman encounters animal spirit guides; I met Christ and Buddha. When contacting spirits of the dead, I did not communicate with dead shamans, but the 'spirits' of numerous people, leading figures from the Western cultural tradition – both dead and alive. My preoccupation with writing a book to change the world is also not a shamanic theme. However, it is somewhat parallel to the shaman's quest to acquire power objects, songs and drums which can be used to heal others.

Shamanistic Crisis as a Calling to the Mental Health Profession

Psychologist Jeanne Achterberg (1987-'88) pointed out that crises and illnesses bestow upon the shaman the wisdom to serve the community as a healer. She then goes on to observe that, *"Such events can occur and have occurred in the lives of health professionals in the modern world and have led to vocational choice. Being disabled, or having a serious disease, or being in recovery from an addiction, or even having a child with a significant handicap has been the wounding or the initiation for many in the health care field"* (p. 20).

Etymologically, 'vocation' stems from an earlier meaning: the hearing of a divine voice summoning one to a religious career. My vocation as a mental health professional followed an audible summoning to the healing profession in the midst of my psychotic episode. During my years of teaching graduate psychology students, giving workshops, and receiving correspondence from readers of my articles, I've learned that many mental health professionals have been 'called' to their profession by a psychotic or depressive episode.

My psychotic experience has continued to guide me in my profession. I believe that my crisis awakened certain healing abilities that contribute to my work with patients having psychotic episodes. For example, it is relatively easy and rewarding for me to empathically enter the delusional reality of patients and to help them find value and meaning in these experiences (Lukoff, 2007). Most mental health professionals seem to find an 'abyss of difference' (as Jaspers, one of the fathers of modern psychopathology, described it) between the 'normal' and the psychotic mind. Through my psychotic experience, I became aware that patients have needs beyond pharmacologically-based treatments. At Camarillo State Hospital, I developed the first holistic health program for schizophrenic patients (Lukoff, Wallace, Liberman, & Burke, 1986). It incorporated jogging, meditation, stress management and art therapy along with a weekly 'Growth and Schizophrenia' group therapy program. These therapy sessions helped the participants to develop a positive attitude toward their illness and improve their self-esteem by pointing out parallels between their experiences and those of shamans, mystics, and artists. My clinical work has also involved harnessing the creativity of psychotic patients by having them write and draw about their experiences. Several of these writings have been published and the art works displayed. During the past 30 years in my clinical practice as a psychologist at UCLA-NPI, Camarillo State Hospital, the San Francisco VA Medical Center, and private practice, I have often found myself face to face with individuals who have had delusions similar to mine. I believe that my ability to work effectively with those individuals has been aided by being given a rare opportunity to journey through the complete cycle and phenomenology of a naturally resolving psychotic episode. Thus, beyond serving as a spiritual awakening, my journey held within it the archetypal gift of the Wounded Healer, providing me with the ability to connect more deeply with persons recovering from episodes of mental disorders.

Had I been diagnosed with a psychotic disorder, hospitalized and medicated, I'm sure that a positive integration of my experience would have been much more difficult to attain. With this in mind, I published an article detailing operational diagnostic criteria for distinguishing mental disorders from spiritual emergencies which are crises which carry the capacity for self-renewal (Lukoff, 1985).

Shamanistic Practices and the Integration of Psychotic Episodes

In 1967, psychologist Julian Silverman noted the similarities between the crises involved in psychosis and those in shamanic initiations. He also lamented the lack of a supportive social milieu in contemporary Western culture as compared with traditional shamanic societies where the social role of the shaman legitimates free access to altered states of consciousness. "*For the schizophrenic, the absence of such culturally acceptable and appropriate* [access] *only has the effect of intensifying his suffering over and above the original anxieties … for the crisis solutions of the schizophrenic are totally invalid ones in the eyes of the great majority of his peers*" (pp. 28-29).

Becoming a shaman to help integrate psychotic experiences is no longer a viable option for individuals in contemporary mainstream Western society. There is little cultural support for such a role in which accessing altered states of consciousness is acceptable. However, in the two decades since Silverman pointed out this lack, the option of utilizing shamanism to integrate psychotic crises has been revived by the neo-shamanic movement. Joan Townsend (1988) points out the practical training that this movement provides: "*While one could 'learn' shamanism one's own by extensive research and experimentation, it is not a very practical alternative. The experience of participating in a shamanic group, even if only for a few days, provides an orientation and a qualitatively different experience so important for a true knowing"* (p. 82). In my case, by pursuing shamanistic practices I changed my self-perception about this very significant episode in my life. I like to think that in an earlier era my psychotic episode would have marked me as a shaman-elect and I would have been apprenticed to a master shaman to learn to control these abilities.

While presenting my views in various workshops and classes I have led, I encountered many others who were drawn to shamanistic practices by episodes of mental breakdown/breakthrough. In one workshop, 'Psychosis: Mysticism, Shamanism or Pathology?' my co-leader, Joan Halifax, explained how her inspiration for establishing The Ojai Foundation was an outgrowth of her own descent into psychosis. Shamanism had provided a map to guide her back to wholeness. She created an educational center where people would be welcomed into a healing community. Guided by authentic shamans, novices learned self-control over entry into and exit from ecstatic states of consciousness. During a retreat in Ojai, Lakota shaman Wallace Black Elk shared with me how his initiatory visions in his early twenties led to his hospitalization but also to his choosing a path as a Medicine Man.

Today shamanistic techniques are increasingly being employed in counseling, psychotherapy and medical treatments. During his years of work treating psychotic patients, Jungian analyst John Perry (1974) found that a primary function of an acute psychotic episode is to enable the individual "*to learn to perceive symbolic meanings as they pertain to the living of one's psychic life, and thus to keep connected with the ever-enriching wellsprings of the emotions which nourish that life*" (p. 1). In integrating my shamanistic initiatory crisis, I found the literature on shamanism and neo-shamanism provided archetypal and experiential parallels to those psychotic experiences. Awareness of such correspondences allowed me to translate my culturally discordant psychotic experiences into a personally meaningful mythology. Contact with shamans and shamanistic practices provided training in self-control of ecstatic states and journeying to spirit worlds. Shamanistic practices, pursued with the guidance of knowledgeable therapists or trustworthy traditional teachers, are an ideal way to extract a symbolically rich personal mythology from a psychotic crisis.

Integrating my personal journey has involved publishing an account of my own and others transformative psychotic episodes and giving presentations targeted to increasing the awareness of mental health professionals about the important role of spirituality in recovery and in mental health in general. This work contributed to the addition of a new category to the *DSM-IV* entitled Religious or Spiritual Problem (V62.89), which I coauthored. I see my professional work as an outgrowth of this shamanistic initiatory crisis.

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Chapter 6

SCHIZOPHRENIA – PRODROMAL SIGNS AND SYMPTOMS – A PERSONAL PERSPECTIVE

Frederick J. Frese

At the recent 2012 National Convention of the National Alliance on Mental Illness (NAMI) held in late June in Seattle, Washington, a presentation was given as part of a panel program (Moller, Jensen & Jensen, 2012) by a young man, perhaps in his early thirties. The presenter's name was Trent Jensen and in his talk he revealed that he had been diagnosed with, and is under treatment for schizophrenia. He gave an impressive overview of his life as he has been struggling to recover and live as best he can. He is currently working as a peer specialist in a recovery center in the small town of Papillion, Nebraska. After his talk time was allowed for questions from the audience. I was one of the audience members who took advantage of this opportunity to ask what I felt was an important question.

I asked Trent if he had had any signs or symptoms before his breakdown that might have indicated that he was in the process of developing schizophrenia. He responded quite confidently that he had no indications at all that he might go on to have a schizophrenic breakdown. Indeed he related that he had been a very successful ROTC cadet while he was in college and had been looking forward to a career in the military.

I was very struck by Trent's answer.

You see, I too am a person with schizophrenia. I was first diagnosed with this condition over four decades ago. After my initial diagnosis I spent the next decade being repeatedly hospitalized, mostly involuntarily, for repeated psychotic breaks. Like Trent was doing at the NAMI convention, I started being open about my by condition about 25 years ago, and have given many hundreds of invited presentations throughout the U.S. and in several other countries, where I have openly and repeatedly identified myself as a person in recovery from schizophrenia. I have often been asked the same question that I asked Trent, that is, "*did I have any indications prior to my diagnosis that I might be a person who was vulnerable to schizophrenia?*".

Like Trent, until now I have always responded that I was a very normal, reasonably successful, teenager and young adult prior to my first hospitalization at age 25. Indeed, details of my experiences since being diagnosed with schizophrenia have been published via several venues (Buie, 1989; Frese, 1993, 1994, 1997a, 1997b, 1997c; Henry, 2007). Virtually none of these publications explicitly reveal indications that I may have had signs or symptoms of schizophrenia before my formal diagnosis.

Recently however, as the foremost experts on schizophrenia and other forms of psychosis, have weighed in on the writing of the forthcoming fifth edition of the Diagnostic and Statistical Manual (DSM-5), there has been considerable discussion as to whether or not to include a condition tentatively labeled: Attenuated Psychosis Syndrome (APS) (Woods, Walsh, Saksa, & McGlashan, 2010). The APS designation would be given, primarily to adolescents and young adults who show signs or symptoms indicating they are at risk for a experiencing a psychotic breakdown.

Indeed, I notice that an esteemed schizophrenia researcher has recently stated that "*very recent publications have detailed that biomarkers can identify and quantify high-risk or prodromally symptomatic subjects who subsequently undergo conversion to psychosis*" (McGlashan, 2012).

Although I have a somewhat limited understanding of the biomarkers to which Dr McGlashan is referring, the use of fluoro-dopa positive emission tomography scanning to measure dopamine synthesis (Howes et al., 2011) or capillary gas chromatography of erythrocycyte membrane fatty acid levels as they relate to brain phospholipids (Amminger et al., 2011), I found Tom McGlashan's comment to be of great interest to me personally. These studies suggest that brain differences as well as behavioral deficits should be considered as prodromal indicators of schizophrenia.

If, in fact, the functioning of the brains of those of us who later develop psychotic conditions, is measurably different from our peers who do not develop these conditions, and there are behavioral and cognitive correlates of these neurophysiological differences as well, then perhaps I need to reexamine my first 25 years, which until now, I have seen as fairly normal, indeed even as moderately successful.

Upon reflection, one major reason why I have resisted any acknowledgement of having signs of schizophrenia before my formal diagnosis, is that the signs and symptoms on which schizophrenia researchers focus are generally characterized as deficits or impairments. Poor performance in school, low intelligence quotient scores, difficulties with various types of memory, attention, decision making, and a wide variety of other cognitive and behavioral deficits (Green et al., 2011).

Indeed, in my early writings about living with schizophrenia, I, too, followed the custom, referring to the 'social deficits' experienced by those of us with schizophrenia (Frese, 1997c). However in the mid 1990's, during the question period after a presentation I was giving at a Washington State NAMI convention, a fellow consumer/survivor/service-user approached me in obvious distress. She held out her hand to me and in a very emotional voice, all but screamed her concern about my using the word, 'deficit'. She said that my using this word was like my pouring salt into a wound she might have in her arm. She said most emphatically that what she had were not '*deficits*', they were '*differences*'. I was taken aback. I realized that she was so very right. Just because we are different, does not necessarily mean that we are defective, impaired, diseased, or otherwise somehow broken-brained.

For the past twenty years or so since my encounter with the young lady in Washington State I have tried to influence other academics and scholars in the schizophrenia research community, to get them to see that the differences that they observe in us are not necessarily defects. My first published attempt to make this point was with an article (Frese & Davis, 1997), where my co-author was also a person who developed symptoms and was hospitalized and treated for mental illness. A *sub rosa* question in the article was, that if we were so cognitively defective, how did we become Ph. D. level psychologists? This modest initial effort was followed by a small edited book (Frese, 2000), where two other doctoral level psychologists wrote chapters identifying themselves as having been diagnosed with and hospitalized for schizophrenia.

Subsequently my effort to assert that we schizophrenics are not necessarily impaired in our intellectual or cognitive abilities was greatly assisted by the publication of the book, *The Beautiful Mind* (Nasar, 1998) and the release of the Academy Award winning commercial film with the same title (Howard & Goldsman, 2001). These productions portrayed the life of the mathematician and Nobel Laureate, John Forbes Nash, who has been diagnosed and hospitalized numerous times for his condition, paranoid schizophrenia. Also very helpful was that the University of Southern California Law School Professor, Elyn Saks (2007), published her widely read volume, The Center Cannot Hold, where she revealed in great detail her diagnosis and multiple hospitalizations for schizophrenia.

More recently, Drs Elyn Saks, Edward Knight and I were able to have published in Schizophrenia Bulletin an article on recovery where we identified some ten psychologists, psychiatrists, and other doctoral level mental health professionals who have openly published books and/or journal articles about their having been diagnosed and hospitalized for schizophrenia (Frese, Knight, & Saks, 2009). Once again, the question being raised in these efforts is, if we persons with schizophrenia are so cognitively and emotionally defective, apparently even before our first breaks, how is it that we have been relatively successful, at least in the academic arena?

Despite these efforts and similar activities by my recent co-authors Robert Miller and Peter Chadwick (Miller, Frese & Chadwick, 2013; see their chapters in this book), the basic concept that persons with schizophrenia should be thought of as different, but not necessarily impaired or defective, has not yet gained much traction in academic/scholarly/research circles. With the exception of some ‘first person’ articles, but very few others, authors of published articles in such high impact psychiatric journals as *Schizophrenia Bulletin, Schizophrenia Research, Archives of Psychiatry,* etc., almost exclusively focus on impairments and deficits. However, a few of these rare exceptions have been and continue to be very interesting (e.g., see Owen, Cutting & David, 2007).

The recent focus in the schizophrenia research community on prodromal signs and symptoms has caused me to realize that my insistence that I was normal until just before my first hospitalization largely emanates from the mind-set that we should look for early deficits such as decrements in intellectual and/or cognitive abilities, social deficits, as well as early signs of delusions or hallucinations.

Rather than stand my ground and continuing to insist that I was just a normal kid, pretty much like all my normal friends, perhaps I should acknowledge that recent scientific findings are suggesting that as a teenager and young adult I may well have had activities in my still developing brain, that may have been reflected in my being *different*, but not necessarily defective, in my behaviors, attitudes and cognitions.

Obviously, in the brief autobiographical sketch that follows, I cannot possibly hope to review most of the ways in which I may have exhibited 'differences' that may have been signs that I was to later become a person with schizophrenia. After all, most of the period about which I will be commenting is over a half century ago and there are surely many developing personality quirks and episodes that I have forgotten. However, it occurs to me that there may have been seminal events in my life that may possibly have foreshadowed my later diagnosis.

For this exercise, I will give a brief overview of my upbringing, as background, and then I will proceed to reflect on events that I remember from the time I became a teenager until my initial diagnosis twelve years later. I will recount events that I feel may be particularly salient with respect to being possible prodromal signs of my eventually being diagnosed schizophrenic condition.

I will select at least one event for each of the twelve years that I review.

Early Life

Like such celebrated personalities as Tiger Woods, John Denver, Newt Gingrich, and Senator John McCain, I am the offspring of a father who had a career in the military. One consequence of this up-bringing is that we 'military brats' usually experience frequent moves between birth and leaving our parents' homes in our late teens. Indeed, I attended some dozen different schools during the K through 12 years.

As an aside, I have been struck by the high number of other consumer/advocates who were also reared in the families of career military personnel, including such well known pioneers as Kay Jamison (1993, 1995), Esso Leete (1989), and the current national NAMI president, Keris Myrick (Frese & Myrick, 2010). Whether or not frequent moves while one is growing up, or something else about military families contributes to an increased likelihood of developing psychosis probably is a topic worthy of investigation at some other time.

The Red River Valley is best known through song and film as the area separating the states of Texas and Oklahoma, but in fact the Red River continues to flow after bisecting the Texas-Oklahoma area where it crosses Louisiana on its way to blend its aquatic contents with that of the mighty Mississippi. When asked, I frequently characterize my birthplace as being in the Red River Valley. This seems to me to be a more colorful reply than stating that I was born at Barksdale Army Air Field, which happens to be located in the Red River Valley. Upon leaving this valley at the age of three months, I understand that I resided in some seven additional states before entering my teenage years at age 13. By that time I was the eldest of the five children of Col. and Mrs. Frederick J. Frese, Jr.

Secondary School

My father, by then a rather high ranking military flight surgeon/space research administrator, clearly wanted me to follow in his footsteps. His plan was to send me to a military prep school in the Northeast, preferably one operated by the Jesuits, like the one where he had been educated, Xavier High School in Manhattan. My mother however felt this would be far too expensive for the family, so my parents compromised. I was sent off to Benedictine Academy in my mother's home town of Savannah, Georgia. There I could live with my elderly grandparents, and could receive a fine education at the all male military prep school where her brother, my Uncle Jerry Sullivan, had been schooled.

After moving in with my grandparents, buying expensive uniforms, and attending classes for a few weeks, I made a weekend visit back home, which was then at Maxwell Air Force Base in Montgomery, Alabama, about a day's drive from Savannah. While at home, I celebrated my 14th birthday with friends from the neighborhood. The next day as I prepared to return to Savannah, I went into the bathroom and broke into an extended crying spell. I did not think anyone could hear me, but when I eventually left the bathroom, my parents apprised me that I would not be returning to Savannah, but would be going to the small Catholic co-educational high school in Montgomery.

This was the most memorable event of the first of my teenage years. Was involuntary crying spell in the face of being sent away again from friends and family an early precursor of my later schizophrenic breaks? I do not know, but I can see how this event may have been interpreted as an early indicator.

The following year, my most memorable event also occurred near my birthday, on October 3. I had recently turned 15 and was still attending high school in Montgomery, Alabama. My father continued to be stationed at the nearby Maxwell Air Force Base, where our family residence was located.

In retrospect, these were about to be very turbulent times in the southern United States. Dr Martin Luther King was a young minister just beginning his career and his political activities as pastor of Montgomery's Dexter Avenue Baptist Church. Although the high school I attended was located near downtown Montgomery, I usually took a military bus from the base to and from school. Importantly, I was also in the habit of sitting in the back seat of the bus.

One day, however, in the early fall of 1955, I finished football practice at the school too late to catch the bus returning to the military base. I found I had to walk several blocks into the heart of the city in order to catch a ride on the public bus.

Upon getting on the bus I proceeded to the back and took my customary seat there. However when I did so, for no apparent reason to me, the bus driver became noticeably upset and started demanding that I move in front of a white line which was on the floor about three rows in front of me. When I did not immediately move from the back seat, the driver got off the bus. After a few minutes he returned accompanied by a rather large police officer, who had a fire arm (gun) hanging from his belt, along his side. The policeman rather forcefully commanded that I move in front of the white line, insisting that the back of the bus was for 'colored' people. I was greatly perplexed. I could think of no logical reason why I should have to give up my preferred seat. This made no sense to me. I did not respond immediately. After a brief delay I felt the hand of a friend on my shoulder. A friend's voice was telling me that it would probably be best to follow the officer's request and move in front of the white line. Very reluctantly, I finally decided to comply with the officer's request, but I remember feeling that something very strange was going on.

This very minor event turned out to have happened, in the same town, and on the same bus system, where a somewhat similar, but historic event was to transpire just a few weeks later. On December 1, 1955, one of the '*colored ladies*' in Montgomery also proceeded to take a seat on the wrong side of that white line on the bus floor. But when confronted by the police and ordered to move, unlike me, she absolutely refused and was arrested. Her name, of course, was Mrs. Rosa Parks and her arrest sparked the now famous Montgomery bus boycott that is considered by many to be the beginning of the modern civil rights movement in America (Brinkley, 2000).

But could my slowness to respond to what I considered to be the illogical activities of the bus driver and the policeman have possibly been in any way an indication that I was later to develop schizophrenia? Over the years, I have often reflected on this temporal, but admittedly tenuous, connection of mine to the beginning of the civil rights movement. Why was I so slow to realize how serious my unintentional crossing of the segregation line on the floor of the bus was going to be? Why did I not respond immediately when asked to move, and particularly after being ordered by the police? Also, although I know my encounter with the police officer on the bus was only coincidentally associated with the Rosa Parks incident, at times I feel somehow more associated with the start of the civil rights movement than rational thought should allow.

In this regard, Gareth Owen and his associates at the Institute of Psychiatry have published findings related to persons with schizophrenia, logicality and common sense (Owen, Cutting, & David, 2007). These authors report findings suggesting that persons with schizophrenia tend to prioritize theoretical over practical rationality, that is, logicality over common sense. I sometimes wonder whether my hesitancy to act in accordance with '*common sense*', recognizing the local customs and immediately following the policeman's order, may have been one of many similar activities I experienced during my youth that might be considered precursors to my later diagnosis.

Prior to my third year of high school, our family had moved back to Randolph Air Force Base near San Antonio, Texas. Again, I was placed in an all-boy, military oriented, Catholic high school, located within the heart of the city. For several months, my life seemed to be proceeding fairly well, but one day, out of the blue, I proceeded to shave my head completely. Although head-shaving is somewhat fashionable today, no one shaved their head in the late 1950's, particularly those of us living on military bases. To this day my sister, Pat, believes I did this because I had recently seen the movie, *The King and I*, where the leading man, the Siamese king, played by Yul Brynner, had a shaved head.

Regardless of the reason for my tonsorial act, I became immediately the center of attention everywhere I went. In a way I sort of enjoyed suddenly being such an object of curiosity. But my father looked at this attention-gaining activity somewhat differently. He took me out of school for a day. He had scheduled me for a full day of psychological testing. When the results of the testing came back, they apparently indicated no serious psychopathology, but the psychologist who had seen me did mention that the testing results indicated that I may have difficulty overseeing the work of others, if I should ever find myself in a supervisory position. I, of course, discounted this comment as being ludicrous. After all, I was quite sure I was a normal, well-adjusted teenager. I am not certain what else the psychologist reported to my father, but a decision was made that I was no longer to attend the same high school. The following year, which was to be my final year of high school, I was enrolled in a quasi-rural, public, co-educational high school located reasonably close to the Air Force base where the family resided.

A memorable incident occurred during this final high school year that may possibly have been a more direct foreshadowing my eventual diagnosis with schizophrenia. I performed fairly well in school generally but particularly well in mathematics classes. One day for some reason I got the idea that I could develop an original method for extracting cube roots. I focused on this exercise to an extent that, in retrospect, seems obsessive. For about three days I paid very little attention to anything other than my working out, in my head, my method to extract cube roots. There were no handy electronic calculators in those days, and although one could use a slide rule to estimate an approximate solution, I had become obsessed with the notion that I could come up with a method to calculate the exact cube root of any positive rational number. I was most inattentive to my assigned schoolwork, or indeed to any other activities. But after about three days I had developed my system. I, of course, wanted very much to compare my recently developed process for calculating the cube roots with whatever the established, traditional system was for making these calculations. I suspected that my system would probably be pretty much the same as the process used by '*everyone*'. However after asking a fairly large number of adults, many of them engineers, I found no one who seemed to know anything about the established method for extracting cube roots.

I mention this incident because later during my entering into states of psychosis, I would also focus very intently and obsessively, on certain problems. I am reminded of the famous quote from John Nash, when he was asked how one as brilliant as he could possibly believe the aliens were communicating with him, responded, "*These ideas come to me the same way my mathematical ideas did, so I believed them.*" (Samels, 2002).

College Years

Being reared on military bases meant that for me the military life and culture seemed quite normal. This being the case, in my final year of high school, not long after my adventure deriving a method to calculate a cube root, I applied for a Naval scholarship in hopes of being able to attend the college of my choice with virtually no expense to me or my parents. Obtaining the Naval scholarship was a fairly competitive process, with only about one of every hundred applicants being selected. Somehow, I was among those chosen. The scholarship was a very generous award. It paid for a full four years of university education, including tuition, fees, books, clothing (uniforms), and a fairly generous monthly stipend. In exchange for this benefit, I understood that my only obligation was to graduate from my chosen college and then serve in the U. S. Navy or Marine Corps for at least four years after graduation.

Due to a convergence of various factors, including its being in reasonable proximity to my home, I chose to attend Tulane University in New Orleans. Shortly after arriving there, I attended a gathering of the incoming students where we were collectively apprised that only one in three of us would go on to graduate. I quickly came to realize that a graduate of a second rate, quasi-rural Texas high school was not expected to be able to compete with my class-mates from private prep schools or from the wealthy suburban schools around the country. I went into obsessive study mode. During the first semester, I did almost nothing but study, eat (sparingly), and sleep (as little as I thought I could get away with). At semester's end I was in the top quarter of the class and the 'A' I had earned in five credit-hour mathematics class was high enough that I was invited to enroll in the elite, advanced mathematics section, for the coming semester. As we shall see, this initial success in mathematics (hyper-logicality?) may well have been an indication that I tended to rely too heavily on thinking and reasoning, at the cost of maintaining a reasonable degree of common sense.

I do remember another event that may have been an indication of my future difficulties with mental illness. I was extremely shy. Shortly after arriving at Tulane, I went to a party with a small group of fellow students. Upon arrival, I was so shy that I would not go into the house where the party was being held. I just stayed in the car, hiding on the car floor, hoping no one would see me. Before long a pleasant young lady, who must have been told I was in the car, came out to encourage me to join the others. She seemed very nice, but by then I was not about to leave my place of protection near the car floor.

Probably the event most likely to have been a foreshadowing of my later psychosis occurred during the six-week cruise I was on before starting my second college year. There were sixteen midshipmen (naval scholarship recipients) from some five different universities on the destroyer (DDE) I was on. Every two weeks we were rated, hierarchically, by several senior midshipmen who all happened to be from Cornell University.

Early into the cruise, I received a letter from the mother of the fellow I was planning to room with during my second year at college. The letter indicated that her son, Anthony, had just been killed in an auto accident. I was so stunned that I did not, and maybe could not, reply to the letter from Anthony's mother. I also learned that a couple of pilots flying jets from the deck of the aircraft carrier we were escorting had been '*lost*' in accidents. Maybe in response to the news of these deaths, one being of someone I was quite close to, I began to behave in a manner that was very unlike me. Normally I had a relatively withdrawn, reserved disposition. But now I suddenly became filled with joy. I smiled and joked with everyone on the ship. I attacked every job I was given with unbounded enthusiasm. I chipped paint and swabbed the deck with overflowing joy in my heart. I did not know what had come over me. It was as though I were in a joyful trance of some kind. Everyone I came in contact with seemed to really like me a lot. I was given the highest rating of all the sixteen midshipmen for the final two of the three rating periods. After the cruise I visited my Jesuit uncle in New York City, while I was still in this joyful trance. He remarked that he was amazed, even '*edified*' by my change in personality. Gradually this period of manic-like joy dissipated, I knew very little about mental illness at the time, but in retrospect, this mini-manic episode may have been a precursor of things to come.

During my third year of college, I had an experience that when later shared with a few friends and associates, I began to hear the view, "*that kind of sounds like some kind of mental illness*". I of course, did not see it that way at all.

Essentially during the first semester of my third year, I began to think that I should become more like St. Francis of Assisi, living in poverty, communing with nature, that sort of thing. I decided to give up all earthly goods, and live in holy poverty. I decided to give up all trappings of wealth and only perform menial tasks, living in abject poverty for the rest of my life. I left school and took off walking towards Mexico where, in my mind, I felt I could live a very simple life and leave all prideful activities and obligations behind. After walking for several hours, darkness began to fall and mosquitoes began to bite. I rationalized that I should not continue walking towards Mexico, several hundred miles away, because even though I might be leaving the trappings of wealth, I would still know that I had the dignity of leaving a successful college career. I decided that this was not an appropriate action. I must return to college and fail my courses so that I would be leaving in disgrace. I would have no dignity. I would be able to live the rest of my life in total poverty, with no pride, no dignity, nothing that would keep me tethered to the prideful, striving, hedonistic, modern society experienced by so many others. After returning to the campus, I attended almost no classes for the next several months. I was quite certain I would fail out of college. Initially I did not plan to take my final exams, but at the last minute I reasoned, that if I did not take the examinations, I would, in reality, be willing myself to fail, but if I took the final examinations, which I would certainly fail, then I could rationalize that I was failed by the professors, as opposed to my deciding to leave school of my own volition. I was thinking that being flunked out by the faculty would be significantly less dignified than willfully failing as a function of my own volition.

I took the exams, tried as hard as I could to pass, but knew that what I was doing was clearly hopeless. When my grades came out I was more than a little surprised. I had passed every class, earning an overall 'C' average. Somehow I took this as a sign from above that maybe I should stay in school after all.

Was my St. Francis experience an early indication of serious mental illness? As I mentioned, some of my friends seemed to suggest as much.

During my senior year at Tulane without a doubt, my most impactful emotional experience was falling in love. The object of my affection was also a senior at Tulane. She was everything to me. I got back on track at school, my grades improved. I asked her to marry me. She said yes. I was the happiest man alive. But I could kind of sense that something was not right. Not long after graduation, she made it clear that our relationship was not to be. I broke emotionally. I cried and cried. I felt I could not go on. It's difficult to think about that time, even today, some fifty years later.

Military Service – The United State Marine Corps

After graduation from college, I entered the Marine Corps as a second lieutenant. I was initially assigned to the six month long, The Basic School (TBS), the Marine Corps initial, six month, training course for all incoming officers, in Quantico, Virginia. This was followed by a month-long combat engineering class at Camp Lejeune, North Carolina.

After my failed romance I decided I could no longer stay in this country. I requested and received two consecutive year-long assignments in Japan. While in that country it occurred to me that if I wanted to be better prepared for employment once I left the military, it would probably be beneficial if I learned to speak and even to read and write the Japanese language, which of course was all around me in that country. I also felt I needed to distance myself as much as possible from the American culture in which I had been so terribly hurt. I threw myself into the challenge of learning Japanese language and culture with great intensity. Unlike the intensity with which I had focused on solving the cube root challenge while I was in high school, I maintained my focus almost incessantly for over two years. I always carried a pocket sized English/Japanese dictionary with me and constantly referred to it all day/every day. I eagerly took the four semesters of Japanese language offered on the base by the Far East extension campus of the University of Maryland. Completing these, I found myself a Japanese tutor. He happened to be an English teacher in a local high school who wanted to improve his English. Several times a week we dedicated time where we practiced speaking in English, then in Japanese. Before long I was fairly conversant in Japanese. I also obtained an evening job teaching English at the nearby Mitsui Polychemical Corporation. Of the several thousand Americans stationed at the U.S. Marine Air Base in Iwo Kuni, Japan, I knew of no other American who was anywhere near as familiar with the Japanese language as I was. But while my Japanese language skills were reasonably impressive, my social, organizational, and particularly, my skills as a military leader, clearly suffered in the wake of my focus on learning Japanese.

Upon leaving Japan, I was stationed at the Marine Corps Barracks at the Jacksonville Naval Air Station, in Florida. In my mind I was to spend my final year in the Marine Corps in sunny Florida, performing my required duties and making final preparations for my return to civilian life. In fact my stay in Jacksonville was to be a nine month, high-intensity journey into paranoid schizophrenia.

Shortly after arriving in Florida, I realized that there were very few opportunities to study or to practice speaking the Japanese language in the northwest corner of the Sunshine State. In that I had handled my duties as a Marine Corps officer successfully, if not perhaps spectacularly, with 'my left hand', during my tours in Japan, I felt I needed to develop a similar intense interest to occupy my leisure time while in Florida. Because I thought I might attend graduate school after my military obligation was completed, initially I started studying for the Graduate Record

Examination (GRE). The exam had two equally weighted parts, mathematics and English. In that I had all but totally immersed myself in Japanese language during the previous two years, I thought I had best concentrate on studying for the English section of the test. But, just to cover my bets, I also started taking graduate level mathematics classes at the nearby Jacksonville University.

My plans were going along fairly well, except for one problem. Having come into the Marine Corps through the Navy Scholarship program meant that to the Marine Corps, I was expected to stay in for a career of 20 years or more. Indeed most of us who were designated as regular, as opposed to reserve officers, did, in fact, make a career of the military service. And I now suspect that if you are a commanding officer, and one of your subordinate regular officers decides to leave the service, this could be seen as a weakness of leadership on your part.

In that I admittedly was somewhat lax in the performance of expected duties, and indeed had learned very little about improving my leadership skills during my duty tours in Japan, I gradually found myself performing in a manner that did not seem to be satisfactory by my commanding officer. In truth, I did not take my duties very seriously and planned to be moving on in a few months. I felt I really needed to focus on preparing for my post service career. My failure to make my assigned military duties my highest priority in life began to create a climate where I began experiencing a barrage of constant criticism. I had duties at least 60 hours per week and no matter how hard I worked I encountered constant hostile criticism. I found I could do nothing right. I thought I could put up with pretty much anything, for the short few months until my four year obligation had been met and I could resign.

In spite of the difficulties in my work setting, about half way through my Florida tour I managed to achieve some notable successes. To my surprise I was selected for promotion to the rank of captain. But much more remarkably when I received my scores after I had taken the GRE test, I was apprised that I scored a 580 (79th percentile) on the English section but a whopping 810 on the mathematics section. This score was then 70 points above that needed to be in the 99th percentile. Neither I nor any of my friends knew that it was even possible to score above 800 on the exam. My propensity for mathematics had come through for me again, this time in spades. Statistically fewer than one in a thousand of those college graduates taking the test would score 3.1 standard deviations above the mean, or better, as I had. In my mind, this high score was my ticket into probably any graduate program in the country. And at another level, I was coming to the conclusion that focused thinking, such as one engages in when doing mathematics, was clearly my talent for overcoming problems and obstacles.

I, of course, still had a rather serious problem. It was my perception that I was being *constantly berated, insulted, and inappropriately criticized* about virtually anything I would attempt to do at work. But now suddenly I had an elevated rank, and, much more importantly, my high GRE test scores began to give me significant confidence that I had unusual abilities to focus on and to solve problems, problems of any kind. I began to think very deeply, believing that in doing so I could apply a mathematical type reasoning to attack the oppressive work environment in which I was finding myself.

Suddenly it came to me. Just as I had focused so intently to figure out how to extract the cube roots, and similar to the benefits I had found by of focusing on Japanese almost to the exclusion of everything else around me, I knew that if I applied myself, I could figure my way out of the hypercritical, oppressive, social environment to which I was exposed while at work. After several days of considerable focus, suddenly I knew I had the answer. It was so very clear to me now. The U.S. was bogged down in the Viet Nam war at the time and obviously our Asian communist enemies had somehow developed a long range hypnotizing weapon. They had now improved on the brain-washing techniques that they had used so effectively during the Korean War and now they were able to have brain control over many of our high ranking political and military officials. They clearly had control of my hypercriticizing commanding officer and many other officials as well. How else could we explain our leaders not letting us win the current war in Viet Nam? Now that I knew that my adversaries were under hypnotic control of the enemy, I only smiled knowingly whenever any critical comment was made to me. I thought, "*How sad. These folks have no idea that they have no real control over their own thoughts or speech*".

Before long, I decided to report my discovery to the person on the base who would know the most about hypnosis and brain washing. That would be the base psychiatrist. When I called him to discuss my discovery, he agreed to see me right away. But when I explained, what to me, was a brilliant discovery, to the psychiatrist, he apparently interpreted my thinking to be some form of delusion. I was escorted out of the psychiatrist's office and soon found myself to be locked away in a psychiatric isolation room. I quickly realized that I had shared my discovery with the wrong person. The psychiatrist who had examined me was obviously under the control of the enemy. And he would surely let the enemy know I had discovered their secret weapon. Now they were certain to send someone to kill me to keep their secret for being exposed. I was surely going to die. I began demanding that I be given the last rights by a Catholic priest. Not long thereafter I discovered I had been given the diagnosis of paranoid schizophrenia.

Conclusion

So, returning to the question that I initially asked at the beginning of this chapter: Did I have any signs or symptoms that may have been early indicators that I was a person who was going on to develop schizophrenia? I would suggest that the answer to this question is probably in the affirmative. As I have presented in this chapter, excessive shyness (social inhibition) would seem to be such a factor. I mentioned an extreme example of this attribute when I recounted my refusal to even get out the car to attend a social event my first year at Tulane. I see this shyness as likely being related to the hypersensitivity to criticism, or expressed emotion (Hooley, 1998), that I portrayed during my final year in the Marine Corps. Some authors may view this as being a fear of social rejection, or a form of interpersonal or ego threat, although I am not sure that I fully agree with such a characterization.

Another such indicator could be my obsessive preoccupation with challenging tasks, often accompanied by an extraordinary display of determination. My focusing on developing a method to extract cube roots while in high school and my taking on the challenge to learn the Japanese language during my time in the Marine Corps would seem to be examples of such a tendency. And as I pointed out earlier in the text, some may view this characteristic as being pursued at the expense of 'common sense'.

Other possible early indicators of my later developing schizophrenia may have been occasional displays of exacerbation of affect, as exhibited in the mini-hypomanic episode I experienced after my first year in college. Another candidate for being a prodromal sign may be my intermittent flaunting of eccentric behavior such as the shaving of my head in high school. This tendency was occasionally accompanied by a preoccupation with religious or spiritual ideation and exemplified by the 'St. Francis' adventure I experienced during my third year at Tulane.

Woods et al.(2011) suggest that low functioning and impairments of social and/or role functioning are associated with likelihood of conversion to psychosis. I can see the challenges encountered in social functioning in my case but I do not necessarily see this factor as being accompanied by impairment in role functioning or deficits in cognitive abilities, at least not as they are customarily measured by psychological testing.

Having now completed this overview I would be curious about the possible prodromal signs/symptoms of schizophrenia that may have been experienced by the ten other doctoral level mental health professionals mentioned in other publications (Frese et al., 2009; Miller et al., 2013), and indeed by anyone who has been living with schizophrenia.

I am also hopeful that in the attempts of psychiatrists to improve the classification of serious mental illnesses, those of us who have experienced the signs and symptoms of these conditions may have better input in the process of developing the systems that are employed to define/label us.

Although this chapter has focused on my life prior to my initial psychiatric diagnosis and hospitalization, I feel compelled to at least briefly mention some factors that may have helped or hindered me on my road to recovery during the past several decades.

Regarding helpful developments, first, after my ten years of repeated hospitalizations, I was able to get married and start a family. Having a supportive spouse has undoubtedly been the major factor in my being able to live with this condition.

Second, I have spent most of my post-hospitalization career working with seriously mentally persons. This opportunity to be employed in the mental health field has been exceedingly fortunate. Attempting to work in an environment where few of my co-workers knew or cared about mental illness would have been exceedingly difficult.

Finally, being able to locate and interact with other persons who have also been living with schizophrenia and other psychotic disorders has been most beneficial. Many of us have been working for changes in the way we are treated and viewed by others. For us, our mantras, '*Advocacy is the best therapy!*' and '*Nothing about us without us*!' have become rallying cries that give our lives meaning and purpose.

On the other hand, some attempts at treatment were not helpful. I am very glad that I resisted taking the amounts of medication that were prescribed for me during my first few years with this disorder. I am very pleased to see the concept of '*shared decision making*' beginning to gain traction in the psychiatric treatment community.

Also, I found psychoanalytic approaches to treatment exceedingly unhelpful. From my experience this approach was far too stressful, particularly when a person might be striving as best he can to hang onto reality. Also I greatly resisted implications by my therapists that members of my family were to blame for my condition. Even if it might be true, it is not a good idea, and certainly not very polite, to make disparaging comments about another person's mother, or other family members.

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Chapter 7

Creativity: A healthy side of madness

Gordon Claridge & Neus Barrantes-Vidal

Madness – or psychosis as it is more technically known – is still one of the most mysterious mental disorders of humankind. It refers to an altered state of mind where the individual loses contact with reality by having distortions in the perception of the outer and/or inner world (hallucinations, altered sense of self and the environment) and odd, false ideas that are held with strong conviction despite contrary evidence (delusions). These alterations of thought and perception are defining features of madness, but the psychotic state spans almost all psychological functions, such as mood, energy, motivation, volition, cognition, and psychomotor and physical functioning.

Descriptions of madness stretch back to antiquity, but its scientific study started in the late 19th century, with the emergence of an experimental psychopathology that was a meeting point between psychiatry and a newly born psychology. However, the former's influence was much greater as psychiatry took over the care of the mentally ill and – in keeping with its medical tradition – sought a cause for their ailments in the brain. This hope for an organic explanation of psychosis was inspired by a significant early breakthrough in psychiatric research: the discovery that one 'mental syndrome', General Paralysis of the Insane (GPI), was actually due to syphilis infection affecting the central nervous system. The promise, then, was that psychiatry would progressively uncover the neuropathological bases of all mental disorders, including psychoses such as schizophrenia – or *dementia praecox* as, significantly, that illness was earlier known.

This 'broken brain' view of madness has dominated the thinking of professional psychiatrists ever since. Apart, that is, from pockets of resistance from some radical thinkers; notably, in Europe, writers such as R.D. Laing (1960), whose book, *The Divided Self*, challenged the whole medical orthodoxy in psychiatry with the argument that madness is more about existential crisis than brain disease. However, Laing's rejection of *any* involvement of biology in psychosis – seen by some as itself a sign of insanity! – eventually led to the movement he started imploding. Ever since, Establishment Psychiatry has continued true to its faith in the neuropathological model. In this it has been encouraged by impressive advances in recent decades in neuroscience and molecular genetics.

The reality is, however, that despite an awesome research effort over several decades, no single neurobiological abnormality has been found that is really specific to psychosis or any of its varied manifestations. We are therefore driven to the conclusion that it is the conceptualization of the nature of psychosis that needs to be revised. Indeed there are very interesting signs of debate about this; even maybe of the onset of what some have called a paradigm shift in psychiatry (e.g., Kendler, 2005, 2012; Read, Bentall, & Fosse, 2009). While not all authors make the same points, we would suggest that there are three issues that signal some change in the way psychosis is coming to be viewed.

