

The Consumers' Atlas to Mental Health

CONVERSATION STARTERS

Vol. 1: The Medical Model

Vol. 2: Entering the labyrinth: Balancing care and risk in clinical services

Vol. 3: Stigma: The precarious balance between social and personal identity

Vol. 4: Mad Studies

Vol. 5: Where mental health is made: Personal autonomy and social regulation

Vol. 6: Musings about the National Disability Insurance Scheme (NDIS): Are we in or out?

Vol. 7: Holding ourselves together in time and space: Living in community

Vol. 8: In the news: The wider context of mental health and illness

Our Consumer Place is Australia's Mental Health Resource Centre run entirely by people diagnosed with 'mental illness'



ourconsumerplace.com.au

RESOURCE CENTRE FOR MENTAL HEALTH CONSUMERS

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ourcommunity.com.au

Compiled by Merinda Epstein in partnership with Jacques Boulet

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The Consumers' Atlas to Mental Health

CONVERSATION STARTERS

*Vol. 3: Stigma: The precarious balance between
social and personal identity*

The Consumers' Atlas to Mental Health

1. Purpose and intentions of the Consumers' Atlas to Mental Health:

Conversation Starters is a set of eight volumes intended to initiate and energise conversations about mental health. They are not statements of 'fact'; rather, they are tentative opinions to stimulate insightful conversations about the ways we understand madness, health and other services, community and mad people's politics. We hope they will assist in exploring issues concerning mental health through conversation, supported and informed by materials ranging from the experiential, the narrative and descriptive through to research-based and theoretical work.

The choice of the assembled materials is, of course, biased; some references are controversially 'conservative' whilst others are controversially 'radical'. We included them because they are all part of the full story. We have, therefore, spent less time accumulating 'mainstream' medical material because this is easier to find and many readers would already have absorbed a great deal of this discourse in their everyday interactions with the institutions of psychiatry or, indeed, through information from mass media and other sources.

2. Eight Volumes

Vol. 1: The Medical Model

Vol. 2: Entering the labyrinth: Balancing care and risk in clinical services

Vol. 3: Stigma: The precarious balance between social and personal identity

Vol. 4: Mad Studies

Vol. 5: Where mental health is made: Personal autonomy and social regulation

Vol. 6: Musings about the National Disability Insurance Scheme (NDIS):

Are we in or out?

Vol. 7: Holding ourselves together in time and space: Living in community

Vol. 8: In the news: The wider context of mental health and illness

An Important Note

Language: We use the word '*consumer*'. For many this is economically determined, over-simplistic and too sure of itself. There is no easy answer for this linguistic impasse because all the words we try depend heavily on context. Most of us are sick of 'everyone else' trying to tell us what to call ourselves. Our Consumer Place is presently writing a booklet about 'Challenging Perspectives' which has a more detailed discussion about this complex and contested issue.

Wikipedia: We use Wikipedia because our readership is wide. Wikipedia provides an easier introduction to most subject matter than strict referencing 'proper' research materials; it is an introduction to 'knowledge' to many people who may never had had a chance to explore the world of learning. Also, there have been many questions raised about the 'validity' and the often questionable methods and ethics of 'proper' academic research; its value base and often ulterior motives and interests on which it is based.

Editorial Comment: This volume is different from other volumes. A decision was made to increase the number of sections and decrease the number of references. This decision was made because of the nature of the topic. We will continue to change the format in line with the content of each volume.

About Style

Most of the resources written for people diagnosed with mental illness are 'how to' guides:

- How to live with a certain illness.
- How to get money for projects.
- How to get around a services system.
- How to find a particular sort of clinician...

Material written in this form favours people who think in certain ways; where 'facts' are needed, analysis certain, and 'how to' is reassuring. Others must work with ideas; questioning the taken for granted, searching for ethical dilemmas, wondering, instinctive, perceiving and feeling. These groups, of course, are not mutually exclusive but the differences **must** be considered. This publication invites everyone to slow down, forget assumptions and see the 'other' differently through conversation.

INTRODUCTION TO VOLUME THREE: STIGMA OR IDENTITY: SOCIAL AND PERSONAL IDENTITY IN PRECARIOUS BALANCE

Prejudice against people who are different seems to have been a phenomenon for thousands of years and is worse in different historical, cultural and political contexts. Right now, given the political realities around the world, judgement, prejudice and discrimination are dangerously heightened.

In this volume we move away from the terminology of stigma largely because it puts the onus of responsibility for bad behaviour on to the person with the mental illness rather than those people who treat them poorly; deflecting fault onto the person who is marked.²

Although some would like to separate *mental illness* stigma out as different and apolitical it isn't. People who are already facing prejudice will be more disadvantaged by such prejudice if they become mentally ill.

Prejudice and negative discrimination around mental illness and serious distress is not easily defined because it includes both the prejudice that people who have been diagnosed with mental illness experience and the interplay of this with the experiences of people who become seriously distressed or mentally ill because of the stigmata attached, for example, to their sexuality. The term, intersectionality, is an important one. Multiple disadvantages operate 'together and in relationship' and this means the experiences of mental illness cannot be understood outside the complexity of community.

This volume offers new ways to understand prejudice. Each of the 30 sections contains five short paragraphs designed to promote '*conversations across difference*'. Here are two examples:

INTERSECTIONALITY: *Adam is 23. He has a profound intellectual disability and serious Autism. He lives with his Mum and Grandparents in social housing. Only his Mother speaks English. She had little formal education. His Grandfather might be violent and is an alcoholic. Neighbours in community housing hate the family, accuse Adam of stealing and say he is always hovering menacingly. His just wants them to love him.*

COLLECTIVE NOBODY: *When clinical psychologists and sociologists think about someone who feels like nobody, they tend to think about them differently. Psychologists may want to steer the person towards thinking and acting in new and more positive ways; sociologists may be interested in the social conditions under which dejection and rejection might come about and lead to identity despair; they might look for oppressive circumstances and ways that may mitigate against them*

The conventional activity around stigma tends to:

- Emphasise biological illness and describe them;
- Teach the public the difference between science and charlatans (with appropriate warnings)
- Celebrate stories and Ambassadors including celebrity; and
- Educate the public about the need for cures.

² <https://www.dictionary.com/browse/stigmata>

This volume creates opportunities for a greater number of voices to be heard and diversity of interpretation. We have assumed:

1. The term 'stigma' can be challenged and the term oppression may be appropriate;
2. The political context is important. Hate and collective insecurity matters in a discussion of prejudice around mental illness;
3. The role of community and intersectionality needs emphasis;
4. What happens in services, the community and institutions of government is important;
5. Identity politics should be explored; and
6. Consumers' worldview and personal experience also leads to prejudice.

The index below allows readers and groups to select conversations. *Conversations across difference* is hard especially when our own stories are involved but it is an important way to fight stigma. Arguments may be unhelpful but recognition of passion may not be. We invite all of us to have a conversation even when it might be hard searching for differences and similarities in the ways we understand prejudice and experience oppression.

This volume does not describe all experiences. Nothing could. However, through speaking together more experiences of stigma will emerge which can be explored.

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INTRODUCTION



The Languages of Judgment

1. The Language of Judgment

GOFFMAN AND 'STIGMA'

Erving Goffman was a mid-20th Century US sociologist. He described stigma as disapproval of someone based on characteristics making them different from (perceived) 'normality'. So it is not just about mental illness and does not refer to social responsibility; it is too easy to apply the notion of stigma and ignore responsibility for what can be pernicious social behaviour.

NORMAL

Maybe 'normality' is just a myth. For many in Australia, 'normal' is perceived as a heterosexual man who has white skin, is middle-class, sane, Anglo-Celtic, non-Indigenous, employed and happy. He lives in a nuclear family with 2.2 children with a female partner earning less than him or being 'just' a homemaker. This possibly leaves less than ten percent of people living in Australia who are, in fact, normal.

THE POLITICS OF JUDGEMENT

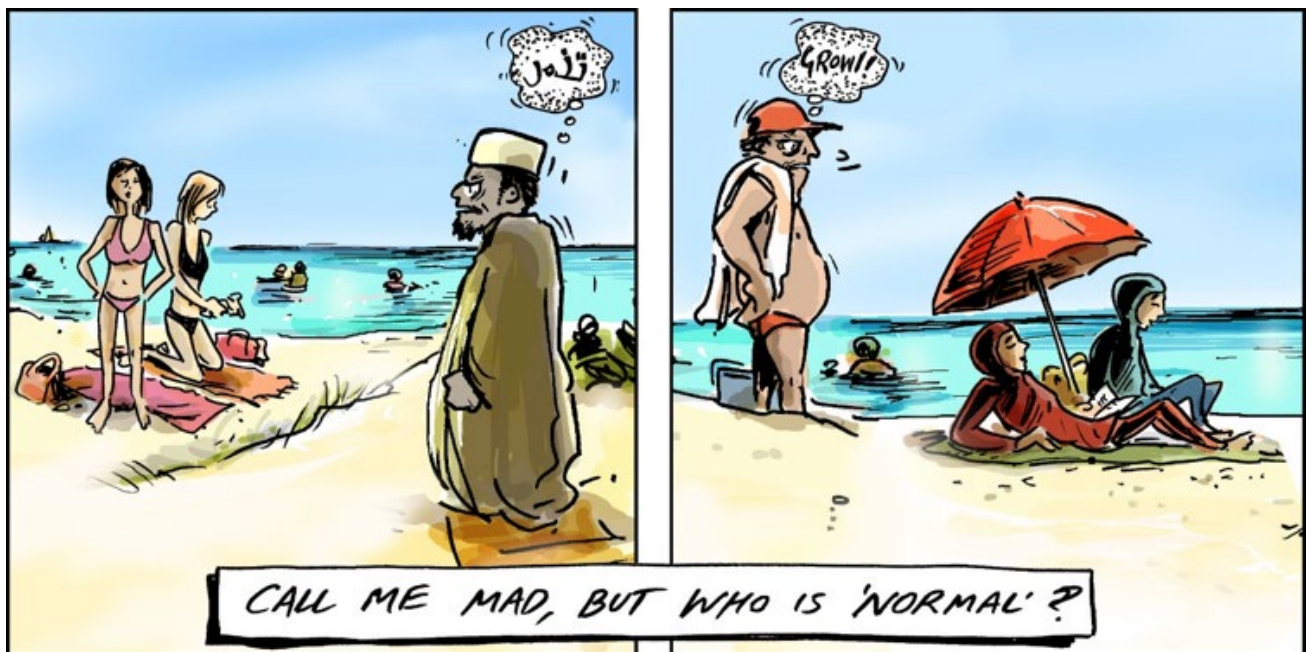
Prejudice is about pre-judging a group, an activity, a thing... using unsound, privileged, inadequate, pre-determined, racist, sane-ist, gendered and other internalised and unexamined criteria of judgement. Prejudice is knowing what you are going to think even before you experience what it is you may need to think about. It is about seeing one word and judging a whole book. It is about a closed mind which defends its knowledge rather than open-up to new ways of thinking - particularly as it pertains to socially rejected groups.

DISCRIMINATION FOR GOOD OR BAD

The term discrimination is often used to describe the ways in which people with mental illness are judged and diminished by society. The term 'discrimination' is deceptive; it is about how we make decisions. We can discriminate in favour or against a group; but there is a pattern to social discrimination. The groups on the receiving end of negative discrimination are predictably some or all of these: homeless, LGBTI, 'the underclass', refugees, living in public housing, mentally ill, Aboriginal, welfare recipients, long-term unemployed and more.

THE REALITY OF OPPRESSION AND WHY CAMPAIGN DISCOURSE DOESN'T LIKE IT

Consumers need to know this stuff. It is easy to be bamboozled into thinking the 'right' term is 'stigma' simply because it is in the interest of politicians, policy makers, many clinicians and those in the community who are socially included (and oblivious to their position of relative social advantage and safety) to tell us so. Stigma lets institutions and individuals divert significant criticism by emphasising the 'difference' of the oppressed rather than the role of society, power and privilege in oppressing them.



A WIKIPEDIA ENTRY TO MADNESS

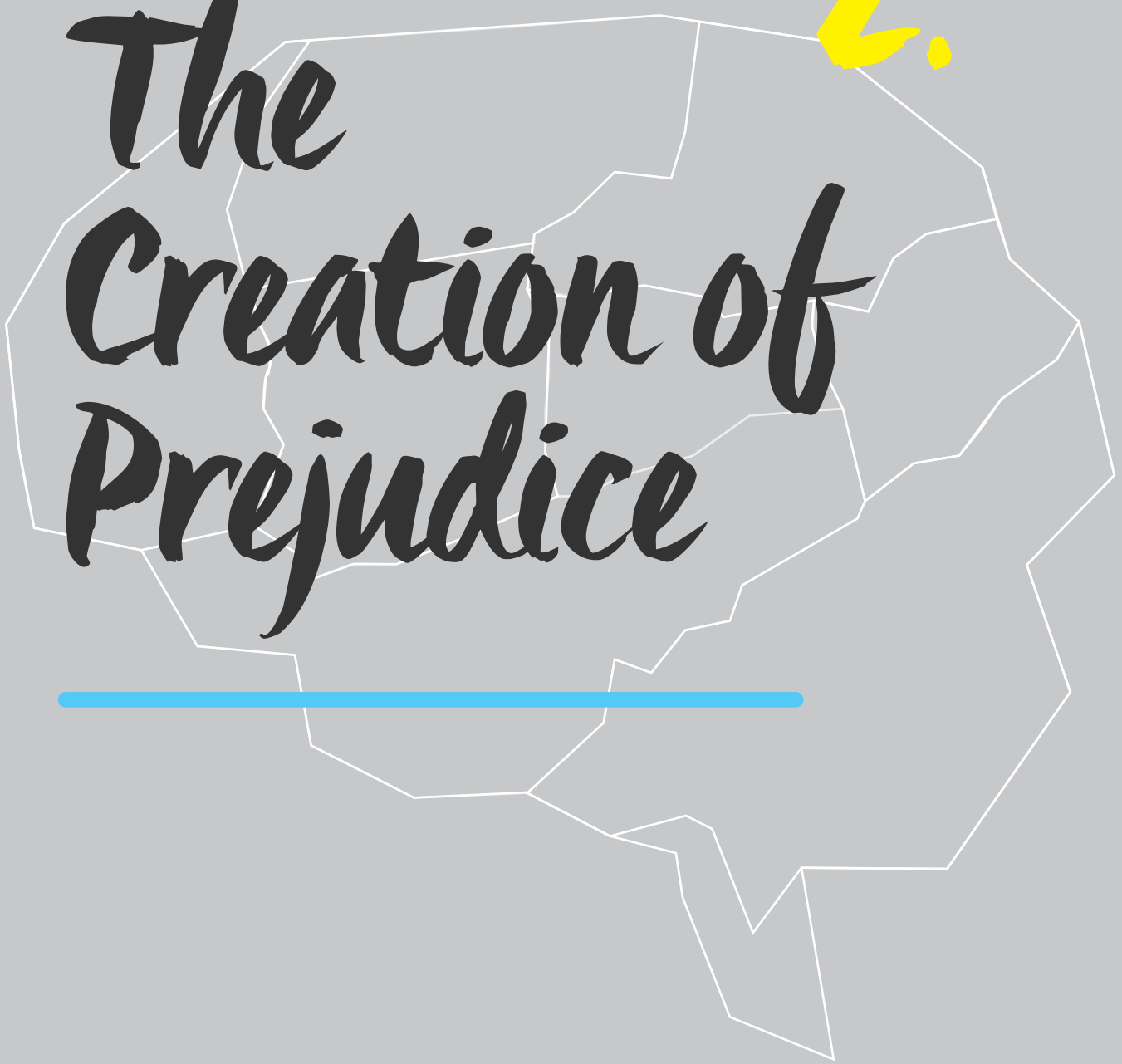
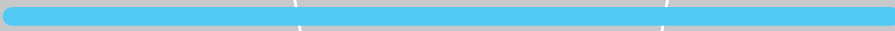
1. Normal: <https://en.wikipedia.org/wiki/Normal>
2. Erving Goffman: https://en.wikipedia.org/wiki/Erving_Goffman
3. Paulo Freire: https://en.wikipedia.org/wiki/Paulo_Freire
4. Oppression: <https://en.wikipedia.org/wiki/Oppression>
5. Social Stigma: https://en.wikipedia.org/wiki/Social_stigma
6. Discrimination: <https://en.wikipedia.org/wiki/Discrimination>
7. Social Campaign (Community Development): https://en.wikipedia.org/wiki/Community_development
8. Community Organising: https://en.wikipedia.org/wiki/Community_organizing
9. Social Control: https://en.wikipedia.org/wiki/Social_control
10. Intersectionality: <https://en.wikipedia.org/wiki/Intersectionality>
11. Social Outcast: [https://en.wikipedia.org/wiki/Outcast_\(person\)](https://en.wikipedia.org/wiki/Outcast_(person))
12. Sanism: [https://en.wikipedia.org/wiki/Mentalism_\(discrimination\)](https://en.wikipedia.org/wiki/Mentalism_(discrimination))
13. Prejudice: <https://en.wikipedia.org/wiki/Prejudice>
14. Ableism: <https://en.wikipedia.org/wiki/Ableism>
15. Social Privilege: https://en.wikipedia.org/wiki/Social_privilege
16. LGBTIQ: <https://en.wikipedia.org/wiki/LGBT>

17. Race: [https://en.wikipedia.org/wiki/Race_\(human_categorization\)](https://en.wikipedia.org/wiki/Race_(human_categorization))
18. Social Exclusion: https://en.wikipedia.org/wiki/Social_exclusion
19. Prejudice: <https://www.google.com.au/#q=prejudice+definition>
20. Social Stereotype: <http://www.simplypsychology.org/katz-braly.html>



2.

The Creation of Prejudice



2. The Creation of Prejudice

DISCRIMINATION – HORSES FOR COURSES

Different 'diagnoses' attract different community judgements. For example, depression means you are lazy, don't try, have lost your sense of humour and are spoilt, rich and privileged. Schizophrenia means you have a brain defect, smell and are violent.

PREJUDICE AND HUMOUR

Social movements sometimes generate change when people decide to laugh at themselves publicly and often together. One of the most effective ways to deal with prejudice is fearless humour. Crip and mad humour, reclaiming the language of the nuthouse, often challenges the community. Our capacity to laugh at ourselves sometimes earns the ire of those who don't get it, including family members and consumers who may feel attacked.

IN-HOUSE PREJUDICE: SEEKING SICKNESS STORIES

Creating and deconstructing public opinion is a task with many manifestations, not all of which talk to each other. The use of story is increasing in many fields including business, but the science community struggles with story. People who have experienced mental illness sometimes feel others attempting to coach them and 'quarry' their lives for 'appropriate true' story-making; stories to fit – or question - the larger narrative of medical science. Some stories seem to be acceptable and others not.

IT HAS NOTHING TO DO WITH TOLERANCE

'Tolerance' is really a rather strange concept... how would you feel if someone would say to you that s-he'd 'tolerate' you and your funny ways of behaving...? And how about being 'tolerant' about obnoxious behaviour and name-calling? Unless 'tolerance' is grafted into a mutual relationship of understanding and support for 'being other' it's really not worth the paper it's written on.

YOUR RIGHT TO FREE SPEECH HURTS ME

It is probably a good time to have a critical look at this 'right' and at several other 'rights'; they are mostly constructed around the rights of individuals with no regard of the social costs of exercising them... calling me names, hearing your opinions about mental illness and the mentally ill, telling me how I should behave and what I could aspire to also denies me my rights and doesn't do anything for the community.


A WIKIPEDIA ENTRY TO MADNESS

1. Crip/mad Humour: <https://www.ndis.gov.au/stories/comicrelief>
2. Stella Young: <https://www.youtube.com/watch?v=8K9Gg164Bsw>
3. Black Comedy: https://en.wikipedia.org/wiki/Black_comedy
4. Linguistic Imperialism: https://en.wikipedia.org/wiki/Linguistic_imperialism
5. Intersectionality: <https://en.wikipedia.org/wiki/Intersectionality>
6. Storytelling: <https://en.wikipedia.org/wiki/Storytelling>
7. Michel Foucault: https://en.wikipedia.org/wiki/Michel_Foucault
8. Narrative: <https://en.wikipedia.org/wiki/Narrative>
9. Rights: <https://en.wikipedia.org/wiki/Rights>
10. Determinism: <https://en.wikipedia.org/wiki/Determinism>
11. Free Will: https://en.wikipedia.org/wiki/Free_will
12. Freedom of Speech: https://en.wikipedia.org/wiki/Freedom_of_speech
13. Positive Liberty: https://en.wikipedia.org/wiki/Positive_liberty
14. Negative Liberty: https://en.wikipedia.org/wiki/Negative_liberty
15. Paradox of Tolerance: https://en.wikipedia.org/wiki/Paradox_of_tolerance
16. Homophily: <https://en.wikipedia.org/wiki/Homophily>
17. Organizational Storytelling: https://en.wikipedia.org/wiki/Organizational_storytelling
18. History and Philosophy of Science: https://en.wikipedia.org/wiki/History_and_philosophy_of_science
19. Sociology of Scientific Knowledge: https://en.wikipedia.org/wiki/Sociology_of_scientific_knowledge
20. Empowerment: <https://en.wikipedia.org/wiki/Empowerment>





3.



Feeling the Glare
Feeling the Silence
Feeling like Nobody

3. Feeling the Glare Feeling the Silence Feeling like Nobody

IDENTIFYING GOOD

Prejudice is insidious. The more we try and fight back using traditional diagnostic identifiers, the more we leave some people's experiences out as we generalise from the stories left in the pool, potentially hurting and dishonouring everyone. We create good and bad, right and wrong, real and not real, deserving and not - we create the 'Other'.

FROM OUT THERE

Some experiences of mental illness are very public. The community judges because they have witnessed, hear people talk about, watched the media and have been fed social media messages. This information may be both real and not real. People with mental illness do fill our prisons, are often homeless and do jump in front of trains destroying the lives of train drivers, but people's narrative of what it means to be mentally distressed is stoked by this often exaggerated information.

HIDING

Some very real and disabling mental illness is experienced almost wholly within the person. Depression, anxiety, extended grief and despair are often experienced internally and this is often a profound problem. When public opinion sees mental illness as 'external and always 'out there,' it can miss and judge others whose experiences are nearly all internal. A life of socially enforced subterfuge is crippling.

RIGHTEOUSNESS

*'I don't treat anyone who is **just** behaving badly'*, said a public sector psychiatrist in a 2016 lecture. She was adamant and righteous. But who is the arbiter of bad and good behaviour? The 'public' more likely accepts deviance if medically sanctioned and the psychiatrist is teaching prejudice, pitting 'good' patients against 'bad' ones. Clinicians' value judgements are rarely based on medical knowledge alone; yet, status suggests authority even in areas where none is to be had.

COLLECTIVE NOBODY

When clinical psychologists and sociologists think about someone who feels like nobody, they tend to think about them differently. Psychologists may want to steer the person towards thinking and acting in new and more positive ways; sociologists may be interested in the social conditions under which dejection and rejection might come about and lead to identity despair; they might look for oppressive circumstances and ways that may mitigate against them.

A WIKIPEDIA ENTRY TO MADNESS

1. Positive Discrimination: <https://www.humanrights.gov.au/quick-guide/12078>
2. Perception: <https://en.wikipedia.org/wiki/Perception>
3. Social Judgement Theory: https://en.wikipedia.org/wiki/Social_judgment_theory
4. Coming Out: https://en.wikipedia.org/wiki/Coming_out
5. Behaviour- sociology: <https://en.wikipedia.org/wiki/Behaviorism>
6. Behaviour- psychology: https://en.wikipedia.org/wiki/Psychological_behaviorism
7. Deviance: [https://en.wikipedia.org/wiki/Deviance_\(sociology\)](https://en.wikipedia.org/wiki/Deviance_(sociology))
8. Psychology Definition of Self: https://en.wikipedia.org/wiki/Psychology_of_self
9. Disability Identity: https://en.wikipedia.org/wiki/Identity_formation#Disability_identity
10. Minority Affiliation: https://en.wikipedia.org/wiki/Minority_group
11. Public Image Disability: https://en.wikipedia.org/wiki/Disability_in_the_media
12. Factitious Disorder: https://en.wikipedia.org/wiki/Factitious_disorder
13. Malingering: <https://en.wikipedia.org/wiki/Malingering>
14. Existential Suffering (Crisis): https://en.wikipedia.org/wiki/Existential_crisis
15. Social Psychiatry: https://en.wikipedia.org/wiki/Social_psychiatry
16. Clinical Psychiatry: https://en.wikipedia.org/wiki/Clinical_psychology
17. Sociology: <https://en.wikipedia.org/wiki/Sociology>
18. Individualism: <https://en.wikipedia.org/wiki/Individualism>
19. Oppression: <https://en.wikipedia.org/wiki/Oppression>
20. Medical Paternalism: https://en.wikipedia.org/wiki/Medical_paternalism





What will **4.**
it take to
care for
each other?

4. What will it take to care for each other?

MENTAL ILLNESS AS A SIDE-EFFECT OF LIFE

What is and is not mental illness is debated. Many people say that by creating such 'illness categories' we move far away from a cultural imperative to care for and about everyone who is living a life of hardship, despair and existential suffering. Can a belief about there being a group of real 'mental illnesses' really be defended in anti-stigma campaigns when it limits community caring to too few. Is expanding our idea of care for those in need pushing the boundaries?

WHAT'S THE POINT?

Whilst governments spend money on anti-stigma campaigns, they instigate laws to jail those who are seen to 'assault' emergency personnel. Who do they think these dangerous people are? It's likely that people diagnosed with mental illness will figure because of the confusion and distress involved.

IS POLITICS CAPABLE OF CARING?

Sometimes language becomes a rhetorical device in relation to organised, state-endorsed prejudice. When politicians create policy, they often create slogans, news bites and sales pitches which judge, discriminate and sometimes fabricate false categories of good and bad or worthy and unworthy. It happens repeatedly in mental 'health,' where governments are forced to justify spending or spending cuts. What's the point of anti-stigma campaigns if political rhetoric consistently hurts people?

ACTIVE AND PASSIVE ASSAULT

Language is important. Language assaults are particularly loathsome when the person being assaulted is already feeling bullied and defamed. Saying horrible things about a person diagnosed with a mental illness can be devastating no matter who speaks the words. Verbal assault can occur in and from care systems. It is truly sad when the word 'care' is co-opted and used interchangeably with the word 'treatment' or used by people who quite obviously don't care at all.

KINDNESS

People do care... some more than others perhaps. Every day, small and sometimes quite big acts of kindness happen for people. Many people say that kindness is at its best when it is reciprocal, non-institutionalised and humble. Genuine kindness is one of the few ways to be with someone diagnosed with mental illness which bears no reference to prejudice.

A WIKIPEDIA ENTRY TO MADNESS

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2. Institutionalisation: <https://en.wikipedia.org/wiki/Institutionalisation>
3. Reciprocity and Professionalism in Health Care: https://en.wikipedia.org/wiki/Norm_of_reciprocity
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6. Prejudice: <https://en.wikipedia.org/wiki/Prejudice>
7. Anti-stigma Campaigns: <https://www.youtube.com/watch?v=kYoi9RAxzvQ&list=PLI8yqrAao0dzQZwGtRko8Tq6bOjuXJ0ZB> https://en.wikipedia.org/wiki/National_Mental_Health_Anti-Stigma_Campaign
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9. Shock Jocks: https://en.wikipedia.org/wiki/Shock_jock
10. Euphemism: <https://en.wikipedia.org/wiki/Euphemism>
11. Concrete Thinking: https://en.wikipedia.org/wiki/Abstract_and_concrete
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13. Bureaucracy: <https://en.wikipedia.org/wiki/Bureaucracy>
14. Democracy: <https://en.wikipedia.org/wiki/Democracy>
15. Meritocracy: <https://en.wikipedia.org/wiki/Meritocracy>
16. Hidden Curriculum: https://en.wikipedia.org/wiki/Hidden_curriculum
17. Discourse: <https://en.wikipedia.org/wiki/Discourse>
18. Abusive Power and Control: https://en.wikipedia.org/wiki/Abusive_power_and_control
19. Co-option: <https://en.wikipedia.org/wiki/Co-option>
20. Identity Politics: https://en.wikipedia.org/wiki/Identity_politics

5.

Pride &
Shame:
Fear & Love

5. Pride & Shame: Fear & love

PRIDE

Shame is our story – for most of us anyway, if we are honest. If shame drives ‘mental illness’ then pride is about claiming back our lives. It is difficult to capture pride when a deficit model has ascendancy.

MERIT-O-CRAZY

We live in a meritocracy. Meritocracies feed on our collective belief and fear that society is made up of winners and losers and that even losers can come good if they can just prove they are resilient. Human worth is judged using a limited pallet of successes.

BLAME DISPLACEMENT

Stigma is the easiest term for the community to hear, as it places responsibility, to some extent, on the person affected rather than on those in the community who play with power. This is particularly so when terms like self-stigmatisation are used; clinical psychologists sometimes diagnose it as the internalisation of stigma. Many of us feel it's a judgement - we feel blamed.

OPPRESSION

Pride and shame are intrinsically – and historically – related to oppression. They are linked with discrimination and exclusion sometimes over generations. It needs more than personal resistance and revolt to change this; it needs a social movement! And identity politics doesn't help either!

WHO ARE WE TO CLAIM A PLACE IN THE STRUGGLE?

Ideally, us mad folk ought to join other groups in solidarity to fight endemic oppression. This is a big ask. Aboriginal peoples, family violence activists, LGBTQI activists, prison reform campaigners, childhood trauma and abuse activists and the disability community, for example, already struggle to survive in a hostile political era. Some groups are keen to avoid being seen as mad. Becoming allies cannot be taken for granted. Prejudice takes hostages.

A LONG TIME AGO IN A FAR AWAY TIME PEOPLE SEARCHED FOR MAJIC MUD TO MAKE OUR FACTORIES WORK, TRAINS RUN, MACHINES GRUMBLE AND LIGHTS TURN ON. BLACK GOLD WAS FOUND. IT NEEDED TO BE DUG UP - DEEP, DEEP DOWN. CHILDREN MUST GO DOWN TO DIG. THE AIR WAS GONE, THE EARTH WAS BLACK AND THE STONES FELL DOWN.



AFTER THE BLACK GOLD WAS FOUND THE CHILDREN WERE SICK. ONE MAN SAID, "I'LL TAKE THIS LITTLE CANARY DOWN TO THE BOTTOM OF THE MINE. HIS LUNGS ARE LITTLE. IF THE AIR IS BAD HE'LL DIE. WHEN THE CANARY STOPS SINGING THE CHILDREN WILL KNOW IT'S TIME TO CLIMB OUT OF THAT PLACE AND BE SAFE."



PEOPLE WITH MENTAL ILLNESS ARE LIKE THE CANARIES DOWN THE MINES OF OUR COMMUNITY. THEY ARE SENSITIVE WHEN OTHERS AREN'T, THEY KNOW STORIES OTHERS CAN'T, THEY FEEL THEIR PASTS INTENTLY, AND THEY KNOW THE TRAUMA OF DYING FROM THE INSIDE.

PEOPLE ARE NEVER PROBLEMS TO BE SOLVED, CREATURES TO BE TAMED, EMBARRASMENTS TO BE AVOIDED. PEOPLE WITH MENTAL ILLNESS ARE THE CANARIES OF OUR TIME. THEY EXPERIENCE THE WORLD DEEPLY, EMOTIONALLY, EXQUISITELY. FIGURATIVELY THEY DIE SO THAT WE MIGHT LIVE, SO WE MIGHT GROW.



A WIKIPEDIA ENTRY TO MADNESS

1. Mad Pride: https://en.wikipedia.org/wiki/Mad_Pride
2. Meritocracy: <https://en.wikipedia.org/wiki/Meritocracy>
3. Activism: <https://en.wikipedia.org/wiki/Activism>
4. Family (Domestic) Violence: https://en.wikipedia.org/wiki/Domestic_violence
5. Oppression: <https://en.wikipedia.org/wiki/Oppression>
6. Social Capital: https://en.wikipedia.org/wiki/Social_capital
7. Proletariat: <https://en.wikipedia.org/wiki/Proletariat>
8. Multigenerational Poverty: https://en.wikipedia.org/wiki/Poverty_trap
9. Prison Reform: https://en.wikipedia.org/wiki/Prison_reform
10. Childhood Trauma: https://en.wikipedia.org/wiki/Childhood_trauma
11. Child Abuse: https://en.wikipedia.org/wiki/Child_abuse
12. Social Inclusion: https://en.wikipedia.org/wiki/Social_exclusion#Social_inclusion
13. Intersectionality: <https://en.wikipedia.org/wiki/Intersectionality>
14. Black Power: https://en.wikipedia.org/wiki/Black_Power
15. 'Me Too' Movement: https://en.wikipedia.org/wiki/Me_Too_movement
16. Solidarity: <https://en.wikipedia.org/wiki/Solidarity>
17. Oppression Olympics: https://en.wikipedia.org/wiki/Oppression_Olympics
18. Social Inequality: https://en.wikipedia.org/wiki/Social_inequality
19. Power: Social and Political: [https://en.wikipedia.org/wiki/Power_\(social_and_political\)](https://en.wikipedia.org/wiki/Power_(social_and_political))
20. Identity Politics: https://en.wikipedia.org/wiki/Identity_politics

PREJUDICE:
TOO CLOSE FOR
COMFORT

6.