One is the realisation, based on considerable evidence, that environmental social adversity is a risk factor for the development of psychosis (Bendall, Jackson, Hulbert, & McGorry, 2008; Read, Fink, Rudegair, Felitti, & Whitfield, 2008). This is significant when put together with more general evidence about the critical rôle that the wide social and interpersonal environment has in the development and functionality of the brain across the lifespan (e.g., Roth & Sweatt 2011; Teicher, Samson, Sheu, Polcari, & McGreenery, 2010). Such observations seriously challenge the orthodox medical view that psychosis is straightforwardly a genetically conditioned brain disease, as it indicates that the environment and individual variation not only merely colour the expression and adaptation to the malfunction, but also causally contribute to the development of the disorder. Evolutionary science (cf. Brune, 2011) has also shown that wide individual variation in terms of genetic, biological, and behavioural features is the norm rather than the exception and that there are not univocally 'good' and 'bad' traits for adapting to the environment. In other words, the evolutionary machinery selects in favour of wide variety, which enables the species to have a varied selection of individuals who are more apt to fit into very different circumstances and demands.

Another sign of change about how psychosis is viewed is the shift away from the idea that its different expressions constitute discrete diseases, each with a distinct ('broken brain') aetiology. This has mostly been discussed with respect to schizophrenia and manic-depression (bipolar affective disorder), where there is now convincing evidence for the so-called unitary model, supported by observations of a significant clinical and genetic overlap between the two disorders (Marneros & Akiskal, 2007; Lichtenstein, Bjork, Pawitan, Cannon, Sullivan, & Hultman, 2009).

Thirdly, the adoption of a dimensional view has broadened the scope of what can be considered legitimate material for discussion within the rubric of psychosis. The idea of a continuum between madness and sanity has been largely developed by psychologists; but in recent years the model has also been adopted by some psychiatrists wishing to recognise that psychotic symptoms can occur along a spectrum of severity, frequently observable in the general population (Johns & van Os, 2001; Stip & Letourneau, 2009). Admittedly, that usage of the continuum idea is not in itself particularly novel since it merely recognises that all illnesses – physical as well as mental – can indeed manifest their signs and symptoms to a varying degree. In principle it could be consistent with a modified version of the broken brain theory of psychosis. But at least it suggests a move in the right direction among some clinical psychiatrists.

Elsewhere (Claridge, 1997), in contrast to that nuanced version of the broken brain theory, we have suggested a more radical alternative; what we have labelled a 'fully dimensional' model. This has its historical origins, not in psychiatry, but in personality psychology, specifically trait theories which see dimensions of personality as having a dual function: describing *both* healthy individual differences *and* predispositions to psychological disorders Trait anxiety and anxiety disorders are the least controversial examples; but the same principle can be applied, we would argue, to more serious mental illnesses.

The arch-exponent of this fully dimensional interpretation was the late Hans Eysenck who, in his early theorising, introduced the concept of 'psychoticism' to capture the idea of a healthy personality dimension connecting normality to psychosis in the clinical sphere (Eysenck, 1952).[1] However, most of the research on the topic has been carried out under the heading of 'schizotypy', with a primary focus on schizophrenia and the schizophrenia spectrum, including the development of questionnaires for measuring specifically schizotypal traits within the general population. But, notably, when a more open stance has been adopted to such work 'schizotypy' has begun to look like a too restrictive concept and Eysenck's term 'psychoticism' – in its original sense – a more appropriate label for capturing the range of variations within this personality sphere. Illustrating the point is the *Oxford-Liverpool Inventory of Feelings and Experiences (O-LIFE),* the only questionnaire developed within the fully dimensional model and, equally to the point, based on a more comprehensive data set of items than those used hitherto (Mason, Claridge, & Jackson, 1995; Mason & Claridge, 2006).

The *O-LIFE* contains four partly correlated subfactors: '*Unusual Experiences', 'Cognitive Disorganisation', 'Introvertive Anhedonia',* and *'Impulsive Nonconformity'*. Interestingly, this pattern copies that expected from the unitary model of psychosis referred to earlier; *viz Impulsive Conformity* is weighted heavily on bipolar (cyclothymic) traits and overlaps considerably with the more 'schizophrenic' features represented in the other scales. Furthermore, another finding with the *O-LIFE* suggests that the 'unitary' view of psychosis and psychoticism can actually be extended beyond the schizophrenia/bipolar connection. Thus, another of the *O-LIFE's* scales – *Introvertive Anhedonia* – has been shown to correlate strongly with Asperger/autism traits (Rawlings, 2008; Claridge & McDonald, 2009). It would therefore seem that within the broad rubric of 'psychoticism' there are several personality trait profiles each having a different adaptive and risk potential.

As we have emphasised, a cardinal feature of the fully dimensional model is that psychotic traits, like other personality features, are essentially healthy forms of individual variation, even though carrying their own risks for psychological disorder. The point is well illustrated from a practical standpoint by results obtained with the *O-LIFE*. Some of the items on that questionnaire, and others like it are occasionally (and not unexpectedly) slightly odd, including asking about such things as 'hallucinations and belief in magic', 'the paranormal', and so on. Many people in the general population endorse such items, and scores on the questionnaires can be very high, in the absence of any concurrent signs of serious mental illness. Indeed it is precisely this fact that leads to the conclusion that the

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[1] Unfortunately in his later writings Eysenck (Eysenck,1992) seriously distorted and narrowed the interpretation of psychoticism, to mean antisocial behaviour. The reader should bear in mind that when we use the term here it is in its original, more general sense.

traits being tapped are essentially healthy, their translation or not (and usually not), into psychiatric symptoms depending on other modulating factors. In favourable circumstances or in individuals with moderate weighting on psychotic traits or with other protective or facilitative personality and cognitive characteristics there will be favourable outcomes: these can include enriching religious or spiritual experiences (Clarke, 2010, Lukoff's chapter in this book), or, as discussed here, signs of enhanced creativity.

The link between madness and creativity has been the subject of an age old and controversial debate which, even in the relatively recent literature, has stimulated numerous books, review papers, and scientific articles (Richards, 1981; Jamison, 1993; Sass & Schuldberg, 2000; Nettle, 2001; Barrantes-Vidal, 2004; Claridge, 2009; Silvia & Kaufan, 2010; Carson, 2011). It would be impossible here even to summarise their conclusions, but one message is clear. Trying to reconcile the idea that devastating mental illnesses can be associated with the proficiency of creativity thought has perplexed some writers on the topic. But the dilemma can be easily resolved. For it follows from the fully dimensional model we have described here that it is potentially adaptive psychotic *personality traits*, not psychotic *clinical symptom*s, that explain the link between the two domains. While clinical psychosis can indeed destroy creativity, psychoticism *may* enhance it. The late Janie Brod (1997), in her own review of the topic, put it as graphically as any:

> *"Is there a causal relationship between states of 'madness' and concurrent acts of creativity? Do you have to be mad to be creative? Could you be more creative if you were able, somehow, to hurl yourself into the depths of 'madness'? Of course not! The answer is 'no' to all three questions. States of 'madness', or, to use a less folksy term. psychosis, involve a number of severely debilitating symptoms which tend to disable many of the cognitive, affective, and behavioural processes required for intelligently adaptive functions in general. This includes creative functioning … the relationship is not between psychosis and creativity, but, rather, between 'schizotypy' or 'psychoticism' and creativity. In other words, the positive link is with non-clinical expressions of schizotypal temperament and information processing style…"*

She adds:

> *"The point is made again here, because it seems, as yet, not to have permeated the comprehension of many researchers, both within the field of creativity research and outside it."*

In judging Brod's comments it should be borne mind that even those who have passed the threshold into clinical insanity are not mad all the time; indeed the psychotic state is frequently intermittent, with periods of relative normality; such is the nature of the spectrum. By the same token, so-called healthy psychoticism is not always strictly neutral with respect to psychopathology; even people whose psychotic traits operate within a normal range, free of the clinical symptoms of insanity, may show some degree of psychic distress. Evidence for this is to be found in the raised anxiety/neuroticism seen in people with high ratings on the features of psychoticism concerned with its 'positive' features; i.e. hallucinations and unusual experiences.[2] It is also neatly illustrated by the findings from a recent study carried out by one of us (GC) of imaginary friends in childhood (Isard & Claridge, unpublished study). Adult participants were asked if, as children, they had had one or more imaginary companions. As predicted, those who reported that they had were higher in psychotic traits than control subjects, and were more creative. However, more of them had also been referred at some point in their lives to the mental health services: not, it should be added, for problems related to psychosis – but mostly for anxiety and depression.

There are several possible, no doubt interacting, causes for this. One – biological – explanation could be that there is simply some natural association between the disposition to experience positive psychotic-like experiences and the tendency to be anxious – a sort of shared sensibility or what has sometimes been called 'skinessness'. In the imaginary companion case just mentioned some anecdotal observation suggests that that might be so, though systematic studies do not strongly bear it out (Taylor, 1999). However, it might be true more generally, across a broader range of expressions of psychoticism.

Another reason for the anxiety found in some individuals high in psychoticism might be that becoming preoccupied with mystical things serves to derail, or distract from, the mundane mental functioning demanded in day-to-day life, causing discomfort. Consequently there might be a drift into eccentricity, giving an appearance of 'living too much inside their own heads', disregarding convention, and avoiding 'normal' social intercourse. Disapproval from others around them is then likely to make them even less adapted, exacerbating their sense of isolation, diminishing their self-esteem, and increasing their anxiety or depressiveness.

Thirdly, there is the possibility that high ratings on psychotic traits are themselves actually caused in part by early adversity or abuse, with an inevitable common element of negative affect (anxiety/neuroticism and depression). It is certainly true that, in addition to the strong genetic influence on the temperamental make-up, child abuse will add to the load of liability for psychotic breakdown; the association between early adversity and high psychoticism ratings probably reflect this (Steele, Marzillier, Fearon, & Ruddle, 2009). It also points to a causal connection. In one illustrative study adults with a history of child physical abuse reported a greater interest in psi and a belief in spiritualism and witchcraft (Perkins and Allen, 2006). The authors concluded that these cognitions act as powerful strategies that abused individuals use in taking refuge from the painful reality of the real world.

A flight into fantasy as an escape from a horrible reality can, in the presence of talent, be expressed as creativity. A case in point was Hans Christian Andersen, considered at some length by Anthony (1987) in his account of vulnerable and invulnerable children. As Anthony discusses, Andersen had both a grandfather and a father – to whom he was very close – who was or was to become clinical insane. He therefore both (presumably) inherited the same vulnerability and, because of his relatives' mental condition, was reared in less than ideal circumstances. He

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[2] Interestingly, this is not true of the 'negative' component of psychoticism representing inherently more introverted, anhedonic personality features: there anxiety/neuroticism is actually rather low and seems, as noted earlier, to reflect more autistic traits.

dealt with this by withdrawing at an early age into fantasy play and then into his writing, through which he was able to transform his cruel world into fairy tales. He himself apparently never succumbed to serious mental illness – only temporary depressions in between his bouts of writing – the working of his imagination keeping the worst of his evident psychoticism mostly at bay.

What we learn from the discussion so far – and considering the theme of this book – is that how individuals 'manage' their psychoticism/psychosis, and what sorts of people need to do it, is a question that can be posed right along the trait/symptom spectrum described. In other words, it is not narrowly about someone having to deal with acute, full-blown bouts of insanity; it is as much to do with people channelling the unstable energies of borderline psychotic states, or, in the case of healthy (albeit sensitive) individuals, finding ways to express their creative talents.

Someone who understood very well many of the distinctions we have made here was the late Anthony Storr whose book *The Dynamics of Creation* (1972) is remarkably contemporary in its theoretical and clinical orientation. This is so in several respects. For one thing Storr recognised the essentially dimensional nature of psychopathology and, relating it to creativity, drew upon examples over a wide spectrum; stressing the blurred boundary between frank illness and personality variation. He also emphasised the wide variability in manifestations of psychosis and psychoticism and the different ways in which these might relate to creativity. While not using the term 'psychoticism', he implicitly relied on a similar assumption as that here; *viz* that variations within states of insanity are strongly reflected in personality and temperament. Here he made particular use of the older, well-established distinction between, on the one hand, the schizoid, schizothymic, introverted 'type' and that more associated with the manic-depressive, cycloid, cyclothymic, extraverted temperament.

Storr's open, broadly based view of psychopathology stemmed from his Jungian background. In his writings Jung had ranged over many topics including schizophrenia, the psychology of introversion-extraversion, and the philosophy of religion. Much of this naturally rubbed off on Storr though we can only speculate whether Storr was also influenced by knowledge of Jung's own mental breakdown. In many accounts of Jung's life the latter is euphemistically referred to as a 'mid-life crisis', but Jung himself leaves us in doubt as to its true nature:

> *"It is, of course, ironical that I, a psychiatrist, should at almost every step of my experiment have run into the same psychic material which is the stuff of psychosis and is found in the insane. This is the fund of unconscious images which fatally confuse the mental patient."*
> (C.G. Jung, 1963)

It was through the process of dealing with this turbulent period of his life that Jung moved into his more mystical phase of thinking and writing, while retaining his sanity. He was indeed a true archetype *(sic!)* of the creative psychotic.

Storr's own insights into creativity equally emphasised using it to help or restore self-esteem or gain insights. How this is achieved is different, he argued, in those of cyclothymic, manic-depressive temperament as compared with schizoid persons. The latter are typically aloof, detached from and have little need of other people: indeed may find them unreliable and not a good reference point for life. Creative outlets will reflect this preoccupation with objects, the inner world, and the lack of need to conform to a shared emotional matrix. Scientists are typically described in this way (Storr cites Einstein); another good example is Outsider Art (‘*Art Brut*’) where the individuals in question – sometimes referred to as on the Asperger spectrum, closely related to schizoidness – paint or sculpt according to their own rules (Cardinal, 2009). By comparison, according to Storr those of extraverted, manic-depressive temperament will have a different reason to boost self-esteem through creativity. Highly dependent on others for approval, and subject to mood swings, they seek to keep depression at bay through creative work. Many artists, musicians, and writers have been considered to fall into this category (Hershman & Lieb, 1998).

An additional important theme running through Storr’s writings on creativity concerns the rôle of solitude, a topic to which he returned in two later books (1988a, 1988b). The wish to be alone, the deliberate separating of oneself from others, and the personality trait of introversion have commonly been regarded as abnormal, even as signs of neurosis. The view is especially prevalent in societies, such as North America, where popularity and sociability are considered indices of psychological health. Most self-help books promote the dogma, usually under the mistaken non-Latinate spelling of the desired trait as ‘extroversion’! Storr was one writer who challenged the idea. He argued that, while human beings are of course social animals, powerfully driven by affiliative needs, they also by nature have a strong impersonal motive, evolved to deal with matters outside the interpersonal domain, where a degree of solitude may be beneficial or even essential. This is true of most creative activity – discovery, invention, artistic production – or working through to personal insights, away from others.

Of course, in judging this theory one must take account of the ever present factor of individual personality differences which at the extremes distort the average picture. As we have seen, in some highly schizoid or autistic individuals the need for others is entirely abandoned; the opposite is true at the other end of the spectrum. But this does not, in our view, take away from the general principle, proposed by Storr, that solitude and social intercourse are equally valid natural needs that complement each other in contributing to mental health. The special significance of solitude in creativity is that it opens up space in which to solve problems, develop theories, resolve issues, or convey feelings in artistic expression. All of these may have therapeutic value.

A genre that represents some of the above is the autobiographical novel. While most fiction contains an element of autobiography, autobiographical novels go beyond this, to give virtually complete accounts of the author’s life experience. But they may do so in quite different ways, as two contrasting examples will illustrate. Both, in their day, were quite prominent English authors, though are now long since forgotten.

Dorothy Richardson (1873-1957) is now mostly discussed as the literary figure who first used the writing method of ‘stream of consciousness’ – or, as it is sometimes known, ‘interior monologue’. The method avoids straightforward concrete narrative *about* a character or characters, in favour of telling the story as if from within, in terms thoughts, memories, perceptions, and feelings, written in a continuous free associative flow. According to Wallace (1989) Richardson 'discovered' the method in a sudden insight, after years of struggling to write a novel, but dissatisfied with the conventional form. The circumstances of her discovery are interesting. Wallace describes it thus:

> *"Richardson, 39 years old, was alone in a cottage in Cornwall, beginning her major life task, when she had a great insight, a turning point in her work … Her solitude there was almost total … she saw no one except a cleaning woman who came once a week to bring provisions. She had written copiously, a 'mass of material', making repeated attempts over a period of about four years…"*

Having found a new style of working Richardson set about writing *Pilgrimage*, a mammoth sequence of thirteen books, the central character of which was Miriam Henderson. Miriam was, of course, herself and the work autobiographical – which no one realised.

Dorothy Richardson's choice of and ease with the stream of consciousness writing mode probably tells us something about her psychology and her motivation for spending the whole of the second half of her life exploring herself in the depth and manner in which she did. As a grammatical form the method is discursive and lacks an obvious structure; the links between ideas and phrases are often loosely connected, making the underlying meaning often difficult to fathom. In short, it looks like what a clinician would label psychotic thought *disorder*. Seen in this way stream of consciousness writing could be construed as a literary version of psychotic thinking. This is by no means a trivial observation. Some writing that passes as 'stream of consciousness' prose, if it lacks literary merit, certainly *is* the product of a disorganised cognitive style – a difficulty in focused attention and thought – that is a characteristic part of psychoticism (and indeed reflected in the *O-LIFE* as a scale in its own right). We believe that this has genuine significance on the literary front. It is no coincidence that one of the most prominent stream of consciousness writers – Virginia Woolf – suffered serious psychotic episodes that finally resulted in her suicide. Elsewhere, in a special literary and psychological study of some psychotic authors – including Woolf – we noted how, in unedited form, their writings often appeared unfocussed, chaotic, even clinically thought disordered (Claridge, Pryor, & Watkins, 1990). This was true of Woolf, so we could conclude that in adopting the stream of consciousness mode of writing she was simply putting her natural psychotic cognitive propensity to stylistic literary use.

Returning to Richardson, she did not, as far as we know, suffer any psychiatric breakdown, or show signs of serious psychopathology. However, her upbringing and early life were far from healthy: a rigid father who insisted on treating her as a boy and a depressive mother who eventually committed suicide, virtually in the presence of Richardson herself, creating considerable guilt and remorse. It would be surprising if she did not both inherit and acquire some traits that placed her on the psychoticism spectrum, as we have defined it here. We might then begin to understand how and why Richardson, having discovered her natural style of expression, turned it from being a risk factor for mental illness into a means for confronting the conflicts in 'Miriam's' life.

Our other example of an autobiographical novelist is a quite different case. Like Dorothy Richardson, Antonia White (1899-1980) also wrote only about herself, but in an entirely different sense. White – another of the authors studied by Claridge et al.(1990) – was a highly unstable woman who hovered on the edge of psychosis throughout her life. In personality she was impulsive, reckless with money, socially and sexually promiscuous, and, as her two daughters attested to in their own writings, an erratic and neglectful mother. As a counterpoint to her need for constant attention and stimulation White would often withdraw from company in order to try to write (sometimes unsuccessfully) her mostly narcissistic prose; the solitude probably helped – just about – to ward off the threat of insanity that constantly plagued her. The first major breakdown she did suffer – in her early twenties – was almost maniacal in quality and led to her admission to the Bethlem Royal Hospital ('Bedlam'). Years later she gave an account of that experience in her autobiographical novel, *Beyond the Glass*, a book written at uncharacteristic speed, as though exorcising some demons.

We noted in discussing White's work that she was not a great writer. Unlike Richardson, her style was noveletish and the content of her work at its best when simply narrating events in her own life. How closely she did that in *Beyond the Glass* is startling if we examine what happened to 'Clara', the heroine, before and after she entered the asylum, and compare that with the real-life events. Uniquely, we had the chance to do so after getting permission to study Antonia White's hospital case-notes covering her stay in the Bethlem Hospital in the 1920's. The match was almost perfect: she had not been writing fiction at all!

Whether autobiography, semi-autobiography, autobiography masquerading as fiction, or fiction concealing from the reader some personal experience, there is a vast literature writing about one's own mental illness, stretching back centuries (see Sommer & Osmond, 1960, 1961 for comprehensive listings up to that time). One of the earliest, mediaeval, accounts is the extraordinary *The Book of Margery Kempe*; ironically not written by her since she was illiterate, but by a scribe. Starting with Kempe, Dale Petersen, in his *A Mad People's History of Madness* (1982), collected together other notable examples, or extracts from them, including: *The Life of the Reverend Mr George Trosse Written by Himself, and Published Posthumously According to his Order in 1714; A Narrative of the Treatment Experienced by a Gentleman, During a State of Mental Derangement; Designed to Explain the Causes and the Nature of Insanity, and to Expose the Injudicious Conduct Pursued Towards Many Unfortunate Sufferers Under That Calamity* (John Percival, 1838 and 1840); *Memoirs of My Nervous Illness (*Daniel Paul Schreber, 1903); *The Maniac: A Realistic Study of Madness from the Maniac's Point of View* (E. Thelmar, 1909); *Brainstorm (*Carton Brown, 1944); *I Never Promised You a Rose Garden (*Joanne Greenberg, 1964).

And such books continue to appear. To name but a few: *Portrait of a Schizophrenic Nurse* (Clare Wallace, 1965); *Operators and Things (*Barbara O'Brien, 1976); *The Trick is to Keep Breathing* (Janice Galloway, 1989); *The Loony Bin Trip* (Kate Millett, 1990); *Girl Interrupted* (Susanna Kaysen, 1993).

In addition to these published works there is a never-ending stream of unpublished accounts by people wanting to describe and make sense of their psychotic experiences. Over the years the first author has accumulated several boxes full of such self-reports (some cited below). These range from quite lengthy typewritten documents to mere handwritten scraps, or letters. The phenomenon seems to be confined to serious mental illness. Granted, sufferers from other psychological disorders – like OCD or anorexia – are often prompted to write about their illnesses. But they are far outnumbered by patients and ex-patients who feel the urge to share their experience of psychosis.[3] Why is this?

One reason is the sheer number of ways that mental life can alter in the psychotic state. The mind can go astray in all modalities – hearing, vision, touch, smell – and in all domains – emotion, thinking, language. And it can also do so to great extremes; for example, emotion that can swing wildly between ecstasy and despair; or, as if to defy this, the absence of all feeling:

> *"Experiences I do not have are good, evil, love, hate, existential death, ecstasy, mystical experience, etc, all experiences belonging to the mind, soul or personality of man. I cannot describe how I 'feel' because there is no feeling or experience to describe."*

Over and above the sheer variety and intensity of change there is, most strikingly, the incongruity: the distortion and loss of reality that comes about through the misperception of imagined events, or the misinterpretation of real but, for most people, unfamiliar events, such as hallucinations, spiralling in the psychotic mind into false beliefs. Typically:

> *"I have dealt with a totally delusional world in which I was God – the Creator and the Sufferer – and that trees held magical power while a great wall and glass dome cut me off from the rest of humanity…"*

There is already here the raw material for stirring the imagination to try to explain the experience to the self; most psychotics – however inchoately – attempt to do so and that in itself, we believe, provides its own evidence for the link between creativity and madness.

The ideas dreamed up may be simple reactions to immediately felt symptoms – but sometimes they are remarkably close to the theories proposed by professional psychologists. A notable example is the following:

> *"So the mind must have a filter which functions without our conscious thought, sorting stimuli and allowing only those which are relevant to the situation in hand to disturb consciousness. And this filter must be working at maximum efficiency at all times, particularly when we require a high degree of concentration. What had happened to me in Toronto was a breakdown in the filter, and a hodgepodge of unrelated stimuli was distracting me from things which should have had my undivided attention."* (Norma MacDonald, 1960)

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[3] The same is true of course in the visual arts, as witness, among others, the large permanent exhibition of paintings at the Bethlem Royal Hospital and the famous Art Brut collection in Lausanne.

This often quoted passage, from the self-report of one schizophrenic woman, precisely articulates an experimental paradigm that dominated laboratory research on attention in schizophrenia for more than two decades (McGhie & Chapman, 1961; Venables, 1973). A more uncanny – because introspectively less obvious – illustration of the same point relates to the explanation of psychosis (and psychoticism) that variation along the spectrum has something to do with cerebral asymmetry, perhaps incomplete lateralisation of the brain (Satz & Green, 1999; Richardson, Mason, & Claridge, 1997). This 'discovery' has been made, even to our own knowledge, by more than one schizophrenic patient! In one case it was formulated as the belief that his mind was, literally, unbalanced and could only be corrected by specially constructed shoes. Another person put it as follows:

> *"All of a sudden I've just done a switch. The left side of me wants to do the right thing and the right side of me wants to do the right thing."*

Often the chaotic states of mind engendered by psychosis 'solidify' into more elaborate narratives (clinicians call them systematic delusions). These take the form of obsessively constructed and often tightly argued theories of almost anything: the human psyche, the cosmos, history, the fundamentals of life. The scope of the thinking here can be outside a box of almost endless proportions.

Taken out of the context of their place in illness, the symptoms of psychosis can appear to be so bizarre as to be hilariously funny. To the sufferer, for obvious reasons, they are only occasionally so. Often it is in novels that the humor mostly shows through (Kesey's (1962) *One Flew Over the Cuckoo's Nest* comes to mind). Or it is implied, for example by one ex-sufferer in a recollection of his own psychotic symptoms:

> *"Thank you, Dr – for listening to me, and reading my letter with a straight face. I know it's your job but you must surely have felt like having a laugh sometimes…"*

Occasionally, even in the state of, or on the verge of madness, comedy and laughter can be used as a protective shield to prevent succumbing to the absurdity of the experience. Peter Chadwick (2001) discusses this in relation to Des, a long standing 'schizotypal' friend who, he notes, 'has made sure that he mixes with people who share his sense of humor and who can share his desire to lighten his load by laughing at it'. Chadwick later counsels on the use of humour as part of his prescription for combating the unwanted intrusions into consciousness that can so easily slip into the psychotically prone mind and get distorted into paranoid and other dysfunctional beliefs.

We see here, then, the tragicomedy of madness: the facility to produce ideas that are so outside the normal frame of references, so bizarre that they can be personally destructive, extraordinarily amusing, or sometimes both at the same time. It is therefore not surprising to discover, as we did in a recent study of a large group of performing comedians, that they score very highly in psychotic traits (Ando, Claridge, & Clark (unpublished). Illustrating the point more dramatically are the autobiographies of some well-known comedians. One of the most striking examples is the English comedian, the late Spike Milligan, erstwhile 'Goon' and lifelong manic-depressive (Milligan & Clare, 1993). At times so depressed he was scarcely able to speak, in his more manic phases Milligan used his freely associating thought processes to generate zany humor and wildly ridiculous ideas that were indeed the stuff of 'madness'. Milligan's illness *was* his comedy.

In this chapter we have traced a number of interlacing themes connecting creativity to psychosis. Part of our argument has been based on scientific evidence, part on biographical material. We believe that, taken together, these sources lift the topic out of the realms of speculation; that indeed – to quote Dr Johnson – 'all power of fancy over reason is a degree of madness'. As important, however, is the more general conclusion to be reached about the nature of psychosis. With notable exceptions, disorders like schizophrenia have traditionally been regarded as neurological diseases, as an example of the 'broken brain' phenomenon, deficit states in which the possibility of return to normal functioning is, by definition, lost. Admittedly in recent years psychiatry has started to move away from the simplistic all-or-none version of that idea, adopting a more dimensional view of symptoms. The fully dimensional, personality based version of that model described here goes further, retaining a greater connection to health and normality than in previous conceptualisation of psychosis. As such, the model is more able to incorporate the idea that, behind (or beneath) the appearance of dysfunctionality in madness, there is a retained sense of the self, of the traits that define *both* the person when well *and*, ironically (and tragically), the disposition to illness.

To illustrate the point, it is fitting to close with one further piece of autobiography, the thoughts of a woman, diagnosed schizophrenic, and sculptor. Here she describes the agonies of her illness, yet also her joy at occasionally being able to see beyond the madness of it:

> *"The reflection in the store window – it's me, isn't it? I know it is, but it's hard to tell. Glassy shadows, polished pastels, a jigsaw puzzle of my body, face, and clothes, with pieces disappearing whenever I move …Schizophrenia is painful, and it is craziness when I hear voices, when I believe that people are following me, wanting to snatch my very soul. I am frightened too when every whisper, every laugh is about me … Schizophrenia is frustrating when I can't hold onto thoughts; when conversation is projected on my mind but won't come out of my mouth … But I know I'm still me in the experience. And I'm creative, sensitive. I believe in mysteries, magic, rainbows, and full moons … Should I let anyone know that there are moments, just moments, in the schizophrenia that are 'special'? When I feel that I'm travelling to someplace I can't go to 'normally'. Where there's an awareness, a different sort of vision allowed me? Moments which I can't make myself believe are just symptoms of craziness and nothing more … These 'special' moments of mine – there are so few, but I look for them and use them to help me pass through the schizophrenic episodes. And I can't even predict when or if these moments will come. But I won't deny their existence; I won't tell myself it's all craziness."* (McGrath, 1984)

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Chapter 8

‘INTOXICATING HAPPINESS’ – THE BLAZING TRAIL OF MANIA

Bruce Kirkcaldy

> *“Happiness is like a butterfly; the more you chase it, the more it will elude you, but if you turn your attention to other things, it will come and sit softly on your shoulder.”*
>
> (Henry David Thoreau, 1817-1862)

My training includes psychology and psychotherapy. The first half of my career as a researcher and then in later years, age around 40, the decision to move into my own clinical practice. Over the last two decades I’ve seen hundreds of patients with various symptoms and diagnoses ranging from anxiety, generalized anxiety disorder, obsessional neuroses, depression and panic, as well as various types of psychosomatic disorders. A background in biology and physiology has always been helpful in my orientation to my work, especially in the first half of my career in research. And most treasured has been my psychological training which has offered me alternative models of human behavior and emotions from that of the classical medical model of illness. When people ask me what I most value in my training, I’m inclined to reply by underlining the *passion in observing the diversity of human behavior, being able to watch persons in many situations.*

In my clinical research, I have ‘brushed shoulders’ with some severely disturbed patients including schizophrenics, psychoses, and presumably manic-depressives. I recall as a child in my home town, wanting to walk next to the people who were behaving bizarrely, wanting to accompany them and understand their world of turmoil. People around were reluctant to communicate with them, preferring to avoid any form of interaction. There would appear to have been a deep-seated curiosity for me to share the inner worlds of these supposedly adult ‘aliens’. Perhaps to some extent this was the same motivating factor that caused me to gravitate to the health sciences, and psychology in particular. I’ve written about many areas of clinical and health psychology over the last few decades, but never about one of the most interesting that human nature has to offer, the state of ‘madness’. As an undergraduate I’d been trained in the 70’s and as many young students had savored the writings of persons such as Ronald Laing, Aaron Esterson, Thomas Szasz, Don Bannister and Alan Watts, but at an understanding that was quite cursory, a bit like reading literary giants when you are in your teens. You vaguely appreciate some of the concepts but don’t ‘really’ ‘understand’ them in terms of a deep-seated perception. I don't think I ever truly understood the psychiatric patients I met whilst conducting psychometric testing and evaluation in clinical settings, and their personal inner worlds, my research was very much a 'cosmetic' communication. I may have sympathized and felt encouraged at my valuing them, but hardly could I call it 'personal understanding or affinity'. Perhaps this is what Chadwick (2012) meant when he wrote of the deep discrepancy in empathy between the scientific clinicians and the poetic patient in a psychotic state.

I recall at this stage of writing, a story about an expert in winemaking, describing the texture and color and organic and mineral components of wine and the process involved in making alcohol and the stages of fermentation, and then going into detail about the effects of drinking alcohol on our cognitive and emotional personal world. But such a detailed description and understanding cannot convey what it means to be 'drunk', and the recipient of this knowledge may never know the experience of inebriation by participating in days of lengthy philosophical or analytical discourse. Having written about anxiety and depressive disorders, obsessional neuroses and eating disorders, and dabbling into reading and trying to understand psychosis, I felt it time now to address that facet of human suffering which had felt least accessible for me to cover previously, yet now of personal significance.

Why now? In part because I'd witnessed the fragility of life, the impermanence of family structures, and the physical and cognitive decay leading for example to my mother's death a few years ago. I was suddenly faced with a myriad of ambivalent feelings related to our relationship. In an instant, feelings surrounding my childhood and adolescence and her dying, seemed to coalesce with the everyday tensions involved in running a clinical practice and with a current disengagement and disintegration of the 'traditional' family network. Then, a couple of months later the death of my wife's brother at an age when no-one expected it. And then more recently, my father who quite abruptly for me began suffering from dementia with its frequent thought disordered qualities (either elicited through epileptic type fits or minor multiple strokes which in turn may have been triggered by years of inactivity and massive smoking habits). Then finally, another close young member of the extended family who quite suddenly revealed sign of an undifferentiated affective disorder, quite abruptly and unanticipated. Added to these unforeseen events, the cumulating number of patients I see, both young and old, who suffer premature illnesses, some dying early in their youth or early adulthood. Never before had I so powerfully felt a personal fallibility and susceptibility … a health professional so exposed to the arrows of misfortune, clinging to uncertainty and being challenged in our expertise, but with infiltrated armor. Little protects us from these slays of adversity[1]. What is worst, we make the same fundamental errors of the novice seeking medical help, being exposed to systems of medical care – decisions about whether or not to take medications, if so, which and in what dosage, and then the additional issues of whether requiring sheltered care and exposure to the psychiatric clinics, which are often so restrictive in form leading to increased self-blaming and personal distrust. Our models of treatment seem so archaic, so desperate and disruptive. I feel this as if one suddenly is a victim of an 'emotional and psychological' earthquake.

Added to this, is an increased understanding, adding depth and familiarity to our experiences appears to increase with advancing age, certainly for me. I've noticed this when I have re-read the works of Shakespeare, Goethe, Saint-Exupery or Hesse, those yellow-stained paper books of several decades ago, and the infusion and assimilation which is now different. The ingestion of those strings of words coalescing into sentences goes through a different level of cognitive filtering. With increased age we have witnessed firsthand, a frontal collision with suffering, having encountered countless events that underline the impermanence and fragility of life: We are no long observers of a play on a stage but are suddenly performers on that stage of life, performers with a temporally limited role, and the virtual world becomes a reality. We no longer brush shoulders with life's injustices, but we inhale the very spirit of disease, illness, pain, aging separation and death. We have witnessed perhaps the birth of our children, their growth and development, their early ailments and disorders, and travelled along the moving escalator of life, have let us witness the death of grandparents, and often process of illness and decay in our own parents and their inevitable death. Friends around us, personal acquaintances also have not been saved the arrows of misfortune. They too go through their personal battles, of confrontation with sorrow and anguish and the permanent uncertainty of living. We observe that the fabric of life begins to wear and tear and the structure around us, the very foundation of our being begins to rock and vibrate and as the remnants of an ancient previous civilization, our 'present' begins to crumble and rip at the seams. In my clinical experiences as well as contact with 'significant others' I've observed the depth of human suffering but also the enlightenment and illumination that these exchanges have brought into my own personal life. And so I take this opportunity to address one of the most difficult terrains of clinical work, the concept of finding meaning in life, and madness in general. Here too over time, I've seen several young individuals

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[1] On making a decision to explore these feelings, it became apparent to me that even much earlier as a child, there had been almost traumatic images associated with deep seated fears and anxieties concerning the fragility and impermanence of living. Surfacing around my time of entering primary school and re-emerging at certain stages of my life (for example, at my transition to secondary education) was the social impairment of a speech impediment. This was something I probably preferred to deny, yet was an everyday factor in my life, certainly during school and to some extent into college life. I have always felt a form of alliance between chronic achievement strivings and my earlier handicap due to speech anxiety. Added to what I'd probably describe as existential anxieties and entrenched insecurities connected with controlling or compulsive anxieties, I had a marked fear of speaking in public, or expressing myself generally, something that I found quite debilitating because I didn't have an explanation for it.

often in my clinical practice, optimistic, bright and enthusiastic, yet expressing existential anxiety, uncertainty and despair with their personal lives. Even among my own family I start to question to what extent our ancestry may have been touched by the 'fire of madness' and/or other emotional turmoil. The boundary between pathology and normality no longer seems so clearly demarcated. Is there a line a dichotomy? Are medical models of illness helpful in coming to understand the nature and ultimately the treatment of such disorders? I find as a clinical and in my private life, a major ethical conflict, in trying to come to grips with whether these people should be stigmatized by a diagnosis that may not be helpful, and the uncertainty of treatment modalities which are confusing at best and frequently without any clear evidenced-based character.

More recently, I've seen a documentary film (Fry, 2008) about the 'secret ailment of manic depression' by an influential British actor and playwright and was fascinated about the relationship which seem to be found between creative, artistic careers and mania, and the openness to address a psychological mood disorder which seemed deviously innocuous, but an innocence that camouflaged escalating pain and torment in almost every domain of human living, personal relationships, finance and working life. And yet one of the few ailments that its sufferers seem to want to relinquish. So what is this facet of human suffering that is fused with an insatiable delight and sparkling appetite?

Incidence of Bipolar Disorders

So let me try and give details of the figures and statistics of this human condition, this alienation or fragmentation or disengagement from reality. My focus will be on the spectrum of bipolar disorders, having been described as one of the most common, serious and enduring mental ailments. They represent a serious lifelong struggle and challenge. Epidemiological figures suggest that perhaps as many as 8-10% of the population may be 'hypomanic' to a mild degree but only around 1, perhaps 2% of the population will exhibit behavior ascribed the 'clinical label' of 'manic-depression'. Figures in the USA are higher with estimates of 2.6% of adult Americans exhibiting manic-depression in a given year, affecting 5.7 million Americans (Ohio University Medical centre, 2012): The median age of onset is 25 years. Developmentally, this is perceived as the most difficult phase of navigation from childhood into adulthood. In a review article, Culbertson (1997) reported a ratio of women to men of around 3:1. For major depression which is more impairing, the ratio is 4 women to each man. For bipolar disorder the proportion is 1:1. These ratios are fairly reliable and stable for depression for developed nations, whereas for developing countries the ratio fluctuates. In their landmark publication, Goodwin and Jamison (2000) cited studies showing the lifetime prevalence of bipolar 1 ranged from 0.3 (Taiwan) to 1.7 (US). They further provide estimate of the life time prevalence/100 of bipolar spectrum disorders which include mania, hypomania, recurrent brief hypomania, cyclothmia and the values range from 2.6 (Israel) to 3.3 (Israel), 3.4 (Italy), 3.7 (USA), 5.4 (Hungary), 5.5 (Switzerland), 6.4 (USA), 6.5 (Germany) and 8.3 (Brazil).

The personal and societal costs of such ailments are enormous. Wyatt and Henter (1995) estimated that costs incurred though such disorders amounted to around US, 45 billion dollars annually. Most of this (84%) was in lost productivity, unemployment compensation, disability payment and law enforcement costs (criminal justice system). In addition to financial costs and loss of employment, the emotional distress for the caregivers, usually close family members is enormous and likely to spill in other areas of life. In the UK (Gupta & Guest, 2001), the cost for the National Health Service of managing bipolar disorders amount to 199 million pounds, a significant proportion (over one third) being hospital admissions. The yearly direct non-health cost has been calculated to be around 86 million pounds and the indirect societal costs (86%) estimated at 1,770 million pounds annually. Overall, the annual costs in the UK amounted to approximately 2 billion pounds (at 1999-2000) for an estimated almost 300,000 individuals suffering. Bipolar disorders represent a chronic malady with phases of remission and relapse. Ayuso-Mateos (2000) reported that in 2000 it was estimated to be the 7th main cause of non-fatal burden accounting for about 3% of the total YLD, thus of similar order of magnitude as chronic lung diseases. And the personal costs of manic illness both psychologically and socially is often huge, leading to excessive overspending and financial ruin, disastrous relationships and separation, disinhibited and socially embarrassing behavior, frequently leading to a loss of job and problems with the law enforcement.

Weissman et al.(1996) had found that the age of onset of bipolar disorders ranged from 17.1 in Canada (18.1 in USA), to later ages in Puerto Rico (27.2 years) and Germany (29.0). They include review of studies of the bipolar spectrum disorders, encompassing mania, hypomania and cyclothymia, which reveal higher rates than for the more narrowly defined bipolar disorder. The diverse studies across several countries showed the lifetime prevalence of bipolar spectrum disorders to be between 3.0-6.5%, indicating how problematic it is to determine bipolar type symptoms. The authors suggest that the rates may be underestimates, partly because respondents are less likely to distinguish hypomanic states from the 'normal highs'.

Societal Pressures

Baumann (2011) has argued that society itself may be conducive to mania. To some extent this may explain the call of an 'epidemic' of mania in contemporary society. He lists the shopping malls ('streaks of glitter' leading to chronic indebtedness); television and media (myriad fluctuating programs a 'kaleidoscope play of grandiose advertising and distraction' … visual images of 'oversexualisation'); economics and politics (over-pressurized speech and urgency, excessive spending and debt leading to financial ruin and depression of a society), and foreign policy ('pleasure in televised vicarious destruction … long distance murder delusionally masquerading as self-defense'). Gartner (2011) has examined the *societal advantages* of mania, postulating a link between craziness and much of the success in America, in discussing the hypomanic characteristics of entrepreneurs (persons who perniciously generate the most wealth for a country) and influential leaders who took risks when migrating to the US, leading to a concentration of hypomanic disposition which have been a source of the nation's wealth, capital and character. These individuals are likely to exhibit elevated energy and arousal levels, ambitious and hard-driving, highly self-assured and creative as well as displaying passion and charisma. And these are among those traits which immigrants tend to exhibit. He uses the data derived from the NIMH survey for more mild manic states and found nations with high immigrant numbers (selective sample of persons who are impulsive and grandiose) also displayed higher incidences of bipolar disorders.

And in this enduring phase of gradual erosion, we divert ourselves in the media and literature world of pursuit of happiness and the reduction of pain and suffering and a neurotic almost fanatical search for the highest state of bliss. The literature abounds with titles of books serving to promote our search for this Holy Grail. We distract ourselves from the inevitability of our own decay and death by a compulsive repertoire of techniques to seek higher ideals of harmony and ecstasy. And what we cannot find and generate in ourselves we turn to street drugs and medications to instill the same goals. And the contemporary healers of this world, the medical health profession and the psychopharmacology complex try and enhance this belief in the 'chemical road to success' (Helman), psychotropic medicine as the 'miracle cure'. Let me cite from Breggin's work on elation and depression:

> *"familiar in our own lives and in those of our friends and family, and we tend to think of these ups and downs as normal responses to being alive. Even when someone we know becomes extremely depressed, we often are able to attribute the reaction to something specific, such as a death in the family, the loss of a job, a failure in love, passing a landmark in aging, feeling trapped or unproductive in one's life, or coping with a life-threatening or debilitating physical illness."* (p. 147)

He goes onto to argue:

> *"Despite its familiarity with depression as a natural response to living, the public has been bombarded recently with medical explanations for depression and elation … a biochemical imbalance theory, a veritable psychiatric gospel."* (p. 148)

There are certainly many reasons to be skeptical of traditional medical treatment, and yet situations in which it is hard to think otherwise.