Passing
the 'i' Test

6. Passing the 'I' Test³

DIAGNOSIS BI-POLAR

You are watching a news feed and an expertly qualified woman is talking about national trends in childcare. You become increasingly aware that she is overweight, has a slight tremor and other signs you recognise as side-effects of medications, probably psychiatric medications similar to your own. You find yourself considering this person differently as you absentmindedly diagnose her. You lose concentration. As you watch, the attributes of the person become more important than the interview content. You have regard for her courage but haven't learnt a thing about childcare.

THE HIDDEN AGENDA OF THE WAITING ROOM

You have a mental illness and are in the waiting room of a General Practice. A woman is upset, speaking loudly. A receptionist makes eye contact with people in the waiting room. She lifts her eyes signalling something close to disdain but meant to reassure other patients. The waiting room feels more comfortable now. You smile back and **are** grateful, because you didn't know where to look; but you feel really bad about it later.

PREJUDICE BY EXCLUSION

You are listening to a person as part of a mental illness awareness campaign; the speaker starts to ask what the group knows about different mental illnesses. He needs a baseline. People call out *schizophrenia*, *depression*, *bipolar*... Someone calls out *borderline*. The convenor says nothing and then he explains that, strictly speaking, this is not a mental illness. It isn't mentioned again. You do not insist on it being included, partly because you dread what any such inclusion might lead to.

JUST LIKE I WOULD WANT IF IT WAS ME?

You are walking down the street and can't help observing a man who seems to be talking loudly to people who don't appear to be there. You know this intimately. People are staring, mumbling and pointing. Two are laughing. You are angry with the man simply for making a spectacle that pushes your buttons; on the other hand, there's anger with the attitudes of those around you. Wondering whether to interfere and defend this man as you would wish to be defended, you stop, think and then walk on.

NOT MY STORY, NOT MY RESPONSIBILITY

You are waiting in an Emergency Department; a woman enters having cut her wrists. At reception, she is addressed quite rudely by a busy and hassled staff member. You agree that the hurt woman is responsible for her own behaviour. The queue is very long, she isn't really sick and superficial bleeding (you assume) is not serious. Anyway, she probably does it all the time. The staff are frustrated, understandably. Gosh! They are busy tonight.

³ Originally used by Janet Meacher a pioneer consumer advocate from NSW

A WIKIPEDIA ENTRY TO MADNESS

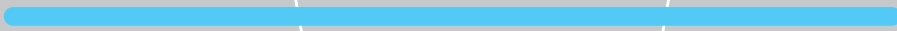
1. Bi-Polar Affective Disorder: https://en.wikipedia.org/wiki/Bipolar_disorder
2. Side effects: https://en.wikipedia.org/wiki/Side_effect
3. General Practitioner: https://en.wikipedia.org/wiki/General_practitioner
4. Cultural Knowledge: <https://www.environment.nsw.gov.au/resources/cultureheritage/commconsultation/09782factsheet1.pdf>
5. Sociology of Culture: https://en.wikipedia.org/wiki/Sociology_of_culture
6. Reading social signs: [https://en.wikipedia.org/wiki/Social_information_processing_\(cognition\)](https://en.wikipedia.org/wiki/Social_information_processing_(cognition))
7. Two Faced (Hypocrisy): <https://en.wikipedia.org/wiki/Hypocrisy>
8. Labelling: <https://en.wikipedia.org/wiki/Labelling>
9. Vilification: <https://en.wikipedia.org/wiki/Defamation>
10. Universal judgement: https://en.wikipedia.org/wiki/Moral_universalism
11. Othering: <https://en.wikipedia.org/wiki/Discrimination#Othering>
12. Self-harm: <https://en.wikipedia.org/wiki/Self-harm>
13. Balancing Care and Risk: <https://www.ourcommunity.com.au/files/ConsumersAtlas-Volume2.pdf>
14. Triage: <https://en.wikipedia.org/wiki/Triage>
15. Abuse, Self-harm & Neglect (Naru & Manus): <https://www.refugeecouncil.org.au/resources/publications-external/manus-nauru-senate-2017/>
16. Self-Preservation: <https://en.wikipedia.org/wiki/Self-preservation>
17. Ethical Decisions: https://en.wikipedia.org/wiki/Ethical_decision
18. Identity: [https://en.wikipedia.org/wiki/Identity_\(social_science\)](https://en.wikipedia.org/wiki/Identity_(social_science))
19. Selective Auditory Attention : https://en.wikipedia.org/wiki/Selective_auditory_attention
20. Selective Perception: https://en.wikipedia.org/wiki/Selective_perception





7.

Reactive Judging



7. Reactive Judging

RECOVERY JOURNEY

You work hard on your own recovery. You are proud. You are resilient. You also know of two women who seem to have been 'in therapy', which you assume is some form of psychotherapy, for many years. You are angry. It is morally wrong when the government pays for this when really sick people can't get services; as well, these people are not taking responsibility for their own lives.

PROFESSIONAL ME

You are working in a consumer role in a carer organisation. To restore your own self-esteem, you need to appear as professional as you can. You start to use clinical language describing people who come for help from a peer as 'cases'. This is good for you.

DESERVED AND UNDESERVED STIGMA

You were diagnosed with Borderline Personality Disorder ages ago. You experienced this as a nonsense label: an assault on your integrity. Last year you were re-diagnosed with a 'real' mental illness (bipolar). You were so relieved. When talking about your experiences, you are now quick to distance yourself from people who 'really do have' borderline. You now always say in public "... but I was wrongly diagnosed."

BEHIND THE TITLE

You work in a consumer organisation in mental health. You have a mental illness but don't want to reveal it. You try and justify why you remain silent when others around you seem braver and 'come out'. You jump into fighting for 'the most disabled', 'the sickest' and dismiss people with 'lesser illnesses,' like depression – like you. The dissonance between your own unrevealed experiences and your overt practice worries you. Your public utterances about 'less serious' patients become more extreme.

GOOD WORK ETHIC

You believe in working hard at staying well and you are disciplined and organised following through a list of expectations you have for yourself. This disciplined approach keeps you well. You are critical of people diagnosed with bipolar who constantly complain about their lot without putting in the effort to keep themselves well. Having grown prouder and more assertive, you decide to call out this laziness in the people you consider whingers.

STOP DUMPING ON ME

You see a psychotherapist regularly. This relationship offers hope and support and you struggle to pay for it by scrimping to pay bills. The professional relationship is ethical and protects your friends and others from being sucked into your life in an unhealthy way. It annoys you that others don't take the same responsibility for their lives, often expecting you to be their unpaid therapist.

A WIKIPEDIA ENTRY TO MADNESS

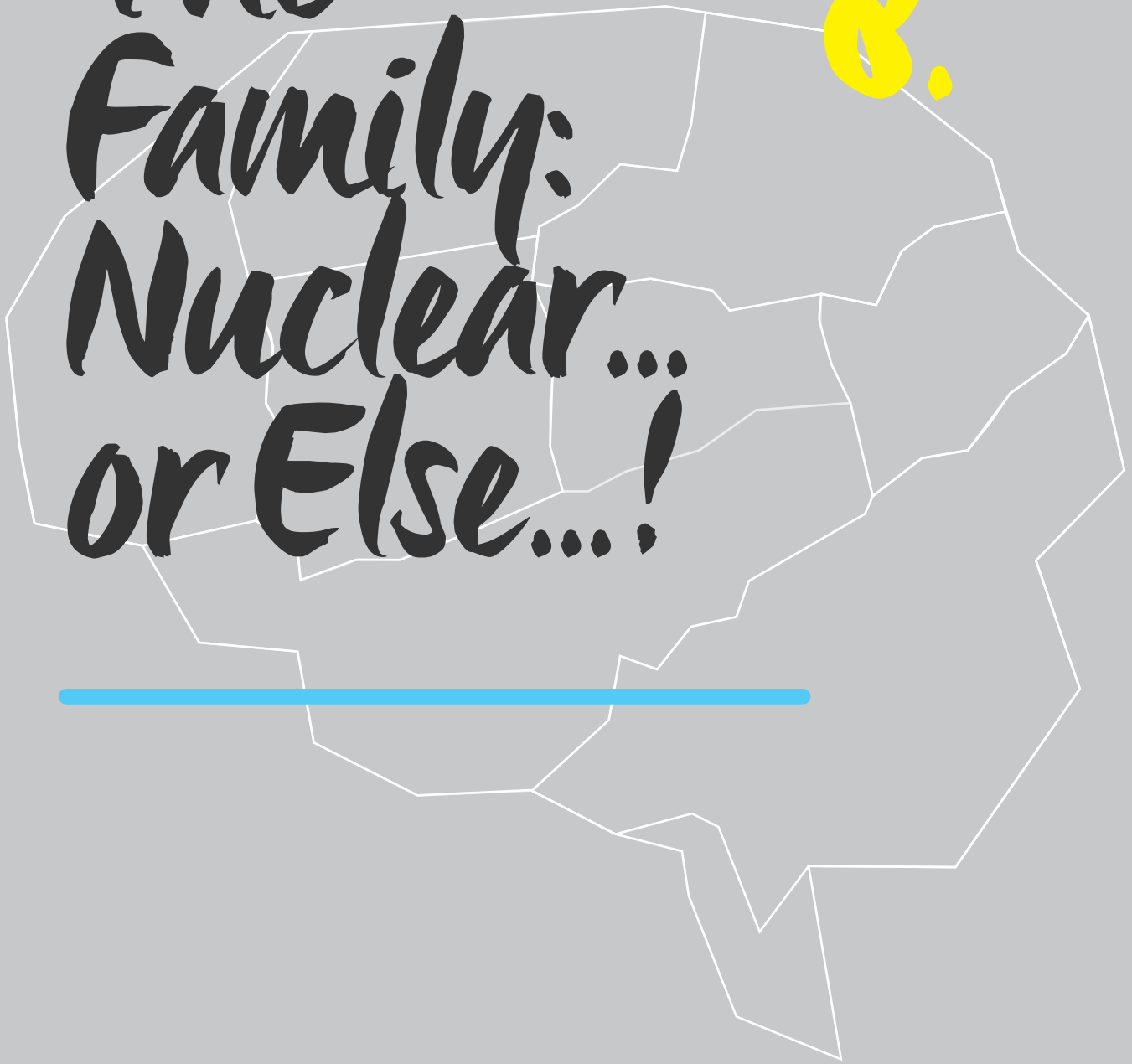
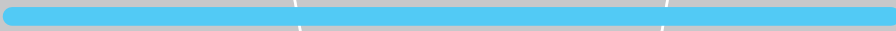
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2. Resilience: https://en.wikipedia.org/wiki/Psychological_resilience
3. Psychotherapy: <https://en.wikipedia.org/wiki/Psychotherapy>
4. Competing Values: [https://en.wikipedia.org/wiki/Value_\(ethics\)](https://en.wikipedia.org/wiki/Value_(ethics))
5. Othering: [https://en.wikipedia.org/wiki/Other_\(philosophy\)](https://en.wikipedia.org/wiki/Other_(philosophy))
6. Social Justice: https://en.wikipedia.org/wiki/Social_justice
7. 'Us' & 'Them' Politics: https://en.wikipedia.org/wiki/Divide_and_rule
8. Social Power: [https://en.wikipedia.org/wiki/Power_\(social_and_political\)](https://en.wikipedia.org/wiki/Power_(social_and_political))
9. Lateral Violence: https://en.wikipedia.org/wiki/Lateral_violence
10. Stereotype: <https://en.wikipedia.org/wiki/Stereotype>
11. Labelling Theory: https://en.wikipedia.org/wiki/Labeling_theory
12. Identity Politics: https://en.wikipedia.org/wiki/Identity_politics
13. Flick Grey: Rethinking BPD: <https://www.youtube.com/watch?v=-ZLTsnHtTaY>
14. Just Borderline Mad: <http://asylummagazine.org/2017/03/just-borderline-mad-by-flick-grey/>
15. Othering II: <https://muse.jhu.edu/article/648235/summary>
16. Consumers comment on stigma interventions: <https://link.springer.com/article/10.1007/s00127-017-1393-x>
17. Role Theory: https://en.wikipedia.org/wiki/Role_theory
18. Supportive Psychotherapy: https://en.wikipedia.org/wiki/Supportive_psychotherapy
19. Social Psychology: [https://en.wikipedia.org/wiki/Social_psychology_\(sociology\)](https://en.wikipedia.org/wiki/Social_psychology_(sociology))
20. Turn-taking: <https://en.wikipedia.org/wiki/Turn-taking>





The Family: Nuclear... or Else...!

8.



8. The Family... Nuclear or Else...!

THE NUCLEUS OF LOVE

The nuclear family, a social institution, is a way of organising people. It is a political idea. It hasn't been around that long historically and is in no way universal. It's a very small group of people to carry out the work society demands of it. When someone is diagnosed with mental illness, not enough internal energy may be available and outside support becomes just a 'service' rather than extended love. Perhaps the nuclear family is a fundamentally flawed idea.

FAMILY FANTASIES AND SOCIAL REALITIES

Prejudice often rises when we behave in ways that don't fit with the family fantasies many of us want to believe. Good women should always love their babies all the time; people should come back from war as heroes not mentally crippled; children must be allowed to be children and not have to care for their parents.

EMOTIONAL, SOCIAL & SPIRITUAL WELLBEING

In extended, traditional Aboriginal families, social interactions are tightly ruled under Aboriginal law. They hold communities and people together. When powerful and careless changes get in the way of these patterns of relating, many suffer and this can generate interpersonal and community chaos, which is seized upon in judgment, a critical driver of this being racism.

SHE NAMED HER LAST EMBRYO SARAH

Societies have differing attitudes about reproduction and parenting. Whilst mythologies of frigidity, 'the barren woman', 'the selfish wealthy' continue to be spread, women who cannot produce children will continue to be judged. Bearing children is regarded as a woman's rite of passage in our culture. Childless despair leads to profound mental health consequences, probably as profound as losing a baby but without recognition even within families.

HAVING YOUR CHILDREN TAKEN AWAY

Unfortunately, we still hear of families in alternative types of relationships or of poor families having their children taken away because of mental illness. This is tragic. We do meanwhile accept some different configurations, but class intersects powerfully with the legal decision to remove the children.




A WIKIPEDIA ENTRY TO MADNESS

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2. Australian Family Law: https://en.wikipedia.org/wiki/Australian_family_law
3. Caregiver: <https://en.wikipedia.org/wiki/Caregiver>
4. Conjugal Family: https://en.wikipedia.org/wiki/Conjugal_family
5. Extended family: https://en.wikipedia.org/wiki/Extended_family
6. Family: <https://en.wikipedia.org/wiki/Family>
7. Fragmented societies: [https://en.wikipedia.org/wiki/Fragmentation_\(sociology\)](https://en.wikipedia.org/wiki/Fragmentation_(sociology))
8. History of the Family: https://en.wikipedia.org/wiki/History_of_the_family
9. Intergenerational: <https://www.encyclopedia.com/psychology/dictionaries-thesauruses-pictures-and-press-releases/intergenerational>
10. Kinship and Skin Names: <https://www.clc.org.au/index.php?/articles/info/aboriginal-kinship>
11. Kinship: <https://en.wikipedia.org/wiki/Kinship>
12. Nuclear family: https://en.wikipedia.org/wiki/Nuclear_family
13. Role Conflict: https://en.wikipedia.org/wiki/Role_theory
14. Role Theory: https://en.wikipedia.org/wiki/Role_theory
15. Socialisation: <https://en.wikipedia.org/wiki/Socialization>
16. Stereotype Threat: https://en.wikipedia.org/wiki/Stereotype_threat
17. Structural Inequality: https://en.wikipedia.org/wiki/Structural_inequality
18. Tax on Childlessness: https://en.wikipedia.org/wiki/Tax_on_childlessness
19. The first Australians: Kinship, family and identity: <https://aifs.gov.au/publications/family-matters/issue-35/first-australians-kinship-family-and-identity>
20. Transgenerational trauma: https://en.wikipedia.org/wiki/Transgenerational_trauma



9.



The Family
Done it! ...
Or Not?

9. The Family Done it! ... Or Not?

SECRECY

Some psychiatric labels hold stigma so pernicious that families hide their 'odd' ones to protect them from community glare. What the community doesn't understand it often fears. Families living this are caught between needing to share their 'burden' and protecting privacy. But secrecy can also create community gossip. No matter how badly informed people are, they judge what they can't see because that's what people do.

THE CASE OF RIGHT VERSUS RIGHT

Ethicists tell us that the real ethical dilemma is not about right and wrong but rather between right and right or wrong and wrong. Consumers and family carers sometimes have different agendas in mental health reform. Perspectives clash, even with both groups having ethical positions. At what point does a conversation about ideas turn from ethics to politics, from ideas to funding and from conversation to argument?

WHOSE STORY IS IT?

We try to use our stories for good. Story elicits empathy which is a tool in addressing stigma. Our stories are never just our own. How much do we tell others about parts of our life when the story is not ours alone? Deciding who we want to protect involves power. Reputation is also a factor. Other factors include being dead, intimate, violent, upstanding, already fragile or likely to sue. It is not just about confidentiality and privacy.

THE FAMILY DONE IT

Many family carers feel blamed for the mental illness in their family. Families, particularly parents, often feel under siege as they try to do the 'right' thing. Experiencing prejudicial attitudes from extended family, schools and other social institutions, they feel misunderstood. Some family carers feel powerless whilst others feel they are the real victims as they battle the demands of an illness that sometimes sorely tests them.

A FAMILY VIEW?

A young woman kills herself after many attempts. Her sister is interviewed on radio, the host turning to questions about the family's response to the suicide. The woman keeps asserting; *"There is no 'we' here, just people with very different responses. My brothers were respectively furious and gutted. My sister wanted to know the science and Mum and I were relieved she found a way to kill herself that didn't involve innocent people"*. This wasn't heard.

A WIKIPEDIA ENTRY TO MADNESS

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2. Badge of Shame: https://en.wikipedia.org/wiki/Badge_of_shame
3. Blame: <https://en.wikipedia.org/wiki/Blame>
4. Caregiver Burden: https://en.wikipedia.org/wiki/Caregiver_burden
5. Carers' Movement: https://en.wikipedia.org/wiki/Carers%27_rights
6. Ethics of Care: https://en.wikipedia.org/wiki/Ethics_of_care
7. Ethics: <https://en.wikipedia.org/wiki/Ethics>
8. Face – a sociological perspective: [https://en.wikipedia.org/wiki/Face_\(sociological_concept\)](https://en.wikipedia.org/wiki/Face_(sociological_concept))
9. Guilt-Shame-Fear Spectrum: https://en.wikipedia.org/wiki/Guilt-Shame-Fear_spectrum_of_cultures
10. Informal Sector: https://en.wikipedia.org/wiki/Informal_sector
11. Normative Social Influence: https://en.wikipedia.org/wiki/Social_group
12. Nuclear Family: https://en.wikipedia.org/wiki/Nuclear_family
13. Scapegoating: <https://en.wikipedia.org/wiki/Scapegoating>
14. Self-blame: [https://en.wikipedia.org/wiki/Self-blame_\(psychology\)](https://en.wikipedia.org/wiki/Self-blame_(psychology))
15. Shame Resilience theory: https://en.wikipedia.org/wiki/Bren%C3%A9_Brown
16. Shame: <https://en.wikipedia.org/wiki/Shame>
17. Social Isolation: https://en.wikipedia.org/wiki/Social_isolation
18. Social norm: <https://en.wikipedia.org/wiki/Disability>
19. Sociology of the family: https://en.wikipedia.org/wiki/Sociology_of_the_family
20. Victim Blaming: https://en.wikipedia.org/wiki/Victim_blaming

10.

Not in my
Backyard

10. Not in my Backyard

INTOLERABLY UNEQUAL

Too often, poor communities are asked to carry too much. We should expect a backlash if all the 'difficult' groups are located in communities which are least able to absorb them. This is not primarily an education problem. Constantly 'educating' people is to disrespect their knowledge and experience. Perhaps it is more an issue of social class, survival and pride. No education needed there.

CLASSY? NO, NOT REALLY

Those living in relative comfort in middle-class communities, even those who work in mental health, sometimes utter well-meaning positive, uplifting pronouncements about prejudice, caring and inclusion. People who, because of mental illness, have had to learn to live subjugated lives in new and frightening economic and social circumstances sometimes experience this as unsolicited pretentiousness.

DON'T FUDGE IT!

Abject poverty is a reality for many. In fighting prejudice, we often deny the reality of dirty clothes, smells, mannerism, dribbling, yelling at nothing, lying on the ground eating grass, gulping tears. People in communities can see only too well and think our denial is hypocritical – anti-stigma campaigns need to be honest with their consumer commentary.

IMBU

Some people deliberately purchase property near facilities for people with disabilities and other marginalised groups to bring up knowledgeable, accepting and compassionate children. This seems to be a genuine attempt to fight prejudice hopefully into the next generation. Unfortunately, it is usually only the relatively well-off who have 'clean air' from everyday survival to make such ethical calls.

ROLE MODEL?

There is a woman regarded by some as a role model for people living well on a disability pension. She learnt about pride and self-worth, separating negative community attitudes from her everyday life. She is poor with little formal education and has a physical disability. She is proud of her unit – a perfect community housing tenant. The recent placement of a woman with schizophrenia in her group of units infuriates her. She is first to report this woman to authorities when she believes a transgression has occurred.

A WIKIPEDIA ENTRY TO MADNESS

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2. Community: <https://en.wikipedia.org/wiki/Community>
3. Poverty: <https://en.wikipedia.org/wiki/Poverty>
4. Learned Helplessness: https://en.wikipedia.org/wiki/Learned_helplessness
5. Social inequality: https://en.wikipedia.org/wiki/Social_inequality
6. Community cohesion: https://en.wikipedia.org/wiki/Community_cohesion
7. Middle Class: https://en.wikipedia.org/wiki/Middle_class
8. Working Class: https://en.wikipedia.org/wiki/Working_class
9. Social Inclusion: https://en.wikipedia.org/wiki/Social_exclusion#Social_inclusion
10. Altruism: <https://en.wikipedia.org/wiki/Altruism>
11. Suburban Sprawl: https://en.wikipedia.org/wiki/Urban_sprawl
12. Rural Poverty: https://en.wikipedia.org/wiki/Rural_poverty
13. Role Model: https://en.wikipedia.org/wiki/Role_model
14. Social Stratification: https://en.wikipedia.org/wiki/Social_stratification
15. Abject Poverty: https://en.wikipedia.org/wiki/Extreme_poverty
16. Critical Pedagogy: https://en.wikipedia.org/wiki/Critical_pedagogy
17. Public Housing in Australia: https://en.wikipedia.org/wiki/Public_housing_in_Australia
18. Community-led housing: https://en.wikipedia.org/wiki/Community-led_housing
19. NIMBY: <https://en.wikipedia.org/wiki/NIMBY>
20. Standpoint Theory: https://en.wikipedia.org/wiki/Standpoint_theory



CLINICIANS, SERVICES AND PREJUDICE

11.



Language
and Other
Mishaps

11. Language and Other Mishaps

IN FRONT OF YOUR NOSE

The medical industry, including psychiatry, dips a toe into community awareness campaigns; they talk about the stigma of mental illness in the community. At the same time, consumers argue that some of the worst prejudice comes from within the industry itself.

HOW IMPORTANT IS LANGUAGE?

The language clinicians from all disciplines are taught to use, to diagnose, treat, write histories and ask questions, is designed to be factual, explicit and precise. This might seem to demonstrate rigor but is often at the expense of unacknowledged prejudice against a whole category of people; 'The Mentally Ill' or specific sub-groups e.g. those with less medically defined, but nonetheless authentic mental health conditions.

MY HEALTH RECORD

People with mental illness must decide between not having to repeat difficult family and medical histories over and over again or letting every medical person, no matter how worthy or how relevant, have access to a summary of their file. The reason people with mental illness often have for refusing access to their health information has more to do with prejudice and fear of litigation rather than privacy. In psychiatry, almost everyone's file will have something that impugns his or her reputation.

CARING IS SOMETIMES ANYTHING BUT

We know that care staff are often overworked, underpaid and totally exhausted; still, it would be nice if their frustrations with that situation would not be taken out on the 'cared-for'.

THE STRANGE WAYS OF COMMUNICATION

Sometimes it is difficult to understand one another across the barriers of language, age, gender and race; if we sometimes can't understand what might hurt another person in our own culture, what hope is there to avoid misunderstandings and relational blockages when clinicians and carers come from another culture...?

A WIKIPEDIA ENTRY TO MADNESS

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2. Cross Cultural: https://en.wikipedia.org/wiki/Intercultural_relations
3. Social Construction: https://en.wikipedia.org/wiki/Social_constructionism
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6. Overseas Trained Psychiatrists: http://tapri.org.au/wp-content/uploads/2016/02/v11n1_6bartonhawthorne.pdf
7. Family Caregivers: https://en.wikipedia.org/wiki/Family_caregivers
8. Caregiver: <https://en.wikipedia.org/wiki/Caregiver>
9. Community Health Workers Comment: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4442123/>
10. Psychiatric History: https://en.wikipedia.org/wiki/Psychiatric_history
11. Medical Ethics: https://en.wikipedia.org/wiki/Medical_ethics
12. Epistemology: <https://en.wikipedia.org/wiki/Epistemology>
13. Language Barrier: https://en.wikipedia.org/wiki/Language_barrier
14. Medical Linguistics: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219831/>
15. Foucauldian Discourse Analysis: https://en.wikipedia.org/wiki/Foucauldian_discourse_analysis
16. Labelling Theory: https://en.wikipedia.org/wiki/Labeling_theory
17. Identity of Psychiatrists: <https://www.tandfonline.com/doi/abs/10.3109/10398560903513051?journalCode=iapy20>
18. Prejudice and Discrimination from Providers: https://www.researchgate.net/publication/278330764_Prejudice_and_Discrimination_from_Mental_Health_Service_Providers
19. Linguistic Discrimination: https://en.wikipedia.org/wiki/Linguistic_discrimination
20. Medical Humanities: https://en.wikipedia.org/wiki/Medical_humanities



12.



*Can Medicine
Cure Prejudice?*

12. Can Medicine Cure Prejudice?

STIGMA AND SCIENCE

Medicine, many believe, is primarily a branch of science. Most doctors believe in double-blind trials, evidence-based practice and proven methods. With positivistic research they believe they work with facts. This is not just good science but gives community security, a faith in standards and results. The test of knowledge when it comes to community awareness programs often resides in the heart and not the brain.

THE TAXI TEST

Simon Champ is a gentle and brave pioneer of the Australian consumer movement. He was very active at a national level, flying about a bit and this involved taxi trips to and from airports. He made a habit of sharing a story with the drivers. Choosing a familiar marker on his way home from the airport, he'd launch into a personal schizophrenia story and see how long it took before the driver's knuckles went scared-white from gripping the wheel too hard.

LAY DIAGNOSTICIANS

Many rolled out anti-stigma campaigns are medicalised, encouraging community members to learn more about diagnostic characteristics fascinating many people. It is frequently about encouraging people to seek treatment. As well, a million amateur illness sleuths in the community might not be helpful. Lecturing to program participants that this information should be used only by qualified practitioners is perhaps naïve.

PERSONAL NARRATIVE AND COMMENTARY

Many campaigns utilise personal story, but too often this is the entrée before the main dish, featuring those with 'real knowledge', real social credence, real evidence and real science. Thus, story-as-knowledge is condemned to a position of eternal relativity and dismissed as 'anecdotal'. Consumers are cast as the powerless antiheroes or battler-heroes or even bystanders.

SO YOU WANT TO KNOW? WHAT?

Do 'mental illness campaigns' work? We won't know until we agree on what it is that we want to tell the community. Some messages are medically authorised because those who hold the view are politically authorised; the consumer story remains 'anecdotal'. As this famous quote reminds us: "Not everything that can be counted counts. Not everything that counts can be counted." (William Bruce Cameron; sometimes attributed to Albert Einstein.)

A WIKIPEDIA ENTRY TO MADNESS

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2. History and Philosophy of Science: https://en.wikipedia.org/wiki/History_of_science
3. Community Awareness Programs: https://en.wikipedia.org/wiki/Suicide_awareness
4. Empirical Evidence: https://en.wikipedia.org/wiki/Empirical_evidence
5. Direct Action: https://en.wikipedia.org/wiki/Direct_action
6. Evidence: https://en.wikipedia.org/wiki/Evidence-based_medicine
7. Social Research: https://en.wikipedia.org/wiki/Social_research
8. Disease Mongering: https://en.wikipedia.org/wiki/Disease_mongering
9. Narrative Research: https://en.wikipedia.org/wiki/Narrative_inquiry
10. Brain Science: https://en.wikipedia.org/wiki/Cognitive_science
11. Prejudice: <https://en.wikipedia.org/wiki/Prejudice>
12. Advertising Campaign: https://en.wikipedia.org/wiki/Advertising_campaign
13. Health Campaign: https://en.wikipedia.org/wiki/Health_campaign
14. Campaigns for Behavioural Change: <http://www.endvawnow.org/en/articles/1192-campaigns-for-behaviour-change.html>
15. Culture Change: https://en.wikipedia.org/wiki/Culture_change
16. Reinforcements Theory: https://en.wikipedia.org/wiki/Reinforcement_theory
17. The Debate Following DSM-v: <http://roar.uel.ac.uk/4540/1/Philippa%20Sweeney.pdf>
18. Attitude Change: https://en.wikipedia.org/wiki/Attitude_change
19. Confirmation Bias: https://en.wikipedia.org/wiki/Confirmation_bias
20. Consensus Decision Making: https://en.wikipedia.org/wiki/Consensus_decision-making



13.

Eyes Wide
Open: Prejudice
and Professional
Education



13. Eyes Wide Open: Prejudice and Professional Education

PRE-JUDGING AS PRACTICE

Clinicians use judgement – medical judgement - as standard practice. Pre-judging is a skill and, for example, can make diagnosis more efficient, but it may also contribute to systemic failings. For clinicians to claim they are not 'prejudiced' is to disown their own *best practice* guidelines.

WHAT CAN A STUDENT DO?

In a Sydney public hospital ward, a senior social worker turned cynical by experience, has forgotten that her patients are adults. She demeans some and several are upset. This is keenly observed by a social work student on placement. He is concerned: is cynical practice prejudice? If students observe behaviour that stigmatises and they voice it, is this more professional than saying nothing?

HERO – ANTI-HERO

Sometimes supervising clinicians mistake the extraordinary for the unprofessional. When study is OK but clinical placements are not, what does this mean? Are student 'dropouts' really unsuitable for practice? What role can consumers play here?

PRAGMATISM

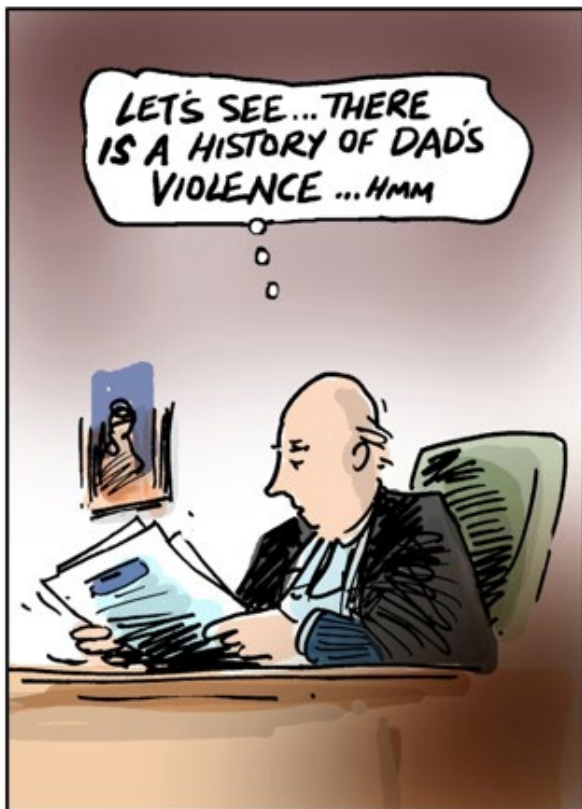
Clinical educational courses (across all groups) increasingly rely on overseas fee-paying students – especially in medicine – and on those who need to work long hours with low pay to 'put themselves through'. Course content that is relational is studied externally. Students assess staff and are excused from practice placements because they have paid work to do. Social change curricula are out of fashion and there have been substantial funding cuts. And what has this got to do with systemic prejudice?

RESISTING THE PULL OF CYNICISM

A young teacher is sent to a very poor school. She notices that when children show emotional distress, the school's first response is to blame families. She is told this is proven, successful practice in this very difficult school. This seems odd to her as there is no obvious link. Perhaps the school has learnt to see things differently because the families are poor. At present she is too junior to drive change, but...