We see that society's emphasis on a 'quick fix' to happiness and joy are to be found either through the manifold distraction and consuming activities of western industrialized nations, or in the many books and journals purporting to teach goals of achieving happiness. On the other hand, focusing on the excesses of striving towards ecstasy and joy in its most extreme and bizarre form, as in mania, we perceive undesirable elements of too much positive affect. There may be a downside to too much happiness. The uncontrolled positive elation associated with mania would appear counterproductive, or more accurately 'toxic'.

And during the last couple of years I've become increasingly interested in the phenomena of psychosis and more particularly mania, one of those conditions that psychotherapists have tended to avoid treating because of a strong message from the medical profession and among many clinical psychologists that this is one of the most severe and debilitating mental ailments – which it undoubtedly is

– which requires a singular treatment modality, that of medication. In the past, I've treated bipolar patients and have never needed to stipulate conditions that they ought to be taking medication or not, and realize as a non-medical practitioner where I'm unable to prescribe medication anyhow, it is not our task to secure compliance, albeit adeherence to medication is a topic that requires addressing. In the same way, I'm free from the 'constraints' of having to deliver 'sickness notes' for an employer. In other words, I don't need the formal label of 'sickness' in my professional vocabulary. To some extent that is 'professionally emancipating.' On the other hand, madness has been a 'quality of human experience' that has drawn interest throughout the centuries, well before the introduction of medication. Certainly, throughout many centuries mania has been the focus of interest of many: Consider Shakespeare's utterance 'There's a method in the madness'. A sense of coherency and orderliness when examined under the microscope.

What observations have I and others made of manic behavior which distinguishes it from everyday hectic and frenetic behavior? There are several phenomena such as pushed speech coupled with an over-activity; compulsive-type acts such as heightened sexual promiscuity (57% reporting such behavior, Goodwin and Jamison) and fanatical purchasing (spending sprees well beyond of which an individual can afford and on articles not necessarily of any practical value); excessive telephoning (running up huge bills); a reduced desire to sleep and rest (sleeplessness and agitated actions); increased startle reactions and inattention (as if a sensory overload, forgetting items such as purse, passports, losing money, leaving garments behind, etc). Overall a *chronic sense of urgency* – this may correspond to what Benthall describes as 'psychomotor pressure' and a virtual total absence of introspective ability. I've read some anecdotal account that in the 1950s and earlier before medication, one of the reasons of death among manics was out of physical exhaustion, *dancing their way into madness and occasionally death*. Overall, there is no single, unitary symptom of mania, rather a constellation of symptoms.

When deliberating about mania, I am reminded of psychological constructs such as sensation-seeking, impulsivity, disinhibition and risk-taking. And obsessionality seems an integral part of mania, the latter generally being associated with sensory overload and inattentiveness (poor judgment quality, lapses of attention, inferior concentration). Rather than focus on medical diagnosis it would seem preferable to collate data on observations of behavioral, emotional and cognitive observations that characterize what manic states:

> *"The manic state is itself a caricature of sensation-seeking behavior with high levels of activity, fast speech, impulsive traveling, euphoria or anger, little sleep, drinking, sexual sensation-seeking and impulsive spending or gambling of large sums of money. Mania is sensation-seeking out of control."* (Zuckerman, 1994, p. 273).

Then I think of communication I have with fellow psychiatrists who advise that I treat psychoses and related disorders in much the same way as posttraumatic disorders, and I too see parallels in the concept of the psychology of intense fear with its biological concomitants of frenzy and paralysis, immobilization rather than anxiety states. Added to this, is the concept of overload in decision making and quite the opposite of procrastination.

Jamison (1993) offers a succinct description of mania:

> *"Mood is generally elevated and expansive (or, if not infrequently, paranoid and irritable); activity and energy levels are greatly increased; the need for sleep is decreased; speech is often rapid, excitable, ad intrusive; and thinking too fast, moving quickly from topic to topic … (such individuals) usually have an inflated self-esteem, as well as a certainty of conviction about the correctness and importance of their ideas. This grandiosity can contribute to poor judgment, which in turn, often results in chaotic patterns of personal and professional relationships … including spending excessive amounts of money, impulsive involvements in questionable endeavors, reckless driving, extreme impatience, intense and impulsive romantic or sexual liaisons, and volatility."* (p. 13)

Like paranoia in some ways, mania is a defense against depression viz. the 'manic defense'. Sadly the patients have absolutely no insight at all into this and perceive themselves as immune from problems!

Shopsin (1979) categorizes the symptoms of mania into three major groups: (1) Moods or emotions (expansive or infectious, euphoria, elation, mood usually consistent with ideation, humorous, irritability and argumentative), (2) Behavior (grandiose acts, reduced need for sleep, socially active (generally over-involved), wasteful expenditure of money, sexually overactive esp. among females, ambitious coupled with check listing and excessive planning) and increased physical-motor activity and (3) Mentation and Speech (including flight of idea, high vocal arguments, pushed or forced speech, distractibility, voluminous detail, humor, illusions, and grandiosity).

Comments about living with family members with mania, has been likened to walking through a minefield not knowing when it is going to explode: a condition requiring constant alertness and a preoccupation of sudden calamity. I'd heard a close physician colleague commenting that finding a doctor who can get people in a manic phase to comply with medication during a 'manic flight' should be awarded a Noble Prize for Medicine. They use the term non-levels of compliancy or insight to describe this kind of 'denial'. Sadly the patients have absolutely no insight at all into this and regard themselves as free of all problems! (Chadwick, 2012, personal communication). Recently, by the entrance to a psychiatric ward, I overheard a young Turkish man's comments about his mother-in-law being admitted against her will … if a member of a family is ill, then the entire family is ill: Some cultures seem astutely aware of the 'contagious' impact of having someone ill within a family. For family members one of the problems in deciding on appropriate treatment, is the many to some extent contradictory claims, which range from a strong classical medical model of chemical imbalance proposing mood stabilizers, sedatives such as benzodiazepine, and atypical neuroleptics (major tranquilizers), to the more neoliberal and psychologically oriented, rejection of the dependency of psychopharmacological agents which serve as 'chemical straitjackets' and do little more than 'crudely' serve as 'quasi-frontal lobotomies' of cortical functions. Added to that, the 'involuntary' aspect of treating psychiatric conditions such as mania, the issue of compliance, etc. The patients communicate among themselves of the various adverse effects of the diverse, competing interventions. And presumably enormous psychological tension and the distress arises because these antagonistic positions does little to instill confidence in any therapy regimens.

Others such as Jamison, have argued at *an individual level.* Her book is about 'temperaments and moods of voyagers' individuals driven by passion and fire, the many creative and artistic persons whose productivity may be fuelled by their disposition, which itself is a double-edged sword.

Wounded Healers (and Artists)

Kay Jamison, herself afflicted with manic depressive disorder, was nevertheless able to pursue her successful career as professor of psychiatry at the John Hopkins University School of Medicine, and become a pioneer in the research and treatment of manic depression. One of her interest is the relationship between this disorder and creativity in the artistic temperament. She provides a list of creative artists who were sufferers from with a major mood disorder such as cyclothymics, major depression or manic-depressive illness. Creative artists and painters included in the listing are; poets – Friedrich Hölderlin, William Blake, Samuel Taylor Coleridge, T.S. Eliot, Victor Hugo, Heinrich von Kleist, Samuel Johnson, Boris Pasternak, Edgar Allan Poe, Dylan Thomas, Walt Whitman and Lord Alfred Tennyson. Writers – Hans Christian Andersen, Honorare de Balzac, John Bunyan, Ralph Waldo Emerson, Charles Dickens, Maxim Gorky, Wolfgang Goethe, Ernest Hemmingway. Hermann Hesse, Henrik Ibsen, William James, Eugene O'Neill, Robert Louis Stevenson, Leo Tolstoy, Tennessee Williams, Virginia Wolff, Emilie Zola. Composers – Hector Berlioz, Anton Bruckner, Edward Elgar, Georg Handel, Gustav Mahler, Sergey Rachmaninoff, Giocchino Rossini, Robert Schumann, Peter Tchaikovsky, Irving Berlin, Noel Coward, Cole Porter. Artists – Paul Gauguin, Vincent van Gogh, Michelangelo, Edvard Munch, Jackson Pollack. In her introduction she suggests that:

> *"The fiery aspects of thought and feeling that initially compel the artistic voyage – fierce energy, high mood, and quick intelligence; a sense of the visionary and the grand; a restless and feverish temperament – commonly carry with them the capacity for vastly darker moods, grimmer energies, and occasionally, bouts of 'madness'. These opposite moods and energies, often interlaced, can appear to the world as mercurial, intemperate, volatile, brooding, troubled, or stormy."* (Jamison, 1993, p. 2)

One of the difficulties – I had mentioned – for afflicted persons and their immediate families, whether parents or spouse, is the array of conflicting theories and therapeutic interventions aimed at treating the illness. In fact, it begins with the notion whether there is an illness at all, and as we have seen psychosis and bipolarity may all be personality dimensions which are fairly normally distributed in the general population. Psychoticism would not be a category of illness separated from the normal population, but an expression of a general personality trait, albeit extreme, distributed on a continuum among the entire population. Imagine a physical attribute such as weight or height. There are different sized people, and it was be foolish to demarcate into diseased, tiny persons, or physical tall 'ill' individuals. The concept of disease being associated with body height would seem absurd, although there may well be evidence that exceedingly tall individuals may suffer psychologically and/or physically because of their size, for example, being too great a strain on their cardio-vascular system, or pressures on joints and muscle tension.

I wonder what realistic alternatives there are to classical medical treatment? Here some of the literary genius, themselves afflicted by manic and related disorders offers their guidance. For example, Johann Wolfgang von Goethe, the German playwright, novelist and dramatist suggests that "*If I accept you as you are, I will make you worse; however if I treat you as though you are what you are capable of becoming, I help you become that.*" Others such as Shakespeare were very much aware of the limitations of medical care for certain human conditions, albeit his work was written several hundred years ago. In the fifth act of Macbeth (scene 3) he converses with his doctor, "*Canst thou not minister to a mind diseas'd, Pluck from the memory a rooted sorrow, Raze out the written troubles of the brain, And with some sweet oblivious antidote Cleanse the stuff'd bosom of that perilous stuff, Which weighs upon the heart?*"

The reply by his physician appears wise "*Therein the patient – Must minister to himself*". The meeting is to try and find a solution to the problems of sleepwalking of Lady Macbeth, which Macbeth himself recognizes as arising from the guilt proneness of his wife. Yet at the same time neither Macbeth nor his wife are prepared to accept this notion that it is a problem of conscience. The doctor realizes that no medicine can cure this issue and the problem is theirs alone. Macbeth responds by scorning medical science and is reluctant to apply psychological techniques, preferring to take up arms as if dealing with a disease, something to fight with physical entities. (Thanks go to Thomas Szasz (personal communication) who drew my attention to this text).

Being somewhat 'medically naïve' in the area of manic depressive disorders enabled me to perhaps bring a simplistic yet critical approach to existent theories, a bit like the Emperor's clothing, criticizing some of the more traditional medical models of mental ill-health, stained with "*pretentiousness, pomposity, social hypocrisy, collective denial, or hollow ostentatiousness*" (Wiki, 2012). It requires the visionary of a child who sees thru the mass misperception of a magnificent leader who is in fact naked.

Mania and Depression – A Single Continuum?

Let me begin with the concept of bipolar, when in fact it could be argued that depression and mania are opposite extremes of a single continuum. But what if their correlation is spurious, and in fact much like the emotional dimensions of negative and positive affect, they are independent constructs, displaying orthogonality? Positive affect comprises such attributes as active, happiness, energetic and alertness in contrast to sleep, exhaustion and tiredness. We know that the behavioral explanations of depression suggest a depressogenic style in contrast to mania which is associated with reward responsivity. Benthall (2003) has also written about the paradox of co-existing depression and euphoria in manic individuals. He asserts too that the circumflex model of emotions suggest that negative and positive mood are independent dimensions of emotion, and although most of the time these moods will be negatively correlated, it is plausible that both emotions – dysphoria and euphoria – can occur simultaneously under certain conditions.

Empathy and Compassion

There is powerful evidence that psychotherapy appears to enhance recovery process among bipolar patients. Mosher had found that *first time psychotic* patients given intensive psychotherapy, without medication fared as well as those receiving medication two years later. Mosher (2000) had also used non-psychiatric qualified personnel emphasizing the need for kindness, tolerance and compassion as the core quality traits for effective treatment.

Excitability Hypothesis (Benthall)

This hypothesis originally developed by Depue and workers leans on Gray's neurophysiological model of personality. In contrast to the behavioral inhibition system which is sensitive to punishment and frustration, The behavior activation system regulates appetitive motivation as well as facilitating goal directed behavior by "*regulating narrower systems such as positive affect, incentive-reward motivation, sociability/social potency, desire for excitement, and motor activity/arousal*" (Depue, Krauss & Spoont, 1987) and the behaviors regulated by the BAS are closely associated "*to the manic symptoms of mood changes, inflated self-esteem, decreased need for sleep, increased talkativeness, flight of ideas, increased goal-directed activity, and excessive involvement in pleasurable activities*" (Johnson, Winters & Meyer, 2006). There is also evidence that attaining an important life goal, not a positive event *per se*, can precipitate manic symptoms by bipolar patients (Johnson et al., 2000).

Sleep Deprivation

Healy (1987) has suggested that due to disruptions in the circadian rhythm, bipolar patients will exhibit an exaggerated response to the delayed tiring after the absence of a night's sleep (deprived sleep hypothesis), he argues that the grandiose feelings and coupled with mania are the response to the heightened energy levels. Some have suggested that the mania causes the sleep deprivation. Certainly, bipolar disorder appears sensitive to the environmental influence in general and to the seasonal effect in specific. Most often, the changes in weight as well as those in appetite were reported to be greater in the winter and smaller in the summer. The most frequent change in weight (in 51% of the individuals) is a gain of 2 to 3.5 kg during the year, and in 32% of the individuals there is a change in appetite by season. In addition, sunny days have a greater positive effect on wellbeing in the bipolar than healthy co-twins. Preference for evening activities associates with pronounced seasonal variation in mood and behavior (Haikarainen et al, 2003).

Psychoanalytical Concept

Neale (1988) adopts a theory derived from psychodynamic model indicating that mania serves as a defense against unpleasant psychological states and/or the mental pain associated with an object loss and the depression related to it. He offers a notion of self-esteem as being a crucial concept in understanding the initiation and maintenance of mania. They argue that we tend to think that low self-esteem is supposedly associated with depression, whereas high self-esteem with the more grandiose facets of mania: In fact, low self-esteem could well characterize the manic phases, but it simply isn't expressed directly. Manics often experiences problems in their interpersonal relationships, including their work and family relationships. They tend to be shallow and display difficulties in introspection, inclined to avoid distressing content.

With regard to the psychoanalytic perspective of the problem, Freud generally equated mania with the atmosphere of the carnival and suggested it represented a conquest over the conscience, a triumph over the superego, whose imagined enmity is responsible for the depression. The condition appears also to represent the height of egocentricity: there is little to no empathy, no genuine altruism and no authentic consideration for other people. They live in their own world addicted to mental pleasure and they are easily irritated and frustrated or even violent and if anything tends to interfere with that mental pleasure. Because their conscience is 'beaten' they think they can do anything to counteract these impulses (Chadwick, 2012, personal communication). Freud (1984) was also aware of the potentially alternating character of melancholy into mania, with periodic relapses: he suggests that both disorders wrestle with the same complex, and in melancholia (depression) the ego has succumbed to the complex, in contrast to mania it has mastered or displaced it. Manic defenses are considered as methods of buying liberty from anxiety and guilt (and depression?) at the expense of profundity of character and awareness and feelings of others (Rycroft, 1972).

Emotional Expressiveness (EE)

Emotional expressiveness describes the emotional responses of family and significant persons towards the patient with a mental disorder. In instances where there is a high incidence of hostility, criticism, or emotional over involvement in the emotion expressed by relatives, there is likely to be a high negative affective style which may not cause the disorder, but certainly impede the 'recovery process.' This may be characterized by excessive self-blaming, over-concern, exaggerated worry (on the part of parents) and self-pitying.

Kindling-Stress Model

Goddard (1967) had noticed that by electric (or chemical) stimulation of the rat's brain at a stimulation too low to cause a convulsion, nevertheless, when repeatedly given over weeks sensitized the brain to evoke convulsions. And the idea of the 'kindling' model was intrigued drawing similarities to the process of combustion in a log fire. We are reminded too of Jamison's title to her book on mania, *Touched* *with Fire*, the log which has the potential of being a fuel for warmth is hard to set alight. On the other hand, by surrounding the log with several tinier fragments of woods, all kindling, the log will likely set fire (Post & Weiss, 1989).

Biochemical Theory

Human brains have developed over evolutionary history and we see that several situations can trigger specific responses. For example, mania can be triggered by excessive stress (psychological and social pressures such as divorce, death job loss, etc), sleep deprivation, sensory/stimulus deprivation, post stress traumatic episodes, chemicals e.g. cocaine, amphetamines, anti-depressants and/or corticosteroids. Research using has shown that after ingesting amphetamine, persons diagnosed as schizophrenic reveal higher levels of dopamine release, especially in the area of the striatum, when compared to non-psychotics. The immediate effects of such dopamine stimulant often include increased alertness, euphoria and over-confidence features common with mania (Jacob and Silverstone, 1986).

Drug-Centered Model vs. Diseased-Centered Model

Moncrieff (2003) herself a psychiatrist, claims that a "*disease-centered model assumes that drugs exert their therapeutic effects by reversing an underlying biological abnormality or disease. In contrast, the drug centered model says that the drugs influence the expression or symptoms of psychiatric problems by inducing an abnormal biological state. Psychiatric drugs are psychoactive drugs… they are drugs that affect the nervous system and alter the way we think and feel … like alcohol and illegal drugs such as cannabis, cocaine and heroin. All these drugs make people feel and behave differently from normal … They produce what is called a state of 'intoxication' and each different type of drug produces a particular sort of intoxication, depending on what chemical effects it has on the nervous system*" (p. 12). She argues that ingesting psychiatric drugs simply substitutes a drug-induced state for the initial state of mental disturbance, so while "*alcohol can help people with social anxiety because a state of mild intoxication, feeling merry in other words, is associated with a lessening of social inhibitions. No one suggests that alcohol works by reversing an underlying biochemical imbalance or correcting an insufficiency of alcohol in the brain*" (p.13).

Distracting Automatisms (Kiersey)

Madness perceived as a trance-like state, not unlike somnambulism, used to execute an absurdly deviant act or series of actions (unintentional and involuntary 'distortions of family conventions' including 'twisting conventions and traditions' aimed at distracting from personal feelings of worthlessness). These over-exaggerated, bizarre distortions generate more pronounced responses from our companions to change our habits (shifting from intended distraction to increased involuntary annoyance). The sufferer feels injustice at being treated for something he or she cannot 'control' because of trance-like state, and the stress resulting from such ill-treatment sees it as the cause rather than effect of the absurd rituals. Keirsey (2008) argues that now because of incessant accusations, there is an excuse to behave 'madly'. He uses the concept of a 'deep sense of unworthiness that survived childhood' and the individual dire need to 'protect themselves from being found out', keeping tightly hold of the role we play (to avoid the secret emerging). He asserts that it is preferable "*our obvious irresponsibility in failing to meet the challenges of life because of madness, than of unworthiness*", hence escaping from personal responsibility. Keirsey argues less for a mental disorder rather an "*overt mental illness that conceals a covert social wellness*" (madness as social arrangement from the perspective of the arranger, not the observer). Overall, he suggests, lending on the work on Janet and Milton Erickson, that these aberrant rituals are strategic messages aimed at others attending to their irrational rather than unworthy features.

As personal autobiographical histories are much, much shorter than our evolutionary histories (in which the brain cortex has developed over hundreds of thousands of years), the neutral mechanisms are almost certainly much more sophisticated, 'flexible' and original in innate ways of dealing with potential stressful and/or traumatic circumstance. The orchestration between mind and body is more rich and diverse in its form and structure than we can imagine. It is likely that these diverse and sometimes contradictory and competing theories of madness are in fact, to some extent all partially valid, they are not mutually exclusive, and certainly will not represent the most accurate model of human mental functioning. Until then mania is an integral constituent of human society, requiring understanding and insight, not stigma and prejudice.

Not only are there diverse theories of bipolar disorders, but some myths or fallacies in the etiology, diagnosis and treatment of manic behavior. The UK clinical psychologist, Benthall (2003) questions the notion that early screening of psychosis may significantly benefit patients, arguing that it has genuine ethical problems administering medication prior to persons becoming ill, exposing a substantial section of the population to a risk of severe unwanted side-effects, for many who may never yield clinical psychosis. So afflicted individuals and their immediate families are not only confronted with the 'stigma' of a diagnosis, which may be unhelpful, but also have to wander through the various often contradictory suggestions for treatment, from the dogmatic medical model of neurotransmitter deficits or overabundance to the other extreme of illness as a metaphor. Unfortunately, added to this is the firm belief among many psychiatrists that specific medications or a cocktail of several are pre-requisite for restoration of health and as early and intensive as possible.

What empirical evidence do we have for these claims? Some make claims such as 60% of untreated patients showing deterioration in their condition over time, although evidence for this is lacking. Research suggests that about one third of patients don't benefit from the use of neuroleptics ('non-responders'), and there is no clear predictor of which patients benefit and which does not. Hence some patients will probably be better without medication although 'drug-free strategies' for coping with symptoms are neglected in research. Benthall (2006) who emphasizes that he is not an opponent of medication but feels it important to underline the potential adverse effects of neuroleptics such as the extrapyramidal effects, including uncontrollable tremors in about one fourth of patients, akasthisia associated with hyperactivity, restlessness and a state of agitation (neuroleptic dysphoria), distress resulting from sexual dysfunction, and weight gain (due to increased appetite and craving), as well as agranulocytosis, and in extreme cases may lead to neuroleptic malignant syndrome. Medical practitioners would do well to address these potential debilitating effects.

There is further evidence that psychiatrists tend to use too high a dosage and too often (in 50% of cases) cf. Cohen (1997). There is also data suggesting that countries of the Third World who have less access to psychopharmaca have better non-relapse rates than do the developed nations, suggesting that the social context may be critical in restoring well-being.

Another question is whether medication is required for many years or even over a life-time. Some have argued vehemently that a combination of a mood stabilizer and atypical neuroleptic are required lifelong. Some clinical researchers are cautious in not devaluing the drugs, but simply recognizing the adverse effects of prolonged use when perhaps not necessary.

Others would argue, as we have, that mania may represent a personality continuum and dependent on which end of the spectrum or what degree is manifested, the disorder will be exhibited. In much the same way, Romme & Escher (1993) had found that auditory hallucinations are not limited to psychiatric patients but are fairly common place (hearing voices). His organization 'Resonance' got people to accept their inner voices as a feature of normal human variation rather than a psychopathology, and this subjective 'redefinition' of their voices attenuated their distress often quite remarkably.

Let me add some concluding remarks. I began by trying to express my own personal difficulties coping with the fact that a group of significant persons, not only clients who attend my practice, but extended family members may likely been 'touched by the fire' of intense emotional reactivity. We all know of someone often a personal friend or family member, who suffers psychologically, and this 'emotional warfield' tears at the fabric of personal lives, not least because of the difficulty in demarcating work from the leisure domain. It is almost impossible to function authentically in helping others in their emotional turmoil when we ourselves are going through the hassles of daily life of coping with intensive mood swings. Then the additional feelings with self-blaming, personal inadequacy and insecurity. But are we not all wounded healers (as a good friend told me when I began writing this chapter)? Health professionals are not immune from the 'arrows of misfortune', themselves sharing much of the autobiographical history of their patients, influenced by our family history and also our own child and adolescent developmental history we learn that we all have to cope with the fragility and impermanence of being human, what Healy describes as the 'perennial problems of history'. He asks how we can *"convey change and discontinuities when some of the most important things remain the same over millennia… People have always fallen in love and been driven by ideals, have needed to find words to tell their children about what it means to be human"* (Healy, 2008, p. 150).

Perhaps the biggest problem for family members is securing the social support and professional network to help them. I have had to confront a very real 'susceptibility or fallibility', an author of my own fate, plagued by errors and uncertainties, not least due to the diverse and contradictory treatment modalities in traditional health care. The traditional medical illness model of restrictive care and conviction of the efficacy of medication, and the alternative, more liberal but often 'blaming' practitioners who curse all or most of what contemporary medicine has to offer.

Bipolar disorders seem to be the most difficult to identify, diagnose and 'decipher'. Many years ago Eysenck had shown that there was substantial disagreement among 'experts' in the diagnoses of psychological disorders, and there is evidence that a half a century after his observation, this is still the case, if not greater due to the vast increase in the number of new 'diseases' being 'discovered/invented' in which as many as up to one half of the population have become diagnosable. Overall the current biomedical model seems incomplete and fails to explain functional illness or lead to appropriate treatment: Individuals become the *victim* of a disease, and a *recipient* for treatment, stigmatizing further into a passive role and a 'lack of responsibility for their illness' (Wade, 2012). This seems congruent with some of the writings by persons such as Thomas Szasz, Peter Breggins and Alan Whittaker who seriously question the medical model which reflects a chronic deficiency of caring concepts, and an overreliance on psychopharmacology agents (e.g. anti-depressants, mood stabilizers, neuroleptics and lithium). The patient and his or her immediate family are caught in the web of 'toxic' struggles between 'academic clinicians' and health practitioners, with quite contrasting ideas, instilling even greater confusion in their already bewildered minds. Furnham & Kirkcaldy (2012) emphasize the need to consider a more biosociopsychological model of treatment, of both physical and psychological disorders. Sociologists and psychologists among others have tried to provide alternative models of disorders counterbalancing last century's bias towards the medical model, heavily supported by the heavyweight of the pharmacological industry. This review is not intended to abrasively attack conventional medicine, simply to look for a more holistic, integrative and multifaceted explanation of severe psychological disorders. Safe havens for persons experiencing their manic or depressive phases need to be provided as a substitute to traditional medical/drug treatment. What alternative, more humane and liberal treatment forms can be developed?

Sufferers should be taught more effective, stable life-styles. For example, we have seen how the sleep patterns play a major role in bipolar disorders, hence promoting ideas of inducing better sleep patterns and facilitating sleep perhaps using tranquilizers in acute situations if necessary, but also psycho-educative sessions explaining the importance of circadian rhythms and regular sleep (monitoring wake-sleep patterns). Taking regular exercise, not too excessive, because of the adverse effects that may ensue from addictive types of compulsive exercise, but rather a moderate, graduated, regular aerobic training program of perhaps 3 times weekly 30-40 minutes (Kirkcaldy & Shephard, 1990). Heightened nutritional awareness, recognizing that *regular* meals containing essential minerals and vitamins (B complex, vitamin D, omega 3 fats, and manganese) are essential, because it has commonly been observed that prior to a manic bout the person frequently fails to have maintained an adequate source of nutrition. Another social component would appear to be the importance of social support and a network whether family or friends, a self-help group, or the help of a professional counselor or therapist to talk to, aimed at increasing the sense of self-efficacy and personal control.

Then there is the clinical psychological domain, psychotherapists should be more 'risk-taking' (less anxious) in their selection of patients. The medically dominated model of manic-depression is sorely lacking in its insight into the psychological and social aspects of their patients. We need to identify the social, family and work pressures that the client is confronted with. There should be a network of legal health professionals to offer support in crisis situations (financial pressures and impending unemployment are commonplace among manic individuals). Psychotherapists can implement the many novel ideas emanating from cognitive behavior therapy in mood chart monitoring (patients should accurately monitor changes in the fluctuation of their moods over time that may trigger or exacerbate manic and/or depressive phases), teaching stress management, more particularly anger coping and resilience training. There are huge developments especially in North America and the UK of the value of mindfulness training to help facilitate control of negative emotions before they become destructive (identification of stress triggers), and closely aligned with this is social skills training, and getting persons to clearly recognize the irrational cognitions that accompany powerful negative emotions such as fear, anxiety and depression (Freeman, Freeman & Garety (2008). There are many interesting internet, psycho-educational resources that can help not only patients, but their families in offering insight into better treatment (e.g. http://mindsontheedge.org/watch/fullprogram/).

And not least, to underline the value of *hope* in medical care (Lown, 1999), again a facet frequently lacking in the biomedical model. Health practitioners from every field, social workers, legal experts, social policy makers in government, and patients and their families should mobilize their strength and resources to implement the more effective and humane forms of treatment for sufferers.

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Chapter 9

CANCER: AN ILLNESS, NOTHING MORE, NOTHING LESS

Nisha Dogra

In this chapter I will briefly outline some of my early medical history and why I think I became a doctor and then a psychiatrist. I then describe my experience of having a paraosteal sarcoma and its treatment and then focus on how I feel this has influenced me in both my clinical and academic career.

Some Background

Before I describe the illness that is the subject of this chapter, it is probably necessary to mention some other background. I had measles when I was a toddler and this left me with chronic suppurative otitis media (ear disease where there is chronic infection of the middle ear cleft, with a perforated eardrum and discharge usually related to a bacterial infection; this in turn left me almost deaf in my left ear by the time I was about ten. Having chronic infections with offensive discharges was not easy to explain to peers. Add to that glasses, and maybe you are getting the picture of a somewhat awkward and socially uncomfortable adolescent.

What led me to Medicine and then Psychiatry?

Given that I am both an admission's tutor and an interviewer for the medical school and constantly asking potential medical students, why medicine, you would think I had a clear answer to explain my own motivation. I had spent so much of my early childhood attending hospital for my otitis media that the appeal of being a doctor was probably ingrained without my even realizing it. Part of my reasoning may also have been that there was a need to prove myself to those teachers who advised against medicine as a career on the basis that as an Indian child, I could only be doing it because my parents wanted me to. I would be lying if I said my parents were against it but that was not my primary driver. I think the idea of medicine rather than nursing was partly because most of my contact was with doctors who were always very kind to me. Nurses in outpatients in those days mostly seemed to undertake rather administrative roles. Not really ever having fitted in at school, I had expectations that university might be different. But I guess it is hard to be different when you don't know how to be someone other than yourself. I may also be overestimating how others can only really be comfortable in the differences between you and them if you are. I was so conscious that being partially deaf put me at considerable disadvantage in so many social situations so that admitting I was deaf felt ‘too much to share’. So I left medical school, still not really very sure of myself. House jobs provided a steep learning curve but it was not until my first senior house officer post (in psychiatry) that my confidence grew. For probably the first time it was okay to be who I was. I honestly don’t know if I was confident because I got into psychiatry or because of the fact that my colleagues perceived me as a good psychiatrist.

Medical school put me off most specialties as I found the competitiveness and slightly ‘macho’ culture unbearable. I decided that community paediatrics would enable me to combine my interest of paediatrics, permitting me to work in community settings and also ensure I could have a good work/life balance (at that point I had anticipated I would marry and have a family because that was what was expected). I did a psychiatry post to fill six months before I took up a two year paediatric’s rotation with a general practice year at the end. I did eighteen months of paediatrics and then started the last six months of the rotation in psychiatry. During paediatrics I had successfully passed my Diploma in Child Health and my confidence as a doctor had grown significantly. I had never expected to take let alone pass postgraduate exams given how I had struggled at medical school. However, whilst doing community paediatrics I found that the most appealing part of the job for me was the psychological components. I vividly recall seeing an eight year boy in a school clinic with recurrent abdominal pain and within fifteen minutes we had established that he was being bullied at school. This was a minor success in that it is not a huge surprise that a child with recurrent abdominal pain might have psychological origins but major in that he had seen several other clinicians who had failed to find out about the harassment he had been experiencing. This really drove home to me that so much of psychiatry is dependent on the clinical skills of the doctor. We have so little to fall back on in terms of tests and so on. I enjoyed the challenge of developing my interviewing skills especially with children. I think, psychiatry if done properly, requires the psychiatrist to be aware of so many different factors and constantly reflect on what is theirs and what belongs to the patient. I don’t think I was trying to resolve any childhood issues or trying to heal myself through others. I liked working with kids and psychiatry was a good way of doing that. I did and still do like the challenge of trying to understand people and whether that is because I want to understand the wider world I am not sure. Families and how they work (or don’t work) have always fascinated me so child psychiatry was a natural choice. But I am getting ahead of myself as there were some challenges before I started child psychiatry. I began my second psychiatry placement under the best circumstances in that I was getting more and more accepting about who I was.

Getting Really Sick

Some six weeks into my second psychiatry job I went on holiday to Paris. I remember trying on some skirts and thinking how uneven my legs looked. Some three weeks later I was playing badminton with some friends and mentioned it in passing. We agreed it was best to have my leg medically examined and better sooner rather than later. We briefly discussed how the lack of pain with a lump was slightly ominous. As I worked at a general hospital I completed an x-ray request card and stated that the reason for the x-ray was to exclude an osteosarcoma. I still don't know if I was just hoping that going through all the due process would be an unnecessary waste of time and magically thinking that if I went through it all, I would not needed to have gone through it. Anyhow, I had the x-ray taken and then went to a ward round. I got bleeped and asked to return to see the radiologist. I assumed I was being seen by the consultant as a professional courtesy and asked if I could go after the ward round. Funny how clear some details remain even after such a long passage of time

So I went along to see him and saw breaking bad news in action. He had already arranged for the orthopedic consultant to see me in two hours (the consultant was making a special trip just to see me after he had finished the outpatient clinic he was conducting in another hospital). My first thoughts were, 'How the hell was I going to tell my parents that I had cancer!' Initial thoughts were that it was osteosarcoma which in 1989 had a relatively poor prognosis. Anyway it went from being: 'I might be dead within a year!' to 'I might lose a leg so I would need a prosthesis and chemotherapy'. All this was within six weeks. Maybe you can see why I don't think I was so hard done by. People always ask "*Did you ask why me?*"and from my diaries I can tell you, I didn't. Anyway I had a biopsy followed by a pretty big operation followed by chemotherapy which was really, really rough. Within seven months I was back at work and from my perspective have never really looked back.

Getting Better

So how did my having cancer at twenty six years of age impact on my job as a doctor. I think there are several answers to this and I will try and cover each in turn. At around the time I had been sick there was a film out called 'The Doctor' starring William Hurt. I so wanted my illness to be as profound an experience as his. However, there was nothing profound about it. It simply was what it was; an illness, a pretty horrible one but nothing more or less.

I did not start suddenly living for the moment fearing I was about to die at any minute; I did not feel I suddenly got a second chance to live my life differently or better. I pretty much remained the solid reliable planner I am inclined to be. I did not find God or any reason or higher explanation for what I experienced; it just was what it was. However, what was interesting was how my attitudes about my illness influenced those around me. Probably for the first and only time in my life I was the cool kid! All I had to do to achieve that status was to have cancer! My illness generated a fair degree of interest – most of my peers had not experienced someone of our age having such an illness. I usually was (and am) very independent and relied a lot on myself but during my illness, I acknowledged that I needed to allow others to offer support and to accept the help offered. I remember deciding not to go home to my parents to recuperate because I knew I would not cope with them watching me being ill. I knew that would be too much for me to manage. My poor sister who was living with me at the time faced the brunt of it and to support her, I had to allow myself to depend on others which was somewhat difficult for me at times. My peers and friends were generally brilliant at being there. People described me as brave and strong because I did not fall apart. Some people needed me to fall apart or show vulnerability so that they could do something to help and in that way feel better. I was aware even at the time that they did that for themselves as well as for me. But what I learnt most was that I did not want to be defined by that one facet of my whole Being. Yes, I was the girl with cancer … but that was not all of me! I was not brave or strong because I had cancer. I was just doing what I *needed* to get through. I made a very clear decision and that was I was not going to spend the rest of my life being a 'cancer survivor'. When I returned to work I sent those that had been central to my network 'thank you cards' for their support. It was my way of making clear that I was no longer the girl with cancer, I was drawing a line under it and saying that I had moved on. I was very careful to ensure that I never sought special status with peers or family because of my illness. I could not dictate or determine how others saw me but I could take some control of how I projected myself. From the outset I was determined that I was not going to apologize, be embarrassed or be self pitying about my experience. I am not sure it was the cancer that made me more confident or it was the fact that being okay emotionally after that tough an experience does make you feel you are doing okay: Is it true that what doesn't kill you makes you stronger?

Changes

The first major change was that I never got to finish my rotation and undertake my year in general practice as the general practice rotation was unable to accommodate the delay caused. The training director of the psychiatry rotation was nothing short of amazing in her support. It led me to decide that since I was already sure I wanted to be a child psychiatrist I would seek psychiatric training posts. I applied for a local post. I had been back at work for just a few weeks and my hair still had not grown back. I attended the interview wearing a lovely straw hat which looked out of place for medical job interviews. I swear the other candidates thought I was crazy and the interviews were fixed. It took years of us being on the rotation before any of them ever asked me if I had already known of the outcomes hence my apparently flamboyant clothes. One of the very early decisions I made was that I could not go back to being that geeky awkward adolescent. I had a fifteen inch scar as a result of the surgery and it was suggested to me that wearing trousers would conceal it. I decided against that and for a while wore the shortest skirts I could get away with. I wanted to make sure that I was okay with it. I did not care what other people thought of it, but I knew that for me I did not want to be forever embarrassed about it. For me that was the beginning of realizing that people may do seemingly crazy and unfathomable things but there is probably some sense for them behind their method. Chemotherapy also caused nerve deafness in my right ear which until then had been my good ear. So I was now considerably deafer. I tried hearing aids but at that time they were pretty poor especially for hearing loss such as mine. I learned to smile and nod even more which made people think I was socially confident and relaxed! I did not try and dissuade them. Again it made me question the homogeneity of meanings and experiences. That is we have a tendency to assume that certain life events lead to particular feelings or ways of being. However, I think while there may be some commonality, we should be open to the idea that individuals make sense of the events in their lives in quite unique ways as they draw on a unique set of circumstances to come to terms with their experiences and the impact of these on their lives.

Even today the term survivor sits uneasily with me. It is so widely used to define success for having survived a traumatic event but for me it seems to define the person by that trauma – as though you can never leave it behind. Maybe some people can't and don't. However, I cannot define myself through only one aspect of who I am. Am I disabled because I am partially deaf, because I have a prosthesis in my leg? I don't feel I am because I have been able to minimize their impact on my life as far as I can tell. Is it the deafness or cancer that defines me? And why are these features of me more important than the fact that I am of Indian origin, female, a doctor or anything else that I am?

Attitudes towards Illness and Life Events

I think my illness did make me more patient centered but not in the ways I had perhaps anticipated. I had thought I might be a more sympathetic or more patient doctor and was a little disappointed that cancer treatment did not cure my impatience! However, what I did find was that it was very easy to no longer make assumptions about the meaning of any illness to any particular patient. I had experienced so many assumptions made about me and what I must be feeling and thinking. Rarely did my experience reflect the assumptions. I had also learnt that there is *no single right way of managing an illness*, there is no guide book or Holy Grail. In some ways, I just had to be incredibly intuitive and do what felt right for me. It really didn't matter if it made sense to other people or not. The main point was not to play games with myself whatever else I did with other people. As a doctor and especially as a psychiatrist, I have learnt to have no preconceived beliefs on whether the way people manage life events really says anything about them at all. Most times I think people just do the best they can to get through difficult times and it may not be until they are through that challenging period that they can effectively reflect and learn for the future.

That philosophy does not apply just to how patients cope with their illness or problems but also how families manage life events and change. I think I find it much easier to have difficult conversations with parents who may not have parented in the best way for their child because of various things that may have been going on in their own lives. I do find though, that I am able to discuss with them what matters is how we *learn to get unstuck* (that is how we learn to adapt and modify our coping strategies to deal with the changes a life event may have caused) and move forward.

I have also learnt through my own experience that making sense of experiences is such an individual and personal construct, that I am not surprised by the things that people do to get through. As a doctor, whilst I have my own very clear values and sense of what is right for me, I have no need to share or impose those on my patients. I also don't need immediate answers or quick results.

When colleagues have experienced illness or life events I don't feel the need to problem solve. I am happy to listen and genuinely talk about whatever it is they need. My own experience was that I was very well supported and supporting others for me is about not having any agenda at all. I don't need to be needed and maybe because I don't, I am easier to be with.

People Engage when they are Ready to

When I returned to work, there were those who doubted that I was okay. There were implications that although I was physically better, surely I carried emotional scars. There was some indirect pressure for me to seek counseling at the very least. In my work experience, I've noticed that children are often placed under pressure to come and see me and talk. I hope I have developed a sensitive way of helping them because of the assumptions made about how I was or was not coping. I make very clear that the choice for intervention is ultimately theirs. If they say they are doing alright and they are functioning reasonably I let them be. This sometimes gets me in conflict with their parents who want me to give them medications or make them talk. It takes a great deal of stepping back and carefully explaining to parents that you can't make people deal with anything just because you want it. And also there is no one way of resolving feelings or situations. I should add, that by taking this approach I am not advocating that we do not work hard to help people engage with therapy if that indicated but that we can't do it as an instruction.

Personal Disclosure

One of the advantages of having been trained well in psychiatry is that personal disclosure and its' use has been discussed and addressed. I remain very measured with what I share partly because I think it is important for the session to be about the patient. Parents and children have often asked about my scar as it is obvious. They often assume it is as a result of surgery following a road traffic accident. I usually just acknowledge that it is as a result of surgery. I disclose I am hard of hearing as not to do so could compromise the care I provide. I don't feel the need to share more and have wondered if I am anxious about being seen to be vulnerable. I don't think it is. I think I see my work as a time that is about other people and meeting their needs. My own needs and baggage have to be addressed elsewhere. I simply don't feel the need for my patients to know that I have experienced illness. I hope I can convey understanding and compassion because of who I already was and am, and not just because I was sick.