THE COST OF LEARNING TO FIT IN

Another young teacher employed by a wealthy school is worried about a pupil who excels in intelligence tests but not in performance and has been moved to the remedial stream. Her parents are informed but not burdened as the problems are 'academic'. The young teacher's view is that her student is struggling psychologically. At present, she is too inexperienced to challenge established institutional culture, but...



A WIKIPEDIA ENTRY TO MADNESS

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2. Deregulation: <https://en.wikipedia.org/wiki/Deregulation>
3. Ethical Issues in Psychiatry: https://en.wikipedia.org/wiki/Ethical_issues_in_psychiatry
4. Globalisation: <https://en.wikipedia.org/wiki/Globalization>
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7. Internship: [https://en.wikipedia.org/wiki/Internship_\(medicine\)](https://en.wikipedia.org/wiki/Internship_(medicine))
8. Medical Education in Australia: https://en.wikipedia.org/wiki/Medical_education_in_Australia
9. Medical Students' Disease: https://en.wikipedia.org/wiki/Medical_students%27_disease
10. Meritocracy: <https://en.wikipedia.org/wiki/Meritocracy>
11. Neoliberalism: <https://en.wikipedia.org/wiki/Neoliberalism>
12. Organisational Culture: https://en.wikipedia.org/wiki/Organizational_culture
13. Privatisation: <https://en.wikipedia.org/wiki/Privatization>
14. Residency: [https://en.wikipedia.org/wiki/Residency_\(medicine\)](https://en.wikipedia.org/wiki/Residency_(medicine))
15. Selling Education (privatisation): <https://en.wikipedia.org/wiki/Privatization>
16. Senior Registrar: https://en.wikipedia.org/wiki/Senior_registrar
17. Social Work: https://en.wikipedia.org/wiki/Social_work
18. Tertiary Education in Australia: <https://en.wikipedia.org/wiki/Globalization>
19. Education Theory of Apprenticeship: https://en.wikipedia.org/wiki/Educational_theory_of_apprenticeship
20. Student Migration: <https://en.wikipedia.org/wiki/Globalization>



74.



Psychiatry
on the Nose

14. Psychiatry on the Nose

SCIENCE, STIGMA AND PSYCHIATRY

In medicine, psychiatry is too often seen as speculative with insufficient evidence; so, some psychiatrists move further into the brain, abandoning historically important understandings of the 'mind' in a search for science and respectability. Likewise, some clinical psychologists move further into positivistic research. Is this about science or is it about ego and the reputation of psychiatry with people who matter?

SKIP THE MENTAL HEALTH LECTURES?

Generalist courses in all disciplines inevitably create competition for students between streams and some courses have electives where mental health regularly has the lowest enrolment. Student choice of subjects reflects students' previous life experience along with their experience of prejudice in medical culture. Such acculturation, in turn, reflects and reproduces community prejudice.

CARING AND POWER

Many nurses want to care for people and avoid discussions of health politics. Relative powerlessness, however, is an everyday experience for many. Some psychiatric nurses use personal experience of disempowerment to sustain pressure for change – for themselves and for patients. Some act but many don't. Perhaps some are scared or see no point becoming cynical about change ever happening. Cynical practice probably means health politics in practice.

POLITICAL IDENTITY AND POWER

Consumers are perplexed by the behaviour of nursing unions, some of us feeling personally attacked. The unions need to defend their members against consumer violence, so they argue, using rhetoric that many of us find offensive and steeped in prejudice. In contrast, the AMA and the APS can lobby governments sedately only because they are powerful. Political organising is necessary when there is no institutional power.

NOT JUST HUMOUR

Medical undergraduates in Australia use humour. Apart from being amusing, it inducts them into medical culture. Later in their careers it will become a way of relieving stress and garnering sympathy. The problem with psychiatry is that it lends itself to ridicule. It is an easy target for would-be pranksters and vitriolic humour. If psychiatrists can't adequately defend themselves from medical culture, how can their patients?



MID-TERM ASSESSMENT YEAR 3 OCCUPATIONAL THERAPY

A WIKIPEDIA ENTRY TO MADNESS

1. Gallows Humour: https://en.wikipedia.org/wiki/Black_comedy
2. Medical Humour: https://en.wikipedia.org/wiki/Stitches:_The_Journal_of_Medical_Humour
3. Medical Culture: https://en.wikipedia.org/wiki/Medical_anthropology
4. Cultural Sociology: https://en.wikipedia.org/wiki/Sociology_of_culture
5. Induction in to Culture (Socialisation): <https://en.wikipedia.org/wiki/Socialization>
6. Medical Practitioner Stress: https://en.wikipedia.org/wiki/Stress_management#Medical_environment
7. Social Stigma: https://en.wikipedia.org/wiki/Social_stigma
8. Anti-psychiatry: <https://en.wikipedia.org/wiki/Anti-psychiatry>
9. Othering: <https://en.wikipedia.org/wiki/Discrimination>
10. The Australian Medical Association: <https://ama.com.au/>
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12. The Changing face of Tertiary Education: <http://ksr.hkspublications.org/2013/05/02/the-changing-face-of-higher-education-the-future-of-the-traditional-university-experience/>
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14. Activism: <https://en.wikipedia.org/wiki/Activism>
15. Unionism in Australia: https://en.wikipedia.org/wiki/Australian_labour_movement
16. Politics of Caring: <http://www.unrisd.org/research/gd/care>
17. Identity Politics: https://en.wikipedia.org/wiki/Identity_politics
18. Mind/Brain Debate: <https://www.talkspace.com/blog/2017/11/neuroscience-and-psychology-unlocking-mysteries-mind/>
19. Organisational Change Fatigue: https://en.wikipedia.org/wiki/Organizational_change_fatigue
20. Occupational Burnout: https://en.wikipedia.org/wiki/Occupational_burnout



General
Practice:

15.

The
Gatekeepers

15. General Practice: The Gatekeepers

SO, WHAT'S IN A DIAGNOSIS?

General practitioners (GPs) must diagnose as this is their trade, but not everything about mental health can be medically diagnosed. GPs are on the front line. They must continually deal with the fundamental contradiction. It is not a health system; it is an illness system.

CALL A SPADE

GPs are required to be all things to all people; nonetheless, language sometimes tarnishes them and their patients. Specialists' derogatory language behind people's back is possibly worse, but they don't see as many people. Euphemisms or code used to describe those who annoy some GPs or from whom they need distance have a role. Naming a group of patients using broad categories of prejudice to deal 'efficiently' with them converges with attending to recalcitrant and difficult specialists, hugely long waiting lists and exhaustion.

FREQUENT FLYERS

This describes patients who want more and more medical attention when they don't 'need it'. It implies some sort of 'mental or social problem' couched in the language of neediness or loneliness. The institutions of medicine have limitations – funding, beliefs about purpose, workload and pressure – but some are not answered by more funding but by bravery. The frequent flyer language is dismissive; medical frequent flyers tend to be poor and female; the aeroplane ones tend to be male and wear a suit.

PRACTISES IN THE WAITING ROOM

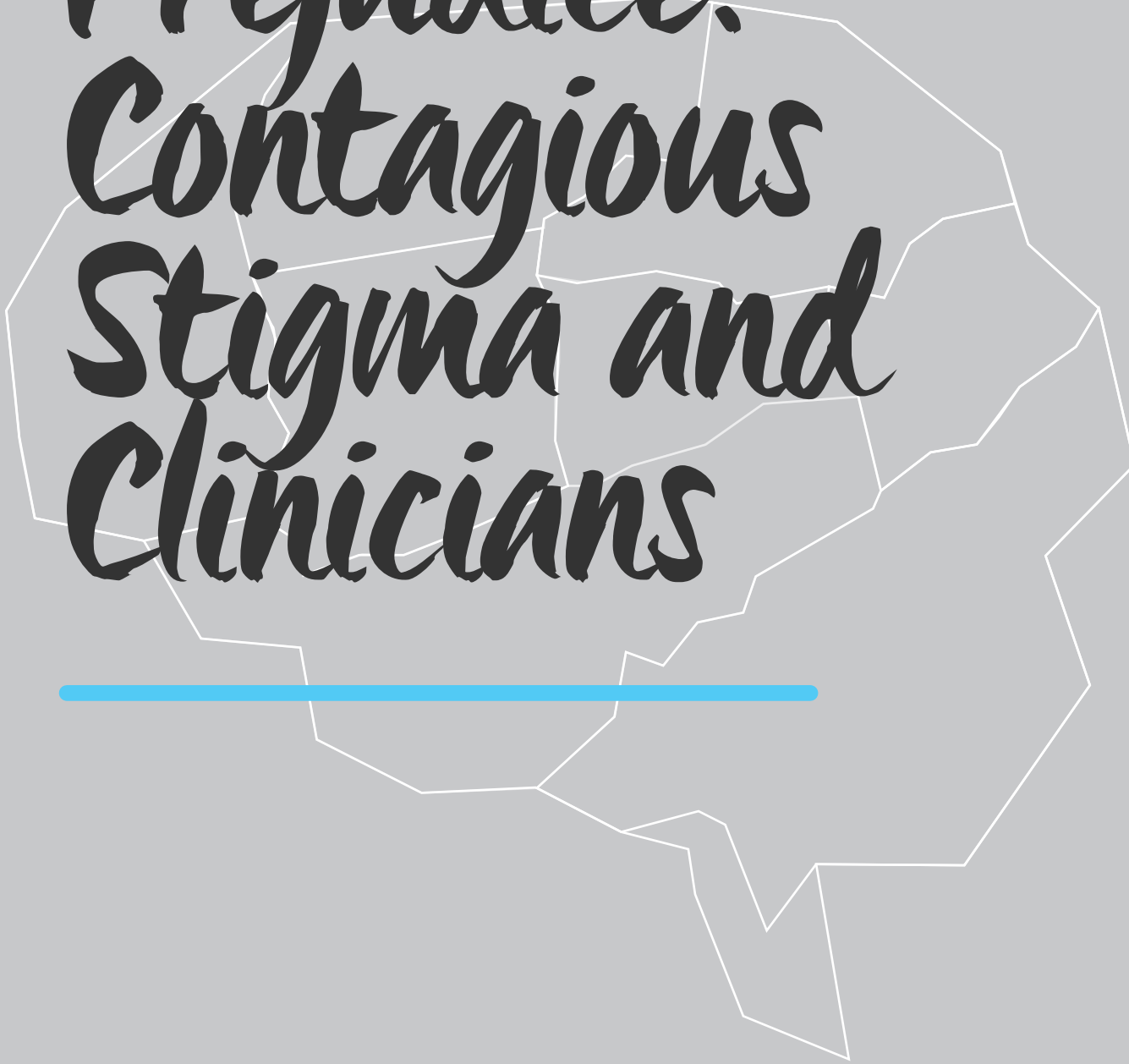
The waiting room is a microcosm of the community. The community will always judge. Crazy things will spread outside the walls of the professional rooms. People with a mental health breakdown will be judged and sanctioned. How the medical practice is established in terms of space and staff will be vitally important in educating the local community what mental illness is and what it is not.

THIS COHORT OF DIFFICULT PATIENTS

The medical profession sometimes fails to achieve an acceptable physical diagnosis and then turns the presenting problem into an undifferentiated psychiatric explanation. What does medicine do with the misfits and the contrary and the things it doesn't understand? Is it stigmatising to diagnose people who don't fit in with a diagnosis (no matter how psychiatric) or is it stigmatising not to do so?

A WIKIPEDIA ENTRY TO MADNESS

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2. General Practitioner: https://en.wikipedia.org/wiki/General_practitioner
3. Family Medicine: https://en.wikipedia.org/wiki/Family_medicine
4. Primary Care: https://en.wikipedia.org/wiki/Primary_care
5. Social Theory: https://en.wikipedia.org/wiki/Social_theory
6. Medical diagnosis: https://en.wikipedia.org/wiki/Medical_diagnosis
7. Poverty: <https://en.wikipedia.org/wiki/Poverty>
8. Working Class: https://en.wikipedia.org/wiki/Working_class
9. Patient Diagnosis and Gender: https://en.wikipedia.org/wiki/Gender-bias_in_medical_diagnosis
10. Cohort: https://en.wikipedia.org/wiki/Cohort_study
11. Women's health: https://en.wikipedia.org/wiki/Women%27s_health
12. College of General Practice: <https://www.racgp.org.au/Home>
13. Specialist referral: [https://en.wikipedia.org/wiki/Specialty_\(medicine\)](https://en.wikipedia.org/wiki/Specialty_(medicine))
14. Feminist psychology: https://en.wikipedia.org/wiki/Feminist_psychology
15. Gender stereotype: https://en.wikipedia.org/wiki/Gender_equality
16. Race stereotype: <https://en.wikipedia.org/wiki/Stereotype>; https://en.wikipedia.org/wiki/Ethnic_stereotype
17. The Difficult Patient: <https://www.ncbi.nlm.nih.gov/books/NBK339/>
18. Words that annoy, phrases that grate: <https://blogs.bmj.com/bmj/2017/04/07/tessa-richards-words-that-annoy-phrases-that-grate/>
19. Patient Participation: https://en.wikipedia.org/wiki/Patient_participation
20. Mental Health: Primary Health Care Networks: <http://healthvoices.org.au/issues/april-2017/health-insurance-psychiatry-covered-not/>



Pass the
Prejudice:
Contagious
Stigma and
Clinicians

15.

16. Pass the Prejudice: Contagious Stigma and Clinicians

CLINICIANS ARE SENTENCED

The downside of the authority and power that our community extends to physicians is that they are largely powerless to talk publicly about their own mental health issues despite the high incidence of mental illness in this group. More public conversations with real doctors talking about real illness would be useful, but a doctor speaking about his or her experience of psychosis would probably be career-ending.

UNIONS, ASSOCIATIONS, POLITICS AND COMMUNITY PERCEPTION

Clinical groups try different ways to attract public support. Doctors and psychologists have deeply politicised and authoritative associations. Their campaigns are sophisticated as they have influence. Nursing unions can be raucous in public and blaming of consumers. Perhaps inevitably, nurses have less power. All groups working in mental health remain vulnerable to societal approbation and ridicule. This is prejudice but does not undo privilege.

PSYCHIATRY - THE UNLOVED CHILD

Medical graduates avoid specialising in psychiatry partly because of the prejudice attached to it. Psychiatrists remain the butt of medical and community jokes. Efforts to defend psychiatry are controversial. Some consumers don't want to fight for psychiatry – quite the opposite; as well, some psychiatrists know they have considerable social credibility just by being a doctor.

HISTORICALLY SPEAKING

From era to era, ideas and practices change. In the 1960s and 1970s, psychotherapy(ies) were considered state of the art treatments. They are not any more but could easily be again. As it stands, there is prejudice not only against psychotherapy but against both those who practice it and those who need it. When defending 'evidence-based practice,' it becomes necessary to demonise the 'other', as certain practices are sold to the community as fact.

IN COURT

Psychiatrists are called to examine and decide whether accused murderers are insane. Our community doesn't like murderers and we don't like people we believe are murderers who 'get off'. Psychiatrists enter the lion's den when they defend a man with schizophrenia who has done something dastardly. The cross-examination will be furious in a way unlikely to happen with another medical professional giving expert evidence. A psychiatrist's reputation will be on the line very publicly, perhaps also in a context of community belief that she is not a real doctor anyway.

DE-INSTITUTIONALISATION?



A WIKIPEDIA ENTRY TO MADNESS

1. Social authority: [https://en.wikipedia.org/wiki/Authority_\(sociology\)](https://en.wikipedia.org/wiki/Authority_(sociology))
2. Soft Power: https://en.wikipedia.org/wiki/Soft_power
3. Industrial (Trade) Unions: https://en.wikipedia.org/wiki/Trade_union
4. Social Influence: https://en.wikipedia.org/wiki/Social_influence
5. Psychotherapy: <https://en.wikipedia.org/wiki/Psychotherapy>
6. Psychopathology: <https://en.wikipedia.org/wiki/Psychopathology>
7. Social Appropriation: https://en.wikipedia.org/wiki/Cultural_appropriation
8. Gallows Humour: https://en.wikipedia.org/wiki/Black_comedy
9. Freud: https://en.wikipedia.org/wiki/Sigmund_Freud
10. Jung: https://en.wikipedia.org/wiki/Carl_Jung
11. Therapeutic Communities: https://en.wikipedia.org/wiki/Therapeutic_community
12. Othering: <https://en.wikipedia.org/wiki/Discrimination#Othering>
13. Psychoanalysis: <https://en.wikipedia.org/wiki/Psychoanalysis>
14. Legal Definition Innocent: https://en.wikipedia.org/wiki/Presumption_of_innocence
15. Defence of 'Insanity': [https://en.wikipedia.org/wiki/Criminal_defenses#Mental_Disorder_\(Insanity\)](https://en.wikipedia.org/wiki/Criminal_defenses#Mental_Disorder_(Insanity))
16. Suicide of Psychiatry Registers: <https://www.mja.com.au/journal/2015/202/5/perfect-storm>
17. Essays by Medical Students on the Mental Health of Doctors: <https://www.ranzcp.org/essaycomp>
18. List of Psychotherapies: https://en.wikipedia.org/wiki/List_of_psychotherapies
19. Timeline of Psychology: https://en.wikipedia.org/wiki/Timeline_of_psychology
20. Timeline of Psychiatry: https://en.wikipedia.org/wiki/Timeline_of_psychiatry

INSTITUTIONALISED PREJUDICE

17.