Having Difficult Conversations with Patients

As a patient I remember being told I would need chemotherapy as the surgeon was leaving the room. It was uncomfortable for him to give me the difficult news so he left before I could add to his discomfort. That of course is the best case scenario. He might just not have been that bothered. As a doctor I am very conscious of the potential power of our words. Balanced with that is feeling secure about how I am that there is no need for omnipotence. I don't avoid difficult conversations with parents or young people. I plan for them and sort out any of my own associated baggage beforehand. Some of the doctors that treated me needed me to validate them as people, and that placed me under enormous pressure to agree with them. It was as though disagreeing with them was challenging them and doubting them. As a doctor I am very honest with my patients and make it very clear that I am happy to be questioned as I need them to be sure about what they are or are not agreeing to. I am not seeking their approval and the focus of our intervention is about them. Of course, I find the work that I do rewarding which is one reason I continue.

The Value of Families

I can never now think about families without thinking of the phrases "*All families are psychotic*" (Coupland, 2002) or "*All happy families resemble one another, each unhappy family is unhappy in its own way*" (Tolstoy, 2003). Families are so unique that understanding someone else's family is an art form. I have to credit that having a family that was supportive but one that did not overindulge me was incredibly helpful. I was never going to be allowed to get away with using 'but I had cancer' as an excuse. Families fascinate me in how they can be our best and worst supporters, especially at the most difficult points of our lives. In my professional life, I am minded to remember that just as with illness, families mean different things to different people. I feel that children need someone on their side to say that we don't have to live with narratives of ourselves that don't sit easily with us. There is no doubt that change is hard but it is possible. I don't agree with either Coupland (2002) or Tolstoy (2003) but they are interesting words with which to start discussions (although I would avoid using psychotic in mental health services).

Dealing with Diversity

My experiences with illness have made me very uncomfortable with the way that issues with diversity are addressed and how many of those involved with the subject are so lacking awareness of how their philosophical stances influence what and how they teach. Much of my work in education has been in the area of cultural diversity which began with my being asked to develop undergraduate teaching in the area. There is no doubt that the approach I have developed and written about has been heavily influenced by the assumptions made about me, many of which became apparent around my illness. Maybe it is because I also don't really fit in easily with any of the groups with which I may identify or be identified as belonging to by others. When I began work in this area, there was a tendency to assume people with similar characteristics are homogenous, so for example the expectation was that medical students as future doctors needed to know how to treat different ethnic groups, people with disabilities, different religious groups and so on. It seemed to be forgotten that people have multiple complex interrelated identities which are subtly altered in different contexts. If my deafness and cancer have taught me anything it is that I may share some features with others who are deaf but in some I am different because there are a whole range of other factors to consider. The approach to diversity education I have advocated is patient centered because I believe that patients decide for themselves about what is ultimately important to them and who they are. It is of interest to me that the discourse is now shifting and traditional ways of dealing with diversity are being challenged.

Summary

It has been surprisingly difficult to write this chapter; but not because of the content of dealing with my illness. It is hard to know how much of who I am today relates to the experiences I had over twenty years ago because that experience is an integral part of who I am. I don't know what my life, or I, would be like if things had been different. I can say without a doubt that having a supportive family, friends and peers who made themselves available helped. But perhaps making a conscious decision that whatever happened, I was not going to let events overtake me was what mattered the most to me. That has allowed me to choose what I take forward and what I leave as something that happened to me in the past. When there are so many aspects that cannot be controlled, for me it was useful to focus on those factors that I could. That helped me retain a sense of myself and maybe that is a key part of surviving difficult events. I have tried to reflect on the approaches or aspects that I did not find helpful (such as the assumptions made about me, the way people needed me to feel or behave) and challenge my own behavior towards others. Additionally, I have also wanted to be genuine but at the same time am aware that writing for a book places material in a public arena. Some aspects of my illness are so personal and have affected my personal rather than professional life in ways that do not feel appropriate to share. Writing the chapter has probably reinforced my belief that it is the interaction between our internal and external worlds that helps us make sense of the world and that is entirely unique to individuals. I hope anyone reading this forgives me if I am more measured than I should have been but then like I already said, some things don't change no matter what you go through!

Suggested Readings

I have suggested three books that were for me really interesting accounts of illness (two are fictional). I should add I was given some help books by friends during my illness and found them rather formulaic and uninspiring but that may say more about me than the books.

Chbosky, S. (1999). *The Perks of being a Wallflower*. London: Schuster & Shuster.

This is fictional and describes a young boy's adolescence and how he struggles with managing depression. The part that stayed most with me from the book was that sometimes we try too hard to reframe people's experiences and what we really need to do is to acknowledge that they have had a difficult time or that things are not so great.

Robinson, E. (2004). *The True and Outstanding Adventures of the Hunt Sisters*. London: Simon & Schuster.

A book about a woman whose sister has cancer and how they help each other through the illness. Given that I have four sisters, a book about sisters that is well written and covers support was always going to have a head start.

Watt, B. (1996). *Patient: The True Story of a Rare Illness*. London: Viking Press.

This is written by one of the members of the pop group, 'Everything but the girl'. They were one of my favorite groups and a concert we had tickets for was cancelled. It was the beginning of a lengthy illness for Ben Watt. The book was an account of his illness. What I liked about it was that it made no claim to be anything more than what it was which was his experience some of which resonated with me and some of which did not. It highlighted how everyone makes sense of their own lives for themselves.

Acknowledgements

There is no doubt that the experience was made more bearable because I had the support of parents who would do almost anything for their children and sisters who knew when to step in and when to leave me alone. Dr Margaret Oates was the training director whose support took away any financial worries and enabled me to focus on really getting better. Thanks also to all those peers and friends who helped in so many different ways – they know who they are.

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Chapter 10

RECREATING SELF: A PERSONAL JOURNEY

Thandi Haruperi

Introduction

My journey towards becoming a 'Wounded Healer' can easily be traced through my past experiences and illustrates my evolution from my childhood, family setting, upbringing, early marriage, divorce, emigrating, emancipation, and culminating in that defining moment when I was diagnosed with HIV. I eventually chose to use these experiences as 'stepping stones' (Progoff, 1975), to facilitate my own growth and that of others thus becoming a 'Wounded Healer'.

Life and Origin

I was born in Zimbabwe (then Southern Rhodesia), in Chiwundura, a rural village of Gweru. The fourth of six children from my parents, I have other siblings from my father's side.

I was four years old when my parents moved us to Zambia, formerly known as Northern Rhodesia. Daring, ambitious and with an entrepreneurial spirit, my parents were in search of a better future. I was to spend all my life in Zambia before moving to England in my late 20's.

My Formative Years

My earliest memories are of spending a lot of time around my mother. Play was mainly of a constructive nature. 'Amai', as I call her, is a meticulous and industrious woman whose life revolved around her children, her home and her work. Resourceful, creative and talented, her energies were spent running different small enterprises. Her passion however, is in craftwork, an area in which I share interest and talent. Appreciating my gifts, Amai was encouraging and supportive and spent a lot of time teaching me the tricks of the trade. Whether at home, by the sewing or knitting machines or in one of her several market stalls, I learned as I watched and helped create things. By the time I was 10 years old, I could sew, knit and crotchet.

I was a clever girl too, curious and friendly. I fared quite badly in the traditional domestic pursuits, often getting into trouble for chores not done to Amai's satisfaction. Comparing me to my domesticated and introverted sisters, Amai was most critical and largely dismissive of my curious, intellectual and sociable qualities. I was characterised as ‘too talkative’, ‘too clever’, ‘too friendly’ and ‘knowing too much’ – bad and valueless attributes for a girl to display and destined to take me nowhere in life. Moments of stillness were regarded as idleness and laziness, and because a woman’s work is never done, I needed to be always busy doing something, and very quickly too. There was no room for complacency and any error was met with ‘try harder and hurry up’ commands. My creative qualities, as well as my big-hearted, helpful and empathetic nature, however received praise and encouragement.

My earliest recollection of my father was of a busy and friendly man who was always talking to different people. ‘Baba’ as I called him, had a lot of time for me and as a 6 year old, I spent a lot of time with him after school, either in his grocery store or in the office where I would do my homework.

A few blocks away, was Baba’s butchery which I hardly ventured into. I found the rows of hanging raw meat boring, and the smell unpleasant. I only went there to ask for small pieces of meat that my friends and I would cook when we were playing house.

Baba’s chemist, on the other hand, was interesting and always had something different to capture my attention. I later understood that what Baba did was business, and he was called a businessman.

Our lively and colourful lives were filled with a strong sense of entrepreneurial creativity and rewards, but this did not detract from a very strict, sheltered upbringing of my formative years through to my teenage years.

Growing Up

My early teenage years were uneventful with my secondary school years passing quietly without much drama. I missed out on all the parties and not once did I go to a disco. By the age of fifteen I had become aware of the attention from boys. However I didn’t start dating until I was sixteen when I met Jeff, the man who was to be my husband and father to my children.

Jeff pursued me for almost a year before I agreed to date him. Five years older than me he was tall, dark, and in my eyes handsome. Very well spoken and articulate, he was also a very charming guy, well-liked and popular, yet in all that he made time for me, showering me with love and attention. Very proud of what we had, he let everyone know I was his girl. After twelve years and two daughters, this intense, intimate and loving relationship ended, along with my hopes and the many plans we had made. Leaving my small daughters behind, I escaped to my sister’s in the dead of night after a beating that left me running for my life. When he came for me the next morning, accompanied by his elders, I refused to see him until our day in court when the marriage was dissolved.

To support myself and my daughters, and wanting independence from my family, I found work with an English doctor who had just started an anti-AIDS project in Lusaka, but I left for England soon after. When things didn’t work out in England, I returned to find my position no longer available. My involvement with HIV and AIDS had ended, or so I thought. Returning to Amai, I helped her for a year, before returning to England at the invitation of my younger sister. I’d left the children behind as this was only intended to be an exploratory visit. Six months later, with my visa about to expire, I made a decision to stay, determined to get a job and start a life for myself and my children**.**

Person before the Diagnosis

Looking for a job was difficult at first. I heard the usual stories about restrictions and difficulties faced by foreigners (especially Africans) in getting a decent job, harder still for someone like me with no qualifications or notable work experience. I refused to consider cleaning, care or fast-food jobs. Deep down I believed I deserved 'better'. Blissfully ignorant and with a strong conviction I tuned deaf to all well intentioned good advice. I believed I would make it. With relentless determination I found a job in housing as a filing clerk on a two week contract.

I started rebuilding my life, and managed to bring my children to join me as I continued to move up the career ladder. Nothing great but notable progress nonetheless, considering my immigration status and work history. In eight years I rose through the ranks in housing development and management until my resignation.

Taking the HIV Test – December 1998

My motive for taking the test was to support a close friend whose health problems were raising concerns that she might have HIV. When all other tests had come back inconclusive, her medical team had strongly suggested she takes an HIV test. She shared her concerns with me and we decided to resolve this and take the test together. After all, I had been thinking of taking mine for a while before then.

Two weeks later she walked out of the clinic with negative results. 'We are so lucky' she said. Unbeknown to her, mine had come back positive a week before. For almost a year I didn't tell her, reminding myself that I had taken the test to support her. She was later diagnosed with Lupus.

Diagnosis

It was December 14th, the day I received my diagnosis. My life turned upside down. Numbness and confusion followed. Everything just seemed to zoom past me like a fully-charged action movie. The doctor, a very caring man, had given me a very positive prognosis; assuring me that all things being equal I could have a normal life expectancy. I had tested early and was still in good health and even better, with a high CD4 count and very low viral load. With no illness or symptoms, there was no clinical need for me to start treatment in the foreseeable future.

I sat there in a blur for what felt like a lifetime, as the news sunk in. I was offered counselling, teas, coffees, water, a nice box of tissue – the usual things that healthcare professionals offer in a crisis – but not really what I needed at that moment. I sat glued to my chair unable to move, staring at him, nonplussed, when he broke the silence asking 'Is there anything else we can do?'

I mumbled "*I want… I would like… is there anyone… another person… in my situation I can see, meet, or talk to?*" "*Unfortunately*" said the doctor, "*due to patient confidentiality, I cannot put you in touch with any of the other patients here. … But* *here is some information of support organisations, where you can find others in your situation*".

With good intentions, he gave me a leaflet with some numbers of organisations to contact. "*When you're ready*" he said.

As I left, he gave me one last piece of advice – "*be careful who you share the news with after you leave the clinic*". That advice alarmed me and sent a chill up my spine. I felt like he had just put a venomous snake in my bag and asked me to zip it up and take it home, stuff it under my bed, never to share its presence with another!

I gathered the leaflets from the desk and walked out of the clinic to my car, dazed and alone. It was this experience that I found most traumatic about my HIV diagnosis. To be given such devastating news, with (well-intentioned) advice not to share it with anyone, to go home alone with no support, especially as I was driving, was not only disturbing but irresponsible.

It was a result of this experience that I chose to stand up and help create a better world for myself and others confronted with a similar situation. If I could save just one person from the fear and isolation I experienced that day and the months that followed, I would have done my bit. This marked the birth of Thandi: the 'Wounded Healer'.

I walked out of the clinic feeling alienated in a world where I did not know anyone else with HIV. Suddenly all the horror I had heard over the years about HIV and AIDS came flooding in. Internalising these beliefs, I suddenly felt different. I was sure everybody could tell I had HIV.

I eventually found my car and finally made it home, after getting lost having driven miles in the wrong direction. I hadn't even noticed that I had subconsciously wet myself whilst driving. Slumped on the sofa, I had spent the rest of the day sighing snorts of derision, shocked that something like this had happened to 'ME'. Not even the pre-test counselling had equipped me for this result.

It was December and the media was awash with news on HIV and AIDS as the world commemorated World AIDS Day, which falls on December 1st, and doing their bit in raising awareness to help stop the spread of the disease. The news was gloomy as people were warned to be careful not to catch the disease. It was alienating to be on the side of the people to be avoided. I felt fenced in, a disease carrier and a danger to be isolated from the whole world. It did not help that I still did not know anyone like me. Lost and alone, I was so, so scared.

What followed was a period of hibernation and listlessness, lacking energy or motivation to get up, go anywhere or do anything. Short of bringing the bathroom and kitchen into my room, I stayed in my bedroom; shutting the world out for months, coming to terms with my new situation. There were a lot of unanswered questions, bouts of shame, fear, guilt, anger and confusion but also some personal reflection and deep soul searching. My life seemed over, until the day I began challenging my perception about myself, my health condition and the personal meaning of health. I discovered literature and re-established my love for learning.

It was also during this period of withdrawal and calm that I began to develop the most beautiful relationship with myself, my personal journey to self-awareness, and a more authentic and purposeful existence. I found my voice and began the re-creation of my new self.

Understanding Health

A huge part of coming to terms with my health condition was my refusal to accept that my life was over because of it. I felt that somehow in spite of the loss, there was still a lot more to me and my health than I could be made to believe, thus provoking weeks of intensive and exhaustive self-exploration of the conflict between the trauma of my diagnosis, especially given the 'good prognosis', the advances in HIV management and my hope for the future.

It became clear that a central feature of coping with my diagnosis would be my personal understanding and interpretation of health. Searching further, I found definitions of health that helped me understand both why I have been devastated, and perhaps more importantly why I had not abandoned hope.

The Meanings of Health

Three types of definition of health seem to be possible and are used. Health as:

- The absence of any disease or impairment
- A state that allows the individual to adequately cope with all demands of daily life (implying also the absence of disease and impairment).
- A state of balance, an equilibrium that an individual has established within themself and between themself and their social and physical environment.

The consequence of adopting one or another of these definitions is considerable.[1]

There are obvious difficulties with the first two, with their consequences being unhelpful and detrimental to my 'health' and well-being and that of many others.

The first paradigm of health is simplistic and negative, focusing solely on lack and disregarding how an individual feels about his or her state. If health is defined as the absence of disease, then only the medical profession can declare an individual healthy. With the advances in medicine, people who are declared healthy today may be found to be diseased tomorrow because more advanced methods of investigations might detect signs of a disease that was not diagnosable earlier. Furthermore, how others judge the behaviour and appearance of an individual is only relevant if their observations are congruent with the criteria of abnormality that the medical profession has produced.

There are people who do not feel ill but have abnormalities that can be counted as symptoms of a disease. There are others whose body tissues do not demonstrate changes but who feel ill and do not function well. There are others who hear voices and might therefore be candidates for psychiatric examination and possibly treatment – yet live well in their community and do not ask for nor receive medical care. There are a significant number of people who have other

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[1] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2080455/.

conditions and illnesses, experiencing no problems, not knowing that they have a disease and do not seek treatment for it. Some of these individuals will also escape the second definition of health because they function as well as expected in their age and gender group of the general population.

Congruent with my health beliefs I adopted the third definition; this means that as a person with a medical condition or impairment I can be considered as being healthy to a level defined by my ability to establish an internal equilibrium that makes me get the most I can from my life in spite of the presence of the condition. Health is therefore a dimension of human existence that remains in existence regardless of the presence of disease, 'somewhat like the ground that remains in place even when covered with weeds.'

The advantage of this definition is that medical conditions do not replace individuals' health: they may affect their balance more or less severely but, at all times, the patients who suffer from a condition (and their doctors) remain aware of the need to work simultaneously on two tasks:

- Remove or alleviate the condition; and
- Establish a state of balance, as best they can, within oneself and in relation with their environment.

In fighting stigma that comes with some acute and many chronic diseases – such as mental disorders, cancer or HIV – this definition is also useful because it makes us speak and think of patients as people who are defined by different dimensions (including health) and who, at a point, experience the condition – and thus make us say:

- A 'person with diabetes' rather than a 'diabetic.'
- A 'person with HIV' rather than an '(HIV) Positive.'

Redefining my health status this way was critical in helping me stay conscious and grounded in self, and not in the patient role, helping me take responsibility for my health and its management and not being subsumed in it. This knowledge further strengthened my sense of self and the possibilities that the self could create. Better armed, I was ready to move on and start living a fuller life with HIV as part of it. This acceptance is a key pre-requisite of moving on.

Acceptance

> *"There is that part of ourselves that feels ugly, deformed, and unacceptable. That part, above all we must learn to cherish, embrace, and call by name."*
>
> Macrina Wiederkehr

One of the most critical ingredients needed in taking the necessary steps to seeking help or moving on towards management or closure is acceptance; that is, coming to terms with anything that is difficult or painful by acknowledging those parts of the situation that we find difficult, unpleasant or unacceptable. Realising that my health condition is not something I could throw away or something that was going to go away by being ignored, I had to learn to find ways to manage it.

Part of acceptance is being able to call ‘it’ by name. Not necessarily like ‘it’, but simply owning ‘it’ in order to find ways to manage one’s relationships with ‘it’. Acceptance does not mean disclosing or telling anyone about our issues, it simply means telling ourselves. This acceptance represents a critical ‘phase’ and its neglect can have negative effects on one’s mental health.

With time I have come to learn that acceptance is a gift not afforded to everyone. At worst, some of us might never get there, and at best we get there at different times even though our diagnosis and circumstances might appear the same. Knowing this has made me more tolerant, patient and empathetic with others, hopefully counting towards making me a more understanding and compassionate ‘Wounded Healer’.

Stages of Grieving

Through all this, and whilst still enjoying a good degree of health, there have been moments when life with HIV was just too hard to deal with. Looking back now, whilst outwardly I never broke down, holding my grief so deep within for many years, my heart bled with pain as I went through so many different emotions.

I went through periods of wondering whether I could have been more careful with my life; questioned whether my decision to take the test had been a good idea. I even played with the notion that perhaps the clinic had made an enormous mistake with my test results until a second opinion from another clinic confirmed the first one.

Accepting that I had a potentially life-threatening condition was not just about confronting death and dying, but also an acknowledgement of some loss in its many guises. The loss of a life I once had, and a future I dreamed to behold. At 36 years of age I still had hopes of meeting a wonderful man, learning to trust again, falling in love and settling down. Perhaps have another child or two and fulfilling my desire for four children! There were also other important quality of life indicators that everyone wants, desires and deserves to achieve that I too still needed to realise.

Reading health-related literature was helpful in understanding that all these reactions were normal stages of grief (shock, denial, isolation, anger, bargaining, depression and acceptance) (Kubler-Ross, 2005), universal to all mankind and experienced by people from all walks of life; facilitating coping or healing over time. With this I was better able to understand my journey and put into context these stages.

Learning that each stage promised a common thread of hope was reassuring. It was also comforting to learn that the stages were mere guides in the grieving process and needn’t be followed in any particular order; but rather to be used as stepping stones in helping understand where in the grieving process one is.

Anger, acceptance and depression are the emotions I identify with the most. I remember being angry with my University tutor once when he referred to HIV as my ‘hobby horse’. Looking back, I can see why. My anger and acceptance had mingled as I talked about my diagnosis and HIV in general to whoever would listen, at any given opportunity. It was as if I was throwing it in people’s faces, as a dare – a yardstick for a stigma and discrimination test. Going through my earlier talks and writings, I now cringe at some of the wrath I let out. There was never a 'why me?' moment. My anger was more about the blame and labels that are put on people with HIV, the assumptions that are presented and accepted as facts, the over-sexualisation of HIV and generally the context in which people with HIV are defined and classified. It's as if people with HIV originate and reside on a different planet or do anything different from everyone else.

I still talk about it, but less now, and when appropriate. Finding networks for peer support has been really helpful in coming to terms with my situation. Finally experiencing the healing power that comes from meeting with someone in the same situation who says 'me too'. It is this, that I too, hopefully continue to share with others.

Years on, my views haven't changed much. What has changed is my ability to communicate the same message with less contention.

The upside of this outpouring of anger has been a catharsis which has helped me begin my journey to healing, unchaining myself from the years of pain and internal conflict.

Deconstruction and Reconstruction

By this time I had slowly began to come out of shabbiness and caring more about my physical appearance. Guilty of looking attractive and fearing accusations for calling the infliction upon myself by my appearance, I had not known what to wear, how to look, or behave, especially in relating to men for fear of being misunderstood. I had toned down my image drastically, shutting down my feminine side in order to survive any perceived attack or rejection; like an earthworm in a state of Aestivation, when it gets too cold, too hot, or too dry, escaping by either burrowing deeply into the soil, or entering a reduced metabolic state. Until the day I gave myself permission to live and shine again.

I crawled out from under the rubbish heap of my mental and social baggage, got up, and started cleaning myself up. If I was going to gain acceptance and make the connection I needed with others, how I presented myself would be an important aspect of my being. And with hibernation and deconstruction over, it was time to reconstruct myself, and my life.

Reframing and Recreating Self

Knowing that my situation put me at a clear disadvantage, it was imperative that I counter this disadvantage by levelling the playing field for myself. A good start was to continue with the affirming mindset that said 'I'm still a human being and therefore deserve as much of a chance as the next person' – and behaving as such!

By now I was very clear that my identity was not going to be narrowly defined by my medical condition only but the holistic embodiment of the many attributes that altogether make me who and what I am. This, I believed, would help improve my standing in society and bargaining power in many of life's difficult and unpredictable situations. I had by now become much clearer about the difference between Self Esteem and Confidence. Self Esteem being about *who* I am and confidence being *what* I have in terms of skills and attributes and what I can do in terms of the competencies. I didn't have problems with my self esteem. The work I needed to do was confidence based. Acknowledging my attributes and abilities, like the Serenity Prayer, to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference. All that can only be done and experienced by and through the Self. The Self (our Centre or Core) can also be defined as the only part of ourselves which remains forever the same (Ferucci, 2004) whilst our status, roles, self perceptions, bodies, skills, competencies, experiences etc. can change.

This led to me to think about the kind of work I wanted to do, and how I was going to find or create it. I did a self-audit and envisioned myself in the future, exploring:

- What I wanted out of life.
- What was realistic and what was not.
- What and where changes and improvements were necessary.

Starting with the positives, I took stock of my attributes, skills, interests etc. deciding which ones I was going to put to use – and perhaps most importantly what I was going to be. I asked myself some of the key questions as follows:

- What did I have?
- What could I give?
- What could I be/do/become:
- What did I have to build on?
- What could I change, learn, and improve?

Following my contact with HIV organisations for my peer support and support for my children, I had become quickly established in the sector. By this time I had been giving talks, both in healthcare and community settings and providing peer support and education to others in and outside clinics. I started volunteering for Positively Women, now known as Positively UK, and I was soon asked to join their management board, the first of many I would be invited to sit on. My work grew very quickly upon which I noticed a gap in the services that were being provided. There was a need for approaches that address cultural issues and the wider aspects of life beyond and outside diagnosis. I imagined these services, would be aimed both at patients and service providers to enable better understanding and bridge the gap between the two sides.

Seizing this as an opportunity to fulfil my ambition to become self-employed, I established a training consultancy (restorEgo). The concept for restorEgo crystallised as I reflected on the course my life had taken over the years, and how the many ups and downs had stripped and restored in me a sense of self and purpose. With this came the realisation that many others might be going through the same difficulties with a need for a minor but significant push. With a conviction that I could use the experiences and strategies that had helped me deal with life's situations, as resources to fulfil my work, the name restorEgo seemed appropriate.

The 'Wounded Healer'

Having fallen into a 'Wounded Healer' role, I enjoyed it tremendously, deriving a great pleasure from it until I found myself crippled by anxiety, self-doubt and internal conflict; feelings so painful and self-defeating I considered leaving the work I so loved and valued. The frustrating thing was that I did not know why I was feeling this way, leading me to explore this problem, and the reasons behind it, further.

In providing emotional support and facilitating the development of others, I have on many occasions been referred to as a counsellor. With no educational qualification or professional experience I rejected the title. Counselling, in my opinion, involved someone who had a qualification and an understanding above and beyond mine. Awakened to my limitations, I started feeling like a fraud. Doubt crept in and my confidence dropped, as I questioned my right to support others. Provoked to understand counselling further, I learnt that the overall aim of counselling was to help others live more fully and satisfyingly through:

- The skilled and principled use of relationships that develop self knowledge, emotional acceptance and growth, and personal resources.
- Addressing and resolving specific problems, making decisions, coping with crises, working through feelings and inner conflict, or improving relationships with others.
- Facilitating the client's work in ways that respect the client's values, personal resources, and capacity for self determination (BAC, 1984).

Learning this validated that what I did was to a large extent counselling, however there were areas I needed to address if I was to grow into the profession given that counsellors are first and foremost people with their own strengths, weaknesses, fears, anxieties and certainties, all of which can facilitate or hinder work with clients. Consequently, counsellors must continuously engage themselves in self-analysis to become aware of themselves, and perceptive of how they affect others and vice versa.

In response, I opted for a counselling module as part of my Healthcare Law and Ethics degree. Completing the module did not make me an expert in the field, it gave me good grounding of the counselling concepts and a foundation for me to build on further study and experience, enabling me to become a more effective helper.

Anxiety and the Paradox of Professionalisation

Helping is a tough, demanding profession, and a burnt-out 'syndrome of emotional exhaustion and cynicism' is not a rare occurrence. There's evidence that along the way helpers run into problems and often have to stop to seek help themselves, and to take care of themselves.

On this journey to becoming a professional helper, I found myself faced with issues. As my work grew and my professional identity crystallised, so did my discomfort and anxiety; increasing my doubts to remain in this work.

Those who know me well allege that helping to empower others is what I do naturally. If this is true, then perhaps serendipitously, the events of my life have conspired to lead me into the Helping role. I had no illusion about there being competency gaps that might contribute to the discomfort and anxiety, however I couldn't understand why the professionalisation of my (natural) role would weaken, rather than strengthen it. To try and address this, I embarked on a Master's programme in Change Management. This, I hoped, would help me gain more insight into the profession and improve my confidence. The resulting impact was a more profound and life changing experience than I would have ever imagined; Thus begun a concerted journey of self searching and deeper self awareness. And what a therapeutic process this experience turned out to be.

I found psychological models, particularly Transactional Analysis (TA), useful in unravelling my feelings and behaviours and in dealing with emotions in a more positive way. A theory of personality and psychotherapy for personal growth and personal change, TA describes how people are structured psychologically and helps explain how they function and express their personality in their behaviour.

At any given time, a person experiences and manifests their personality through a mixture of behaviours, thoughts and feelings. According to TA, there are three ego-states that people consistently use, Parent, Adult, and Child. Berne (Berne, 1961) differentiated these three ego states from actual adults, parents, and children, by using capital letters when describing them. These ego-states may or may not represent the relationships that they act out. For example, in the workplace, an adult supervisor may take on the Parent role, and scold an adult employee as though they were a Child. Or a child, using their Parent ego-state, could scold their actual parent as though the parent were a Child. Or an adult using their Child ego state behave accordingly.

At the heart of TA is the premise that relationships between our behaviours and our earliest experiences in our family of origin, and the nature of this experience has a profound effect upon our being and our subsequent experience of, and response to, the world around us. Furthermore, this influences the roles we play and how we behave with others.

We have Life Positions which are basic beliefs about self and others, and use these positions to justify decisions and behaviour. Starting as children, we create stories or beliefs about our lives, what we have been and what we will be. We weave our perceptions of ourselves and of the world around us into a story about what we can and will do, depending on how we are treated by our parents or other authority figures and the messages or instructions they give us. These beliefs and decisions about 'reality' become embedded in memory – and continue to run automatically as subconscious programs into adulthood. These 'stories' (called Life Scripts) continue to have a deep and unconscious effect on how we live our lives, affecting the decisions we make.

Injunctions, parental messages or messages from our childhood, become distorted realities of our lives such as 'Don't be…', 'Don't be you.', 'Don't…', 'Don't be Important', 'Don't succeed' etc. Against these are Drivers, or instructions within which a child is often told other things he or she must do such as 'Please me', 'Please others', Be Perfect', Be Strong', 'Try Hard', 'Hurry Up'. Some of these messages are good and helpful, but others become limiting beliefs, which can sabotage our relationships and life goals.

These basic elements of a person's existential position are usually at the root of whatever problems exist in our present-day life as adults. They shape our self-image and control what we think we could easily do and could never do. Yet we seldom realise where they come from or might not even know that they exist at all.

These life scripts, directly expressed or implied through role modelling, are often encouraged and shaped by parents and other family members, whose life scripts were shaped by their parents and so forth. In this way, we become a product of our family's history. The scripts may also be significantly affected by individual events, such as being criticised by a teacher/other authority figures or bullied by other children and siblings. Likewise, our scripts are also woven by cultural, political and national concepts.

Looking at my history, deeper assessments and analyses revealed that there were three main things that were driving my restrictive and frustrating cycle of behaviour:

- Life Scripts – Conflicting Realities.
- Self Concept – Confidence and Self Esteem.
- Fear – Rackets and Racket Feelings, by which I mean the behaviours I expressed out of fear; fear of failure and punishment/payoffs I got for this failure. And the feeling I received for this inauthentic behaviour.

Some striking parallels emerged with dynamics continuing to play out in arenas of systems that resemble experiences from childhood. Still steeped in parental messages and instructions of who I was, what I should and shouldn't do and be, I discounted and downplayed my natural positive qualities as I continued to re-play outdated strategies that are counterproductive, painful and self-defeating.

These messages and the extent to which I complied with prevailing parental needs, demands and expectations, defined who I was, my worth and my potential. Rather than being valued for myself, my value was attached to what I did and the levels of competency I demonstrated. Without a role, I didn't exist. Within a role the pressure to meet expectations was paralysing. Lost, and not sure about who I was, threatened my existence, leaving me emotionally insecure, with a skewed sense of Self. Given this, I lived in a state of constant anxiety, unable to relax as I spent time evaluating my behaviour, criticising myself and worrying about the impending consequences rather than be in the 'Here and Now'.

In analysing this, I now realise that a large part of my childhood was lived in nervousness, fear, and dread (anxiety). Out of this, were born creative strategies and adjustments which 'helped me cope with the physical and psychological threats of the environments in which I previously lived' (Mackewn, 2004). These strategies included avoiding doing things, to extreme procrastination, not finishing or taking forever to finish them. Sadly these behaviours have continued to run in my life long after they've become useful, explaining why avoidance and procrastination have been the banes of my life.

Recognising this was useful in helping me understand my avoidance for groups or long term programs and a preference for group leadership vs. taking part in them. Having never been clear about what my place in my family was and not being permitted to freely express myself, unless spoken to, I have never been comfortable or sure how to behave and advance into intimate phases of relationships, struggling to find my voice and identity in the uproar of family dynamics. Being a group leader therefore provides me both the opportunity to be 'busy' whilst also being in permission to talk or act freely without feeling I am taking 'too much' or acting out of turn. With this understanding, my need to lead groups is ebbing away as I learn to become more and more comfortable in letting go of the need to clutch to a role in order to be (me), but rather just be in them regardless of whether I have a role or not. This has given me deeper awareness and sensitivity to group processes and how we can effectively utilise the emotional space and impact of working in groups. This has also enabled me to pay attention to the behaviours of others in any group and the impact these behaviours have in limiting or facilitate growth.

Not all things originate in childhood. Major trauma in adult life may make a person want to regress (unconsciously) to a safer childhood, so they do go into childlike behaviour but not always because the childhood was bad. In the earlier sections I described being carefree, helping with arts and crafts from an early age, my confidence in these areas has stayed with me throughout my life. Therefore it may be that it is in more public, academic and 'professionalised' environments that I withdraw, or even since my failed marriage and diagnosis that I lost confidence and started procrastination and anxiety. I was also physically and emotionally burnt out, from providing emotional support for others with no support and supervision for myself.

Some change is extremely difficult though. These clearly self-defeating, alienating and hurting behaviours may appear to be resistance, stubbornness, rebellion, disrespect to others etc. but are strategies that leave me feeling very sad and frustrated. I am trying to break them, but don't seem to know how to get there quicker. It took me so long to get started on this chapter, and forever to complete. Even though I had genuine reasons such as dealing with the sudden death of my elder brother and birth of my grandson, both having occurred during the stage of writing this manuscript, I struggled to write, and found myself with periods of being idle, unable to write. I even came down with psychogenic illness. When the chapter was almost complete, I went back almost rewriting it, 'trying harder' and harder to get it 'right', wasting so much time in the process, getting more and more confused and further delaying the project.

In trying to put this into context, the irony is that becoming a published writer is one of the most important aspirations of my life. Yet, my behaviours contradict this. It's as if I was inviting an exclusion from the book in order to gain approval for not breaking the 'Don't be successful' command. After all, completing the chapter would require applying intellectual qualities that are 'destined to take me nowhere in life'. Furthermore, if I don't release the chapter, I don't open myself up to failure (criticism) and the consequent punishment. This finally explained why I never got to write my Masters dissertation (I stopped at the postgraduate

Diploma stage instead); choosing to convince myself that I really didn't need it, after all I had finished the programme and therefore had got what I really needed, my learning.

The problem-solving functioning of the three authentic feelings: fear, anger and sadness, deal respectfully with the future, the present and the past (Thompson, 1983). When as grown-ups we continue to cover our authentic feelings, what we present are substitute emotions known as 'racket feelings' in TA. A racket is the strategy of expressing 'permitted feelings,' while covering up feelings which we truly feel in the here-and-now full adult thinking, but which we regard as being 'not allowed'. Because racket behaviours' covert aim is not so much to solve the problem, but to experience these permitted feelings, they are maladaptive as an adult means of problem solving (Stewart and Joines, 1987). It is therefore important to distinguish between racket and authentic feelings.

Authentic feelings are for solving problems in the present and help finish or put closure to the situation for us. In sharp contrast to this problem-solving function of authentic feelings, racket feelings never help complete resolution of the situation. Consequently, unless addressed, these feelings are likely to continue to create an ongoing struggle. This is the work I now need to focus on, an ongoing process from which I continue to live and learn.

In what I shall term the 'Paralysis of Professionalisation', was my inability to honour my non-professional but effective natural helping qualities; to give them value and give myself the permission to transfer them into the professional domain. Caught between the fear of failing to meet the expectations of the professional role and the fear of succeeding and breaking the 'Don't be important, intelligent, know too much' parental messages, I became paralysed. It is certainly possible that my lack of confidence was in the professional role.

Fortunately the Script is a decisional model – given the right circumstances, we can free ourselves of these false messages through discovering them and choosing to make a change to our Script (Redecision) and consequently our realities. This is now the 'wound' that I am working at healing by changing my restrictive beliefs and outdated self defeating strategies.

It was most encouraging and a relief to learn that while my academic and professional experience added to my helping profession, my role was fundamentally underpinned by my natural qualities. Whatever problems I had therefore, were more psychological than competency-based.

As I moved back to the helping role, more confident, given my new understanding, I mused at the oddness of turning 'helping' into a profession with training, accreditation, status, case conferences and institutional politics etc. and more interestingly, how this 'apparatus of paternalism' (Heron, 2002) might distort the helping relationship. A distortion in my case, that caused my paralysis.

Personal Meaning

My philosophical approach to life has been helpful in finding meaning in my experiences, and through that some sense of purpose. Within this is the belief that my quest for understanding and growth to become the person I can be are much greater than a stagnation that comes from succumbing to fear and conforming to medical, social, cultural and political assumptions that don't fully take into account who I am. This is not just in my HIV journey, but in the many aspects of my life that I've had to experience.

Choosing to move on from staying steeped in the past, or stuck in the present mourning my entire life, I took a chance and moved on, beginning all over in a new career and profession, in the hope of finding or creating a fuller, freer and more joyous life. This is the very thing that had driven me to leave my marriage, my family, my motherland Africa. The very hope that twice drove me to leave a secure but unfulfilling job when there was nothing guaranteed or planned ahead but the belief that there had to be more to life. The conviction and determination that makes me persevere and sees me through the hazy stages rather than select abandonment.

In attempting to summarise why I stood up to become a change agent, I would say I am driven by the need to Be, to Belong, to Become. What stood in the way of achieving this was not so much HIV itself, but society's interpretation of it which includes stigma and the related baggage that comes with it. To survive in this world, it was therefore imperative that I help create the world I needed to live in. To this end, I stood up to do my bit in redressing that by living my life as fully and authentically as possible, and in the process raise/provoke the conscience of others.

Courage and Vulnerability

I have been referred to as courageous and inspiring. I don't think I am any more courageous than most. The truth is that whilst many of us may become paralyzed following a life threatening change, we eventually stand up to reclaim our lives and doing the most amazing things in the face of adversity. Defining vulnerability as emotional risk, exposure and uncertainty that fuels our daily lives, Brown suggests that vulnerability is our most accurate measurement of courage, because it is to be honest and let ourselves be truly seen (Brown, 2011).

My discomfort in choosing to work and live openly with issues that are inconvenient and perhaps challenging, is therefore countered by a belief that my experiences are just that, experiences; pathways, and means to an end, rather than an end in themselves. The decision to use my experience as conduit for my work therefore comes from weighing the costs against the benefits of taking what others might see as a difficult road.

The Paradox of Helping

The golden rule for all would be practitioners is to never become a helper until you have worked on how angry you feel at your parents' and teachers' mismanagement of you in the interests of making you 'good'. This means my own anxiety and distress, accumulated from past traumatic experience, does not drive and distort my attempts for help (Heron, 1990).

To this effect, I am pleased that one of the most valuable things to come out of this was the development of my emotional competence. Identifying and diagnosing of my emotional wound helped me begin to deal with the angry and sad elements of past, my upbringing including my failed marriage and diagnosis. This experience also introduced yet another paradox. That it took my 'wounds', to heal the 'wounds' of others and in this process identify another 'wound' – an emotional 'wound' that had gone undiagnosed, and yet more crippling to my life and relationships than HIV ever has, serving to further challenge the popular health definitions.

Nothing could have prepared me for the emotional cleansing and growth this journey has brought. In continuing to cure my psychological illness, the cathartic process purified, purged, and 'intellectually-clarified' my thinking and emotions, and gave me more tools for addressing my anxieties, both archaic and ongoing.

Furthermore, whilst it has been found to be deeply painful, personal tragedy can bring value, both to ourselves and in what our lives can offer to others. The greatest minds in history have wrestled with, and disagreed about the value of tragedy to the human experience. The only thing they agree upon is that it is of great value.

Phases of Recognition

My journey towards becoming a 'Wounded Healer' has been challenging, interesting, and above all rewarding.

Nothing can ever express the honour and gratitude I feel for the opportunity to create the life I desire and in that, the privilege to contribute to that of others; becoming an inspiration and role model to many, and an authority in my field of endeavour.

Both in my work and activism, I have worked with many organisations, across various sectors. A speaker and guest lecturer at academic and medical institutions amongst other fora; my practice extends to training, educational and consultancy assignments, including policy, and leadership at Advisory and Management Board level. I have participated in campaigns, given media interviews, contributed to various magazines, academic and research journals and policy documents. My assignments have meant extensive travels across the globe, allowing me to combine my commitment to my interests with an opportunity to further explore and learn about other people's realities across the world.

The privilege of meeting and working with so many remarkable, highly intelligent and committed people has been an enriching and affirming experience.

Increasingly, I am living more holistically, reconciling my different worlds. I have finally been able to break into fashion, introducing a new product to the industry and combining my art interests with community developments both in the UK and Africa.

In evaluating the feedback I have received over the years, I cannot begin to measure the satisfaction and pride I feel in how my life and work has impacted on others. Here is evidence and validation that paraprofessional helpers can be as effective as professional helpers and in some cases even more helpful (Durlak):

> *"Thanks again Thandi for your excellent session last term – I attach the results of the student evaluation for your interest. I note your morning was one of the most popular of the term."* (Dr Liz Green GP, Co-ordinator Clinical Practice 2, Brighton & Sussex Medical School – Mar 2006)
>
> *"When I question whether it is worthwhile to stand in my purpose and to submit to it, I think of you. Even when there is doubt and disapproval, I gain a little courage each time I think of you because you've done it."* (Workshop Participant – Mar 2012)
>
> *"Personally, I came out of that room with a whole new outlook on life. Thandi lives her life to the full and no one can deny it. Her positive outlook on life was so inspirational, as was her brutal honesty. Thank you so much Thandi, I will always remember 'when life hands you lemons, make lemonade,' just like you have done."* (Student, St Dunstan's College, Feb, 2012)
>
> *"Just been thinking and wanted to let you know that if there was any one person who really motivated me to become a doctor, then it was you. Do you remember when you started calling me doctor ages ago? The university finally awarded me Doctor of Social Science. I am genuinely grateful for your encouragement over the years – thank you a million"* (Dr Acomo Oloya – July 2012)

When I look at this, I would like to believe that when the understanding of others is enhanced, the world becomes a better place for many more of us to live in. I am also proud knowing that when each one of them graduates, I graduate! Now, that is my greatest honour.