Making the Body
Fit the Jumper:
The Predictable
Rhetoric of the
NDIS

17. Making the Body Fit the Jumper: The Predictable Rhetoric of the NDIS⁶

RHETORIC AND FIBS

Organisations charged with providing services to oppressed groups have a dilemma; they need to sell their 'wonderful new product' but also prevent budget over-runs. So as people are urged to 'buy' this 'product' – and they will – agencies will have to figure out 'eligibility' criteria to accept some and refuse others... and that's where the fibs start...

POLITICAL CONSTRUCTION OF DISABILITY FRAUD: AUTISM PREJUDICE AND THE NDIS

Political rhetoric has defamed people diagnosed with autism; not only have those responsible for the NDIS threatened to withdraw services, they justified their decision because of the lack of resources. Their previous decision to not increase the Medicare levy now leads them to single out one group, trying to convince the public that people diagnosed with autism are unworthy. Regardless of their retraction, the damage of prejudice is done.

PAINT YOURSELF BLACK BEFORE ENTERING

How can a system that insists on everyone having to prove they are the most seriously disabled not be prejudicial to people with psychiatric disabilities? This works within each 'type' of disability as well as across disabilities. This forces everyone with a disability onto a 'downward' slope of claiming greater gravity of their disability or onto an 'upward' slope of feeling that theirs is a disability not grave enough for funding.

SOCIAL (DIS-) LOCATION

No-one is ever completely on their own in the world – we are not isolated entities totally singular or totally individual. Disabilities (like abilities) are social; people are 'disabled' in context, communities being a vital living context. The NDIS has re-individualised provision for people with disabilities with its 'case-based' approach. Has the importance of true interrelatedness, reciprocity, power sharing, respect for adult identity and having a stake disappeared?

CALL-CENTRES, BUREAUCRACY AND MULTINATIONAL THEATRE

So, large multinational companies mainly working with non-disabled people are perfect for making subtle, humane and knowledgeable judgements for the NDIS...? They will not be swayed by those representing more 'serious' levels and areas of disability. They won't be influenced by the wealthy, the influential and the politically well-placed. They will be kind and non-judgemental in their adjudication. You bet...

⁶ National Disability Insurance Scheme - https://en.wikipedia.org/wiki/National_Disability_Insurance_Scheme

A WIKIPEDIA ENTRY TO MADNESS

1. National Disability Insurance Scheme (NDIS): <https://www.ndis.gov.au/about-us/what-ndis>; <https://www.ndis.gov.au/people-disability/access-requirements.html>
2. Disability: <https://en.wikipedia.org/wiki/Disability>
3. Social Construction of Illness: https://en.wikipedia.org/wiki/Social_model_of_disability; https://en.wikipedia.org/wiki/Sociology_of_health_and_illness
4. Socioeconomic Status: https://en.wikipedia.org/wiki/Socioeconomic_status
5. Disability and Indigenous Communities: https://en.wikipedia.org/wiki/Institutional_racism#Australia
6. Call Centre: https://en.wikipedia.org/wiki/Call_centre
7. Intersectionality: <https://en.wikipedia.org/wiki/Intersectionality>
8. Individualisation and Human Rights: <http://rightnow.org.au/opinion-3/will-the-ndis-and-individualisation-of-disability-services-enhance-human-rights/>
9. Social Construction of Disability: https://en.wikipedia.org/wiki/Social_construction_of_disability
10. Who is in and who is out of the NDIS: <https://www.tandfonline.com/doi/full/10.1080/15017419.2015.1064026?src=recsys>
11. Who wins and who loses NDIS: <https://epress.lib.uts.edu.au/journals/index.php/mcs/article/view/3915/4348>
12. Rhetoric: <https://en.wikipedia.org/wiki/Rhetoric>
13. Political Communication: https://en.wikipedia.org/wiki/Political_communication
14. Disability Fraud: https://en.wikipedia.org/wiki/Disability_fraud
15. Disability Determination Services (DDS): https://en.wikipedia.org/wiki/Disability_Determination_Services
16. Forced to Fake Disability by System: <https://thebodyisnotanapology.com/magazine/forced-to-fake-it-how-the-system-forces-disabled-people-to-lie/>
17. A Brief Guide to the Disability Discrimination Act: <https://www.humanrights.gov.au/our-work/disability-rights/guides/brief-guide-disability-discrimination-act>
18. Impairment: <https://en.wikipedia.org/wiki/Impairment>
19. NDIS - Redressing or Enhancing Health Inequities: <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-017-0682-z>
20. Personalisation: <https://en.wikipedia.org/wiki/Personalization>





Centrelink?

18.

They Wouldn't
be Pre-judging
Would They?

18. Centrelink? They Wouldn't be Pre-judging Would They?

COMPETING MESSAGES

At the same time as we spend money on expensive anti-stigma campaigns, we are also funding community attitude programs dressed as government welfare. Demonising pensioners by questioning their 'eligibility' directly undercuts many of the messages aimed at stigma reduction. Creating an underclass has political currency and anti-stigma heroism does too. For many of us, they are contradictory.

POLITICALLY SPEAKING

The Keating (Labor) Government sought to lower unemployment figures, moving the unemployed onto disability pensions. Many had back problems, fibromyalgia, repetitive strain injuries and psychiatric issues. Subsequent governments (very publicly) blamed these people for receiving disability pensions when 'just unemployed'. It is made worse because disability pensioners are too often also a public punching bag.

CONGRATULATIONS

Some of us fail the real '*disability pension test*', losing our souls to disgrace, believing to be losers and whingers. Some can live well and psychologically healthily on meagre incomes whilst not being devastated by community judgment; this is resilience and might well be a positive part of every anti-stigma campaign. But of course it is not...

THE OFFICE OF THE DEAD

Social workers surviving toxic work conditions at Centrelink sometimes experience mental health challenges. Compromised workers are traumatised by workplaces that have become places of judgement and retribution. Unions might do what they can, but mass retrenchments are justified by rhetoric about '*productivity*' and lack of funds. How can anti-stigma campaigns about mental illness be seriously enacted when the systems who promote them continue to make those who work in them sick?

IMPAIRMENT TABLES

If you haven't seen these, do; they establish inflexible criteria for getting a Disability Pension based on one's capacity for employment. One applicant for unemployment benefits sighed: "*How I yearn for a disability*" and then she was jumped on. Why can't she say that? Could this be another form of prejudice? It's the truth for many, but at the same time, the disability pension is equally inadequate and the prejudice is still there if a little less terrifying. But first you have to pass the impairment assessment...

http://guides.dss.gov.au/sites/default/files/guide_impairment_tables.pdf

A WIKIPEDIA ENTRY TO MADNESS

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Operating **19.**
Undercover:
Discrimination
and Workover

19. Operating Undercover: Discrimination and Workcover

WHAT DO YOU DO WITH A RETIRED PSYCHIATRIST?

Psychiatrists sometimes go on working after retirement by becoming WorkCover psychiatrists. They make good money which potentially puts their impartiality into question. Many consumers reckon that it would be hard to do this work when remaining committed to the patient being central to their professional ethics. Consumers feel that clinicians are paid to make sure no claim is successful. This information, true or not, creates fears so great that people simply don't try.

WHY BE KIND WHEN YOU COULD BE CRUEL?

Stories of bad behaviour surround WorkCover, some of it by would-be claimants who cheat at the expense of the rest of us and this lack of ethics is matched by some clinicians. People have experienced major breaches of confidentiality, re-diagnosing people after only a thirty minute interview and dismissive and demeaning attitudes to the people applying but also to their long-term psychiatrist.

MAKING US MENTAL

Some of us have pre-existing mental illnesses, which can be retriggered in the workplace caused by racism, sexism, sexual inappropriateness, bullying and horizontal violence. Those already diagnosed carry a burden of doubt whether submitting a claim is worth it; others who carry psychological damages from the workplace are so averse to being labelled mentally ill that they don't even pursue a very winnable claim.

THE BOGEY DIAGNOSES

As far as WorkCover goes, there are diagnoses and there are 'diagnoses'; for example, it is doubtful that anyone with a personality disorder would win a claim, even if it was for a physical injury totally unrelated to psychiatry. On the other hand, some people really do lie. Mental illness is a medical area vague enough to encourage some to lie. The trouble with this, like the trouble with Centrelink, is that everyone is judged for someone else's duplicity.

REFLECTIONS IN THE SAND

Why can't we see each other as people (not 'individuals') who share a common humanity? Why must bureaucracies be allowed to destroy people, in this case those who are already suffering? The idea that one is presumed innocent until found guilty has gone missing; a sense of fairness, care and compassion is not allowed because vigilance against misrepresentation is foremost.

... AFTER A MONTH OFF WITH A SERIOUS DEPRESSIVE EPISODE...



WORKING CONDITIONS ARE DREADFUL. WE'LL GET YOU BETTER ADJUSTED. HERE'S YOUR BACK TO WORK PLAN



THE PSYCHOLOGIST SAID YOU MUST DOCUMENT EVERYTHING YOU DO



LATER...

YOU'VE HAD A MONTH NOW, WHY NO IMPROVEMENT?

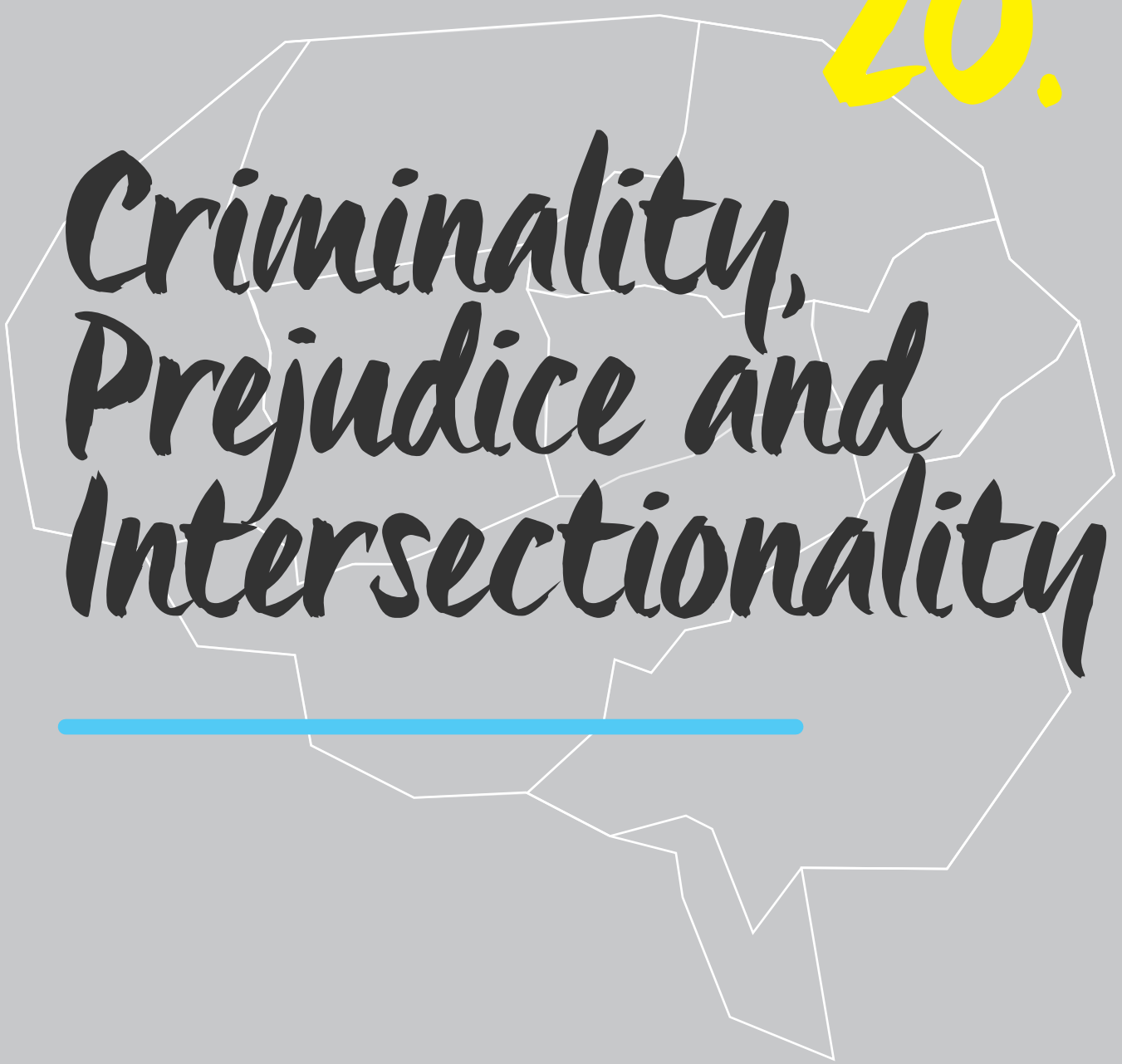


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20.



*Criminality,
Prejudice and
Intersectionality*

20. Criminality, Prejudice and Intersectionality

MULTIPLE PREJUDICES

When released from prison, people diagnosed with 'mental illness' face multiple prejudices; immediately judged as people with mental illness, they are judged again for their criminality. Imagine finding work, accommodation and community with such history hanging over you. People lose contact with community and services. Public housing disappears. Perhaps the worst prejudice is reserved for people lost in this abyss.

KINDNESS

An elderly couple told me about their son; diagnosed with schizophrenia at 19, he was lost to central Sydney: addicted, sometimes violent and with stints in prison. The couple contacted a police officer over twenty years ago. The constable, now in senior command, lets the couple know several times per year after she has seen and talked with their son to tell them that he is still alive. This is a story for the anti-stigma almanac.

ALL PRISONERS ARE EQUAL BUT SOME ARE MORE EQUAL THAN OTHERS

Research tells us that many people with psychotic illness can now be found in prisons. There is outrage about this and talk about the failure of deinstitutionalisation and the paucity of community support structures. Lobbyists describe prisons as the new institutions; however, there is another factor: an influx of mentally ill people has caused *intolerance* amongst other prisoners.

INTERSECTIONALITY: WEIRD WORD BUT IMPORTANT CONCEPT

There is a problem with new words; when medicine produces big words, even ones that are unpronounceable, they are *obviously* important; but when other groups do the same thing, they are likely to be attacked. Intersectionality describes how multiple disadvantages or exclusions don't operate *separately*. Thus, to understand criminality, mental illness and stigma, we must understand other factors including: Aboriginality, social class, gender, poverty, homelessness, ethnicity, race and lack of education.

JUST BAD: PORTRAYING 'PERSONALITY DISORDERS'

Rhetorically, people described as personality disordered are the criminals. Our prisons hold huge numbers of people diagnosed with '*personality disorders*'; they may not be 'nice' people at all; indeed, they probably are not. Unrelenting childhood abuse circumscribes the adult lives of many. We know that childhood trauma and deprivation have insidious long-term effects. This is not an excuse, but it is *prejudice* to ignore it.

A WIKIPEDIA ENTRY TO MADNESS

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POLITICS, CAMPAIGNS & PUBLIC MESSAGES

21.



Government
Pollie-Wobbles

21. Government Pollie-Wobbles

PREJUDICE IS USEFUL

Prejudice is useful for governments; as they are funding anti-stigma campaigns, one of the most effective tools they have to curb demand for services is prejudice. Fear of community judgement stops treatment seeking, which is in the government's interest until someone who 'didn't seek help' kills someone else. Then it becomes a different story. Messages meant to help people find services are only meant for some.

THE ENGAGEMENT RING

Many anti-stigma campaigns overtly claim that they aim to get people to use services. These campaigns are supported because the community should be kept safe by 'taming the mentally ill'. This sometimes needs no designated campaign; when a public incident has occurred, the campaign runs itself. A more benevolent reason is to positively present a 'mentally ill life' with 'real facts' and real hope – if only people would engage. Whether an anti-stigma campaign should include an advertising opportunity for services is something to think about.