I believe true change begins at home, in our personal lives and relationships. Out of this experience has come the emotional competence to work at building healthier relationships with those closest to me. I couldn't love my mother any more if I tried and credit a lot of whom I am today to her, and I tell her so. Within that has been my ability to address my issues with her with less anger. She remains my greatest inspiration. As a mother myself, this experience has helped and better prepared me in how to relate to my daughters, and the messages I give them, directly or indirectly. A tall order I dare say and one that needs God's unending Grace.

The most important thing out of all this is not so much what I have achieved but the journey I have taken and the person I have become. A journey whose meaning lies just in as much the travelling itself and as it does in reaching the destination… a knowledge journey across terrain where the distinction between cognitive and emotional no longer makes sense.

It's been a far cry from arriving into the UK those many years ago, with nothing but hope and determination, to reaching where I now am.

What Helped?

I credit my parents for giving me the foundation I had. Just like I have found some of the parental messages painfully restrictive, on the flip side I have been able to draw huge inspiration and empowerment from my parents. Their modelling, direct and implied, gave me a self belief and outlook that has enabled me to chart the journey I have taken, and becoming the person I have become. My early involvement in their work gave me both experience, and the ability to envision what was possible for me. I can see the parallels in our lives; The ability to take personal responsibility and determine my life and in the process influencing that of others; Leaving the familiar to settling into a new country driven by a desire to create something; the resourceful and enterprising nature; the ability to push through challenging experiences with relative ease and adapt to different situations, confident I would survive no matter what.

Family and friends who have stood by me and supported me, spurred me on in good and bad times; holding me together when my own faith failed or my world came crashing down.

My daughters, for giving me the reason to carry on. Firstly, as their parent, I owed most to them not to give up, but to carry on in a way I hope has set a positive example. Secondly, they, being the closest to me, bore the heaviest brunt of my diagnosis, and my response to it, during the most precarious stage of their lives. My mother, for all that she is, and all that I have become. To them, I dedicate this journey to. God knew what I needed to learn and that is why He gave them to me.

Last but not least, my debt of gratitude is reserved for all the clients, participants and sponsors, for believing in me, using and supporting my services. This includes all the amazing colleagues who have made the restorEgo, ThandiWrap and EthnikAccents teams. Because of them, not only have I developed my practice, I can also confidently and ·proudly call what I do ‘work’.

In all this, for me personally there is a spiritual dimension, and I thank God for his Grace.

What didn’t Help?

I chose to make my life a part of my work, yet, when punctuations of conflict and contradiction, shame, stupidity, self doubt, confusion and guilt etc., emerged, I questioned myself about whether what I thought I was doing was a good idea. HIV had defined me. This forced me to evaluate and recreate myself again; reminding myself that I was on a journey to somewhere when my diagnosis happened. I opened myself up to other interests and opportunities, diluted my objectification by HIV and crystallised my ability to survive and move through different experiences.

The complex dynamics created by my two diametric roles, of service provider and service user set me apart from both my peer community and health and social care teams. I survived, learning to balance between the different roles fairly comfortably and objectively.

Implications and Future Concepts for Health and Social Policy Makers

The goal of health promotion is to empower individuals and communities to achieve the highest possible levels of well-being available to them. This includes reducing infections, and keeping people with medical conditions healthy.

It is important to know that with medical advances the quality of life expectancy for people with HIV is now significantly longer. They can now live a healthy life; work, study, attend school or college, have relationships, get married, and have children without passing on HIV; within that have fulfilling emotional and sexual relationships. Ensuring that people's quality of life matches their increased lifespan is therefore vital.

Addressing specific needs and empowering people with medical conditions can ultimately contribute to their health, and also give them a chance to improve their life chances. This can go a long way in helping them become more self-determining, fully integrated and independent. Work, like love, is the cornerstone of our humanness and this premise is valid for many individuals whether 'wounded' or not.

What can they Learn from my Experience?

Most patients are experts in understanding their own illnesses and states of wellbeing and perhaps most importantly what they want and feel is possible for them in becoming meaningful members of their families, communities and societies; helping and healing themselves and others in the process rebuilds their lives, enabling them to live fuller, happier and purposeful lives.

What I have Learned Personally

There's not always a clear reason why things happen the way they do. Our task is to make sense of our experiences, in the way that is both helpful and meaningful for us.

As self determining beings, we can either choose to deal with life's challenges by remaining passive and inactive victims of our autobiographical histories or confront the situations head-on to play a part in shaping our own futures and the world around us. Rather than accept behaviour and beliefs as a static commodities, we can see ourselves as self determining beings with the ability to learn to choose how we behave and/or respond.

All human endeavours have their shadow side and managing the shadow side is an exercise of integrity, social intelligence and competence, not cynicism (Egan, 2007). Considering some of the issues raised above, and their resulting consequences, caution needs to be exercised in remaining open and not 'reducing' every defensive behaviour down to inner pathology.

There are other factors like culture and ethnicity that need to be taken into account (Guisinger and Blatt, 1994). As a Black African woman living, learning, and practicing in the West, I remain conscious of the fact that not everything presented to me in this process makes sense in my culture and therefore needs to change. Managing this tension brings along added anxieties, discomforts and at times, conflicts.

My journey has helped me better understand myself, life and the human condition in general. The realisation that as human beings we have the power to influence who and what we want to be or not to be, depending on the decisions we choose to make and actions we take is deeply adaptive. But that ultimately we become who we are and the possibility towards that change is therefore closely connected to what a person is willing or is able to be aware of and deal with to become what one believes so they can be. In that process many of us might need some help in navigating towards our desired destinations and selves.

In surviving this journey, I have learned that life is a dynamic process, a personal and never ending one! A journey of bumps, potholes, slopes, plains, hills and mountains where we can become bruised, hurt and slowed down, or fly like the wind. That as one wound heals, another one might appear, offering us an opportunity to fix ourselves again, and again, and in the process take others along with us.

Conclusion

In my own way my life story is testament and affirmation that ultimately, we must learn to trust ourselves, to dare to dream and have the courage to sing our song. That when we do this, genuinely and wholeheartedly, the world opens fully to give meaning before us and to us. That when our dreams, desires and aspirations come from a place deep within us, the universe will conspire with us to make things happen to us, because of us, and for us – and within all of this we will have enough to share with others.

Yet, with my journey so far, I feel am just commencing the task.

The Future

I am not sure what the future holds, but as is the nature of my life, I am confident there is something waiting to unfold. I believe that in my interests, skills, experience and outlook on life; I have enough resources that offer a positive platform for exploring my possibilities with regards to the type of practitioner I need to be. The most important thing is that as a practitioner I feel authentic; knowing, trusting and acting under the basic assumption that ‘the power is in the person receiving my help or service. As a facilitator, my job is to help them navigate and apply that power.

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Chapter 11

ON THE MEANING OF SELF-KNOWLEDGE, CREATIVITY AND PERSONAL RESOURCES IN A CASE OF COPING WITH CANCER

Aleksandra Tokarz

Introduction

Scientific meetings held in the Institute of Psychology to which I belong are concerned mainly with papers presented by well-known Polish and international psychologists. However, several decades ago, special discussions were organized for the academics in our Institute. The themes discussed were unconventional, e.g. 'Is *experimentum crucis* possible in psychology?', 'Novel, creative research projects', or 'Search for a psychological notion with a large quantifier'. The last discussion led us to the simple conclusion that 'all people differ from one another'.

The notion of individual differences, as well as the assumption that both you (as clinician) and your client represent specific, unique, consistent individuals, that makes it necessary to underline personal characteristics at the onset of their treatment including the history of their illness, the individual's battle with it, and their idiosyncratic recovery will be different in every case. There may be several common elements in the experience of a specific illness, which compose a particular entity (*Gestalt*), but it also depends on the person, circumstances, and also on coincidence. Psychologists tend to overestimate the importance of psychological factors as the main determinants of action, efficacy, success or failure[1]. However, much depends on external factors and on chance, which, in fact, cannot be influenced.

Biographical Note

I was 57 years old when I was diagnosed with breast cancer. I had (and still have) a permanent status position in the Institute of Psychology[2] at the Jagiellonian University in Krakow, Poland. My scientific position is also well established. I live

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[1] For example, there was much research on the prognosis for the achievement of gifted children for many years, until Feldman's (1992) concept of coincidence was developed.

[2] http://www.psychologia.uj.edu.pl/index.php/site/employee/aleksandra_tokarz.

together with a dog in a spacious flat in the centre of this beautiful medieval city. I am also a parent, with a daughter, who is currently studying psychology at the University of Innsbruck, Austria.

Resources

When we concentrate on ourselves, or on another person (e.g. a client), it is important to recognize our or the other person's condition, the way they act, and also the details of the situation. I value the theoretical approach of stress and coping that was initially proposed by Richard Lazarus (1991). Certainly, the primary and secondary appraisal and reappraisal of situations that arose during the course of my illness – from diagnosis to the end of radiotherapy influenced my emotions and behaviours during subsequent events, in my episode of 'adaptation' to breast cancer, as it is termed by Lazarus.

A different view of stress, which is equally useful, was proposed by Stevan E. Hobfoll (2006), focusing on stress in terms of perceived resources, namely their application and conservation. Hobfoll defines these resources as objects, circumstances, personality traits, and energetic potentials that directly or indirectly better enable people to survive in situations of stress, and which they acquire, maintain, and conserve (Heszen, Sęk, 2008, p. 61). In addition to successfully accomplished goal-oriented behaviour, Hobfoll finds the course of action and the action *per se* important in dealing with stress. If I had applied the Conservation of Resources Evaluation (COR-Evaluation Hobfoll, Polish version: Dudek, Gruszczyńska, Koniarek, 2006) to myself, I would certainly have arrived at the conclusion that my resources were indeed considerable.

Which Resource was the Most Important in my Dealing with (Stress) Cancer?

Three and a half years after surgery (insufficient time to conclude that I have recovered), I think the most important resources in my dealing with stress were: self-knowledge; realism, even pessimism, in appraisal of the situation; the possibility to continue working; flexibility of acting and thinking; and a particular hedonistic attitude. External support consisted of my small but loving family – the daughter, the brother, and the mother – and some close and very loyal friends.

The basic characteristics that are required to cope effectively with the stresses of life and maintain development and growth of one's personality as well as influencing oneself and overcoming difficulties – are self-knowledge and an atypical, creative approach to tasks and problems. It is so-called 'everyday creativity', spelled with a lower-case 'c' (Nęcka, 2001, Strzałecki, 2003, Tokarz, 2005). I have always tried to cultivate such creativity in myself, not only as an intellectual feature, but also to ensure flexibility in acting and thinking in all areas of my life.

Self-knowledge is a concept that was developed by Jozef Kozielecki (1981). The theory is based on functional assumptions that 'an individual collects information about the external world, other people, and oneself in order to use it in various situations and to act purposefully in a situation of external information deficit' (Kozielecki, 1981, p. 57). The most crucial assertions and hypotheses of the theory relate to the regulatory function of self-knowledge. From a structural point of view, self-knowledge consists of self-reports, which involve a wide range of content categories, self-evaluations, personal standards, and rules on how to acquire self-knowledge. There are generative rules (on the basis of which we construct beliefs about ourselves) and communicative ones (which regulate self-presentation). The formal qualities of the above-mentioned elements of self-knowledge correspond to importance, certainty, and adequacy.

As an adolescent I studied at a boarding school where I enjoyed a lot of recreational time. Therefore, I devoted my time to the school library, I read many books, and practised sports. I had a lot of time for self-reflection and the development of self-knowledge, the propensity for which might have resulted from the strict upbringing I had received at home (I was born into a family of teachers), and afterwards from a conservative school. My life situation facilitated self-discovery and the development of resistance towards social pressures, including pressures of assessment, external tasks and orders.

Self-knowledge is a theory of oneself, and as with any other theory, it has explanatory, predictive, and practical functions (Kozielecki, op. cit.). It is one of the essential adaptive tools and resources that enable a person to solve problems effectively.

Diagnosis

The diagnosis, confirmed by a biopsy, did not surprise me. For many years I had undergone medical examinations, and although a cancerous change was considered to be unlikely, it was conceivable. Unrealistic optimism, which many people experience is alien to me because there have been too many difficult and tragic events in my life. Thus, for years I held a fatalistic belief that distress was an inherent feature of my life. I was not, therefore, surprised at the appearance of yet another life ‘impediment’. I was, however, very sad, for I knew the stresses that this illness would cause. Fortunately, my scientific work has helped me to develop the habit of objective, accurate, and rational thinking, and I try to apply it to my own life constraints, as well as to my academic pursuits.

Unrealistic optimism, in the case of personal causation, is characteristic of ‘ordinary’ people; however, it could be argued that ‘realism’ is a trait that is shown by people in a depressive state (Alloy, Abramson, 1979; Alloy, Abramson, Viscusi, 1981, Kofta, 2001). On the one hand, the unfavourable diagnosis evoked a fear in me, and coupled with my pessimism this darkened my mood. On the other hand, it strengthened my motivation to change my plans, and to learn more about my illness. It was not until six months later that a result obtained from a histopathological examination complemented my diagnosis, so I had much more opportunity to study the available information during the ‘intervening’ period.

Pessimism turned out to be helpful as I re-examined my life and my family situation. I arrived at the conclusion that I had already accomplished most of the important tasks in my life, and I felt close to the end of my life. I was aware that people are mortal, and that the end of existence should not pose a great problem for them, but that suffering may. And I was afraid of it.

I was afraid of leaving my only daughter, as I was still important for her. She is remarkably intelligent and has great skills of adaptation. She has a supportive family, and she has support from my friends – the thought of this alleviated my fears slightly.

I had a lot of work to do. There were short-and long-term tasks.

Performing these tasks helped me to repress my problems; I often turned to the rationalization that 'here and now' was most important.

Work and Planned Activities

Given the fact that my work entails continued commitment, good organization, and is time-consuming, I decided not to make too many changes in the rhythm of my work, nor to take sick-leave, but to undergo treatment during the Christmas period. It was the first, crucial step in my fight against cancer – my decision was to remain active and to work as much as my health allowed me to. I can say that I hedged against the change by committing myself to my work.

I decided to use all my motivational and mental possibilities and not to cease working (with students). I was preparing a conference on theories of personality at the time that I was diagnosed with cancer. In the conference, my idea was to generate a competent discussion about the functions of personality theories in contemporary psychology under the heading 'Great personality theories: the end or the beginning?' During the conference, I planned to collect papers and record discussions in order to prepare a book[3] afterwards.

I was involved, with short breaks, in preparing the details of the conference, contacting colleagues and psychologists working in the field of personality, elaborating the content of the event, and engaging assistants and students, until the time of my operation. The conference took place between my second and third chemotherapy treatments, and I organised it with great difficulty, but fortunately, with success. I did not manage, however, to elaborate the text of the discussion, because of a financial deficit. Nevertheless, the book[4] was finally published.

I ran classes with students and pursued other professional tasks throughout my treatment (chemo-and radiotherapy). I had many tasks to perform during the course of my illness. The responsibilities involved work on the conference, supervising BA and MA theses, consultations, writing reviews and papers, preparing my own book on motivation, just to name a few. They were relatively difficult, time limited, and socially oriented, which required sustained engagement and physical endurance from me. I derived a certain amount of satisfaction from my activities, although perhaps not too deeply rewarding. Certainty derived from specific features of goal oriented activities, the social role I played and still play, the demands of my environment, and my own sense of duty.

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[3] An excellent example of collective work, where discussion about the issues is based on real discussion, is the book the *Nature of Emotions* (1994), edited by Ekman and Davidson. I wanted to publish a similar book on personality.

[4] Tokarz, A. (Ed.) 2010. *Big Theories of Personality: the end or the beginning?* Lublin: Wydawnictwo Towarzystwa Naukowego KUL (in Polish).

It was crucial to maintain some rhythm of work and activities, although this could not be done as effectively as prior to the illness, of course. Research on behaviour motivated by goals (Zaleski, 1993) revealed that a goal-oriented activity, which we value more and have stronger motivation to pursue, is a short-term activity, as opposed to a long-term one.

One of the most valuable papers in relation to the psychology of motivation, the field in which I have worked for more than 40 years, is White's (1959) paper on the notion of competence, which is underpinned by and gradually develops effectance motivation. The number of references to White's paper is impressive. We read about it (White, 1959) in course-books and can appreciate his contribution to the development of contemporary theories of motivation (see Tokarz, 1985, 1995).

Similarly to many of his predecessors, as well as modern commentators, White (1959) showed that the theoretical grounds of drive reduction theory is inadequate as an explanatory tool for motivated behaviour. It is not appropriate to explain the mechanisms of visual exploration, grasping and creeping, crawling, exploration of new objects and places, using language and thinking, object manipulation, and the implementation of changes in the surroundings in situations in which there is no pressure owing to unfulfilled biological needs and related tasks. White asserts that all these behaviours have a common biological meaning: they are an integral part of a process in which an animal or a child learns to interact effectively with their environment. White applies the word 'competence' to that common meaning.

Behaviours that relate to competence are motivated in their own way. They are linked to effectance motivation, and are characterized by a feeling of efficacy and satisfaction that is derived from the experience. However, a reinforcing result of efficacy cannot be identified distinctly, because it occurs during a repeated, circular, and constant interaction with the environment.

Other, more specific, types of motivation develop from undifferentiated effectance motivation, e.g. mastery motivation. Competence, however, is an integral and necessary part of each living thing, because it plays a crucial role in adaptation, not only in the biological sense, but also with respect to social and civilization. It determines expression and autonomy, which in its simplest form consists in independence from a current condition and a search for optimal conditions. Competence behaviours enable us to gain experience which, in turn, builds a base for further and better adaptation.

The determinants of competence behaviours are the environment and the spontaneous adaptive activity of the nervous system, such as elements of feedback generated by the activity of an individual. The prevailing quality of a competence activity is that it is self-motivated, and it is characterized by an average intensity and durability. Furthermore, such activities foster experimentation, multifaceted exploration, and play. Efficacy, and new results, intensify competence, rather than reduce it.

The inspiring influence of White's paper can be perceived in several other papers – e.g. deCharms' (1968) monograph concerning personal causation – in two major textbooks, and a large number of papers, and reports of Deci and Ryan's (1975, 1985) findings on their Self-Determination Theory.

A pragmatic approach to notions that is derived from this area of research leads us to conclude that short-and long-term activities that are conducted on a daily basis can be a potential source of reinforcement, rewards, and satisfaction, provided these activities have the source of tasks, are family based, work based, and also take the form of social activity, as well as being related to and requiring competence. I agree with Hobfoll (2006) that it is as important to pursue a goal as to achieve it.

A group of German motivation psychologists, including Juergen Beckman, Peter Gollwitzer, Heinz Heckhausen and Julius Kuhl (see resumé: Kofta, 2001), have also presented essential concepts and findings concerning goal-oriented activity. They have highlighted the cognitive and energetic properties of engagement in a goal-oriented activity, as a different state of mind, which results from an activity-orientation (Julius Kuhl) or an activity-implementation (Gollwitzer). Personality adjusts to activities, and this adjustment can be explained by changes in thinking (cognitive processes), feelings (emotions and moods), focus mechanisms, perception of oneself and attitude towards the future. Gollwitzer's (1996) research revealed that when an individual engages in a complicated task of unknown outcome, the energy associated with the activity rises, their mood lifts, and unrealistic optimism and the illusion of control also increase. Indeed, these factors are true determinants of efficacy. The notion of task-challenge, which I described above, causes competitive motifs to become blocked, because only one activity option is being implemented. The characteristics of the implementary state of mind are richer, and these properties give grounds for the conclusion that task-oriented activities provide one with beneficial feedback during the period of undertaking the task, executing it, and finalizing it.

On the basis of the practical approach mentioned above, which asserts that each individual shows a specific configuration of object properties and interactions with the environment, I was looking for an overall formula for a concept of personality that would match mine. Bernard Weiner (1986a, 1986b) found that the sources of basic motives for behaviours comprise hedonism and the need to understand reality. However, in this case, the source of motivation is rooted in an attribution of causality, which is seen as a process that is instrumental in the attainment of goals and as a support in achieving cognitive mastery. Weiner's motivational mechanism, i.e. causal attribution, can be interpreted in terms of personal causality – which is an imminent property of an actor.

In planning my activities during treatment, I wanted to continue my work and to 'achieve cognitive mastery', because it is my personal and professional endeavour. This is one of the most important values in my life, and I had concluded that this must be my goal.

Anger

The first event that affected me positively, although it also produced negative emotions, was the visit to the surgeon. We scheduled the date of surgery, according to my wish, before Christmas, and he handed me his business card at the end of the consultation. After some time, and conversations with his other patients, I realised that this had been a veiled invitation to give him a bribe, which I later handed in.[5] My helplessness and fear of my illness led to anger at the fact that I had to give away almost an entire month's salary to a dishonest doctor.

Anger and aggression towards this doctor gave me the energy to analyse my situation and oppose anything that would humiliate me again in the future. These negative emotions stimulated me and mobilized me to act. They were even strengthened by the events that followed.

The decision about the type of surgical intervention was a key issue during the first phase of my illness. The doctor, following standard procedures, supported mastectomy. However, the change in my breast was small. A surgeon in my family who worked in Germany, my daughter's half-brother who was interested in the course of my illness, told me that the procedures in other countries were different, and that such a small cancerous change would qualify for lumpectomy – a breast-saving surgery. Thus, I questioned the doctor's decision and, just before the operation, I was invited to participate in a medical consultation where I was to hear arguments against this kind of surgery.

I had prepared for this meeting by accessing the professional MEDLINE database. I knew more than other patients and I was consistent with my decision. The doctors agreed. Thereby, I was the author of my breast-saving surgery.

I remember that discussion as a struggle against a rational, doctor's decision, and I felt as though I was attacking a group of opponents, one of whom had behaved immorally and taken a bribe, and the other of whom did not want to undertake a breast-saving operation, which was possible, but finally performed it.

I became more angry and aggressive.

Symbolic Acts

I invented certain symbolic acts, which were supposed to be 'magical' activities that enabled me to ease my aggression towards doctors. I lived approximately 400 metres away from the Institute of Oncology, where I attended as a patient; thus, it was easy to take aim at this building. I thought that it was a great idea to place on my computer desktop a picture of a pistol that was aimed towards the hospital. I used a poster of Jean Reno from 'The Professional'. My good friend took an expressive photo of me – bald-headed (I had lost my hair as a result of chemotherapy), and another colleague, a computer-wise professor, substituted my face for Reno's. He was very creative and used other famous photos from 'The Professional', too. He even invented a new word to describe these five new photos: 'oleons'.[6] They were admired by people. They were also the object of my planned magical acts.

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[5] I am sorry to write about it, but corruption in the Polish health system is a fact. However, I know many professional and honest doctors, too.

[6] The Polish title of 'The Professional' was 'Leon Zawodowiec'. The letter 'O' is the first letter of my name 'Ola', thus the blended word created by my colleague was Oleons, in the plural.

All in all, it was not about attacking those hapless and corrupted doctors. It was a joke, an idea, a personal association with the time my friend spent on preparing the photos, which really mattered to me. Adding a skinhead haircut called a 'Mohawk' must have taken him a couple of hours. Indeed, he spent a considerable amount of time on this game; thereby displaying great empathy and compassion towards me. Family, friends, even some students saw these photos. All of them laughed at it and admired the idea and the result.

I wrote about the functions of humour in one of my papers (Tokarz, 1991). Dziemidok (1967), in an attempt to create a synthetic framework, divided the notion of humour into two categories: more popular theories of contrast, which highlight contradiction, inconsistency, and deviation from the form of a described object, and rarer theories of degradation[7], which stress the fact of lowered value and demean the object of the humour. Therefore, according to Dziemidok, humour can be defined as a deviation from the cognitive and axiological norm.

Theories of contrast (inconsistency, deviation) involve cognitive features of humour, whereas theories of degradation refer to evaluative aspects of humour, together with a relationship between a subject – the receiver of humour – and the object of the humour.

The relationships in this configuration are very complex. Zillman and Cantor (1976) conducted a series of experiments to examine humour in a variety of messages among people who either approved or disapproved of the object of the humour. The researchers found that merriment depends not only on what we like and laugh at, but also on the object of humour, whether it is extolled or deprecated. We are amused more by something that is ridiculed when it is hostile to and rejected by us, and less by something that is deprecated or ridiculed when it is close and beneficial to us.

This is how our laughter is explained. What is more, laughter flouts taboo (Chapman, 1976, Ziv, 1984) and allows us to experience positive feelings even when confronted with something serious, such as a life threatening illness (cancer).

Support

Just before the operation, I was paid a visit by one of my MA students, who had also studied as a soprano at the Music Academy of Krakow. She gave me several CDs of classical music, mainly baroque, oratorio, and opera music, which she used to master her voice. She told me it was worth listening to music when one is ill. I was touched and felt a great sense of support, especially because I found it surprising, friendly, and very sincere. The collection of music was really exceptional and I still cherish it today.

I do not have any professional knowledge about music, nor about music performance. I am familiar only with some of the issues that are concerned with the psychology of music performance, and I know a little about music therapy. However, this was insufficient to provide an explanation for the way in which music affected me. Certainly, it caused my mental re-tuning ('formatting'), which

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[7] Their origin is found in Aristotle's concept of humour from 'Poetics.'

eased my emotions, mitigated my moods, and consolidated my thoughts (see Sacks, 2008/2009). Music provided me with great pleasure. I listened to it for hours.

The support that I continued to receive from my daughter and my friends was wholehearted and strong throughout the course of my illness. I felt secure, surrounded by their sincere thoughts, readiness to help, and empathy. It felt very generous.

I was further grateful to my colleagues from the Catholic University in Lublin for their prayers for me. It was support that I did not expect to receive.

Pleasures

There is a sizable amount of reported research in psychology on happiness. This research can be divided into two research approaches and two types of explanation: the first approach and explanation concentrates on the idea of hedonism (here the central notion and researched object is happiness), and the second concentrates on eudemonism, which is focused on analysis of well-being (Waterman, 1993, Czapiński, 2004).

Hedonistic orientation relates to research on happiness and its correlates. This area of research is currently very popular; however, there is no clear explanatory theory so far. Ideas related to hedonism have not yet generated any coherent explanation of mechanisms of pleasure and satisfaction.

In contrast, eudemonistic orientation is based on humanistic notions and concerned with self-actualization (Maslow, 1954/1970/1990), which is a typically human motivation to realize one's full potential. According to Maslow, self-actualization occurs when someone achieves their full mental competence, and all their potential achievements transpire: 'What a man can be, he must be. This need we may call self-actualization. […] It refers to the desire for self-fulfilment, namely, to the tendency for him to become actualized in what he is potentially. This tendency might be phrased as the desire to become more and more what one is, to become everything that one is capable of becoming' (Maslow, 1943, p. 382, see: Maslow, 1954/1970/1990, p. 86). The eudemonistic aspect also appears in Deci and Ryan's (1975, 1985) concept of self-determination, which I have already mentioned.

My professional, as well as my personal, vision of happiness is related principally to the eudemonistic component. During my illness I began focusing intensively and intentionally.

It was always important to me to experience sensual and intellectual pleasures. A visual metaphor of my preference is the collection of textiles at the Cluny[8] museum in Paris, known as The Lady and the Unicorn. It consists of six tapestries from the fifteenth century entitled: Le Goût (taste), La Vue (sight), Le Toucher (touch), L'Odorat (smell), L'Ouïe (hearing), and A mon seul désir (to my own desire). I have admired them every time I visited Paris, for nine consecutive years.

There are various other places, paintings, and landscapes that I also admire.

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[8] Musée National du Moyen Age, Paris.

I have my own, relatively obvious, conception about sightseeing, and admiring. It results from an elementary knowledge concerning perception and the way in which we experience new things. What we perceive depends on the perceptual categories we possess; therefore, before we see something in reality, we should seek to gain knowledge about the object. When we see an object, we should study it. The more we repeat this, the more time it takes, and the more pleasant it becomes. I think that Brickman and Campbell's (1971) hypothesis of the hedonic treadmill, which assumes that the outcomes of changes for better or for worse, eventually neutralize each other and an individual is left at the same level of satisfaction that they had achieved initially is not conclusive. It is not the case if an individual's degree of activity, especially cognitive activity, towards a pleasurable object is high.

There is a character, Lodovico Settembrini, in Thomas Mann's novel The Magic Mountain who personifies a subtle intellectualism. He speaks about '*placet experiri*', the pleasure of experience and experiencing, (v.1, p. 126); in other words, he talks about the pleasure of epistemic and cognitive activity. This type of pleasure underlies my basic standard and motive for experiencing my own sensual impressions and intellectual pleasures. It is a reliable, secure, and controlled hedonism.

My Friend's Comment[9]

> *'I would like to share a few of my observations, as a friend, about Aleksandra's fight with illness.*
>
> *When Aleksandra told me about her illness I had an impression she was talking about yet another challenge she had to face. I could hear some irritation in her voice, caused by the fact she had to postpone some of her tasks because her fight with cancer was her priority. She did not flee from the problem; on the contrary, she knew she had to try her best to solve it. I could conclude that the support, both emotional and informative, she received from significant others mattered a lot to her. In the most difficult moments, she found real support only from among her beloved. It was sufficient, and very precious.*
>
> *At the same point, in her struggle with illness and herself, the irritation and fear turned into readiness to act. Aleksandra prepared her body and mind for a fight. In my point of view, her mind began to appeal to her immune system, and it responded with mobilization. This reciprocal information flow, presumably by means of biochemical transmitters, between the nervous system, endocrine system, and immune system, is the subject of a relatively new science called psychoneuroimmunology.*
>
> *My friend does not work in psychotherapy, and she seldom studies anything from this area. Her interests include mainly motivation, and this is the field that inspires her in her daily activities as well. I noticed, however, that her behaviour reflects 'healthy thinking' which*

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[9] My friend, Prof. Jan Blecharz is the author of this comment. He is well-known in Poland and throughout the world as a sport's psychologist, the author of a highly valued monograph on injury in sport (2008), and co-author of many successes helping Olympic and international athletes, e.g. Adam Malysz the ski jumper.

is a principal element of Simonton's Program in emotional crisis. According to Maultsby (1992), healthy thinking:

- *Is based on real facts*
- *Helps protect life and health*
- *Helps achieve short – and long-term goals*
- *Helps solve undesirable conflicts and avoid them*
- *Helps us to feel the way we want to feel.*

Not only did such an attitude help Aleksandra to overcome her illness, but it also introduced many changes in her life. Her satisfaction with life seems to be much greater than it was before the illness' (Blecharz, 2012, pers.com.).

Conclusion

In relation to the comment above, I can conclude that there are many ways of rescuing oneself in a difficult situation, and they vary in terms of adopted notions, procedures, and therapeutic systems. Furthermore, a person in dire need must find these approaches to be credible, just as I found knowledge about activity and personal causation relevant to my situation. I was also convinced about the value of the emotional support provided by my family and friends.

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Chapter 12

SCARS OF THE WOUNDED HEALER

Emile Allen

After I had completed medical school and my urology residency in 1991, I felt as though my life path through retirement was set. My father had been a urologist, so I knew what to expect and felt confident in my future. In fact, I worked hard and experienced career successes quite early on that had surpassed my expectations. I enjoyed helping people heal and lead better lives. It was my destiny, and I was passionate about it.

However, in 1998, my life took an unexpected turn. I experienced an event that totally changed my career, my identity and my capabilities. What I didn't understand at the time was how significant the impact of this incident would be to this day.

It all started with a routine day at the hospital, making my morning rounds before spending five or six hours in the operating room. I had two cases on the schedule, a three-hour long nephrectomy, followed by a two-hour radical prostatectomy. The 75-year-old woman scheduled for the nephrectomy had multiple medical conditions, including high blood pressure, diabetes, and obesity. Her abdomen was riddled with multiple incisional scars from previous abdominal surgeries for recurrent bowel obstructions and the removal of her gallbladder. I knew this would be a challenging case due to the intra-abdominal adhesions.

When I arrived at the operating room (O.R.), the nurses had already brought the patient into the room and prepared her for surgery. She was prepped and draped; the electrocautery grounding pad (an electrode pad that functions like a grounding wire in your house to prevent electrical shock) was placed on the patient's leg and connected to the electrocautery unit. The electrocautery scalpel looks like a pencil with a toggle switch that can be pushed to either cut tissue or cauterize blood vessels to control bleeding.

I'd used this machine tens of thousands of times throughout my career. It is a vital piece of equipment used to decrease blood loss and improve operating time. This allowed me to complete a surgery as quickly as possible and get the patient off the operating room table, thus decreasing the risk of complications.

My O.R. team scrubbed into the surgery, and we were ready to begin the tedious operation. I made my initial 14-inch incision in the left upper quadrant of the abdomen, just a few inches underneath the left rib cage. Immediately, I encountered a large amount of scar tissue from her previous surgeries for bowel obstructions. Meticulously, I dissected away the adhesions to free the small and large intestines in order to gain access to the kidney. All was going well.

I held the bowel in my left hand, freeing it from the adjacent organs by using the electrical scalpel in my right hand. Suddenly, in a split second, a large popping sound and an arc of electricity came out of the electrical scalpel. The arc blew through the patient's bowel, into my left finger, up my arm – and as I found out the next day – through my heart and brain, and out my right ankle. In this split second, the electrical force threw me back approximately six to eight feet, and I collapsed onto the operating room floor.

I screamed in pain, holding my hand as I saw blood quickly fill up my surgical glove. The non-stop, excruciating, and burning pain was unlike any I had experienced before. Imagine having your hand severed at the wrist without anesthesia and feeling the pain radiate up your arm and through your shoulder. I kept screaming, begging someone to stop the pain.

Quickly, I felt cold, clammy, and weak. I rapidly went into shock. As they were losing me, I had a seizure on the cold, sterile operating room floor. My O.R. team frantically ran around the room shouting orders:

> *"Call a CODE! Get the crash cart!"*

Although I could still see a blur of my colleagues, I could no longer hear the sounds of everyone trying to save my life. The room became quiet. Everything went dark. The physical suffering vanished, and I felt at peace.

After a week total in the hospital, four days of which were spent in the Intensive Care Unit (ICU), I was sent home with a diagnosis of a slight concussion and nerve damage to my left hand and arm. At that time, little did I know how extensive the injuries really were or how long it would actually take to recover.

Over the next three months, the muscles in my left hand and arm atrophied down to nothing but skin overlying bone, tendons, and ligaments. I soon developed reflex sympathetic dystrophy (RSD[1]) of my left arm and hand. A person with this condition experiences the frequent and painful feeling of *pins and needles,* similar to a foot or forearm that has fallen asleep and is just waking up. The skin of my arm and hand was mottled in various shades of red and purple. I also had extreme sensations of hot and cold with profuse sweating for no apparent reason. In addition, I had peripheral neuropathy with poor motor coordination. The physical therapists and doctors continued to be particularly concerned about my arm and hand and wondered what their ultimate function would be.

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[1] Reflex Sympathetic Dystrophy (RSD) or Causalgia or Complex Regional Pain Syndrome (CRPS), is a chronic progressive disease characterized by severe pain, swelling, and changes in the skin. It often affects an arm or a leg and may spread to another part of the body and is associated with dysregulation of the autonomic nervous system resulting in multiple functional loss, impairment, and disability. Though treatment is often unsatisfactory, early multimodal therapy can cause dramatic improvement or remission of the syndrome in some patients. The International Association for the Study of Pain has proposed dividing CRPS into two types based on the presence of nerve lesion following the injury. Reference: Wikipedia.org

Sadly, I had no choice other than to close my practice, since I could no longer care for my patients. I would certainly miss all of my patients who depended on me so much. Moreover, I was the only urologist for this rural community with a population draw of over 200,000 people. Who would take care of them? Guilt set in. Yet, I had to take care of myself.

With this change, I was now realizing that my identity, as I had known it, was beginning to fall apart. I knew I was losing my independence, my job security, and my financial well-being. I felt deep loss and was uncertain of where my life was going.

As the weeks rolled by, my physical and mental health continued to deteriorate. I was slipping into a state of despair the likes of which I had never known. What's worse was that my physicians were ignoring my true condition. No one paid very much attention to the chronic fatigue I was experiencing. Some days I literally could not get out of bed.

Despite my complaints, my doctors at that time thought my symptoms of lethargy and depression were the result of post traumatic stress disorder (PTSD[2]). At this point, I was taking 36 pills a day from nine different prescriptions. I had also developed seizures and was having difficulties concentrating to the point I couldn't read a book or count change. I felt that something had been missed in my diagnoses. It was overwhelming.

About six months after the accident, I finally had the right team of doctors in place. While the struggles I encountered were demoralizing and my self-esteem had hit rock bottom, I now had hope. They had figured out what was actually wrong with me, adjusted my medications to decrease side effects and put me on the path to recovery. It wasn't long before I had a list of diagnoses: traumatic brain injury (TBI), petit mal seizures, reflex sympathetic dystrophy (RSD), peripheral neuropathy, migraines, post traumatic stress disorder (PTSD), and depression.

As a part of my new team of doctors, I was now seeing a psychiatrist who helped me rebalance my medications, which, thankfully, reduced my side effects by about 80%. My seizures and migraines became more tolerable and less frequent. In spite of this improvement, my physician still advised me not to drive anymore due to my brain injury, seizures, and the remaining side effects from medications. At age 38, I had to be driven to the grocery store, to buy clothes, to see a movie, or even go on a date. I felt like I was a 14-year-old all over again.

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[2] Post traumatic stress disorder (PTSD) is a severe anxiety disorder that can develop after exposure to any event that results in psychological trauma. This event may involve the threat of death to oneself or to someone else, or to one's own or someone else's physical, sexual, or psychological integrity, overwhelming the individual's ability to cope. As an effect of psychological trauma, PTSD is less frequent and more enduring than the more commonly seen post traumatic stress (also known as acute stress response). Diagnostic symptoms for PTSD include re-experiencing the original trauma(s) through flashbacks or nightmares, avoidance of stimuli associated with the trauma, and increased arousal – such as difficulty falling or staying asleep, anger, and hyper vigilance. Formal diagnostic criteria (both DSM-IV-TR and ICD-10) require that the symptoms last more than one month and cause significant impairment in social, occupational, or other important areas of functioning. Reference: Wikipedia.org

During this time, through hard work in physical therapy, the muscles of my arm and hand were coming back to a normal size. Only a trained observer would see a difference between my left and right arm and hand. In addition to the painful RSD, I still had a neurological deficit in my left hand and difficulty with fine motor coordination. Despite many tough days, I had learned to live without addictive pain medications.

I also began working with a psychologist to help me with the depression and symptoms of my brain injury I was experiencing. As a result of my TBI, I underwent extensive neuropsychological testing to gather baseline information. Results found that my IQ had temporarily dropped over 50 points from a previous baseline level. No wonder I was having trouble functioning in basic daily activities. This *subtle* brain injury was not so subtle after all.

Given that I had difficulties concentrating and performing simple math skills, I was extremely frustrated. For over three years, going to the store was a significant event because I couldn't count change. Since this was in the days before debit cards, I would put cash down and hope it was for the right amount. I felt so embarrassed, and I prayed that no one would notice.

It also took three years after my injury to get to the point where I could read a book from cover to cover. The first book that I was able to read was *Tuesdays with Morrie* by Mitch Albom (1997), which still sits on my bookshelf as a reminder of how far I have come.

After I had made enough progress on my math skills and concentration, I applied for jobs; however, that wasn't working out as planned. I still required two to three hours of naps throughout the day because of my disability and side effects of medication, which interfered with a full-time job.

Here I was an M.D. with 13 years of professional education and seven years of private practice who had taught medical students and residents, served as an expert witness, and was chairman of urology and vice-chairman of surgery at a prestigious medical center. That split second in the operating room had taken away the value of all my education and experience.

I was scared. I was trying to hold on to what little identity I had left as a physician and surgeon, and I didn't know what I was going to do, or what else I could do, with my life. Would I ever get back to where I was or who I was? All of the years of medical training and knowledge were trapped inside me; yet, I didn't know what career I could still have that would use my medical background. My identity was changing, and it was definitely affecting my self-esteem. I felt powerless.

I found it very challenging to find a job in the healthcare field. As a result of my injuries, I could no longer be a surgeon. I just couldn't see going back to do another three to six-year residency program all over again. It would be too demanding and demoralizing. I researched medical director positions at pharmaceutical and medical device companies, but I could not get a break. Either they were not looking at that time or I was too specialized. The longer I was without work, the more difficult it was to explain the lapse. Three, four, five years had gone by. I wasn't lazy. I wanted to work, be productive, and contribute to society; however, what was my niche?

I continued to struggle. I was aware of the loss I had suffered and that my identity had been changed forever; however, I only had the questions, not the answers. I had trouble letting go of my past and accepting that my life would be different from now on. I was grieving the loss of so many things. Acceptance was very difficult for me; nevertheless, it had to be done. I had no choice since I was living in hell and certainly wasn't going to stay there. I took a hard look at where I was and asked myself:

> *"Do I want to live in this place for the rest of my life? If I do, I might not make it to next month, next week, or the next day. What relationships will I miss? What business opportunities will never materialize? Will my physical health deteriorate due to the stress I am under?"*

My despair over my situation deepened. My physicians, friends, and family kept saying I was depressed, and that things would get better. It just takes time. From a medical standpoint, I certainly felt depressed. However, I knew it was more than that. I was grieving. I was mourning a huge list of losses. I had lost my freedom and my independence. I had lost my career, my status in the community, and my patients. I had lost my home, my lifestyle, and my significance as a man. I had lost so many things, and all at the same time. I soon realized I was grieving over the loss of my identity, which was manifesting as the signs and symptoms of clinical depression.

As a physician, I felt ashamed and feared that I would be judged for seeing both a psychiatrist and a psychologist to help me process my accident. I even judged myself because of the negative connotation that seeing a therapist represented to me. It was painful.