MENTAL HEALTH WEEK: WHY?

Is Mental Health Week about educating the community about ways of understanding psychiatric diagnoses? Is Mental Health Week an opportunity to hear from people who have been silenced and if so, is this really achieved? Is it about making young people into heroes and, if so, where are all the old people? Is it about turning very ordinary art into an exhibition that people come to for dubious artistic reasons, but the Minister gets to open it nonetheless?

TAKING SIDES

Whilst the medical model dominates and individualisation continues to dominate our conversations and speeches about mental illness, the public will often hear conflicting and competing stories about what should and should not be funded by government. Frantic efforts to 'read' the sub-text of policies will continue. Government officials will hold value judgements even before they start listening to anyone. Policy is never value-neutral and neither are anti-stigma campaigns.

WHEN THE LEFT IS RIGHT

People who are actively involved in consumer politics are sometimes required to simultaneously be the most competent role models and the 'sickest' specimens of madness. The politically left, in particular, needs our representatives to illustrate their solidarity with the most disadvantaged. Politicians may avoid consumer activists and consult with family carers – especially those lobbying for psychosis. It feels odd and leaves out a lot of relevant voices.

A WIKIPEDIA ENTRY TO MADNESS

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22.



Community
Awareness
Campaigns

21. Community Awareness Campaigns

TOP DOWN

The ideas about what the community needs to know often comes from senior clinicians, bureaucrats, large non-government agencies and, if you're lucky, consultations with consumers and carers; as to the latter, on average, people get 10.5 seconds each to speak.

BRING ON THE ADVERTISING COMPANIES

There is a particular relationship between mental health, society, poverty, meritocracy, life trajectory and community. All of this is entwined with social class, ethnicity, gender and poverty. Maybe advertising companies cannot be trusted with all (or any) of this.

THE CIRCUIT

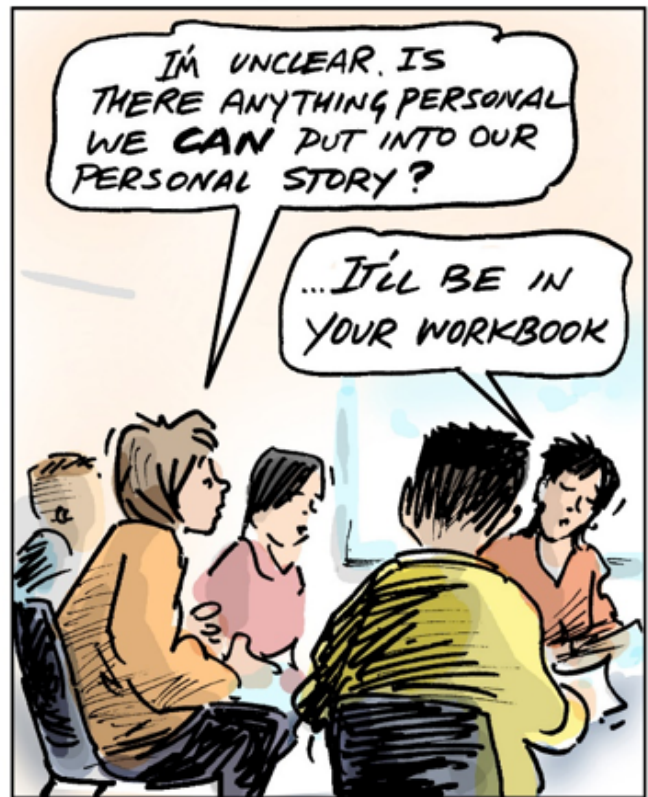
Campaigns often collect acceptable stories from acceptable people with strong positive messages to reassure the community that with the *'right care and support'* people with mental illness can cease being violent, approximate normal and even have good teeth.

FORMULA

Mental Health First Aid and Mental Health Literacy are our community awareness standards. We are divided. Many of us find them a cliché, over-simplistic, too medicalised, creating stereotypes and othering people who do not fit into a fixed and rigid diagnostic picture. Others find them useful to help explain their story.

GRASSROOTS

We really *CAN* do it, but our campaigns are deeply imbedded, local, honest and real. We take responsibility for helping our immediate community to understand both the mess and the tidiness of living with 'mental illnesses'. The abject is included with the guiding idea that all experiences are important. We make mistakes, we disagree in public, we wonder, we cry and sometimes get angry. We read poems and we paint. We also write peer-reviewed papers and use big words. We are the antiheroes of psychiatry's efforts in community-building. There is no script.



A WIKIPEDIA ENTRY TO MADNESS

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23.



**Ambassadorial
Testimonials**

23. Ambassadorial Testimonials

AMBASSADORS

Perhaps anti-stigma campaigns divide us as much as they bring us together. We need our experiences, often bad ones or perhaps very inspiring ones, to be reflected in the discourse. Many of us believe in the power of empathy but we are not equally sellable to the public. Young people, middle-class, articulate 'ambassadors' are, perhaps, a sexy way to sell a message. Whilst potentially educative, the ambassador model also individualises people, stories and experiences as well as homogenising the message.

IS IT ELITIST OR A GOOD BUSINESS MODEL?

Why is it that most people asked to provide public testimonials are so often young and well-educated? Perhaps it showcases the opposite of the dominant stereotype? Organisations in the sector apply media, campaign and messaging advice. Presenting 'real' stories of very difficult battles sounds authentic. Using young people brings hope and it not only suggests that we are 'just like you', but that we are *just like the best of you*.

I'M AFFECTED BY...

Anxiety disorders often fly under the radar but there are still young ambassadors battling to be heard out there. Post-Traumatic Stress Disorder has been getting a run with the Invictus Games. Ambassadors working in these areas shy away from alignment with mad people, but the stories we tell about the worthiness of our journeys are actually very similar. What is missing is community; we share multiple and parallel stories, separated by a gulf of mutual misunderstandings.

EATING DISORDERS

Stigma are marks of disgrace; eating disorders yell in the face of the public, bodies are crippled. Yet, this is a different prejudice than that about physical disabilities because of the assumed wilfulness. Still, there are young ambassadors who represent organisations like the *Butterfly Foundation*, telling a story of survival and hope. Even in hospitals people with eating disorders are judged appallingly; why is this prejudice so profound that solidarity seems too difficult? What drives us to disown some and embrace others?

COMPETITION

A man with Schizophrenia addressed us; he was a young and articulate. Beyondblue, he claimed, is a privileged and narrow organisation with too much money and a disproportionate amount of community compassion. Probably, the 'depression' message has been more successfully sold or the advertising formula works. This is bad, not good. It's divisive but not the fault of people with depression. This is about medical politics, not about relative degrees of suffering. Never forget: there are homeless people with depression.

A WIKIPEDIA ENTRY TO MADNESS

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24.



Listening to
Famous People
Talk About
Themselves

24. Listening to Famous People Talk About Themselves

NO ONE PERSON HAS THE KEY TO WISDOM

Sometimes people believe that a story from a famous person about mental illness is particularly wise. The rich and famous have a story stoked by money and that makes the narrative different: private clinics, different prejudice and often no political, economic or social analysis.

FAMOUS EGOS

Famous people are a coup for organisations wanting someone to be the *'face of the campaign'*, giving specific, pre-determined, messages that are positive, motivating, articulate, and confident. Influential carers are not exempt from this predicament.

ONLY SOME

Doctors in practice will still lose patients, lawyers will still lose clients and politicians will still lose preselection; not all well-known people are able to deal publicly with community prejudice. Some people's experiences of mental distress can be talked about more easily and perhaps heroes come regardless of fame. Even amongst the famous and privileged some taboos continue and are socially enforced.

START THE WORKOUT FROM THE RECOVERED POSITION

There's a temptation for all of us to speak with an aura of success; looking back on our experiences, pleased to have graduated. Triumphs are easier to speak of than the awful, ongoing daily grind when life doesn't reflect our plans and hopes. It should be OK to speak from a position of stasis and ordinary struggle. To insist on being brave makes us feel judged and doesn't help.

LEARNING ILLNESS

I went to a talk about mental illness and came away convinced that I had a mental illness as well as my Mother and my Aunty and my friend Sue and the twins...
Interesting talk I thought...

A WIKIPEDIA ENTRY TO MADNESS

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25.

Messages



25. Messages

HUMAN INTEREST STORIES

Often stories appeal because they are the ever-present narratives of triumph over adversity; people who have beaten the odds, survived terrible illness or divorces or the loss of limbs. These are *heroes* many consumers read about with deep ambivalence; we are sometimes horrified that we don't feel joy in others' triumphs. *"My mother once told me that there was a man who complained about having no shoes until he met another man who had no feet. I figured he must be a duck."* This is not what she meant.

PUTTING BRAVERY TO THE TEST⁷

What does it mean to be constantly told you are 'brave' when you are just being 'normal' happy or 'normal' eloquent or 'normal' knowledgeable, insightful, funny or intelligent? Does that make you a coward when you are being 'normal' unhappy or 'normal' fed-up with a life that's not funny at all? We have our own idea of heroism which might be very different from the hero they want to make of us. *"I don't want you to say 'She's brave' when I speak up. I want you to listen to what I am saying."*

OF FROST-BITE AND SLASHED WRISTS

Self-harm on Mount Everest is sometimes treated as a trophy or adventure, a toe donated to public heroism. The medical costs, mostly, are covered with regard for adventure (and masculinity). In the Emergency Department, the self-harm of the young woman is treated very differently; there is no mystique, no admiration for survival. There is judgement, anger at the cost to society, cruelty, blame and systemic prejudice. Yet surely, if one is culpable (or heroic), so is the other.

THE GOOD WOMAN

When women's magazines were very important, many women regularly rushed for their Women's Day. The magazine appealed, because it had a predictable and reassuring formula of fame, unachievable posh clothes, diets, baking and human interest stories. The problem with mental illness stories is that they don't just appear as an article. They are absorbed into every page as the magazine subliminally reaches readers with messages about what and who is good.

WHAT MEDICINE HAS TO SAY

Not long ago, he met a woman who knew his sister who killed herself when she was young. His sister and this lady met in a psychiatric hospital and they became friends. When his sister, a young doctor, died, she was found with a medical journal beside her, with underlines, bold, crossings-out and different coloured ink for emphasis. This man learned from the woman that if his sister had not been so committed to medical psychiatry, she may have lived.

⁷ This framing is attributed to Flick Grey

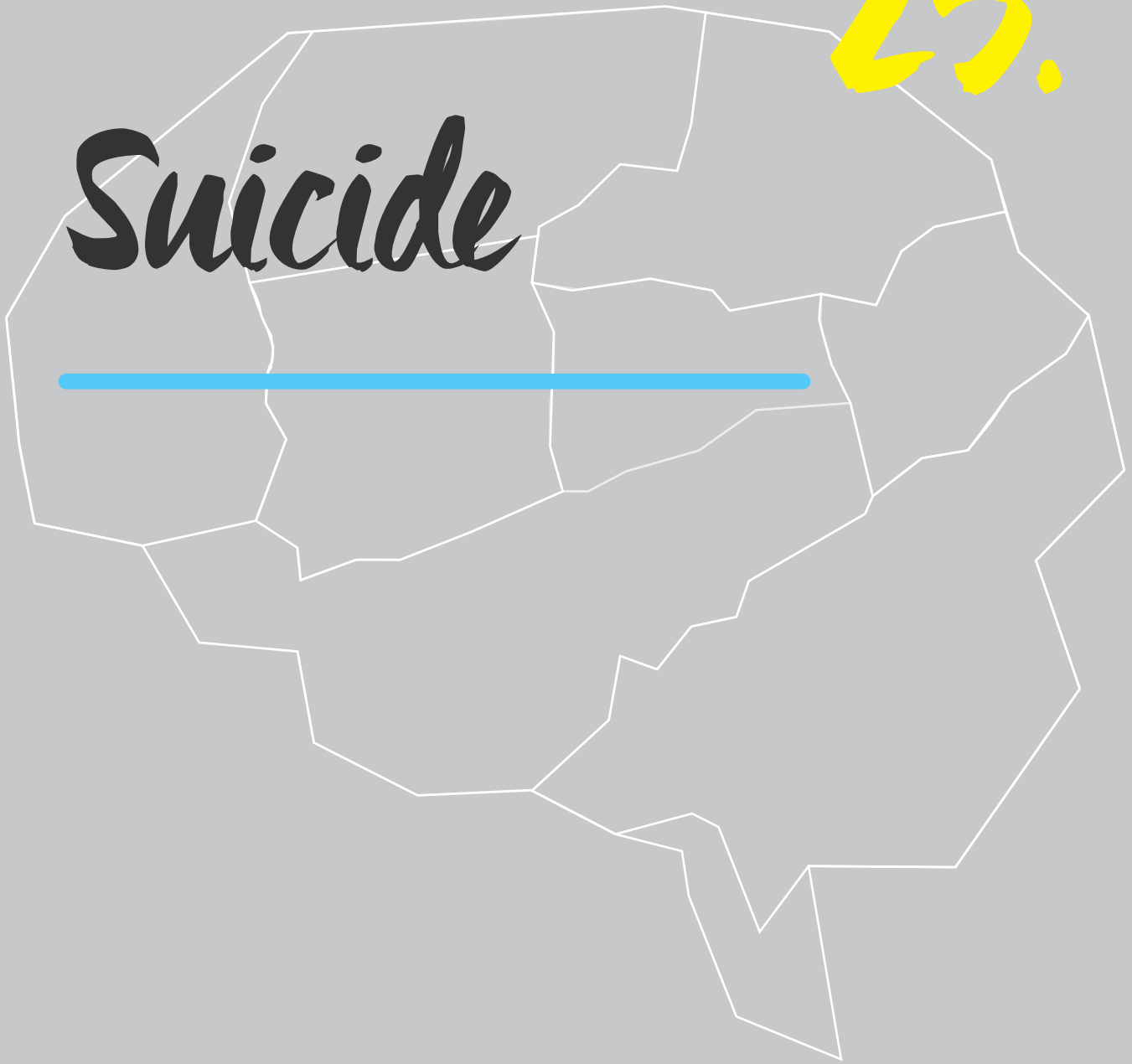
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25.

suicide



25. Suicide

IT'S MEN

Researchers speak about suicide in gendered terms. Is the violence of men more 'genetic' or is it about maladaptation to relational life, post-trauma or some other social or learned vulnerabilities? How can anti-stigma campaigns reflect learning from other cultures about how to bring up men in ways that mitigate against violent deaths? Will individualising the issue and targeting '*vulnerable men*' improve both genders' prejudice against men who need psychological support?

WHEN BRAVERY IS KNOWING WHEN TO DIE WITH DIGNITY

Why can't anti-stigma campaigns promote a more differentiated discussion about suicide? Can we campaign 'against' whilst still allowing people to speak in ways that appreciate the decision-making of those who have had enough? After one woman died, her family was united; "thank goodness, enough pain is enough" they wanted to say. But society allows only one script – grief and despair. Is this social justice?

RESPONSIBLE SUICIDE?

The act of an impetuous teenager whose girlfriend leaves him shooting himself in the head is very different from the deeply depressed woman who pre-thinks the eventualities over and over again. There are people who try really hard to 'look after' others in their search for peace. They can't completely, but they would never jump in front of a train or take an overdose in front of another.

OVERDOSES AND CLINICAL ATTITUDES

In the heat of a presentation in an emergency department, there is no time for niceties: '*conscious?*' – tick; '*substances swallowed?*'; '*Got the bottles?*'; '*How long ago did she take them?*'... In these situations prejudice is more overt, especially with people who have taken a non-life-threatening number of pills. Then there's talk about 'mini-suicidal gestures' or "'just" behavioural' or '*demanding attention*'.

FIFTY DIFFERENT WAYS TO UNDERSTAND SUICIDE

Suicide has many dimensions: youth, internet, copycat, sometimes the jolt of no warning, for others, desperate warnings that are ignored. 'Suicide prevention' rolls off the tongue of governments and publishing 'new' pathways, action plans and reviews is easy. It's true that people should not be allowed to kill themselves in psychiatric hospitals, but even then, some consumers suggest that 'dignity of risk' is equally important. The Inuit people from Alaska have 50 different words for snow... consumers have 50 different ways to understand suicide.

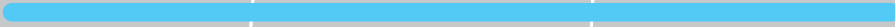
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27.

Sanism



25. Sanism

SANISM

Sanism is a term describing discrimination and oppression against people who have been diagnosed/labelled with mental illness. It's a good word; however, people sometimes don't like these sorts of words sounding abstract, academic and too angry. The more accurately we describe what it is that we are talking about, the easier it is to explain it to others. It's a tool.