At this time, I found myself reflecting on the experiences I'd had as a third-year medical student in 1984 during a six-week specialty rotation in the psychiatric (psych) unit. As part of our training, we were required to take rotations in different medical and surgical specialties so that we would have a comprehensive view of healthcare.

I hated going to the psych unit. I felt as though I was working in a high-security prison because the unit was literally in lockdown. Many of the patients were severely depressed, and some had even tried to kill themselves. I didn't understand then why they would attempt such a thing. I use to think:

> *"I'm not going to be a psychiatrist, and I'm not going to be treating psychiatric patients. Just put me back in the O.R. where I can get some real work done. I don't have the time for this. They're all crazy."*

That was when I was 24 years old. What a callous viewpoint I had. I honestly thought many of those patients could just get over it, and that, on some level, they'd created these problems for themselves. I didn't have the patience, and I judged them without understanding them. During this reflection, I realized I was faced with the same situation that millions of people who are chronically depressed struggle with every day. I used to think they were crazy, but now I was in a similar boat.

I thought a lot about depression in those days, and I've thought even more about it since. I have come to believe depression is not simply a chemical imbalance in the brain that can be managed by the right cocktail of medications. Although there are many reasons for depression, I believe that acute and chronic grieving is a major factor that goes hand-in-hand with depression. Yet, so many aspects of physical and mental healthcare are based on treating a symptom here and a symptom there; focusing only on the fragmented pieces instead of helping a person put their life back together.

When we experience the loss of something, whether it is our career, our life savings, or the loss of a loved one, grieving can show up as the physical and emotional signs and symptoms that the medical community calls depression. Research has shown chemical imbalances exist in the brains and bodies of patients with clinical depression. However, in my view, depression is often overused and inappropriately diagnosed. If we ask the right questions, we will frequently find that people are not depressed. Instead, they may be grieving over a loss that is significant to them, which needs to be identified and processed. Depression is simply the clinical symptomatology.

Problems usually occur when people do not recognize that they are grieving and living in a state of numbness. It is natural to deny grief in order to avoid feeling emotional pain. Of course, that doesn't actually work. The pain of the suppressed grief still seeps through like a toxic leak and knocks us out of balance chemically, which can lead to a lifetime of physical and emotional issues.

I know this for a fact because I lived it. I realized that I had been judging myself in the same way that I had judged the psych patients back in 1984. My loss was important to me and no one else, and I had every right to grieve. No one could tell me how to do it, any more than I could tell anyone else. Grieving is intensely personal and unique to each individual. I realized I couldn't bypass the grief stage. During grieving, it was absolutely essential for me to be selfish in the sense of taking care of myself. Identifying my losses and letting go of my attachments to them, propelled me through the grieving process.

While I was going through my process, I found the prospect of changing and moving into the unknown to be incredibly frightening. I was afraid to step out and do something different or new from an empowered perspective. I believed that the emotional pain of the change would be worse than the circumstances with which I'd learned to live. This could not have been further from the truth.

Facing the emotional pain was the only way out of my circumstance. By dealing directly with the impacts my accident had on my life, I was able to learn to let go of the judgments I had about myself. In time, this release of self-judgment translated to less interpretation of judgment by others. I was beginning to set myself free of my suffering. While there wasn't anything more I could do about my disability, I definitely could choose my attitude and approach to life. In fact, I decided to learn as much as I could about my experience in order to become an even more enlightened person.

Thus, I embarked upon my real journey in life. I began learning to take full responsibility for all that had happened to me, even if it hadn't been my fault or anyone else's. Life happens. I could either react as a victim or respond as an empowered individual. I found that life became much more fulfilling and energizing when I chose to respond from a place of self-empowerment. No matter what had happened to my physical body, I remained the same person I had always been. I still had something to contribute to the world. After my accident, I had lost sight of this fact. I was transforming a feeling of worthlessness into a knowing of intrinsic value.

With this change in mindset, things did begin to open up for me little by little. I became employed part time as a medical consultant for an insurance company, and eventually, over the years, have served as a consultant and medical director for various health care companies. Instead of seeing my positions as being beneath my capabilities as a surgeon, I started seeing my work as simply making a different contribution than I had been before. I was still making a difference. It just wasn't as dramatic as before and didn't have as much prestige attached to it. I had to learn to let go of those attachments and be at peace with my current situation.

As time went by, I was able to reflect on the whole of my past experiences and was able to see the value in the lessons I had learned after my injury. I slowly began to realize that I had a composite of information that could be very helpful to others. I wrote down everything that I was grateful for since my accident. During this process, the significance of my lessons learned became even clearer. I could now see that the real value I had to contribute was not necessarily through the various consulting and medical director positions I had had, but rather in sharing the insights I had gained through my process of healing.

The urge to share my lessons learned became my new passion. I wanted to write and speak about my experiences in order to help others live better lives, which was the same reason I had become a doctor. I found the flame of the passion once again. Even though I had never written anything before, or done any public speaking other than presenting medical papers at conferences, I knew I had to gain these skills.

As a first step, I knew I had to learn to be comfortable giving engaging speeches to an audience. Reading a PowerPoint presentation is not the same as speaking from your heart to a group with whom you want to connect. I was scared of that. To overcome this fear, I decided to join Toastmasters, an organization that teaches people how to succeed at public speaking. Gradually, I learned to conquer my qualms and awkwardness. Eventually, to my surprise, I even began to enjoy giving speeches. I found a new sense of power in being able to communicate with humor and depth to a group of people and help them improve their lives.

Now that I was comfortable giving speeches, I began seeking opportunities to share my personal experiences, which I found to be much more difficult than I had anticipated. I now had a new hurdle to surmount – being vulnerable in front of a group. Even though it was very painful and brought up intense feelings of shame and fear of judgment, I stuck with it until I was able to be more relaxed sharing my journey. As I became more willing to expose myself, I found that the audiences responded with more appreciation and depth of understanding. I was grateful for my accident and for the fact that I was finally in a place to touch the lives of others.

During the process of putting together my speeches, I began to see the possibility of a book come into view. I had always felt that a book would be an essential tool for sharing my lessons learned, but the writing of the book seemed beyond my reach. The speeches brought the gift of content and coagulation of ideas. I decided to begin gathering all of these bits of information and compiling them into one place. The concept of the book was born.

Over the next couple of years, I went through all of the steps most new authors go through: self-doubt, vulnerability, and fear of failure, etc. Each challenge brought another opportunity for growth. I either had to choose to work through each fear or stop writing. I knew I needed to write this book for others and myself. I had to keep going; so I did.

Reliving the accident again and again as I put my thoughts on paper was just too much sometimes. Other times, it felt cleansing and freeing to do so. This emotional rollercoaster continued throughout the process of writing the book until I finally made it through to the end. Upon completion, I felt a deep sense of accomplishment. I had done something that I couldn't have seen myself doing ten years ago, or even five.

Going through the pain had proved to be a growth process in and of itself. I decided to call the book *Eaten by the Tiger*, *Surrendering to an Empowered Life* because I felt it represented the complete surrender required of me on my journey to wholeness since my accident. I had to let go of my deep emotional wounds in order to move on and create the life I wanted. The progression of writing this book brought all of these wounds forward once again for even deeper awareness and healing. My existing insights became more evolved than they were before.

My passion now is to help people restore their lives to wholeness by reaching out through my book and my speeches. While I am not a surgeon any longer, I am still a healer – a wounded healer – striving to improve the lives of people that I touch. As a surgeon, I had a limited number of people I could help. Now, with this format, I am able to assist many more people than I ever could have as a surgeon. Helping people heal their metaphoric heart rather than their physical body is now my goal. I love what I am able to do with my life experiences. It is all a choice. I am grateful to have the opportunity to be of service and to live in this manner. In fact, I find that I am much happier with this lifestyle than I was as a practicing surgeon. When we go with the flow of life and expand, all things work together for the good of all.

As a physician, I literally have seen people work and worry themselves to death in order to hold on to material objects that were definitely not as valuable as their own lives. Even health care providers are not exempt. In fact, many physicians I know have worse health and more stressful lives than the patients they treat. I could certainly relate to that.

The longer we hold on to something that doesn't serve us, the longer we, and those around us, will continue to suffer. People fear being judged by others as a failure, or worse, seeing themselves as failures. We hold on to emotional baggage because we don't want to admit that we are wrong. However, letting go allows us to have more clarity to face the inevitable and overcome our fears. When I let go of the need to feel in control of my life and the lives of others, my life opened up and became more fluid.

Life is not a linear process, although we may think it is. Life is a culmination of random events that can become life lessons, if we recognize the true gifts in them. If I hadn't experienced my losses, I wouldn't have had the opportunity to realize my insights. Recognizing these lessons has become a way of life for me, and has made me the person I am today.

I always look for the insights in the challenges in my life. Hidden gifts are the lessons learned through those struggles. These lessons can make us stronger, if we choose. Oftentimes, the situations and people that cause the most adversity in our lives are our best teachers. It is not enough simply to recognize these insights. We need to determine how to apply them every day in order to improve our lives.

As I reflect on my surgical career, I often wonder how many scars, other than the physical, I had left behind on my patients. Years after their surgery, what would a patient looking in the mirror think about their scar-branded body? Would the scar represent healing or the emotional pain associated with the treatment and progression of the disease? I had not thought of it this way while I was practicing, as I only saw surgery as a necessary healing act. However, after my accident my awareness heightened regarding the emotional impact surgery had on my patients.

I realized I had emotional scars, too, that I had not processed from the various failed treatments, whether surgical or medical such as chemotherapy, which my patients had experienced. Sometimes the disease was too far advanced for the treatments to have an impact. I, as well as some of my colleagues, have felt distraught and powerless as we tried unsuccessfully to combat various medical conditions. These are scars that I found myself processing.

In addition, as health care professionals, we amass our own emotional scars as we negotiate a mangled health care system. The unconscionable actions of insurance companies take its toll as we try to negotiate life-saving treatments for our extremely ill patients. Dealing with these ongoing frustrations can accumulate and lead to chronic stress.

Moreover, we have our own personal traumas with which to deal. Life does not stop for us either. We, as health care providers, experience deaths, divorces, illnesses, accidents, financial issues and other life events to counter as we remain available to our patients. How do we do that without compromising our own lives? We perform a very difficult juggling act. However, it is imperative that we take the time to process our own ordeals. We need to honor our scars.

I am not a psychiatrist, psychologist, social worker, or hospice expert. I am a surgeon. I am a surgeon who has seen thousands of patients and counseled their families. I am a surgeon who sustained a life-altering injury, and went through the well-known stages of grief, learning to find the gifts in the adversities of life in order to move past being a victim.

My accident was the greatest gift. It opened up my eyes and freed me from my silent suffering. I am grateful for everything that has happened to me: the accident, the losses, and the pain. Yes, I lost a lot; however, if I could go back and do it all over again, I wouldn't change a thing. What happened to me, and the long road thereafter, drastically modified my perspective on life and reminded me how anyone's circumstances can be altered in a split second.

Every person's journey is singular and unique. Many of us come to the end of our life and never make the chance, take the chance or have the chance to put the pieces together. In the end, the question we have is, '*Is that all there is in life? Is that it?*' All we have left are haphazard, disconnected pieces representing the residue of unresolved pain in our lives; however, we can still heal.

Whether you apply these concepts to your own life, or use them to assist your patients in moving through the challenging terrain that life frequently offers, I hope my life story provides the missing component. Helping individuals truly reconstruct their entire lives is an honor and a privilege. I respect all of you who have had life-shattering experiences and yet continue in your dedication to serving others. We are all in this journey together.

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Chapter 13

IDENTIFICATION AND SEPARATION – CAREER CHOICE FOLLOWING PARENTAL DEATH IN ADOLESCENCE

Amanda K. Ekdawi

> *"Although we know that after such a loss the acute stage of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely it never the less remains something else. And actually this is how it should be. It is the only way of perpetuating that which we do not want to relinquish".*
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> (Freud 1939 quoted by Frankiel 1994, p.70)

This chapter explores the processes of separation and identification in both adolescence and mourning. Using my experience of parental death in my own adolescence by way of illustration I will explore how the ordinary tasks of adolescence to do with identity, separation, loss and reorganization of the internal world can be affected by parental loss. In addition I will consider how these tasks have much in common with the work of mourning, and will explore how my personal experience (of the death of a parent in early adolescence) initially appeared to complicate ordinary adolescent separation processes, leading to my initial career choice before finding my professional identity as a child and adolescent psychoanalytic psychotherapist.

Introduction

By the time a young person reaches the age of sixteen, over five percent will have experienced parental death. (International Centre for Child Studies, 1970 cohort). In a well-known and ground breaking sociological study *The Social Origins of Depression* (1971) Harris and Brown explored what they termed the 'provoking agents' of depression. These provoking agents included life events, such as losing a job, and long term difficulties, such as a spouse's unemployment. They found that one fifth of those with such agents broke down. This led them to consider vulnerability factors. One significant vulnerability factor to emerge was the loss of a parent in childhood. They were particularly struck by the age the women lost a parent concluding that particular difficulties were encountered when the loss occurred in childhood or early adolescence. However it remains a 'puzzling omission' (Garber, 2000, p.101) that adolescent parental death and its subsequent effects remain an area of limited research. Perhaps even less is known about the effects of mother loss because children under the age of eighteen are statistically three times more likely to experience the death of a father than a mother (Clark et al.,1996). For this reason Lenhardt et al.(2000) postulate that even less is known about the impact on adolescents of maternal death. They suggest that the effect of this may be two-fold. Health professionals are less experienced in working with this population and adolescents are unlikely to find supportive peers who have experienced a similar situation.

Non psychoanalytic research has found that adolescent girls are reported to respond differently to the loss of a mother than to the loss of a father. Meshot and Letner (1993) found that in general daughters responded more negatively to the loss than boys. A number of factors differentiate the experience of mother loss for adolescent boys and girls. These include differences in relationship and identity building (Chodorow 1978, Gilligan, 1982), the surviving parent's response to the death (Gray 1987, Parish & Hortin 1983) as well as the tendency of adolescent girls to take over the maternal role (Edelman 1994).

In adolescent mourning recent research suggests that environmental factors continue to play a role in how mourning is negotiated. For example, Gray (1987) studied grieving adolescents and found lower depression scores correlated with high social support, good relations with the surviving parent prior to the loss, a balanced personality style and religious belief. Less attention has been paid to internal processes in adolescent mourning which will be the focus of this chapter.

Although limited, research suggests that although bearing some similarities to the process of mourning in adulthood and childhood, adolescence is a unique time to experience parental death. Before considering bereavement in adolescence I will offer an overview of the importance of adolescence in terms of psychic development.

The Importance of the Adolescent Period

According to the Oxford English Dictionary the term adolescence is derived from the Latin word '*adolescere*' meaning, 'to come to maturity'. Although the term was known at the end of the nineteenth century and used in a 'disparaging' sense, (Perret-Catipovic & Ladame 1997, p. 1) it is very much a twentieth century concept. It was only in the 1950's, mainly for sociological reasons, that adolescence became *"increasingly popular as a subject of both celebration and investigation"* (Dartington 1994, p. 1). It is now almost universally recognized to be a unique period in terms of growth and development. Adolescence is generally regarded as encompassing the psychic process that usually follows the physical changes of puberty. It is now known that structural changes in the brain are also occurring at this time. A normal transition through adolescence entails upheaval and some measure of disturbance. It is characterised not only by the changing body of puberty but also by changes in the nature of relationships. The young person's image of him or herself as a child changes with bodily changes. The physical changes mean the young person is required to adapt to changes of size, build, strength and cognitive ability as well as sexual maturity. The peer group takes on a new sense of importance as the adolescent strives to become intimate with people in new ways. The adolescent endeavours to fit in with his or her peer group whilst at the same time, developing a sense of values and opinions that are often very different to their parents. The emotional challenges of adolescence have been referred to as a 'normative crisis situation' (Tonnesmann 1980, p. 623). During this crisis the adolescent is making the transition from the familiar ways of childhood to something more unknown. As adolescents take on new freedoms and responsibilities, their relationships with parental figures must also necessarily change. Psychoanalytic literature has drawn attention to the crucial tasks of adolescence and has increasingly recognized that the way in which the challenges of the adolescent period are negotiated play a vital part in the development of the personality. For example Laufer, an influential psychoanalytic investigator of adolescence wrote in 1966: "*There seems to be general agreement that this process is crucial and must be completed to enable a person to proceed emotionally into adulthood".*

Links between Mourning and Adolescence

As late as 1987 Corr and McNeil state that: "*Much has been written about adolescence and especially recently a good deal has been written about dying, death and bereavement. But very little has been written about the issues involved in the conjunction of these phenomena…"*

However, all psychoanalytic researchers in this field conclude that mourning in adolescence is especially complicated. The demanding tasks of adolescence, such as separation from parental objects and establishing oneself in the adolescent group are being negotiated alongside the demanding work of mourning. Adolescence itself has also been likened to the process of mourning. In this paper I argue that the themes that seem to link mourning and adolescence most strongly include the need to establish a new sense of identity (as adolescent/ widower etc) and loss, separation and feelings of abandonment. The re-negotiations of relationships to external figures are a central concern of both the adolescent and the mourner.

Anna Freud was a pioneer in making an explicit link between the processes of adolescent development and those of mourning. In her 1958 paper Anna Freud wrote that she was: "*…impressed by a similarity between the responses of these young patients and those two other well known types of mental upset, namely the reactions to treatment during unhappy love affairs and during periods of mourning"* (Anna Freud 1958, p.258).

Relationships occupy 'the central concern' (Blos, 1967, p. 64) in the life of the adolescent. In psychoanalytic terms this would include the reworking of the Oedipal Complex (Freud) and the nature of the depressive position (Klein). The complex has become associated with the entire range of feelings the child and adolescent might experience towards his parents.

Root (1957, p.318) spoke of the 'painful grief' when an adolescent attempts to make a shift in relationships – moving from parents as the central love objects of childhood. He argued that for the bereaved adolescent the normal 'letting go' of a parent can become equated in his or her mind with actually letting the parent die.

He explored the way the normal developmental tasks of adolescence can become entangled with the process of mourning.

Although loss is not usually considered a central feature of adolescence, some psychoanalytic writers have drawn attention to the link between these two processes. Linked to the move away from dependence on parents to independence, a sense of loss for their childhood self and past relationships with parents (although often devalued) may be activated. The adolescent's prior identifications with parents therefore need to be given up and reworked. This process can entail painful feelings of loss akin to mourning. The loss of a loved person necessitates a change in the mourner's external relationships. Freud discussed the way in which time is needed for the mourner to draw libido (or energy) away from the lost loved person and invest in other relationships.

Keefer and Reene (1987, p. 246) writing on female adolescence draw attention to the development of a sense of identity as being at the very heart of adolescent development. They define identity as an internally consistent sense of self and drawing on the work of Blos, state that successful resolution of adolescence results in a firm sense of identity. The adolescent must find his or her identity that is different from his or her childhood self. Achieving an identity of one's own involves the task of separation from parents. The adolescent's awareness of his or her sexually maturing body and physical strength leads the adolescent to search for new intimate relationships. This necessarily includes sexual identity. Loewald (1978) emphasised the very active role adolescents have in this process describing the way in which adolescents must forge their own identity and independence by effectively ridding themselves of their parents. Finding a new way of living and with that, a new identity is also a central task of mourning.

Some writers caution against comparing mourning with adolescence. For example, Wolfenstein (1966) thought it was vitally important to consider the ways in which they differ. In particular because the parental objects from which the adolescent is freeing himself are still available, aggression could be directed at the parents with the knowledge that they will survive. Winnicott in writing on adolescence also draws attention to the need for the continuing presence of the parent discussing the adolescents: "*…need to defy in a setting in which dependence is met and can be relied on to be met*" (Winnicott 1961).

Personal Experience of Adolescent Maternal Loss

My mother had never been physically strong and growing up developed a scoliosis of the spine which had required major surgery. She was diagnosed with breast cancer just prior to my transition to secondary school. After numerous treatments (including chemotherapy and various surgeries) she died in my early adolescence, a few weeks after my fourteenth birthday.

I was of course aware of the various hospital treatments my mother underwent during the years of her illness and the necessity for my sisters and myself to 'be quiet' whilst she was 'resting'. However neither of my parents discussed her condition openly with me. It was only in her last few weeks of life that I learned the name of her diagnosis and the likelihood that she would not get better. My mother died at home during the night and my father delivered the news the next morning.

I clearly recall going into school as usual the morning after the death of my mother. I had chosen to attend after being given permission by relatives to take the day off. My insistence in carrying on as if nothing had happened was I think unfortunately reinforced once at school. I have been told subsequently that the school were telephoned that day by relatives to alert them to the fact that my mother had died. However this was in the 1970's and none of my teachers approached me or mentioned the death either that day or in the months to follow. I can only guess at the reasons for this – a fear of upsetting me? Not knowing how to approach the subject? I too did my best to avoid the subject with friends and continued school as if nothing had occurred. This stance led to both an illusion of a sense of normality alongside an equally strong sense of unreality.

Looking back it is hard to explain what now seems to be such a denial of an event of such significance. In my later research I have come to link this (non) reaction of mine in part to an adolescent's need to fit in with the peer group.

Garber draws attention to the importance of peer relationships and acceptance, and suggests that for this reason the adolescent will try to diminish the importance or significance of his experience: *"He will go to great lengths to act and appear as normal as possible"*.

Garber (1985) also suggests that alongside this wish to fit in the adolescent may feel 'overwhelmed' especially by his feelings of longing for the lost parent. Klein (1940, p. 384) discussing manic defence mechanisms draws attention to the way in which they: "*…are essentially directed against the 'pining' for a lost object"*.

Copely and Forryan (1987) describe a manic response as one that involves a denial of the truth of psychic reality. A particular risk therefore is that adolescents may respond to parental loss by inhibiting their grief (Harris 1991). This may lead adults to assume that since they do not appear distressed, they are adjusting to the death without difficulty (Lenhardt et al., 2000). Garber however emphasised the way in which non-clinical studies of adolescence conclude that good transitions to adulthood are the norm. Citing Hogan and Greenfield (1991), Oltjenbruns (1991) Garber suggests that coping with bereavement in adolescence leads to greater maturity and can be viewed as 'growth promoting' (Garber 1985, p.103). I would argue that there is a risk that observed signs of maturity may in fact be evidence of pseudo-maturity. My personal and clinical experience is that adolescents who have been parentally bereaved often present as coping and not wanting help. However this pseudo-maturity can be a defence against extreme feelings of vulnerability.

Cournos (2001) a researcher in this field, has written movingly of the death of her mother in childhood describing denial of the death accompanied by partial acknowledgement: "*I could certainly recite the fact that my mother was dead and never returning. The belief existed side by side with a fantasy of remaining in an on-going relationship with her"* (2001, p.145).

In terms of understanding both my parents' lack of forthrightness in discussing my mother's illness (as well as the other adults around me) I would suggest that this was in part to do with the social context. Both my parents were been born in the 1930's – a time when feelings and difficulties were not shared openly between adults and children. However it possible that there was also another dimension to this – Erna Furman also points out (as Robert Furman notes) that: "*For many adults, a child's grief is so poignant they prefer for their own sake to deny its existence*".

Absence of Grief

Absence of grief can be a particular risk for the bereaved adolescent. Although bereavement services are often targeted at the newly bereaved, adolescents who have experienced parental death might not seek treatment until some years after the event. Initially they might appear to be coping well. The reasons for this are complex: an adolescent might wish to reassure the surviving parent as well as endeavour to continue to fit in with the peer group. In her work with adult patients, Deutsch (1937) introduced the notion of absence of grief as indicative or predictive of pathology, affecting future relationships. She stated that: "*The process of mourning as a reaction to the real loss of a loved person must be carried out to completion.*"

Deutsch described the effect on psychological development if mourning is incomplete. In particular her work drew attention to the risks of depression, affectlessness and superficiality of relationships.

My own experience was much like those patients of Deutsch. Although there were indicators (if one was looking for them) that things were not progressing as smoothly as they might appear on the surface. My school grades had slipped and I was required to repeat my O level year. In retrospect I think this extra year also afforded me the opportunity of doing a bit of emotional catching up. I also think my friendships in early adolescence were of a transient and superficial character.

Sense of Merged Identity following Bereavement

In his seminal work of 1917 entitled 'Mourning and Melancholia' Freud suggests that grief work is the process by which libido (or energy) is gradually withdrawn from the loved one, so that energy is gradually available for investment in other relationships. According to Freud grief work entails the internal struggle of opposing impulses, one towards accepting the loss and the other towards attempting to deny it.

He described the way in which following bereavement the first reaction is identification with the object and denial of the loss. He postulated that it was only later that reality could be faced and the object relinquished. Freud distinguishes between normal and pathological mourning, which he termed 'melancholia'. Although drawing attention to the similarities of the two states, for example loss of interest in the outside world and inhibition in activity, there were significant differences. In particular Freud detailed how the melancholic refused to give up the 'love object' trying instead to become one with it. This is a complicated process whereby one foregoes ones own identity and becomes identified with the deceased. Thus the pain of true separation can be evaded. Freud's position at this time was that identification with the lost object was defensive and pathological. Sussilo (2005) draws attention to a shift in his thinking following his own experiences of bereavement. In particular she highlights Freud's acknowledgement that the bereaved person requires some sense of continuity with the lost figure.

Approximately five years after my mother's death and still apparently coping well to the outside world, I decided to follow in her footsteps and train as an Occupational Therapist. In retrospect I had little interest in this as a career choice myself. At school I had been interested in Art and Art History and indeed had been offered places at university to study these subjects. However I felt compelled to apply for and attend a college to study Occupational Therapy. In retrospect I think this compulsion was fuelled by a largely unconscious drive to 'become' by mother – merging with her in just the way Freud has described. It is of course impossible to be certain but I feel it is unlikely that is the path I would have chosen had she survived. During the training I felt increasingly disillusioned and uninterested with the course of study I had chosen.

However, it was during the second year of training that I was asked to review a book on play therapy. As I recall the book chartered the therapy of a deeply unhappy boy by a patient and sensitive therapist who was able to find meaning in the child's communications. (Axline, 1969) Although I only had one lecture on child psychiatry during this training I decided that without doubt this was an area of work I wanted to explore. At this stage I do not think that I was consciously aware of my identification with this child and his struggles to understand and verbalise his feelings.

The Beginnings of a Sense of Separation

After qualification as an occupational therapist I worked in adult mental health before the opportunity arose for me to gain experience within a child and adolescent mental health team. During this time I worked with many children who had experienced parental loss. Choosing this specialty was I think my first step away professionally from my mother's training (and her first and only job working with physically disabled adults) However I am aware that working with bereaved and traumatised children allowed great opportunities for projection. That is parts of the self becoming split off and located in others!

I also attended a conference and was fascinated by a lecture given by a prominent Child Psychotherapist. It was to take four more years before I was to fulfil the criteria (including a masters degree) to embark on the clinical training to become a psychoanalytic child psychotherapist. However, during the pre-clinical years I was able to begin personal analysis. It was here that I began to understand with more clarity what had unconsciously led me to the work with children and adolescents. I was afforded a second chance to more fully explore and mourn the death of my mother that had occurred so many years before. It was only within the transference relationship that feelings of loss, separation and fear of dependence re-emerged.

Various psychoanalysts including Altschul and Fleming (1963) have written about the way in which psychotherapy can help facilitate the mourning process. In their 1963 paper 'Activation of mourning and growth by psychoanalysis' they discuss how repressed grief was activated through the repetition of separations in the analytic transference. Sussilo writing in 2005 postulated that the analyst could help facilitate the patients: "*affective experience of felt continuity with the absent object that ultimately allows separation and the transformation of the primitive bond".*

Although a treatment period can be precisely defined this is not true of the mourning process itself. Once set in motion, it is my contention that mourning is a lifelong process. Dates of special significance such as anniversaries (Freud 1893) and mother's day (Edelman 1994) can be especially painful. Life events such as marriage, the birth of a first baby or reaching the age at which a parent died can also reactivate feelings of loss and abandonment (Rando 1993). However if progress has been made in the work of mourning, they might serve as reminders of positive internal connections and reassurance that one's fate can be different from one's parents. For me, my choice of a different career path has served as such a reminder.

Within the Context of Clinical Work – Over-identification or Enrichment?

Working in child and adolescent mental health services I encountered a number of young people whose psychological development appeared compromised by earlier parental loss. The nature of this loss took different forms, parental rejection, separation from a parent, or loss through death. My impression was that what linked some of these children was unresolved mourning. I was also aware that some of the children I had worked with appeared to be struggling with legacies of loss because their own parents had been parentally bereaved many years previously. In some cases this event seemed to have profound effects on the parent's confidence and capacities as parents. In her book 'The uninvited guest from the unremembered past' Coles explores the unconscious transmission of grief, loss and trauma upon second and third generations.

During my training as a child psychotherapist I had the opportunity to work on an intensive basis with two adolescents who had lost their mothers under very different circumstances. I also worked less intensively with other young teenagers who had lost their mothers. My interest in working with this particular age group was fostered when I became a participant in the Adolescent Workshop at the Tavistock Clinic. The potential to become over identified with particular patients was kept in mind during the theoretical seminars, ongoing close supervision as well as and perhaps most vividly via the continuing analysis which lies at the core of the training.

The potential for over-identification emerged in my clinical setting when a young woman was referred to me whose mother had died in similar circumstances to my own. During a session this particular patient poignantly recounted her last memories of her mother.

Unexpectedly a long forgotten image of my own mother dying came unbidden into my mind. Although at times I felt as if I intuitively understood this particular patient I was aware that our similar experiences had the potential to cloud my work with her.

I would argue that via analysis and supervision the dangerous potential for over identification was somewhat ameliorated. Because of these safeguards to the work I think I was able to separate my experience from that of my patient and I would argue that instead my experiences might act as a source of enrichment to the clinical work. It is that which remains unconscious and therefore not understood that Freud argued leads to unhelpful repetition.

As my clinical training came to a close I felt able to revisit mother loss with a different eye and for my doctoral thesis became interested in researching the effects of parental loss in early adolescence. My research and clinical experience has I think heightened my alertness to teenage bereaved patients who present as if they have superficially coped with the death well and are reluctant to view any of their difficulties within this context. From my research (as well as my own experience of analysis) it became clear that it was within the context of the transference situation that enabled patients to more fully engage with the work of mourning that for some had been foreshortened and had begun to impact on their adolescent development.

Non-psychiatric and psychiatric research has drawn attention to the risks of early parental loss. I also think that my research enhanced my clinical work with others who have experienced loss in different and multiple ways. It also strengthened my opinion that currently young people within the sixteen to twenty one age groups are not well catered for within mental health services. They can be considered too old to embark on long periods of work within children's services but often to not fit the criteria for adult mental health services. Adolescents have particular needs regarding a sense of autonomy and for this reason a unit accepting self-referrals would be especially helpful. The development of specialist services catering for young people in this transitional period would be especially helpful.

Conclusion

This paper has argued that adolescence with its demanding psychic tasks is a particularly difficult time to experience parental death. The work of mourning has to be engaged with alongside the demanding tasks of adolescence. It has highlighted the risks of a merged sense of identity which unconsciously endeavours to evade the painful feelings of loss. My personal experience of this I think led to my initial career choice before finding my own sense of professional identity. For others merged identities might take other forms, for example, viewing one as vulnerable, frail or ill. I have argued that what is not fully explored and made conscious has the potential to cloud clinical work.

Urwin's work on qualitative research emphasized the prime importance of *'credibility checks'.* In particular she drew attention to the vital importance of: "*owning one's own perspective – that is, making clear the personal, intellectual and professional allegiances of the investigators*" (Urwin 2007, 153).

I think this remains the case not just for researchers but for all clinicians engaged with working psychologically with others.

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Chapter 14

WORKAHOLISM

Adrian Furnham

Introduction

The concept of the wounded healer comes from Carl Jung, who took the idea from classic Greek legends. The idea that people are (rather than always are) better healers (physicians, clinicians, counsellors) *if* they have experienced some of the pain of their patients has been central to the concept of 'wounded healers'. Wounded healers in Jungian terms are highly vulnerable because their patients can reopen their wounds. Equally, the healer can adopt the archetype of the healer and become egocentric or narcissistic. Clearly, being wounded does not guarantee in any way that one understands others better or can give more insightful or efficacious therapy. Other factors must be involved.

Clinical psychologists talk of financial stress (if in private practice), abuse, blackmail and the difficulty of various ethical problems leading to breakdowns. Work psychologists have similar issues. Many record disillusionment, disengagement and depression as a function of burnout (Thoreson, Miller, & Kuauskopf, 1989).

It has also often been observed that psychologists study their own personal problems. Those with poor social skills focus in on emotional intelligence; those with lax morals study moral development; those with a history of family difficulty study attachment. There may be some truth in this, though of course this is a generalisation.

This chapter is about workaholism. The chapter starts with a personal statement which is more about the addicted researcher than the wounded healer. It continues with the early work on workaholism which could be seen in both a positive and a negative light. It continues with a look at early work in the field which attempts to differentiate between different types of workaholics. The next section is on current theorising and research, followed by a conclusion.

A Personal Statement

I am a workaholic. It is Sunday at 14.00. I have been in the office since 05.00; just like I do every Sunday. I work, if I am at home in London, seven days a week, every day of the year. I cycle just under two miles into my office and have done so for 30 years. I like to think of myself as an 'adjusted workaholic'. I make a joke out of it. When people remark that I work abnormally hard I respond that I have never worked a day in my life because my work is my hobby. This is mostly, but perhaps not *entirely*, true.

I like to be at work in my office, but I do and can work in my study at home. I can rarely think of something that I would rather be doing. It is fun but some find it odd that I spend so much time alone given I am a strong extravert. And yet I have my books, the web and at the weekends everything works and there is nobody to disturb me. And yes, the threat of retirement is horrendous …but then it is for many academics who are not that different from me. Am I just an extreme case or is this pathological? Is it compensating from some sense of inadequacy? Is work refuge, or paradoxically a prison: a place to escape from life's responsibilities of family life? Is my fragile ego too caught up in my work persona? Will I regret, as apparently so many do, on my deathbed, that I wished I had not worked so long, so hard … and most worrying of all, to such little effect?

But don't assume I don't enjoy holidays: I go abroad about 15-20 times a year on business and we tend to have at least 5 family holidays a year. This year we went on holiday to Dubai, Norway, Sardinia and South Africa as well as a seaside holiday in England. That is common. Yes, I do work on holiday but it is only scribbling articles for my newspaper column. And I do that early in the morning before the family has got up. I spend about 3-4 hours (05.00-09.00) ideally outside on a veranda with a fine view, writing 'popular' as opposed to academic stuff. I genuinely don't see it as work at all.

I think my major defence is that I rarely take work home in a case or a computer and I do not have a mobile phone. I do not ruminate. I rarely worry about it: I am in my head where I am physically and geographically: the work place is for work; home for relaxation. When on holiday or at home I don't work in the conventional sense though I do – as mentioned – write columns. I do not have a very stressful job. On the contrary I have *low demands* and *high autonomy* rather than the other way around which is real stress. Or is stress in the eye of the beholder? From the perspective of the Greek Galen I am sanguine: A stable extravert. I tend not to be moody and anxiety prone; I am optimistic and fun loving. I am known to my students as the 'fun Professor'. And yet…?

And yet I am still haunted by the oft quoted remark that no one, on their death bed, had ever commented that they wished they had worked harder. Harder meaning longer, not smarter? Surely, a life spent in idleness where talents are not explored and exploited is a wasted life?

Certainly many men admit regretting not spending more time with their children when (both) were younger. But do they really mean it? Time is finite: you have to make difficult choices. And it maybe that just at the time your children are young you are having to work hard to get ahead and bring in the money to support one's family and give them material comfort.

There are different ways to try to 'cheat' death. One is to be religious and hope for an after-life. A second is to have children and live on through them. A third is to make a lot of money and then establish great foundations baring your name. Fourth, there is the hope of writers and authors that one may live on through the printed word. That is my hope; and maybe all this manic effort is part of that hope. But I see very famous people I have known who have written important words slipping out of public consciousness….with few citations. So for how long is one remembered for what you have written?

I think I am pretty *work obsessed* but not a workaholic. True, I am pulled, not pushed to work, and I have a lot of fun at work and I am invigorated, not exhausted by work. I experience *flow.* I do a lot of management consulting, senior manager training and motivational speaking outside of my academic work. I travel to many countries every year (often every few weeks) but this too is work.

When people ask me to do something I always say I have three motives: fun, money or data. They all say it will be fun; rarely this is the case. I am motivated to make money because this is a metric of success (I save most of it) but also to get data to write more papers. And, when I travel abroad I work all the time: indeed a favourite place to work is airline lounges and hotel swimming pools. I also come back immediately rather than tagging a holiday on to the trip.

But do I pay a price? Yes, my whole concept of self is probably too bound up in my work making retirement a terrifying idea. I do get emotionally tired but recover easily and I do not get physically tired often enough. And do I neglect my family and domestic duties? Yes, I admit reluctantly and guiltily, I do.

And so I am a wounded healer. I do coach business people: I have three 'on my books' at the moment. They have been sent to me: conscripts, not volunteers. None have a workaholic problem though all work very hard, often 12 hours per day. Their issues are always managing work relationships. Perhaps workaholics are never sent for coaching because organisations value them so much. But should they: Is the workaholic not someone joyless to be around and prone to illness and derailment?

It is time to study the literature to ask some of these questions.

The Early Literature

Oates (1971) claimed to have invented the neologism workaholic meaning the addiction to work and the compulsion or the uncontrollable need to work incessantly. But unlike other forms of addiction which are held in contempt, workaholism is frequently lauded, praised, expected and even demanded. Signs of this 'syndrome' according to Oates (1971) included boasting about the house of work, invidious comparisons between self and others on the amount of work achieved, inability to refuse requests for work, and general competitiveness:

"*The workaholic's way of life is considered in America to be one and the same time (a) a religious virtue, (b) a form of patriotism, (c) the way to win friends and influence people, (d) the way to be healthy and wise. Therefore the workaholic, plagued though he is unlikely to change. Why? Because he is sort of paragon of virtue… he is the one chosen as 'the most likely to succeed"* (p. 12).

From a Christian perspective Oates (1971), a professor of the psychology of religion, looked at 'Sunday neurosis' or the difficult for a workaholic of coping with a 'work-free weekend'. He offered six pieces of advice to the workaholic: Admit that you are a workaholic, powerless to do anything about it without help beyond yourself. Make a fearless inventory of all the busy-work you do which is not essential or part of your job and throw it overboard. Make a plan to spend part of each weekend in meditation. Remember something that you enjoyed doing when a teenager, and do it again. If you read at all, find something you do not have to read as part of your job. Meet some new people you have not met before, and renew contact with some old acquaintances with whom you have lost touch.

Other advice includes re-evaluating the whole economy, pattern, productivity, and purpose of holidays. The dangers of workaholism are seen to be not only the physical and mental illness of the workaholic him or herself, but also of the spouse who might become hyperactive or alcoholic, and the children of workaholics.

As is customary with popularist expositions of a psychological variable, taxonomy was provided by Oates (1971) who listed *five types of workaholic:*

Dyed-in-the-Wool – with five major characteristics: high standards of professionalism; tendency to perfectionism; vigorous intolerance of incompetence; over-commitment to institutions and organisations; considerable talent with marketable skills. Next, *Converted* – a person who has given up the above but may behave like a workaholic on occasions for the rewards of money or prestige. Third, *Situational* – workaholism not for psychological or prestige reasons but necessity within an organisation. Then *Pseudo-Workaholic* – someone who may look on occasion as a workaholic but has none of the commitment and dedication of a true dyed-in-the-wool character. Finally, *Escapist* as a workaholic – these are people who remain in the office simply to avoid going home or taking part in social relationships.

Finally, Oates (1971) considered the religion of the workaholic. He argues that they are worried by the future with its meaninglessness and hopelessness. Workaholics tend to be unforgiving, lacking in a sense of irony and humour as well as wonder and awe. Once these are renounced, a workaholic experiences a much better quality of life.

Machlowitz (1980) has defined workaholics as people whose desire to work long and hard is intrinsic and whose work habits almost always exceed the prescriptions of the job they do and the expectations of the people with whom, or for whom, they work. According to Machlowitz (1980) all true workaholics are intense, energetic, competitive, and driven but who also have *strong self-doubts*. They prefer labour to leisure and can – and do – work anytime and anywhere. They tend to make the most of their time and blur the distinctions between business and pleasure.

All workaholics have these traits, but may be subdivided into four distinct types. The *dedicated* workaholic. These are quintessentially the single-minded, one-dimensional workaholics frequently described by lay people and journalists. They shun leisure and are often humourless and brusque. Then the *integrated* workaholic. This type does integrate outside features into the work. Thus, although work is 'everything' it does sometimes include extracurricular interests. Third, the *diffuse* workaholic. This type has numerous interests, connections and pursuits which are far more scattered than those of the integrated workaholic. Furthermore they may change jobs fairly frequently in pursuit of their ends. Finally, the *intense* workaholic: This type approaches leisure (frequently competitive sport) with the same passion, pace, and intensity at work. They become as preoccupied by leisure as work.

To some extent it is thought that workaholism is an *obsessive-compulsive neurosis* characterised by sharp, narrowed, focused attention, endless activity, ritualistic behaviours, and a 'strong desire to be in control'. It is perhaps linked to perfectionism, pathological ambition, even the OCD personality disorder.

However, the aetiology of this 'syndrome' is seen to lie in childhood where workaholism is fairly easily recognised. Machlowitz (1980) argues that some children are driven from within, but others are pushed by parents, for example by reinforcement. That is, parents threaten to withdraw love if ever-increasing expectations are not fulfilled: "*Seeing parental love as contingent on achievement instead of unconditional surely spurs progress, but it may also be the source of self-doubts … success is self-perpetuating, but the promise of failure is even more propelling and compelling*" (pp.41-42).

Further, parents may encourage workaholism by providing a model for their children. But because the parents are so busy they may be poor parents in that they are inattentive or simply exhausted when at home. To find workaholics 'at play' may simply be an oxymoron.

Machlowitz (1980) offered a number of reasons why workaholics shun vacations and time-off: they have never had a good experience of holidays either because they have expected too much or chose the wrong type; as their jobs are their passion they do not feel that they need to get away from it all; traditional forms of recreation seem like a waste of time and incomprehensible to them; the preparation for and anxiety that precedes taking a holiday are more trouble than they are worth; and, finally, workaholics are afraid that they would lose complete control of their jobs if they left for a holiday.

However, many workaholics do report being remarkably satisfied and content with their lives. Machlowitz (1980) found little difference between workaholic men and women's source of joy and frustration. These were fourfold: whether in their home life the workaholic felt free of the responsibility for supervising or performing household duties; whether their job offered them autonomy control, and variety, whether the job needed the workaholic's 'particular' skills and working styles; whether the workaholics felt healthy and fit for work. Though they appear to never feel successful many non-frustrated workaholics do report happiness. Finally, Machlowitz (1980) offered some advice for workaholics, maximising the pleasures and minimising the pressures of that particular life-style:

- Find the job that fits – that exercises one's skills and abilities.
- Find the place that fits – that provides the most convivial environment.
- Find the pace that fits – that allows one to work at the most desirable speed.
- Create challenges in your work – to deal with pressures effectively.
- Diversify each day – because of short attention spans.
- Make sure that every day is different – to improve levels of stimulation.
- Use your time; don't let it use you – establish your own circadian rhythm and plan your day around it.
- Don't deliberate excessively on decisions that don't warrant the attention.
- Let others do things for you – learn how to delegate.

- Work alone or hire only other workaholics – to prevent intolerance and impatience with others.
- Become a mentor, teacher, guide, and counsellor to others.
- Make sure you make time for what matters to you – such as your family, leisure pursuits.
- Get professional help – if you have a job, home, or health crisis as a function of your life.

The early work was of a more popular nature. It caught the *Zeitgeist* where work-life balance was thought to be a good thing. Studies tended to emphasise all the downsides of workaholism like problems with self-concept, rigid thinking, withdrawal symptoms, the progressive nature of the condition and denial of the problem (Porter, 1996). Many reviewers listed all the negative behavioural, emotional, interpersonal, physical, interpersonal and physical problems associated with workaholism (Gini, 1998), though some workaholism related to successful work outcomes (Burke, 2001). The workaholic was seen as a person trying to improve their personal feelings of low self-worth and insecurity. Gini (1998) suggested workaholism as a failed attempt to overcome the emptiness or unhappiness in people's lives: a cure for metaphysical angst! Some researchers even attempted to document the prevalence of workaholism. Burke (2000) reported estimates for 5% of the overall (American) population to 10-20% of people in very specific careers like medicine, law and general management.

It is interesting that workaholism was considered a bad thing when the economy was growing but is a lot less 'fashionable' now. However, over the last 20 years there have been some important studies which have attempt to clarify the definition of workaholism and also attempt to describe both the origin of the syndrome as well as the mechanisms and processes by which it operates.

A Note on Addiction

These days all types of behaviours are described as addictive. A recent film on 'sex addiction' has opened up the debate again. What is addictive and what not? How can these seemingly irrational and deeply unhealthy behaviours be explained? Can you simply put the suffix 'aholism', of course derived from alcoholism, after any word like work and expect to have described and delineated a real, meaningful , problem or is that little more than lazy journalistic typing and categorising?

An addiction is a reward driven activity over which an individual has 'impaired control'. It is an activity to which a person gives an unhealthy priority because of their disordered motivational system. Addictions are associated with cravings and withdrawal symptoms. Many researchers focus on that substance (alcohol, nicotine, chocolate, drugs) or behaviour that seems to give pleasure, relief or excitement. They are interested in the extent to which people do things to get those stimuli and the positive and negative balances they make to do so.

Nearly all researchers see addiction as a part biological, psychological and social process. Biological theories focus on neurochemical reinforcement processes, while psychological theories emphasise individual susceptibility as a function of their genes, personality and upbringing. Social factors like sub-culture, social class even tax systems are important to understand addiction.

Yet it seems clear that definitions of addictions vary considerably across time and culture. Thus undesirable, pathological and pathetic addiction in one culture at one time may, to an outsider or indeed a historian looking back, seem perfectly adaptive. It could be argued that in some job sectors at certain times it is effectively a job *requirement* to become addicted to work. Employers want to see an employee totally dedicated to their work ignoring their family, their health and indeed government laws on working hours. The totally work obsessed worker is seen to be a hero in the organisation and those who don't show that commitment half-hearted, slovenly, even work shy. Clearly, this is using the concept of addiction in a very specific and non-orthodox way.

Later Work

Research in the topic of workaholism and related topics like burnout and engagement has been steady for the past thirty years attempting to describe and delineate the syndrome of high work involvement and drive to work but low work enjoyment (Aziz & Zickar, 2006; Swider & Zimmerman, 2010). It is a study of the *joylessness of work*, but almost exclusively with white, as opposed to blue collar workers. Workaholism is often thought of as working both excessively and compulsively (Van den Broeck, Schreurs, De Witte, Vansteenkiste, Germeys, & Schaufeli, 2011). The current interest is in the very opposite of workaholism, namely work engagement characterised by vigour, energy and resilience; dedication, enthusiasm and pride; and absorption, and engrossment at work (van Beek, Hu, Schaufeli, Taris, & Schreurs, 2012).

There have been some impressive attempts to build a model of the antecedents, consequences and dimensions of workaholism such as that of Ng, Sorensen and Feldman (2007). The model specifies three types of antecedents (dispositions, socio-cultural experiences and behavioural reinforcements), dimensions of workaholism (affect, cognitive and behavioural), consequences (satisfaction, mental health, career success) and overall long and short term performance.

The rise of interest in the concept of work engagement has led to an attempt to differentiate related and opposite concepts like burnout and engagement. Thus Schaufeli, Taris and van Rhenen (2008) showed burnout and engagement were opposites but that workaholics and the work engaged did share some factors like excess working time but also job satisfaction and organisational commitment. They measure different aspects of well-being.

Workaholism has been studied as the main predictor of problems at work but also as a moderator and mediator variable (Alarcon, 2011; Taris, van Beek & Schaufeli, 2010). Some have looked at the issue of workaholism and marital estrangement and considered whether workaholism is a cause or consequence of marital difficulties and breakdown (Yaniv, 2011). Thus spending too much time on work may be seen as a cause of breakup but equally work may be seen as a refuge from an unhappy marriage.

Much of the research has been concerned with definitions and distinctions using different methodology like distinguishing between the work enthusiast, the workaholic, the enthusiastic workaholic, the unengaged worker, the relaxed worker and the disenchanted worker (Spence & Robbins, 1992). Van Beek, Taris

& Schaufeli (2011) in fact conceived of the engaged workaholic who does not experience burnout and has many components similar to genuinely engaged workers like intrinsic motivation. Others too have tried to differentiate between passion for work as opposed to addiction at work (Burke & Fiksenbaum, 2009).

Harpaz and Snir (2003) rejected the more than 50 hours at work per week for the idea of work centrality: the notion that people allocate considerable amounts of time to work-related activities and thoughts because work is more important than leisure, community, family and religion. They believe it stems from the Protestant Work Ethic view that work redeems the believer because it is a virtue, while play is a sin. Some reviewers want to move on from the concept of workaholism to things like 'heavy work investment' (Shir & Harpaz, 2011)

Many have argued that the essential criteria of a workaholic is a combination of *excessive* working and *compulsive* working. It is the funless, joylessness at work which leads to mental and physical ill-health (Gorgievski & Bakker, 2008).

Some studies have looked at very specific issues. For instance, focusing on personality, Burke, Matthiesen & Pallensen (2006) found extraversion was positively correlated with work involvement and joy in work, while neuroticism was related to the feeling of being driven to work. Thus Clark, Lelchool & Taylor (2010) found workaholics tended to be neurotic, narcissists, characterised by negative affectivity and high standards. Andreassen, Hetland and Pallesen (2010) found weak but explicable correlations between personality and two features of workaholism: enjoyment (positive) and drive (negative). Conscientiousness correlated with both; extraversion and openness with the positive facet and neuroticism with the negative facet.

But the tide seems to have turned and most researchers are currently interested in passion and joy at work.

Work Passion

Over a 20 year period Vallerand and colleagues worked on the psychology of passion. Vallerand (2008) defined passion as "*a strong inclination toward an activity that people like, find important and in which they invest their time and energy*" (p1). Over time people discover that some activities rather than others seem to satisfy their needs for competence, autonomy and relatedness. They thus become a passionate, self-defining, identity-determining activity into which people put their time and energy. Passion has powerful affective outcomes and relates strongly to the persistence in various activities.

He distinguished between *healthy harmonious* (HP) and *unhealthy obsessive passion* (OP). He suggests HP is the autonomous internalization of an activity into a person's identity when they freely accept the activity as important for them. It is done with volition, and not compunction. HP for an activity is a significant but not overpowering part of identity and in harmony with other aspects of a person's life. On the other hand, the drivers of OP are essentially specific contingencies like self-esteem, excitement or self-acceptance. They feel compelled to engage in particular activities because of these contingencies which then come to control them. OP clearly has an addictive quality about it because it is perhaps the only source of important psychological rewards. In this sense workaholism is a sign of OP not HP.

The theory suggests that HP leads to more *flexible* task engagement which in turn leads to more engagement through the process of absorption, concentration, flow and positive effect. OP on the other hand leads to more *rigid and conflicted* task performance which reduces engagement. HP controls the activity; OP is controlled by the activity. The former promotes healthy adaptation while the latter thwarts it.

This work has been applied to behaviour in the workplace. Vallerand and Houlfort (2003) developed a relatively simple model that suggests HP but not OP predicted psychological adjustment at work. They argue that passion has long-term consequences. OP workers seem akin to workaholics while HP workers show greater job satisfaction and performance. Passion is related to affect at work, work-family conflict, turnover, health and performance. Vallerand et al. (2010) showed HP was positively correlated with work satisfaction which in turn was negatively correlated with burnout while OP was strongly correlated with conflict which in turn was correlated with burnout.

The question is *how* can organisations encourage HP, rather than OP in their organisation? The answer is to "*provide employees with a healthy, flexible, and secure working environment, one where their opinion is valued, will create conditions that facilitate the development of harmonious passion … organisational support seems to foster an autonomous-supportive context that allows individuals to internalise the activity in their identity in an autonomous fashion*"(p.193).

Others have been inspired by Vallerand's work. Thus Burke and Fiksenbaum (2009) administered a questionnaire which measured 'feeling driven to work because of inner pressure' and 'work enjoyment' which they called *passion* and *addiction* to different groups in Australia, Canada and Norway. They found that those who scored higher on passion than addiction invested more heavily in their work, and were more job satisfied while showing less work obsessive behaviours and higher psychological well-being. Equally Gorgievski and Bakker (2010) distinguished between *work engagement* and *workaholism.*

The Manifestations and Correlates of Passion

*Energy and Vigor at Work***.** Energy is a hot topic. Whether it be the energy that powers our cars and computers or physical energy to remain alert, active and attentive at the end of the day. Personal energy is equally important and has various components. The *first* is *physical energy:* Older people have less energy than younger people. Sick people have less energy than healthy people. Sleep deprived people are less energetic than the well-rested.

The *second* is *psychological energy*. This has been conceived of in different ways. The Freudians conceived a psychic energy: a force, which drives us to want and do things we barely understand. Thus we can be driven to a-rational, irrational, bizarre behaviours because of these unconscious libidinous springs.

Personality factors are related to energy. Extraverts appear more (socially) energetic but burn up easily with their impulsivity and impatience. Introverts have a much slower burning fuse and are able to sustain longer periods of attentiveness under conditions of poor arousal. Neurotics waste their energy. They burn it up on the irrelevant and the imaginary. They can easily become anxious, then depressed, by small things. They fritter away their additional nervous energy rather than conserve it for the long haul or the really important. Paradoxically then, they appear to have more energy than their stable opposites but waste it on worry. And they end up exhausted.

Third there is *intellectual energy*. The bright have more intellectual energy: more curiosity, more openness-to-new-experience. They use their energy more efficiently. Indeed one definition of intelligence is about energy efficient brain processing.

Shirom (2011) has defined this as physical strength, emotional energy and cognitive liveliness. He argues that genetic, physiological and psychological factors determine vigour which in turn is related to job performance and satisfaction, as well as physical and mental health. He perceives vigour as a personal resource, like optimism and self-efficacy related to energy and the way it can be directed in the workplace. His argument is that vigour predicts interaction with others at work, leadership style as well as group processes and the use of organisational resources to be successful at work.

Flow

Over 15 years ago, a Transylvanian psychologist called Csikszentmihalyi wrote a book called 'Flow'. People felt best, he found, when *engrossed* in some challenging activity. During flow they lost track of time, felt more capable, more sensitive and more self-confident even though the activities may be work-based challenges. The activity was its own reward: intrinsically motivating. Flow banishes depression, distraction and creeping dispiritedness. So what are the preconditions of flow?

Csíkszentmihályi identified the following factors as accompanying an experience of flow:

- *Clear Goals* (expectations and rules are discernible, and goals seem attainable and align appropriately with one's skill set and abilities). The challenge level and skill level should both be high.
- *Concentrating*, a high degree of concentration on a limited field of *attention* (a person engaged in the activity will have the opportunity to focus and to delve deeply into it).
- A *loss of the feeling of self-consciousness*, the merging of action and awareness.
- *Distorted sense of time*, one's subjective experience of time is altered.
- Direct and immediate *feedback* (successes and failures in the course of the activity are apparent, so that behaviour can be adjusted as needed).
- *Balance between ability level and challenge* (the activity is neither too easy nor too difficult).
- A sense of personal *control* over the situation or activity.
- The activity is *intrinsically rewarding*, so there is an effortlessness of action.
- A *lack of awareness of bodily needs* (to the extent that one can reach a point of great hunger or fatigue without realizing it)
- Absorption into the activity, narrowing of the focus of awareness down to the activity itself, *action awareness merging*.

Vallerand (2008) sees flow as the consequence of (harmonious) passion. Thus for flow to be experienced at work a person needs a clear goal in mind, reasonable expectations of completing satisfactorily the goal set, the ability to concentrate; being given regular and specific feedback on their performance, and having the appropriate skills to complete the task.

We all appreciate the flow experience both at home and work. One can observe flow in those jobs where people experience greatest work satisfaction. They include mainly artisans – potters and painters, writers and weavers, woodworkers and designers. They exercise their talents, work at their own pace and are the opposite of 'alienated from the products of their labours'. Indeed they are the products of their labour. They *are* what they produce. They are bound-up in the product. Their identity, their being, are in the product of their talents.

Happiness at Work

The word 'happiness' means several different things (joy, satisfaction) and therefore many psychologists prefer the term 'subjective well-being' (SWB) which is an umbrella term that includes the various types of evaluation of one's life one might make. It can include self-esteem, joy and feelings of fulfilment. The essence is that the person *himself/herself* is making the evaluation of life. Thus the person herself or himself is the expert here: is my life going well, according to the standards that I choose to use?

It has also been suggested that there are three primary components of SWB: General satisfaction, the presence of pleasant affect and the absence of negative emotions including anger, anxiety, guilt, sadness and shame. More importantly SWB covers a wide scale from ecstasy to agony: from extreme happiness to great gloom and despondency. It relates to long term states, not just momentary moods. It is not sufficient but probably a necessary criterion for mental or psychological health.

Many researchers have listed a number of myths about the nature and cause of happiness. These include the following which are widely believed, *but wrong*:

- Happiness depends mainly on the quality and quantity of things that happen to you.
- People are less happy than they used to be.
- People with a serious physical disability are always less happy.
- Young people in the prime of life are much happier than older people.
- People who experience great happiness also experience great unhappiness.
- More intelligent people are generally happier than less intelligent people.
- Children add significantly to the happiness of married couples.
- Acquiring lots of money makes people much happier in the long run.
- Men are overall happier than women.
- Pursuing happiness paradoxically ensures you lose it.

The first books on the psychology of happiness started appearing in the 1980s. Then there came the appearance of a few specialist academic journals but it was not until the turn of the millennium that the positive psychology movement was galvanised into action by significant grant money as well as the research focus of many famous psychologists. The psychology of happiness attempts to answer some very fundamental questions pursued over the years by philosophers, theologians and politicians. The first series of questions are really about definition and measurement of happiness; the second are about why certain groups are as happy or unhappy as they are; and the third group of questions concern what does one have to do (or not to do) to increase happiness.

Most measurements of happiness are by standardised questionnaires or interview schedules. Conversely, it could be done by informed observers: those people who know the individual well and see them regularly. There is also experience sampling, when people have to report how happy they are many times a day, week or month when signalled by a beeper going off, and these subsequent ratings are aggregate. Yet another is to investigate a person's memory and check for whether they feel predominantly happy or unhappy about their past. Finally there are some, as yet crude, but ever developing physical measures looking at everything from brain scanning to saliva cortical measures. It is not very difficult to measure happiness reliably and validly.

The relatively recent advent of studies on happiness, sometimes called 'subjective well-being' (SWB) has led to a science of well being (Huppert, Baylis, & Keverne, 2005). Argyle (2001) noted that different researchers had identified different components of happiness like life satisfaction, positive affect, self-acceptance, positive relations with others, autonomy, and environmental mastery. It constitutes joy, satisfaction and other related positive emotions.

Myers (1992) noted the stable and unstable characteristics of happy people. They tend to be creative energetic, decisive, flexible and sociable. They also tend to be more forgiving, loving, trusting and responsible. They tolerate frustration better and are more willing to help those in need. In short they feel good, so do good. Diener (2000) has defined subjective well-being (SWB) as how people cognitively and emotionally evaluate their lives. It has an evaluative (good-bad) as well as a hedonic (pleasant-unpleasant) dimension.

Positive psychology is the study of factors and processes that lead to positive emotions, virtuous behaviours and optimal performance in individuals and groups. Although a few, mainly 'self psychologists' were always interested in health, adjustment and peak performance, the study of happiness was thought to be unimportant, even trivial. Finding work and leisure activities that really engage your skills and passions help a great to bring about SWB.

Conclusion

This chapter has been about work addiction: the idea that people spend excessive time and effort in the work place trying to achieve some end but essentially failing. Are they sad, bad or mad? Clearly not the latter two?

Psychological concepts, like workaholism, tend to go through phases. Once the description/discovery is made some effect is spent in clarifying it and often coming up with subtypes or factors. This often leads on to measurement issues and model building. The research on workaholism is no exception. The literature is now 40 years old and is considerable more sophisticated than it was. We are now much clearer about the components and antecedent of workaholism.

Perhaps the greatest change is to see some of the positive sides of what was erstwhile thought of as almost exclusively negative. Spending a long time at work can be seen as positive and possess many beneficial psychological consequences.

Postscript

So, am I a wounded healer? First, my defence is that I am an academic not a healer in the therapist sense, though a lot of what I do could be considered sort of therapeutic. Do I work very long hours? Yes. Is the compunction to be at work something that comes from outside (work demands) or inside (my work ethic)? Inside. I am unable to relax? No. Is my whole self-concept too caught up in my work … Professor, not father, nor husband, nor son? Probably. Do I worry about that death bed wish of working less? Alas yes! But then what would I rather be doing? Pass!

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Chapter 15

LOST IN SHADOWS?

Michael W. Eysenck

Introduction

Most of the contributors to this book have had to cope with what by any criteria must be regarded as extremely stressful life situations. Accordingly, I should make it crystal clear at the outset that I do not believe for a moment that what I have had to cope with in life is remotely as stressful. Since in addition I am not a trained clinical psychologist it may appear that I am somewhat of a charlatan or interloper for writing a chapter in a book on 'wounded healers'. However, where my situation perhaps differs from most of the other contributors to this book is that the major stressful life situation with which I have had to contend has lasted throughout my life so far and I am sure will continue to do so until the day I die!

Why, then, did I decide to contribute to this book? First and foremost, I did so because I am fascinated by the relationship between psychologists' scientific knowledge of human behaviour and their personal lives. In fact, in my own everyday life, I very rarely decide what to do or how to interact with others on the basis of my knowledge of psychology. An important part of the reason for this is that it can be ill-advised to apply generalisations about human behaviour to specific situations because of the complexities and idiosyncratic nature of most situations. In addition, deciding how to behave in everyday life on the basis of established generalisations about human behaviour leaves one in danger of losing one's own individuality and simply acting in a rather mechanical way. However, my involvement in this book means that I have found myself considering the extent to which my understanding of psychology is helpful in making sense of the course of my own life.

Famous Father

It will come as no surprise to the reader to discover that having a famous father creates a certain amount of stress. This is perhaps especially the case when the son (i.e., me) decides (for better or for worse) to develop a career in the same discipline as his father. Additional factors that served to increase the stressfulness of the situation will be discussed shortly.

How great an impact has my father had within the field of psychology? An approximate answer can be obtained by considering the evidence assembled by Haggbloom et al. (2002). They endeavoured to rank order the 100 most eminent psychologists of the twentieth century by using various quantitative and qualitative measures. The quantitative measures were journal citation frequency, survey response frequency, and citation frequency in textbooks. The qualitative measures were membership of the National Academy of Sciences, President of the American Psychological Association, and receipt of the Distinguished Scientific Contributions Award from the American Psychological Association.

The above criteria are heavily skewed in favour of American psychologists. This is most obviously the case with respect to all three qualitative measures. However, it is also present in two of the quantitative measures. First, the survey carried by out by Haggbloom et al. (2002) involved only members of the American Psychological Association, and so the overwhelming majority of the respondents to the survey were American psychologists. Second, the great majority of textbooks in psychology (perhaps two-thirds or more of the total) are written by American psychologists. In spite of this overt bias, my father was ranked the thirteenth most eminent psychologist of the twentieth century. On what is arguably the least biased and most useful criterion (journal citation frequency), he came third after Freud and Piaget but ahead of world-famous psychologists such as Fred Skinner and Albert Bandura.

For me, some of the consequences of having a very famous father were fairly obvious. In the course of a long career, I have very rarely met a psychologist in any country in the world who is unfamiliar with my father's name and research. In addition, millions of non-psychologists in many countries (especially the United Kingdom) have some knowledge of my father and his achievements.

It is also relevant to mention that the name 'Eysenck', which is of German and/or Dutch origin, is exceptionally rare in England. To the best of my knowledge, there are fewer than two dozen people in this country having that last name. Believe me, there have been occasions on which I wished that my last name was 'Smith' or 'Jones' to achieve anonymity and avoid intrusive questions!

One of the more unusual (or even bizarre) features of the whole situation in which I have found myself is that most people who have only a passing knowledge of me probably envisage that my life has been very different to what was actually the case. The 'received wisdom' is probably that I became a psychologist because of the strong support and encouragement I received from my father. After that, my father used his power and influence to promote my subsequent career as a psychologist. The fact that he and I wrote two books together (combined with me following him in having a career within psychology) could very easily and naturally be taken as evidence that we got on really well. As will shortly become apparent, all of these assumptions and interpretations are seriously mistaken.

Chapter Structure

The structure of the chapter is as follows. First, I will endeavour in a relatively neutral and dispassionate fashion (assuming that this is actually possible!) to provide a descriptive account of my life history and the ways in which it interacted with my relationship with my father. Second, I will provide my interpretation of my underlying motives and the desirability or otherwise of what I did at various stages of my life. This includes a consideration of my life history in the context of therapeutic approaches, indicating ways in which it now seems to me that expert advice might have proved useful. Third, I will broaden out the discussion to identify what seem to me to be the optimal forms of therapy.

Background Information

During the time that I was growing up in the 1950s, the world was a very different place to the way it is nowadays in the early part of the twenty-first century. For example, the divorce rate in England has increased almost non-stop over the past 50 or 60 years and is now approximately 40%. If we extrapolate from the past, there will undoubtedly come a time when young people whose biological parents are still married to each other will become a minority. In stark contrast, when my parents divorced (I was five years old at the time), the divorce rate was approximately 2%. As a result, I practically never had any schoolmates or friends whose parents had been divorced. I don't know whether psychologists have studied the issue, but it seems probable to me that divorce tends to have a greater negative effect on children when it is a very rare event within their peer group.

Another way in which the world of the 1950s differed considerably from nowadays is in terms of what typically happened in the aftermath of divorce. One difference was that no-one considered it appropriate to ask me whether I had any views or preferences about what might happen post-divorce. I was sufficiently a child of my time that it practically never occurred to me back then that it was unreasonable for those in a position to influence what happened to me to ignore any wishes or desires I might have. Several years later, I began to realised how disadvantageous that approach was to the children of divorced parents and am very pleased that a more enlightened approach is now prevalent.

The first time I saw my father after the divorce was approximately eight years later when I was already a teenager. I don't have any statistical evidence to hand, but I would imagine that such a prolonged gap would be almost unheard of today. When I saw my father again, I had lived almost two-thirds of my life without seeing him at all. As can be imagined, the meeting itself (in a café on Regent Street in the centre of London of all places) was somewhat traumatic and emotionally upsetting and did not have any beneficial effect at all on me.

Why did the enormous eight-year gap in the relationship between my father and me occur? As is discussed later, that is a question I should have spent much more time asking myself. What happened in fact is that it was a question I was frightened to ask myself and so mostly repressed the entire issue. Subsequently, it became clear to me (but unfortunately only many years later) that this eight-year period of not seeing my father occurred mostly because of his only modestly positive feelings towards me. In the years that followed our re-meeting, we saw each other sporadically rather than on a regular basis.

While I was a student at Dulwich College, I studied English, French, and German at 'A' level. At that time, the overwhelming majority of students going on to university studied one or more of their 'A' level subjects at degree level. However, I had already convinced myself (entirely correctly!) that I was no linguist and did not especially enjoy studying either French or German. Accordingly, I decided to follow the unusual route of studying a completely different subject at university.

Psychology

I confess that I knew very little about the range of subjects available at university level and this was an era in which careers' guidance was either non-existent or in its infancy. From my limited knowledge base, law was my preferred subject. However, the somewhat precarious nature of being a lawyer with no contacts was rather daunting (this was the era of the 'old boy network') and deterred me from pursuing that route. I knew something about psychology, of course, and so stumbled into studying it rather than anything else at University College London. That is the absolute truth in terms of my thinking at the time. However, most people's reaction when I say that seems to be one of disbelief.

I am not sure with the benefit of hindsight whether it was a good thing or not, but the fact remains that I enjoyed studying psychology and found it a much easier subject to master than French or German. I suspect that part of the reason why I found it easier to be a successful student at University College London than at Dulwich College was that at that time Dulwich College had an outstanding academic reputation. For example, it was generally the case during the late 1950s and early 1960s that more Scholarships and Exhibitions to Oxbridge were awarded to students at Dulwich College and Manchester Grammar School than any other schools in the whole of England.

Of relevance to my future after University College London was the publication of the Robbins Report on higher education, which was published in the early 1960s. It concluded that university places 'should be available to all who were qualified for them by ability and attainment.' The Robbins Report led to a rapid expansion of the university system. This, of course, meant that there needed to be a substantial increase in the number of academics in British universities in order to provide good teaching for the increasing number of students. Without giving the issue much thought, I applied for a Lectureship at Birkbeck College in the University of London before completing my degree and was offered the job shortly before my twenty-first birthday.

I found being an academic in the University of London with a famous name and essentially no help (or even a modicum of interest) from my father very tough going. It took me approximately 7½ years to complete my PhD and this lengthy gestation period should certainly not be taken to indicate that the research was of very high quality. In fact, the research was fairly mediocre, only just merited the award of a PhD, and led to precisely no publications.

As the years went by, my intellectual confidence slowly grew, but I still often had the feeling of being a 'failure' who had almost totally failed to live up to his famous name. That feeling only really abated when I was appointed Professor of Psychology and Head of Department at Royal Holloway University of London in 1987. I finally felt that I had achieved something worth achieving and that I had become successful in my own right. As a consequence, the quality of my research improved and I began to establish a higher research profile. Without a shadow of doubt, the twenty-two years I spent at Royal Holloway were the happiest of my professional career.

A few years after moving to Royal Holloway, I decided for a variety of reasons to examine my father's research contribution in some detail and also to consider our relationship in a more systematic way than I had done before. However, the main intention was to write a book about his research, and to that end I spent a considerable amount of time and effort examining his contributions to psychology especially focusing on the extent to which these contributions had stood the test of time. I endeavoured to provide a fair and balanced assessment of all the contributions including those that seemed completely wrong.

In spite of the investment of all that time and effort, I gradually lost my enthusiasm for proceeding to the point of publication with this book. There were various reasons why I decided not to pursue this project. One reason was that the putative book was intended to provide an unbiased overview. However, with the benefit of hindsight I was probably the last person on the planet from whom to expect a lack of bias. Other reasons are discussed shortly.

In the several years between the end of my work on my father's research contribution and his death in 1997, I saw my father very rarely, perhaps once every three years or so.

My Life History Interpreted

One of the fascinating mysteries of anyone's life is that it is never possible to know for certain what would have happened if they had made different key decisions. However, that does not mean that it is entirely pointless to address the issue. In my case, a lack of certainty about the consequences of following a different life course has not deterred me from becoming engaged in such speculation. With the benefit of hindsight, I am fairly certain that I should have studied law at university instead of psychology. The main reason is that I found law intrinsically more interesting than psychology (indeed, I still do) even though when I was at school I didn't know a single lawyer.

In addition, I think entering a profession that was totally different to that of my father would have had a liberating effect on me in that comparisons between me and my father would have been much fewer than was actually the case. As it was, studying psychology being the son of a famous father from whom I was estranged made me feel an oddity in the same way that being the only boy in the class whose parents had divorced had done while I was at school.

Here we have the first major error of judgment in my life. While it is impossible to be sure, I am reasonably confident that my life would have been happier if I had followed a completely different career path to my father by becoming a lawyer. In spite of my reservations and doubts about becoming a lawyer, it turned out as only became really apparent many years later that the early 1960s was an excellent time to enter the law. The law profession was expanding rapidly and for the first time those with few or no contacts had a reasonable chance of succeeding. For example, several well-known politicians a few years older than me had very successful careers in law before moving full-time into politics. The aspects of the law that I found of special interest were those relating to being a barrister and arguing cases in court.

How could I have been dissuaded from following the mistaken path that I took? Any psychodynamic therapists who happen to read this chapter will undoubtedly think that their approach is ideally suited to examining the strong emotions that exist within families and to providing insight after a lengthy examination of my childhood.

I cannot, of course, disprove the notion that I had repressed intensely emotional memories of early childhood and as a consequence my life thereafter was diminished. Indeed, I fully accept that there is some truth in that viewpoint. All I can say is that the psychodynamic approach appears excessively complex and involves too great a focus on early childhood rather than the adolescent and early-adult problems that were of most concern to me.

Personally, I believe that any reasonably competent cognitive therapist would have found my case to be a very straightforward one. There is a grain in truth in the repression notion – I certainly failed to deal with distressing issues but I really don't think that numerous therapeutic sessions would have been needed in order to uncover the truth.

In my opinion, the theoretical approach of Erikson (1959, 1968) sheds some light on why I failed to spend sufficient thinking about and planning my future career when I was a late adolescent and early adult. He argued that there are four possible identity statuses that adolescents can have. The optimal one is identity achievement, in which various options have been carefully considered and firm commitments made on the basis of that careful consideration.

Another identity status (and the one most clearly applicable to me) is foreclosure, in which future commitments are made even though identity issues have not been considered seriously. Foreclosure is most likely to be found in individuals who are anxious about themselves and want to reduce that anxiety by committing themselves to a certain course of action so that they don't need to think about major issues. That sounds like a very accurate description of what I did and why I did it. It is very similar to the notion of intolerance of uncertainty, and is something I have attempted to change in myself.

Rational Emotive Therapy

Which therapeutic approach do I feel would have been appropriate? Various cognitive approaches would almost certainly have worked, but my preference looking back to my former self would be for the cognitive therapeutic approach pioneered by Albert Ellis (1962, 1978) and encapsulated in his rational emotive therapy. As is well-known, he put forward a three-point A-B-C model in which an unpleasant event (A = activating event) is followed by a cognitive reaction based on the individual's beliefs (B = beliefs which may be rational or irrational). If the cognitive reaction to the event involves irrational thoughts or interpretations, it is likely that this will trigger a state of anxiety or depression (C = consequences).

Where Ellis's rational emotional approach seems mistaken to me is in the implicit assumption that anxiety and depression result primarily from irrational thoughts and interpretations. In the real world, of course, many distressing losses and future threats are all too genuine and anxiety and/or depression may be a perfectly natural reaction (see Keenan's chapter on parental death in early adolescence, and the subsequent grief reaction in this volume).

Much of what I like about Ellis's rational emotive therapy is his no-nonsense approach. This is captured neatly in this quotation from Ellis (1978): "*If he* [the individual] *wants to be minimally disturbable and maximally sane, he'd better substitute for all his absolutistic 'It's terribles' two other words which he does not parrot or give lip-service to but which he incisively thinks through and accepts – namely, 'Too bad!' or 'Tough shit!'*"

The essence of what Ellis is saying is that individuals who are anxious or depressed should re-interpret the negative events they have experienced in ways that reduce or eliminate their emotional distress in a constructive fashion. While rational emotive therapy is in essence an extremely simple approach (indeed, almost simplistic), it has a directness and immediacy about it that seems preferable to the lengthy and rather oblique psychoanalytic approach to therapy.

How would Ellis's rational emotive therapy have worked with me? There was a blatant contradiction or cognitive dissonance in my beliefs that would not have taken much time or expertise to uncover. On the one hand, I was strongly motivated to have a close relationship with my father. I remember often thinking that it is 'natural' for fathers to love their own children. On the other hand, I was well aware of the fact that he had expressed little interest in seeing me over the years. The only sensible approach on my part would have been to say, 'Too bad!', 'Tough shit!', or something similar, and then to get on with my own life. My failure to do that was the cause of various negative emotional states over a period of many years.

What I actually did (with very little conscious awareness of what I was doing) was to come to the conclusion that the best way of enhancing the probability of a close relationship with my father was to become a psychologist! It is indisputably true that psychology formed a very large part of his life, and so the idea perhaps made superficial sense. However, my approach was so obviously simple wish fulfilment that I can hardly believe I ever thought the approach was worth pursuing.

My Father's Research and Expressive Writing

I found the work that I did on my father's research and our relationship (warts and all) had a much greater impact on me than I had anticipated beforehand. In essence, I discovered that all this work had managed to 'get the monkey off my back'. What I mean by that is that the negative thoughts and feelings about my father that I had had over the years almost entirely disappeared. I finally realised that there was absolutely no reason for me to define myself with reference to my father and that there was no way of making him care about me. These re-interpretations had a very liberating effect on me psychologically, an effect that remains with me to this day and I am sure will continue to do so for the rest of my life.

Why did writing something like two-thirds of a book that never saw the light of day have these extremely beneficial effects? In my opinion, the main answer is to be found in the influential research by James Pennebaker (e.g., 1997). As is well known, he pioneered research into expressive writing, in which the individual writes in a heartfelt way about a topic of deep personal and emotional significance to him or her. As we will see, this remarkably simple approach has fairly consistently produced beneficial effects.

In one study on expressive writing (Slatcher & Pennebaker, 2006), one person in each of numerous dating couples wrote about their intimate thoughts and feelings concerning their relationship or about daily activities on three consecutive days. Three months later, those who had engaged in expressive writing were 50% more likely to still be in the same relationship as at the outset of the study (77% vs. 52%, respectively).

Frattaroli (2006) carried out a meta-analysis of 146 studies on expressive writing. She found that there were significant beneficial effects of expressive writing on psychological health, physiological functioning, reported health, and general functioning. As one might expect, the positive effects tended to be greater among those who had engaged in expressive writing on the most occasions. I would certainly qualify here since I spent hundreds of hours writing about my father!

The $64,000 question is why expressive writing has these beneficial effects. It is certainly tempting to explain the effects in quasi-Freudian terms by arguing that expressive writing increases the probability that the individual will gain insight into his or her negative experiences. So far as my experience with expressive writing is concerned, that is undoubtedly of major importance. I realised more than ever before that my father was a very fallible human being and that it is important not to dwell on what might have been.

My Father's Research: Limitations

There is another less important reason why assembling information about my father's research probably had a beneficial effect on me. Most psychologists are reasonably familiar with his major research achievements. However, relatively few, I suspect, are aware of the poor quality of some of his other contributions to psychology. When I considered his overall research contribution, I came to the conclusion that its quality was more variable than that of any other leading psychologist.

At some level, I have to admit in all candour that the fact that the worst of his research was even worse than the worst of my research provided me with some comfort. It meant that I did not necessarily come off second best in all research comparisons between me and my father. In case the reader feels that my evaluation of my father's research is excessively biased, I will consider two examples: his research on smoking and his research on personality and longevity.

My father argued consistently over a long period of time that the dangers of smoking had been greatly exaggerated. The key arguments that he advanced in support of this very controversial viewpoint were discussed in detail in various books including *The Causes and Effects of Smoking* (1980) and *Smoking, Personality,* *and Stress: Psychosocial factors in the prevention of cancer and coronary heart disease* (1991).

His 1991 book contains numerous totally erroneous statements. I will briefly discuss five of them. First, he argued that, "*The evidence suggests very strongly that smoking by itself has little effect on cancer or CHD* [coronary heart disease]*.*" In fact, the evidence available prior to 1991 indicated with great clarity that long-term smoking on average reduces life expectancy by about 10 years, and so it was grossly irresponsible for a well-respected scientist to claim the opposite. A summary of some of the strongest evidence is provided by Doll, Peto, Boreham, and Sutherland (2004).

Second, he argued that there is little point in smokers deciding to quit smoking: "*The biological effects of smoking may follow a negatively accelerated growth curve nearing its asymptote after 1 or 2 years, with smoking thereafter or quitting smoking making no difference.*" This is totally wrong. Even those who have smoked for several decades have a significantly increased life expectancy if they manage to give up smoking. Naturally, the benefits of giving up smoking are even greater in those who stop smoking when relatively young (see Doll et al., 2004).

Third, "[Smokers] *continue to smoke because they derive certain benefits from smoking, just as they do from eating, drinking, and many other activities…The addiction model is not suitable for cigarette smoking, and a continued use of the word addiction in relation to smoking behaviour has no scientific validity.*" What nonsense!

It may be true that the term *addiction* is hard to define in precise scientific terms. However, if anyone doubts the addictive power of nicotine they will be convinced after considering the following account of Buerger's disease by Brecher et al. (1972): 'If a patient with the condition continues to smoke, gangrene may eventually set in. First a few toes may have to be amputated, then the foot at the ankle, then the leg at the knee, and ultimately at the hip. Somewhere along this gruesome progression gangrene may also attack the other leg. Patients are strongly advised that if only they will stop smoking, it is virtually certain that the otherwise inexorable march of gangrene up the legs will be curbed. Yet surgeons report that it is not at all uncommon to find a patient with Buerger's disease vigorously puffing away in his hospital bed following a second or third operation.' Note that this was written almost two decades before my father's assertion that smoking isn't addictive.

Fourth, he claimed that, "*Little, if any, evidence links cancer or CHD* [coronary heart disease] *with ETS* [environmental tobacco smoke] *exposure.*" In other words, non-smokers' health isn't damaged by exposure to tobacco smoke (i.e., passive smoking). This was known to be untrue on the basis of research carried out several years before the publication of my father's book (e.g., Peto & Doll, 1986).

Several studies reviewed by Jee et al. (1999) provide additional evidence that my father's dismissal of the harmful effects of passive smoking was completely wrong. In their own large-scale study of 160,130 Korean women and their husbands, 54% of the husbands were smokers compared to only 1% of their wives. Their findings were clear-cut: non-smoking wives with husbands who smoked were 90% more likely than non-smoking wives whose husbands did not smoke to develop lung cancer. Among those non-smoking wives whose husbands had smoked for 30 years or more, there was an increased morbidity of 230% of developing lung cancer.

Fifth, he claimed that, "S*moking has certain positive effects that account for its popularity… Among the positive features of smoking … are its power to increase attention and vigilance.*" As had been clearly established several years prior to 1991, this interpretation of the evidence is wrong. Among the researchers who discovered what is actually happening is Andrew Parrott (for a review see Parrott, Morinan, Moss, & Scholey, 2004). In essence, what happens is that nicotine deprivation has very negative effects on smokers and so the apparently beneficial effects of smoking merely reflect the reversal of these negative effects.

The other example of limitations in my father's research that I will discuss concerns his collaboration with Grossarth-Maticek. For present purposes, I will focus only on a single study. Some of the most remarkable findings were reported by Grossarth-Maticek and H. J. Eysenck (1995) using the Self-Regulation Inventory, a personality test they had devised to assess personal autonomy or independence. Using this inventory, Grossarth-Maticek and my father assessed mortality over a 15-year period in inhabitants of Heidelberg aged between 45 and 68 at the start of the tie period. They used unusual statistical methods in their analyses. However, when the data are analysed in terms of correlation, there was a correlation of -.79 between self-regulation and mortality, with individual differences in self-regulation accounting for approximately 62% of the variance in mortality.

The strength of the relationship reported by Grossarth-Maticek and my father is hugely greater than that reported by any other researchers who have related individual differences in personality to mortality. The failure of any other research to confirm the earth-shattering discovery that longevity depends almost totally on individual differences in personality may help to explain why this research is largely ignored in textbooks on health psychology.

It should be noted that the correlation of -.79 between personal autonomy and mortality must be regarded as an underestimate of the 'true' correlation for two reasons. First, it is artificially reduced because of the 23-year age range present within the sample. The correlation would almost certainly have been greater if the sample had been more homogeneous in age. Second, the Self-Regulation Inventory does not provide a completely reliable measure of self-regulation, and this partial lack of reliability would have reduced the correlation.

One obvious potential explanation of the extremely high correlation between personality and mortality is that the items used by Grossarth-Maticek and my father were markedly superior to those used by all other researchers. Here is one of the items devised by Grossarth-Maticek: "*Do you change your behaviour according to consequences of previous behaviour, i.e., do you repeat ways of acting which have in the past led to positive results, such as contentment, well being, self-reliance, etc. and to stop acting in ways which lead to negative consequences, i.e., to feelings of anxiety, hopelessness, depression, excitement, annoyance, etc.? In other words, have you learned to give up ways of acting which have negative consequences, and to rely more and more on ways of acting which have positive consequences?*"

According to conventional wisdom, valid and reliable questionnaire items need to be short and unambiguous. It follows that the above 85-word item is hugely inferior to all the items found in any well-established personality questionnaire. I cannot honestly see how such an item could possibly be superior to items in other personality questionnaires, but perhaps that reflects my unconscious biases.

In sum, much of my father's research and writings contains ideas that are either completely wrong or at least apparently not susceptible to replication. Shortage of space precludes considering other evidence that confirms that statement.

My Father's Life: Limitations

Another advantage of writing most of a book about my father's research and our relationship was that it led me to understand somewhat better the reasons behind his lack of warmth and involvement with other people. His childhood was blighted by the unusual circumstances in which he grew up. Neither of his parents wanted to look after him, and so he was entrusted to the care of his grandmother throughout most of his childhood. He was an only child (like me) and this meant that there was no one else with whom he had the shared experience of parental rejection.

I suspect that this parental rejection and then the culture shock of having to leave his native Germany because it was so dangerous for a Jew to live there after the Nazis came to power had two major effects on him. First, he was determined to attract the positive attention he had been unable to do with his parents or his native country. Second, his experiences had an inhibiting effect on his personality and made him excessively defensive in his personal life.

An example of the last point can be found between pages 152 and 153 of my father's autobiography, 'Rebel With a Cause'. It shows the two of us together in the garden of my house. Anyone looking at the picture would naturally assume it reflected a warm and personal relationship between us. In fact, that picture was taken on the only occasion I saw my father in a five-year period when he popped in for perhaps three or four minutes on his way home from some function. As they say, 'there's nowt so queer as folk'!

Focusing on my father's life brought it home to me that there were several commonalities in our life experiences. This realisation helped to soften my feelings about him.

Relevance to Therapy

From what has been said so far, it is clear that I believe that my life might well have been happier if I had had the advantage of cognitive therapy (especially the version of cognitive therapy associated with Ellis's rational emotive therapy). If we expand the customary definition of cognitive therapy somewhat, it could plausibly be argued that expressive writing also falls within its ambit.

In spite of my general endorsement of cognitive therapy and cognitive behavioural therapy, I do feel that the emphasis with these forms of therapy (and other forms as well) can be too unemotional in its approach. Patients who are in distress with clinical anxiety and/or depression often feel that their distress is not being taken seriously enough when the major focus in therapy is on their irrational and inappropriate thoughts and beliefs.

In my opinion, most forms of therapy are more likely to produce successful outcomes when clients have a strong emotional engagement during the therapeutic sessions than when they do not. Of course, it has been known for a long time that emotional factors are of important and successful therapists have always taken such factors into account. For example, therapeutic alliance (which involves a good emotional connection between the therapist and the client allowing the client to trust the therapist) is well-known to enhance outcomes in therapy (see Horvarth, 2005, for a review). Recently, Johannsson et al. (2011) found that the beneficial effects of client expectancy about the outcome of therapy are mediated by therapeutic alliance.

There is an accumulating body of evidence that supports the importance of emotional processes in therapy (e. g., Whelton, 2004) and that in addition suggests that several such processes are involved. For example, Greenberg and Pascual-Leone (2005) identified four emotion processes that impact on therapeutic outcomes. First, there is awareness and arousal of emotion, which can appropriately be regarded as a general goal that is established at an early stage of therapy. Second, there is emotion regulation, an important part of which involves producing psychological distance from overwhelming feelings. Third, there is a process of reflecting on emotion, which involves attaching meaning to emotion. Fourth, there is emotion transformation in which an undesirable or negative emotion is changed into a more desirable and/or positive one.

In sum, my life experiences suggest to me that cognitive therapy would have had a considerable amount to offer me. The ideal would probably have been cognitive therapy 'with a human face'.

Conclusions

I have focused in this chapter on the ways in which my life has been influenced by my father. That should not be taken to mean that other factors are not of more importance. What is of massively more importance to my psychological well-being is my long-lasting marriage to my wife Christine, our three wonderful children (Fleur, William, and Juliet) and our grandson Sebastian. They have played the major role in providing a loving context in which I have been able to adjust to the stresses and strains of life.

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Chapter 16

Empathy, woundedness, burn out, and how to love being a therapist

Peter R. Breggin

We are all wounded. It is impossible to get through childhood, not to mention the rest of our lives, without at times enduring what seems like insurmountable or overwhelming emotional harm. To be psychologically wounded is to have lived; to live is to be repeatedly wounded. There are no meaningful biographies or autobiographies that declare, "*And then life became easy ever after.*" That's the stuff of fairy tales, not existence here on planet Earth.

How we handle our own trauma, loss, and suffering is central to our work as therapists, as well as to our lives. Our response to suffering affects our usefulness to our patients, our enjoyment of work, and potential burn out.

Most importantly, we must use our knowledge of our own emotional wounds to understand and to feel at one with those who come to us for help. But there are emotional pitfalls along the way.

Becoming a Source of Love

When we feel or perceive ourselves as wounded, it becomes harder for us to find a way to love. Overcoming our feeling of being wounded, our 'woundedness,' is a universal struggle and not limited to those of us who have been especially harmed.

The great challenge is to love despite our fears of being harmed again. I remember reading somewhere decades ago in one of Erik Fromm's books that each generation must relearn for itself how to love. To love always requires overcoming the feeling of being too vulnerable to dare. To love always requires courage and personal effort, sometimes in defiance of commonsense and societal norms. Hence Romeo and Juliette's timeless appeal. To love is always to be ahead of oneself and ahead of one's time.

My working definition of love for many years has served me well – Love is *joyful awareness* (Breggin, 1997). It can be awareness of almost any aspect of life from sunsets and nature to great art; from children to a lifetime partner; from pets to friends; from doing a good job at work to writing a book or gardening. Joyful awareness of our patients makes therapy worth doing and simultaneously is the best aspect of ourselves that we can offer them.

Joyful awareness motivates us to treasure, nurture, and protect. Whether loving ourselves, other people, nature, art, or any other aspect of life, we cherish when we love. We no longer struggle between self-interest and altruism: Self-interest and altruism become inseparable in our desire to do what we can on behalf who or what brings joy to us. It's in our interest to look out for those we love. In this way, love preempts conflict. When we love those who seek help from us, it may be the first time in their lives that they have experienced genuine concern for them.

Therapy as a Sacred Trust

If we fully appreciate being therapists, we will view the practice of therapy as a sacred trust. We will understand that to be a therapist is much more than an opportunity, it is a gift. We realize we are privileged to be intimately admitted into the lives of other people in a way that rarely happens elsewhere in life. We become privileged to be allowed to help other people in their most personal struggles in life.

We will prosper and so will our clients when we approach therapy in awe of the responsibility, the opportunity, and the gift to us that it is. Go to the office as you would enter a sacred place and you will never burn out.

A secret to life is to love life. For therapists this means feeling grateful and happy every day for the work we allowed to do. It means unequivocally enjoying and loving it. If being a therapist is a calling, it should be a happy one. Being a therapist should make your heart sing, or else you will do more harm than good.

Love and Suffering

Love is not a painful emotion. Love is a happy, invigorating, inspiring awareness of other people and life. The suffering that surrounds love lies not in love itself but in the corruption or loss of love.

Loss of a loved person is one of life's most demoralizing experiences, but it should not be mistaken for love itself which is always fulfilling. Being rejected or harmed by a loved one is also demoralizing, but again failed relationships must be distinguished from love itself.

When we reject love, avoid love, or run from love, then our lives become devoid of meaning; that's not the fault of love, but arises from our fear of it. Keeping lost love alive within ourselves – even after loss or rejection – can eventually and ultimately ameliorate or overcome the traumatic experience. In therapy, this means that we feel an unconditional regard and love for our clients throughout the ups and downs of the therapy and their lives.

Abusive relationships can be horribly painful, but they should not be mistaken for love. Guilt toward a loved one can be mistaken for love, but if you remember that love is joyful awareness, you will realize that guilt is not love at all. The ultimate source of guilt lies in abusive childhood relationships that build into us self-punitive attitudes. Helping our patients realize this can change their lives forever.

To be a source of love, and to know we are a source of love, even when times get tough, is the great foundation for spiritual strength and happiness in life. This is true in every relationship in life, and is no less true in therapeutic relationships. The therapist as a source of love encourages and inspires the patient to become a source of love, and to seek other loving people.

As therapists, how we feel about every moment in the therapy session affects how our patients feel about themselves. Many of our patients already feel unloved and unlovable. If we don't love working with them, if we don't fully appreciate and enjoy them, and feel happy to be in their presence – we will reinforce their worst attitudes toward themselves and life.

We obviously feel best when we love doing therapy and love our patients as well, and so too they will have the maximum opportunity to prosper in a therapeutic relationship in which they feel appreciated and even loved.

Feelings of Helplessness in Therapy

Being a therapist can easily stir up our own emotional sore spots and still-bleeding wounds. If we listen to and genuinely engage our patients, we will at times be re-stimulated by our own painful feelings and memories. That can become exhausting. It can interfere with remaining open and empathic toward our patients. It can lead to burn out, by which I mean, the loss of love for our work and our patients.

Childhood is the initial and often the most indelibly damaging source of our wounds. We tend to categorize these wounds as emotional, physical and sexual abuse; as deprivation and rejection; and as other specific injuries. Beyond that, simply being a child – helpless to take care of our own needs and at the mercy of others for everything – is wounding. No one escapes childhood without at times feeling dreadfully helpless, along with a measure of loneliness and other distress. To remain open to the suffering of others, we need awareness of our own childhood legacy of painful feelings, including those potentially demoralizing feelings of helplessness.

When our own feelings of helplessness become stirred up during therapy sessions, our patients are likely to respond to them, even if unconsciously, and to begin feeling helpless as well. When we start to feel helpless in therapy, usually we are taking too personally our patient's struggles. We mistakenly believe that it's up to us to 'make' our patients face their problems, take responsibility, and make the most of therapy.

Instead, our first task as therapists is to provide a safe space and a healing presence (Breggin, 1998), which we can only offer if we see our patients as ultimately responsible for their own thoughts and actions, and personal growth. If we don't grant our patients their responsibility for themselves, then we will wear ourselves out while undermining the personal sovereignty of our patients.

Accepting our Wounds and Darkest Emotions

It's important as a therapist and a human being to accept our vulnerabilities, losses and trauma – without bringing them into therapy sessions. Even more so, it's important to recognize and accept the sometimes unethical and self-destructive ways we've handled problems in our own lives. Unrecognized, our own personal issues will become precisely those areas in which we will become intolerant and judgmental of others.

I noticed this early on in my career. When I became irritable or intolerant toward one of my patients, it usually turned out that I had been struggling somewhat ineffectively with similar problems. Indeed, I may have behaved badly – or at least, I wanted to behave badly – in a similar fashion to my patient. Being kind and forgiving toward ourselves allows us to bestow the same gift of kindness and forgiveness upon others.

A big caveat must be added to the notion of being kind and forgiving toward ourselves. We must also take responsibility for ourselves and our actions. Recognizing how hard this is for us to do, we are likely to acknowledge to our patients that being human is hard and at times discouraging work that demands enormous personal responsibility. It's helpful at times to let our patients know that we also find life difficult and must make an effort to remain responsible at all times.

Recognizing our own vulnerabilities and faults is very different from feeling guilty. Feeling guilty is living under the punishing influence of early life experiences when others blamed us or we blamed ourselves, usually without any correspondence with sound ethical values or reality. We have all worked with genuinely decent and admirable human beings who treat themselves worse than dirt. Those of us who are active in the forensic arena have worked with murderers who know no guilt.

Guilt is built into us in childhood and sometimes reinforced by others later in our lives. Guilt does not make us into good or better people. Guilt is not a redeeming feature. It doesn't prove that we 'care' or are 'sensitive.' Guilt suppresses the rational analysis of our real self-interests, including our desire to love, and leads us instead to feel unworthy of giving or accepting love. It leads toward resentment of the people who make us feel guilty and can lead us to harm ourselves, loved ones, and patients. Guilt feels so bad that it discourages us from honestly self-evaluating and therefore stifles change.

In contrast to guilt, remorse is a genuinely rational moral re-evaluation based on sound ethics and love which says, 'I did wrong. I need to make amends if possible and I have to improve my conduct from now on.' Remorse encourages us to examine ourselves and to change.

Our darkest emotions swirl around the harms we have endured and harms we have comitted. Accepting our darkest emotions enables us to be comfortable with our patient's darkest emotions. The creation a healing presence requires being comfortable with our own and hence our patients' suffering, including their most negative emotions from guilt, shame and anxiety to rage and hate. If we can accept our own vulnerability as part of the universal vulnerability of all human beings, we are in a better to position to welcome our patients' most distressed and distressing emotions.

Induced Suffering

When we allow doing therapy to stir up persistently helpless feelings in us, it contributes to burn out. Without realizing it, we may decide that our suffering makes us better therapists. We justify being depressed. We tell ourselves we are 'sensitive' and 'caring,' when we are victims of 'induced suffering' – an emotional helplessness in the face of inevitable human suffering (Breggin, 1998).

A grave risk for these therapists is emotional over-involvement with the suffering of their patients. This is true for any service profession that demands close contact with others who are suffering, including the law, where good lawyers are often those who care the most, putting them at risk for similar over-involvement in their client's suffering and fate.

Therapists who 'take their work home with them' and worry about their patients are not helping themselves. Worse, if they communicate that worry to their patients, they encourage these patients to feel more helpless and overwhelmed. We can all remember when our parents 'worried' about us. On one level it may have felt good. Mom and Dad cared. On another level it made us resentful because we were being treated 'like children.' It is not good to make our patients feel like children.

Therapists often come from family experiences that made them feel guilty. Feeling guilty about our patients' suffering, or even about their lack of progress in therapy, is like worrying about our patients. It is not good for them or us.

Similarly, when being with our patients, experiencing their suffering as if it were our own is counterproductive. At least one member of the therapy partnership needs to maintain a clear head and good judgment unclouded by emotional suffering; and of course, that's supposed to be us.

Worrying, feeling guilty, and experiencing our patients' suffering easily become confused with feeling empathic and 'caring.' It is more useful to see it as induced suffering. We are allowing our relationship with our patient to induce suffering in us; and induced suffering will cloud our judgment and make us resentful and even exhausted (Breggin, 1998). It can lead us to reject or distance ourselves from our patients' feelings in order to escape the painful emotions we experience with them. It is a common cause of burn out – the overwhelming feeling that we just can't give anymore.

In a sense, I often 'take my patients home with me' in my thoughts, but it's more like taking a friend home than taking a burden in my heart. I like and even love my patients and it's common for me to think of my patients happily.

But what about patients that we should be thinking about – the ones we seem to be failing to help and the ones who remain in desperate trouble? It can be useful to think through what more we can do and perhaps to consult a trusted colleague. But this is not about guilt, or a fear of failure, it is about doing our work as ethically, responsibly and effectively as possible.

Empathy and Burn Out

Genuine empathy gives us strength, knowledge and a sense of efficacy. When we feel and express empathy for another human being, we do so from a position of love and understanding, and we know that the very expression of that empathy can be helpful in itself for the other person if they choose to accept it.

True empathy is closely tied to love – and love is a joyful awareness of others. Empathy does not make us the victim of suffering; it allows us to see and share the suffering of others from a loving, rational and ethical perspective, without succumbing to it. That is one of the most essential ingredients of being a healer – approaching those we wish to help from an empathic, loving perspective that welcomes their pain without becoming afflicted by it. This is a large part of a healing presence.

> *Be comfortable with yourself and you will give comfort to others.*
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> *Be uncomfortable with yourself and you will give discomfort to others.*

Think of it this way: If you are burning out on the job, what must your negativity be doing to your clients? It cannot be good for them. For your sake and the sake of your clients, find a way to make doing therapy a joyful experience.

Why Therapists Become Abusive

When communications from our patients stir up our own unresolved inner conflicts, suffering, and irresponsible behaviors, we want to stop this induced suffering. Without realizing what we are doing, we suppress our patients' feelings in order to suppress our own. Many abuses inflicted on patients in the form of authoritarian or controlling therapies, drugs, electroshock and even lobotomy are driven by the inability of healthcare providers to face their own suffering and bad conduct, and to overcome it.

When therapists deny their own human limits, they can also end up abusing their patients. Therapists are taught that when the patient doesn't benefit from therapy, they need drugs. If they are already taking drugs, and still not benefitting from therapy, then therapists are taught that their patients probably need even more drugs. This flawed reasoning is nowadays taken for granted: 'The patient wasn't doing well in therapy, and I referred him for medication.'

Therapists are taught this kind of arrogance: 'Since you're not benefitting from what I have to offer, you need drugs.' Wouldn't it have been much more reasonable to refer the patient to a new and different therapist? When a patient fails to do well in therapy with us, does that mean the patient wouldn't be doing much better with someone else…or perhaps without any therapy at all?

As therapists we will avoid burn out and do much less harm to our patients if we accept and apply three basic principles:

1. When patients stir up our own dark emotions, we must not let ourselves act on them. We must learn to handle the painful emotions that commonly get stirred up while working with distressed patients.

2. We must not take responsibility for our patients' lives. We must recognize and empower the patient's the personal responsibility and autonomy.
3. We must never assume that we are the patient's only or last resort. If a patient is not doing as well as hoped in therapy with us, we must never assume that the patient needs drug, shock treatment, or hospitalization. We must consider instead that we need to improve our therapeutic approach or help the patient find a more suitable therapy or therapist. Many times, the patient will do better with no therapy at all.

If you respect the reality that each person's life is in his or her own hands, you are much less likely to end up resenting or hating your work as a therapist. Know that your job is not to succeed with your patient but to offer your patient time with you as a loving, caring, respectful, empathic, and thoughtful human being. Make your presence and your office a welcoming place where you will try, to the best of your ability, to create a healing presence and to provide whatever understanding and guidance you can – without requiring that your patient reach the goals you harbor for them, however unspoken they are.

A great deal of frustration and burn out among therapists is caused by the failure to recognize that people, including our patients, are ultimately responsible for themselves. We can offer them our best; we cannot make them benefit from it. When you start to feel frustrated, angry or resentful toward a patient, the odds are that you have taken on a burden that does not belong to you – the patient's 'burden' of living his or her own individual life in a responsible and loving manner.

The Threat of Suicide

Because the fear of having a patient commit suicide stirs so many painful emotions in us, we need to be careful not to over-react and to end up acting abusively. None of us want to have a suicide on our watch. A suicidal patient can stir up a host of confused emotions in us including guilt, shame and anxiety; fear of consequences; loss; and failure. If these fears and emotions dominate our psyche and our actions, we are likely to go to extremes by pushing our patients toward undergoing psychiatric drugs, electroshock, involuntary hospitalization, or more subtle forms of bullying.

Suicidal thoughts and feelings, like any dark emotions, should be welcomed to the light of day. Patients can be told that the intensity of their wish to die in reality reflects the intensity of their wish to live. No one wishes passionately to end life without having an equally passionate vision, however unconscious, of a life that they are missing out on. A wish to die is not driven by apathy or indifference but by profound disappointment and resentment of what life has become. That same potentially deadly passion can be harnessed for moving forward in life.

Never shrink from helping your patients express their most dismal emotions. It's a basic step toward finding how passionate they real are and how much they really want to live. Welcome all of your patient's emotions, including suicidal feelings, and you will almost always start a process that encourages life.

Although psychiatrists often act as if drugs can prevent suicide, no drug has been FDA approved for that purpose because there is no scientific evidence for the claim. To the contrary, there is growing evidence that most psychiatric drugs cause or aggravate suicidal behavior (Breggin, 2008a, 2008b, 2013). Ironically and tragically, the antidepressants, which are the drugs most often given to these patients, have the highest potential to *cause* suicide.

Don't have Emergencies

A key to effective therapy is not to have your own personal emergencies. When the patient feels overwhelmed, emotionally paralyzed, violently enraged, suicidal, or psychotic, it is tempting to respond as if it is a crisis or an emergency that requires an immediate intervention. But when we respond to the patient's crisis as if it is a crisis, we compound the problem and push the patient into feeling even more helpless and overwhelmed. After all, if the therapist reacts as if we are heading towards disaster, then it must be so.

When the patient has a crisis, we should not have a crisis, and if we don't have a crisis, the patient will probably start gaining a better perspective within minutes. Be confident in your healing presence. When extremely distressed, all people need above all else the company of someone who acts as if this too can be handled and will pass.

When a therapist refers a patient for medication, it is often in response to a perceived crisis or emergency. The referral then confirms for the patient that the problem cannot be handled by therapy or other ordinary human means. Even if the patient isn't in a crisis, a referral for medication always means 'you and I can't handle your problems without drugging you.' This is not a good approach to helping people.

An End to Enforcing 'Medication Compliance'

Time is past when therapists should enforce 'medication compliance.' For the therapist who respects patient autonomy, the very word 'compliance' should be anathema. In my most recent book, *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients and Their Families*, I urge therapists, patients and their families to actively engage with prescribers (Breggin, 2013).

It is also time for therapists to learn about psychiatric drugs, including their lack of efficacy and their enormous risks, and to become active participants in discussions with their patients about medication. Your obligation is not to enforce drugging; it is to represent your patient's best interests and to discuss anything that's relevant to their psychological well-being and personal growth.

Boundaries in Therapy

Empathic therapists must set strong boundaries or limits on how they relate to their patients. Within therapy, in order to be as open and loving as possible, physical contact must be avoided as much as possible, and the therapist must avoid all sexual and romantic temptation while doing therapy. This is required to protect ourselves from crossing any boundaries when we are engaged in this passionate enterprise called psychotherapy. For similar reasons, relationships with patients outside of therapy, if unavoidable, should be respectful but not emotionally or physically intimate. That's not patronizing our patients; it's acknowledging our own human vulnerabilities while respecting the boundaries set in therapy that enable us to be the best we can be without trying to fulfill our own needs through our patients.

Inescapable Burnout

Sometimes burnout is inescapable – unless we decide to escape and find a better way to live and work. That is, there are many situations that can make any of us feel burned out no matter how hard we try. Usually these situations involve internal or external forces that we feel are out of our control. As therapists, it is extremely important to feel in charge of our clinical practices, including what kinds of patients and how many patients we work with. Control over our professional activities may not be possible while working for a clinic; but it is more likely to be possible in private practice.

As a therapist you will generally do much more good if you are working under circumstances of your own choosing that are fulfilling to you. Beyond that, I believe in our inalienable rights to life, liberty and the pursuit of happiness, including in our professional work.

It's useful to determine if our feelings of burn out have to do with our therapy relationships, which we can usually modify for the better, or with our job conditions, which may be less under our control. Therapists in the West still have a variety of opportunities to work under varying conditions, including in private practice, and should take every opportunity to find or create a setting in which they can enjoy and bring their best selves to their work.

Love, Empathy and Courage

It is not possible to be as loving and empathic as we can without having great courage and determination. Love, of course, can result in enormous pain from rejection, disappointment, and loss. In order to love, we have to accept our vulnerabilities without letting them take over or misdirect us. We must find the courage to risk loving.

Empathy is closely akin to love with additional emphasis on understanding life from the other's perspective. It requires both thought and feeling – our whole selves – as we grasp the other's experience without losing our own perspective. We should not succumb to the other's experience or viewpoint; we need to grasp it from the perspective of feeling separate and loving in regard to the other person.

My own life and career was forever changed in 1954 as an eighteen year old freshman at Harvard when a friend coaxed me into volunteering at a local state mental hospital. The appalling conditions and the suffering of the inmates motivated me to make the Harvard-Radcliffe Mental Hospital Volunteer Program the center of my college experience. I became a leader in the program, created a very successful case aid project in which we worked with individual students (Breggin, 1991), and helped to promote the idea of mental health volunteers through speeches, papers, and a book. Eventually I became a premedical student with the goal of becoming a psychiatrist.

For reasons I cannot fully understand, I never felt essentially different from the most desperate and seemingly disordered people I met as patients in the state hospital. I felt in my heart, 'there but for the grace of God go I.'

Because I identified with the patients in an empathic fashion, it was quickly apparent that the hospital and all of its treatments were doing them far more harm than good, and that no one deserved or could ultimately benefit from incarceration, humiliation, shock treatment, and toxic chemicals.

It was also apparent that the psychiatrists had the most authority and power over the patients, but the least understanding of them as individual persons. It was the beginning of my realization that power over the lives of others inevitably corrupts our ability to understand and empathize with them. When we have power, we seek to maintain power, and in order to justify doing so, we have to ignore its negative impact on the lives of the people whom we control against their will.

My empathic connection to the patients led me to know that they needed human services and even love, as well as freedom. It led me to realize that all of the 'treatments' were humiliating, disempowering, and brain-damaging. It would eventually lead me to reject involuntary treatment as wrong in principle and anti-therapeutic.

I am sure that other young students and even young professionals have had a glimmering of what I saw. Perhaps some have seen it with equal or better clarity. But in the several centuries of psychiatry's existence, only a handful of us psychiatrists have found the courage to base our work on these truths.

As a reformer taking on some of the most powerful institutions in the world – from the pharmaceutical and mental health industry to federal government agencies – I have endured attacks beyond the imagination of many people; but along with the assaults have come even greater satisfactions (for documentation of my reform work, see ICSPP, 2010).

If you find it difficult to fully appreciate, love and empathize with your patients, and if you find it burdensome to do therapy, it may be in part because you are afraid to face how damaging psychiatry has become to your patients and to your practice of therapy. Have the courage to love, to understand, and feel empathy – and you may also feel the need to stand against biological psychiatry on behalf of your patients and the millions of others who have been damaged and will be damaged by modern psychiatry. You will stop submitting to psychiatric authority and you will gently but firmly refuse to enforce 'medication compliance.' You will let your patients know that they will not be able to fully benefit from therapy or from life as long as they accept psychiatric diagnoses and drugs.

My wife Ginger and I have named our new organization The Center for the Study of Empathic Therapy, Living and Education (www.EmpathicTherapy.org). Guidelines for Empathic Therapy can be found on the center's website. For a presentation and analysis of my own empathic approach to therapy, see my training film (Breggin, 2010).

Ginger and I continue not only to promote empathic therapy but also to make available the most up-to-date critiques of the falsehoods and hazards associated with biological psychiatry. However, our new emphasis in our center on empathy expresses the genuine roots of reform which ultimately lie in empathy for those who are being injured.

To avoid burn out and to avoid harming our patients, we need to find the courage and determination to create the therapeutic conditions in which we can be loving, empathic and ethical with our patients.

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Peter R. Breggin (MD) is Founder and Director of the Center for the Study of Empathic Therapy, and a psychiatrist in private practice in Ithaca, New York. Dr. Breggin has been called "*The Conscience of Psychiatry*" for his efforts to reform the mental health field, including his promotion of caring psychotherapeutic approaches and his opposition to the escalating overuse of psychiatric medications, the oppressive diagnosing and drugging of children, electroshock, lobotomy, involuntary treatment, and false biological theories. Dr. Breggin's new reform organization brings together professionals and laypersons concerned with a critical analysis of biopsychiatry but with additional special emphasis on effective empathic approaches in mental health and education (www.empathictherapy.org).

A Harvard-trained psychiatrist and former full-time consultant at NIMH, Dr. Breggin's private practice is in Ithaca, New York, where he treats adults, couples, and families with children. He also offers consultations in clinical psychopharmacology and often acts as a medical expert in criminal, malpractice and product liability suits. He is the author of dozens of scientific articles and more than 20 books including, *Toxic Psychiatry* (1991), *Talking Back to Prozac* (1994, written with Ginger Breggin), *Brain-Disabling Treatments in Psychiatry, Second Edition* (2008) and *Medication Madness: The Role of Psychiatric Drugs in Cases of Violence, Suicide and Crime* (2008). His latest book is *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients and Their Families* (2013).

Dr. Breggin was honored in 2009 with the biography *The Conscience of Psychiatry: The Reform Work of Peter R. Breggin, MD*, a compilation of over 100 essays by colleagues as well as excerpts from over 50 years of media coverage of Dr. Breggin's reform work and other accomplishments.

Peter Chadwick (BSc, MSc, PhD) is a retired lecturer in abnormal psychology (DSc) and personality at Birkbeck College, University of London. His qualifications include two degrees of Bachelor of Science – one in Earth Sciences and another, a First Class Honours from the University of Bristol in Psychology – a Master of Science, DIC. (in Earth Sciences), and two PhDs (one in cognitive and abnormal psychology) as well as a Doctorate of Science (in Psychology from Bristol University). He has published some 130 papers, five books: *Borderline* (1992), *Schizophrenia – The Positive Perspective,* (1997, 1st edition), *Understanding Paranoia* (1995), *Personality as Art* (2001), and *Schizophrenia – The Positive Perspective* (2009, 2nd edition).

Gordon Claridge (BA, PhD, DSc) is Emeritus Professor of Abnormal Psychology in the University of Oxford Department of Experimental Psychology and Emeritus Fellow, Magdalen College, Oxford. His career has been a mix of some clinical psychology practice and (increasingly) abnormal psychology teaching and research (He was director of two University clinical psychology training courses, first in Glasgow and then in Oxford). Originally a student of Hans Eysenck, in his early work he studied biological aspects of personality and psychological disorders, focussing eventually on attempts to understand psychosis. In the last two decades the latter has been increasingly concerned with developing a dimensional model of psychosis that incorporates the notion that its underlying traits have a healthy, adaptive function.

During the course of his long career he has published papers in several different areas of knowledge, including personality measurement, abnormal psychology, and psychopharmacology, and the following books: *Personality and Arousal. A Psychophysiological Study of Psychiatric Disorder* (1967), *Drugs and Human Behaviour* (1970), *Personality Differences and Biological Variations. A Study of Twins* (1973, written with S. Canter, and W.E. Hume), *Origins of Mental Illness.*

Temperament, Deviance and Disorder (1985), *Sounds from the Bell Jar: Ten Psychotic Authors* (1990, written with R. Pryor and G. Watkins), *Schizotypy: Implications for Illness and Health* (1997, editor) and *Personality and Psychological Disorders* (2003, written with C. Davis).

Nisha Dogra (BM, DCH, FRCPsyc, MA, PhD) is currently professor of psychiatry education and an honorary consultant child and adolescent psychiatrist at Leicester. She currently works as a generic child and adolescent psychiatrist within a MDT. She has been involved in the development and delivery of a wide variety of teaching and training events in undergraduate and postgraduate education, locally, nationally and internationally (in South Africa, Nigeria and India). She is a Fellow of the Institute of Learning and Teaching and the Academy of Medical Educators, which recognize quality educationalists. She has developed innovative programs to teach diversity and child psychiatry as well as leading national work on developing a core curriculum for undergraduate psychiatry. Her research interests include effective methods of training, diversity training for medical students and healthcare professionals, evaluation of training, young people's perceptions of mental health services, and child mental health and diversity.

Her main books include: *Ten Teachers: Psychiatry* (2011, written with S. Cooper and B Lunn), 2010) *100 Cases in Psychiatry* (2010, written with B. Wright and S. Dave), *Nursing in Child and Adolescent Mental Health*. (2009, written with S. Leighton), and *A Multi-Disciplinary Handbook of Child and Adolescent Mental Health for Front-Line Professionals* (2009, 2nd edition, written with A. Parkin, F. Gale and C. Frake).

Amanda K. Ekdawi (Dip COT, MA, D Ch Psych Psych) worked in child and adolescent mental health clinics for over twenty years. Initially she practiced as an occupational therapist (Diploma Occupational Therapy) before retraining as a child and adolescent psychoanalytic psychotherapist. She completed the preclinical aspect of the psychotherapy training and was awarded an MA (in psychoanalytic observational studies) for this in 1993. Later Amanda trained in psychoanalytic psychotherapy at the Tavistock clinic and was awarded a doctorate in child psychoanalytic psychotherapy in 2008. Her doctoral research focused on parental loss (via death) in early adolescence and its subsequent impact on adolescent development. Currently she is employed as the lead child psychotherapist in a child and adolescent mental health out-patient team in Leicester.

Michael W. Eysenck (BA, PhD) was a Lecturer and then Reader at Birkbeck College University of London between 1965-1987. He then moved as Professor and Head of Department at Royal Holloway University of London (1987-2009), becoming Emeritus Professor upon his retirement. He is now a Professorial Fellow at Roehampton University. He has published 42 books – including *Fundamentals of Cognition* (2006), *Memory* (2009, written with A. Baddeley and M.C. Anderson), *Individual Differences: Normal and Abnormal* (1994), *Principles of Biopsychology* (1994, edited with N. Hayes and S. Greene), *The Blackwell Dictionary of Cognitive*

Psychology (1991, edited with E. Hunt, A. Ellis and P.N. Johnson-Laird), *Happiness; Facts and Myths* (1990), *The Scientific Basis of Psychiatry* (1991, written with M. Weller), and *Anxiety and Cognition: A Unified Theory* (1997). In addition he published approximately 170 book chapters and articles. Most of his research and book writing has been in cognitive psychology, with his main research interest being in the relationship between anxiety and cognition. His research has been cited over 6000 times in the literature.

Frederick J. Frese (PhD) is a psychologist, specializing in the area of schizophrenia for over forty years. He has been diagnosed with this condition himself when he was 25 years old, and has worked tirelessly as a clinical practitioner and advocate for consumers and their families. Dr. Mike Hogan, Chair of the President's New Freedom Commission that is revolutionizing the delivery of mental health services in the United States, referred to him as "*a national treasure*." He is a prolific writer and outstanding speaker revered both for his sense of humor and his remarkable ability to translate research and public policy into usable information, Dr. Frese is often quoted – and sometimes misquoted.

Dr. Frese was a panelist for *MINDS ON THE EDGE: Facing Mental Illness*, which aired October 2009. This video is part of a national initiative that encompasses comprehensive content with tools for civic engagement, active social media on Facebook and Twitter, and an ambitious strategy to engage citizens, professionals in many fields, and policy makers at all levels of government. The aim of the project is to advance consensus about how to facilitate support and treatment available for people with mental illness.

Adrian Furnham (MSc, DPhil, DSc, DLitt) was educated at the London School of Economics where he obtained a distinction in an MSc Econ., and at Oxford University where he completed a doctorate (D.Phil) in 1981. He has subsequently earned a D.Sc (1991) and D.Litt (1995) degree. Previously a lecturer in Psychology at Pembroke College, Oxford, he is now Professor of Psychology at University College London. He has lectured widely abroad and held scholarships and visiting professorships at, amongst others, the University of New South Wales, the University of the West Indies and the University of Hong Kong. He has also been a Visiting Professor of Management at Henley Management College.

He has written over 1000 scientific papers and 75 books including *The Protestant Work Ethic* (1990) *Culture Shock* (1994), *The New Economic Mind* (1995), *Personality at Work* (1994), *The Myths of Management* (1996), *The Psychology of Behaviour at Work* (1997), *The Psychology of Money* (1998), *The Psychology of Culture Shock* (2001)) *The Psychology of Physical Attraction* (2007), *The Body Beautiful* (2007), *Personality and Intelligence at Work* (2007) and *Dim Sum Management* (2008).

Professor Furnham is a Fellow of the British Psychological Society. He is on the editorial board of a number of international journals, as well as the past elected President of the *International Society for the Study of Individual Differences*. He is also a founder director of Applied Behavioural Research Associates (ABRA), a psychological consultancy. He is also a newspaper columnist. He writes regularly for the *Sunday Times* and the *Daily Telegraph* and is a regular contributor to BBC radio and television.

Thandi Haruperi (BSc, PgD) is an educator, speaker, facilitator, adviser, mentor, fashion designer and Entrepreneur. She believes we all have the ability to learn, grow and give from our experiences no matter how challenging and seemingly insurmountable. Her focus therefore, is promoting Wellbeing, Empowerment and Contribution.

Born in Zimbabwe and raised in Zambia, Thandi moved to England in 1990 where she began her career in housing. Following her diagnosis with HIV, Thandi turned her career to training and education to help herself and others in her situation. She subsequently founded restorEgo, a cross-cultural consultancy, whose work now extends to personal, professional and organisational development programmes. Thandi sits on several boards locally and internationally.

Thandi has been instrumental in influencing and shaping policy by highlighting issues and needs of those affected especially women and African communities in the UK. She has given media interviews, written many articles, contributed to various magazines, academic and research journals and policy documents. Thandi has participated in many forums and patient campaigns, petitioned at Downing Street and contributed to, amongst other things, The All Party Parliamentary Group on AIDS and the London Assembly.

A much sought-after speaker, Thandi contributes to academia, public health and health promotion by delivering lectures and running workshops for healthcare professionals, medical students and secondary schools as well as pharmaceuticals and faith leaders, with the aim of improving health care practice, patient experience and primary prevention.

Thandi has been recognised with awards for Positive Leadership, Community Development and Innovation and Creativity.

Bruce Kirkcaldy (MA, DrPhil) has academic degrees in psychology from the Universities of Dundee and Giessen, as well as postgraduate professional training as a Behavioural Therapist and Clinical Psychologist. He is Director of the International Centre for the Study of Occupational and Mental Health, and runs his own psychotherapy practise specializing in the treatment of anxiety and depressive disorders and psychosomatic ailments. In addition, he is Visiting Professor for Psychology at the Jagiellonien University, Cracow in Poland. Currently he is Affiliate Professor at the Centre for Educational Resilience & Socio-Emotional Health, University of Malta.

He has published over 200 articles including some 25 book chapters and eight authored/edited books including: *Individual Differences in Movement* (1985); *Normalities and Abnormalities in Human Movement* (1989); *The Art and Science of Health Care: Psychology and Human Factors for Practitioners* (2011), and most recently, *Family, Child Health and Education* (2013). His research and writing interests are directed towards clinical and health issues and organizational and leisure psychology. He is/was on the Editorial Board of 5 international journals in the area of organisational and health care, and reviewer for over 20 peer-reviewed scientific journals.

David Lukoff (BA, MA, PhD) obtained a B.A. Civilizations from University of Chicago in 1969. Two years later a M.A. Social Anthropology, Harvard University, 1971, and earned a Ph.D. Clinical Psychology, Loyola University of Chicago, 1980. He is a Professor on the core residential faculty and a licensed psychologist in California whose areas of expertise include treatment of schizophrenia, transpersonal psychotherapy, spiritual issues in clinical practice, and case study methodology. He applies many transpersonal approaches in clinical practice including meditation, compassion training, and guided imagery.

He is author of 70 articles and chapters on spiritual issues and mental health; co-author of the *DSM-IV* category Religious or Spiritual Problem; Co-president of the Association for Transpersonal Psychology; and founding board member of the Institute for Spirituality and Psychology. David has served on the faculties of Harvard, UCLA, Oxnard College, California Institute of Integral Studies, and Saybrook, and been an active workshop presenter providing training for psychologists in spiritual competencies in areas such as loss and grief (UC Berkeley), death and illness (SSU, CIIS), spiritual problems and emergencies (Esalen, CSPP, CIIS, SSU, JFK) as well as in Japan, Mexico, Canada, Brazil, Russia, Romania, Portugal, France, Sweden, Scotland, Ireland, and England.

Robert Miller (BA, BSc, PhD) was a medical student at Oxford in the early 1960s, during which time he became interested in brain research. However, he never finished the medical course, because he was overwhelmed by a psychotic illness. After a few years break, in 1969, he started work in the Zoology Department at Glasgow University, and in 1973 obtain his doctorate from there. After that, and a second period in hospital, he started to rebuild his life as a scientist, pursuing research to integrate personal experiences of psychotic illness with his growing understanding of brain function. Following several periods of postdoctoral study at British Universities, he emigrated to New Zealand in 1977, to become a lecturer in the Department of Anatomy, University of Otago. His first book, "*Meaning and purpose in the intact brain*" was published in 1981. Since then he has published many journal articles and three more scientific monographs. One of these, published in 1996, on the theory of the functional differences between right and left hemispheres is entitled: *Axonal conduction time and human cerebral laterality*. Another, which appeared in 2007, had the title: *A theory of the basal ganglia and their disorders*. Robert Miller has, for many years tried to use his theories about normal forebrain mechanisms to shed light on psychosis, and the complex disorder called schizophrenia. His major scientific work to date is an overall theory of schizophrenia, entitled *A neurodynamic theory of schizophrenia and related disorders* (2008).

Amongst other things, such work has also led to writing autobiographical accounts of his own illness as a young man, and also to the production of an educational booklet, entitled *Straight talking about mental illness, with emphasis* *on schizophrenia: An Educational Guide*. Robert received the award "Officer of the New Zealand Order of Merit", in 2007, for services to schizophrenia research.

Aleksandra Tokarz (PhD, DrHabil) is a psychologist by training with a Doctor Habilitatus in Psychology from Jagiellonian University, where she has been Associate Professor since 2006. Her main research interests pertain to motivational and emotional mechanisms of creative activities (artistic and scientific) as well as intrinsic motivation and its properties/characteristics, methods of boosting and stimulating achievement motivation and epistemic motivation. Her current research has addressed aspects of occupational motivation, and in particular psychological features of job burnout, workaholism and laziness. The second research area focuses on emotional determinants of sport and artistic activities especially in relation to public performance. She has published in areas of emotional processes in creative activity, cross cultural differences in creativity, high ability research, etc., and her last book published in 2005 was entitled *Creative Process Dynamics* [Dynamika procesu twórczego].

Arnold Weinstein (AB, MA, PhD) qualified with a PhD in Comparative Literature from Harvard University in 1968. He is currently Edna and Richard Salomon Distinguished Professor of Comparative Literature at Brown University, USA.

His books include : *Vision and Response in Modern Fiction* (1974), *Fictions of the Self: 1550-1800* (1981), *The Fiction of Relationship* (1988), *Nobody's Home: Speech, Self and Place in American Fiction from Hawthorne to DeLillo* (1993), *A Scream Goes Through the House: What Literature Tells Us About Life* (2003), *Recovering Your Story: Proust, Joyce, Woolf, Faulkner, Morrison* (2006), *Northern Arts: The Breakthrough of Scandinavian Literature from Ibsen to Bergman* (2008), *Morning, Noon and Night: Finding the Meaning of Life's Stages Through Books* (2011). The Scandinavian book was Runner-up for best book of 2009 for the *Atlantic*, and his most recent book, *Morning, Noon and Night* was nominated for a Pulitzer Prize in Nonfiction. He has lectured regularly to medical students and audiences on the topic of literature's relevance for the practice and understanding of medicine. He was an Associate Editor of the journal *Literature and Medicine* from 1998 to 2003, and edited its Special Volume on *Infection and Contagion* (2003).

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