THE 'ISMS'

Sanism belongs to a group of concepts expressing ideologies or beliefs like ableism, sexism, racism, eurocentrism, heterosexualism and others. Together fighting against injustice makes us all stronger and models the way we would like the community to behave towards all of us. Some people are annoyed by this language, but fighting for ourselves in solidarity with others is empowering.

POLITICAL CORRECTNESS (PC)

When people are scared or threatened, they often lash out with accusations of 'political correctness' by those who defend the rights of minorities, including people with 'mental illness'. Many use PC as a derogative term or they say "*political correctness gone mad*," which, in our case, is ironic.

SANISM AND 'THE MOVEMENT'

Is there a consumer movement? Whether those who are passionate about 'mental illness' and those who care about social justice have enough in common yet or whether there is even a mission is perhaps debateable. The next question is whether there is 'enough consensus' to locate the problem within a society that discriminates or prejudices on the basis of perceived reasoning.

MENTALISM OR SANISM?

When existing language is unable to describe new phenomena, new language needs to be created. Often our attempts to claim a place in society (and history) are defeated by language disputes. Judi Chamberlin, a famous *mad* activist, coined the term '*mentalism*' to describe our cause. Others prefer '*sanism*' as '*mentalism*' has alternative meanings in philosophy, psychology and the fine arts. Sanism is seen as less confusing.

A WIKIPEDIA ENTRY TO MADNESS

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AND WHAT ABOUT
'SERIOUS' AND
'NOT-SO-SERIOUS'?

No

28.

Euphemisms

Please -

Psychosis

is Shit

28. No Euphemisms Please- Psychosis is Shit

OF COURSE IT'S PREJUDICE

The unmarked (but obvious) crisis team car, the police, the ambulance are conspiring. You get pulled out of your home. The children are scared and your sister is called. The neighbours are watching. The pepper spray is all over you and its burning. Reluctantly you get dragged away and your dog runs down the street after the police car. At that moment, it is *oppression*.

CARING

Sometimes family carers do it tough. They might be cornered between a relative who needs a lot of care and a service system that will not talk to them because they are not 'the patient'. As advocates, they may feel hamstrung and angry. The system, as it presently operates, does not recognise their knowledge, expertise or experience.

DEFILING YOUR NAME

A psychiatric ward is pre-warned. They are bringing you in. They prepare for you in ways that are familiar to them and, unfortunately, familiar to you. Your medical history is re-opened. They have judged you before you arrive and call it preparation, efficiency, readiness. You endure. After you are discharged, harmed, you call it unneeded punishment and torture. You call their preparation prejudice: your reputation defiled. What do you call it three or four or six months later?

IS MENTAL ILLNESS (JUST) SCHIZOPHRENIA?

People sometimes speak about psychosis as if it is all there is about mental illness. Mainly family carers are good at this, because it highlights *their* plight. It *feels* like the truth. It *feels* like the most debilitating and biological of all mental illnesses. Ordinary people who really don't know, believe schizophrenia is about crime and violence; few think about gender. This is selective prejudice based on selective ignorance.

LOSS

All psychosis is thought to be at the 'deep end' of mental illness; but even if they didn't have schizophrenia, profound life losses would be debilitating. Many people lose the life they planned, the love life they hoped for, the weight and figure they admired, the children they wanted so badly, the money that would purchase nice things, the house with the picket fence and the brain they prized more than anything. Then add mental illness... then add prejudice...

THERE IS NO SUCH THING AS A PSYCHIATRIC
CRISIS WITHOUT A SOCIAL CONTEXT



ONCE EMERGENCY VEHICLES GET INVOLVED YOU CAN BE
PRETTY SURE THAT EVERYONE AROUND YOUR HOUSE WILL
EITHER SPY YOU CRAZY OR RUN AWAY. WHAT IS GOING ON, OH!
IT'S JUST HER AGAIN? GET THE CHILDREN AWAY?
TAKING PHOTOS ON MOBILE PHONES, PUTTING THEIR BIB
IN WITH AMBULANCE AND POLICE; POLICE TRYING TO
HOLD STICKY BEAKS BACK. NEIGHBOURS YELLING ABUSE
BECAUSE THEY ARE SCARED.

A WIKIPEDIA ENTRY TO MADNESS

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Stigma
Everywhere...
It's Following
Me

29.

29. Stigma Everywhere... It's Following Me

THE SHOPPING MALL

Pelican Gate Shopping Mall, Thursday 3.00pm. A woman in her fifties has a polka-dot dress, a green ribbon in her hair and bright red lipstick applied very strangely. She seems to be resilient in the situation, been here before, as she politely insists that she hasn't stolen anything. She has no contraband in her bag. The shopkeeper still insists: "We've told you before, you're not to come into this shop."

IN THE FLAT

A young man with schizophrenia had his own flat in a shared block of apartments. He recently became very unwell and, without support, he behaved in ways that frightened his neighbours. The crisis team came with the police. They took him to hospital and he never returned to the flat. It was up to his mother to try and fix the damage, collect his things and apologise to the very frightened neighbours. She found this hard, experiencing humiliation and shame⁸.

ON THE LAND

Barbara was born into a caring, conservative farming family, well-known and respected in the district. At 19 she was diagnosed with schizophrenia. A flat was found for her in town and she was quietly nurtured but her parents withdrew. Resources were scarce and paranoia made contact difficult. When her mother died, her sisters and brother who had stayed in contact, urged Barbara not to come to the funeral because it might aggravate her symptoms.

IN THE FAMILY

A young man experiences drug-induced psychosis. Unable to be the person his professional father wanted and expected, he started drinking and taking drugs. He is a big man just like his father, but on drugs he sometimes frightens people. His father won't let him come home and tells him he would have more sympathy if his psychosis was genuine and not brought on by illicit drug taking, as that behaviour was his choice.

COURT OUT

Robert Carnegie is a battler but streetwise. Growing up in a home characterised by multigenerational poverty and welfare dependency, he learnt how to survive. One day he met Harry Jenkins. He liked him instantly and had no idea he had schizophrenia. He did know he was 'weak'. Robert instinctively defended Harry on the streets. Harry needed his help. One time this went terribly wrong and Robert found himself in court on assault charges. In court, he feigned psychotic symptoms trying to reduce his sentence.

⁸ This story retold from a true story from Robert Bland, QLD social work academic

A WIKIPEDIA ENTRY TO MADNESS

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30.



Stigma
Everywhere...
No Escape

30. Stigma Everywhere... No Escape

IN THE CAFÉ

The gossip is keen in the undergraduate café. Credentials are everything and medical students must strive for good marks. There is a nervous young woman at the end of the table unable to join in the banter. She is quiet and preoccupied. No one talks to her or takes any notice of her. One semester later she drops out.

IN THE STORE

A woman looks around vacantly. Her gait is slow and she seems disoriented, maybe drugged; pills prescribed or not? She doesn't appear to be shopping and this attracts attention as she wanders around the store. As you watch, she places unpaid-for items in her bag. You've read the literature on the link between clinical depression and shoplifting and you contemplate your choices...

IN THE HOME

He gets out of bed so late his Mother is cranky: "You're 23 and your friends are out working and studying but you do nothing all day. Why don't you play sport or join a music club – you used to love music. Do you want to punish us for something? We're the ones who have to cope with you... we're not the enemy."

ON THE STREET

A mother lives with her three small children in the back of an old station-wagon. Life is pointless. She is deeply depressed. She tends to her children as best she can, but they become poorer. She ignores her own feelings, tries desperately to cope, her material and emotional resources depleted. Wanting her children to be 'better' looked after, she notifies the authorities who remove them. Her mood darkens. On her first child's birthday, she kills herself. Who's responsible?

IN HER OFFICE

There is an exciting new appointment at the university... within weeks staff know there is something wrong. The new academic, so well credentialed, is 'strange'. She seems to be withdrawn and unpredictable. Students are divided; some think she is inspiring and others that she is weird; nobody wants to interfere with her academic autonomy. One week after her contract is not renewed she is admitted to a psychiatric hospital.

IM ALL FOR UNDERSTANDING ... BUT...
HE REALLY IS FAT ...

SHE IS DISABLED ... HE IS PSYCHO
AFTER ALL ... THEY ARE BUDGERS
GOD, THEY ARE WHINGERS!

WE ALL HAVE TO
MAKE OUR OWN
LUCK IN THIS
WORLD...



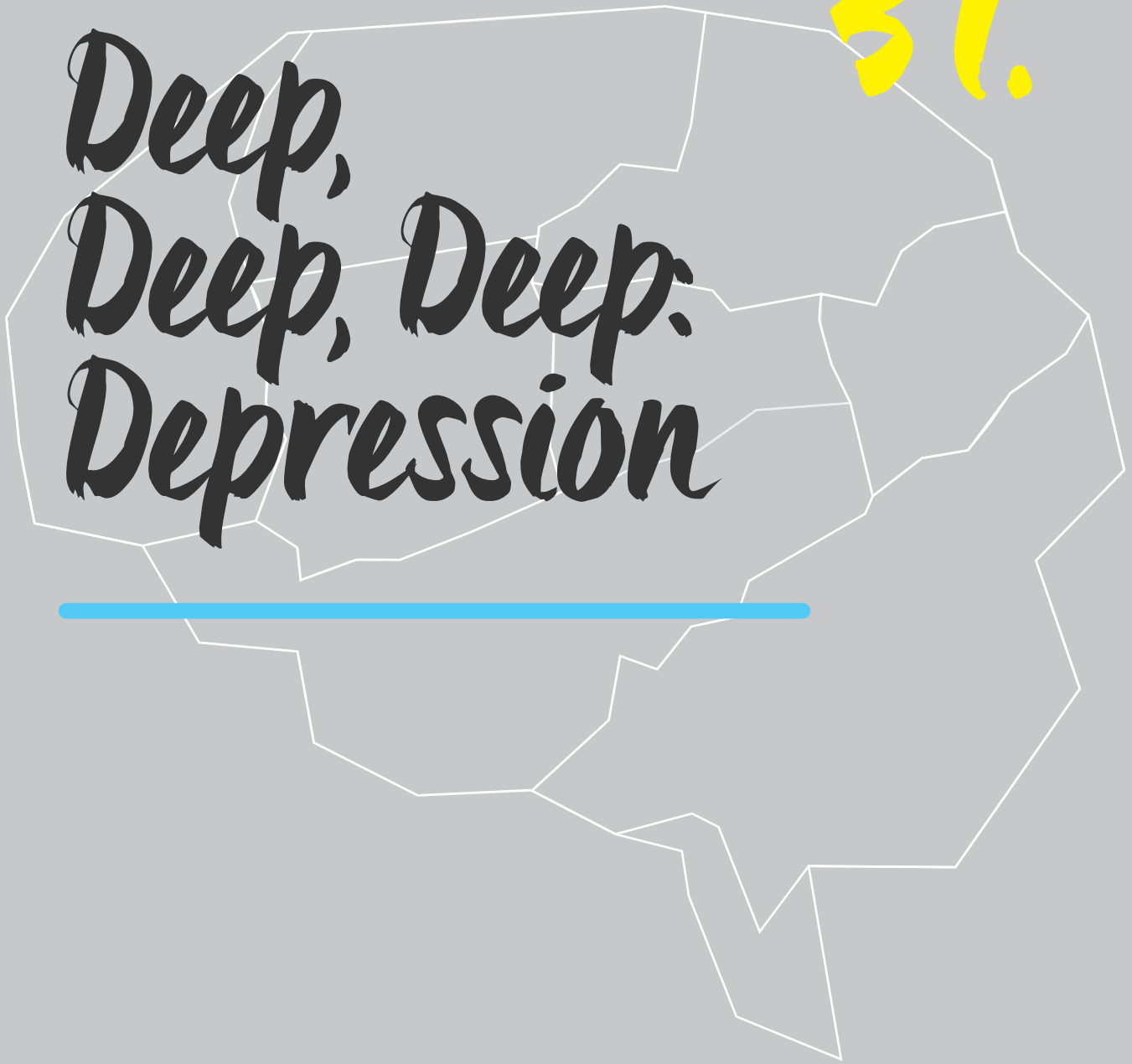
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31.

Deep,
Deep, Deep:
Depression



31. Deep, Deep, Depression

THERE IS NOTHING SUPERFICIAL ABOUT DEPRESSION AND ANXIETY

Public awareness campaigns are simplistic by nature and lead to misunderstandings. Many people living with invisible but debilitating depression can be burdened twice because they are both too obvious in the community as well as hidden behind the prevalence. There is no evidence that anxiety and depression are less serious than other expressions of mental illness.

HOMELESSNESS

Circular thinking sometimes leads to strange reasoning; people with schizophrenia profoundly lose their grip on life, their careers and their homes – they become homeless. So, homeless people with mental illness *must* have schizophrenia; if you 'only' have depression, you really *shouldn't* be homeless ... or, depression must *come from* being homeless and is *natural*.

DEPRESSION IS NOT RESERVED FOR THE RICH

Many people diagnosed with depression are assumed to be wealthy. This myth is fed by some anti-stigma formulations; people who are poor and have chronic debilitating depression disappear into nowhere and, possibly, contribute to suicide statistics. Selective intake criteria in public services render depression invisible because of the 'rich-girl' mythology.

MESSAGE CONFLICT

High profile advocates in the mental health field promulgate stigma. Lobby groups claim a right to funding by arguing their interest is the most worthy and the most cost effective, a necessary competition in our system... As arguments rumble, people sometimes hear simplistic messages and form opinions about the worth of others.

THE PROBLEM IS IN THE WORD

The community believes it understands depression better than other mental illnesses because 'depression' is part of a common vocabulary and relating to 'normal' ups and downs. Many use an idealised perception they have of themselves to gauge what a 'depressed person' ought to be able to do with sufficient willpower ... if only they would use it...

A WIKIPEDIA ENTRY TO MADNESS

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5. Stigma, Depression & Anxiety: <https://www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf>
6. Stereotype Threat: https://en.wikipedia.org/wiki/Stereotype_threat
- Stigma & Prejudice Around the World: <https://www.everydayhealth.com/depression/mental-health-stigma-and-prejudice-strong-around-the-world-8505.aspx>
7. Prevalence of Mental Disorders: <http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-m-mhaust2-toc~mental-pubs-m-mhaust2-hig~mental-pubs-m-mhaust2-hig-pre>
8. Prevalence: <https://en.wikipedia.org/wiki/Prevalence>
9. Disability-Adjusted Life Year: https://en.wikipedia.org/wiki/Disability-adjusted_life_year
10. Disease Burden: https://en.wikipedia.org/wiki/Disease_burden
11. Medicare (Australia): [https://en.wikipedia.org/wiki/Medicare_\(Australia\)](https://en.wikipedia.org/wiki/Medicare_(Australia))
12. Health Insurance & Psychiatry: Covered or Not: <http://healthvoices.org.au/issues/april-2017/health-insurance-psychiatry-covered-not/>
13. Mental Health: Primary HealthCare Networks: <http://healthvoices.org.au/issues/april-2017/health-insurance-psychiatry-covered-not/>
14. Existential Depression in Young Men: <https://www.chrismackey.com.au/existential-depression-in-young-men/>
15. Major Depressive Disorder: https://en.wikipedia.org/wiki/Major_depressive_disorder
16. Endogenous Depression: https://en.wikipedia.org/wiki/Endogenous_depression
17. Exogenous Depression: <https://flowpsychology.com/exogenous-depression/>
18. Universal Health care in Australia: https://en.wikipedia.org/wiki/Universal_health_care
19. Health equity: https://en.wikipedia.org/wiki/Health_equity
20. Social Determinants of Health: https://en.wikipedia.org/wiki/Social_determinants_of_health_in_poverty



Resources and Reference

Resources and Reference

1.

Beyondblue (2014) 'Invisible Discriminator' campaign July, <https://www.beyondblue.org.au/who-does-it-affect/the-invisible-discriminator>

Abstract: *"Subtle' or 'casual' racism can be just as harmful as more obvious forms. Imagine not getting a job because of the way you look. How would you feel if you were watched in a shop or someone didn't want to sit next to you on the bus? beyondblue's Invisible Discriminator campaign highlights the impact of racism on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people."*

A community education campaign to challenge what beyondblue terms 'invisible discriminator', the negative impacts of 'everyday' or 'casual' racism.

2.

Ciftci, A., (2012) Mental Health Stigma in the Muslim Community, Journal of Muslim Mental Health, Volume 7, Issue 1, Stigma <http://quod.lib.umich.edu/j/jmmh/10381607.0007.102/--mental-health-stigma-in-the-muslim-community?rgn=main;view=fulltext>

Abstract: *"Mental illness stigma continues to be a major barrier for individuals with mental illness. This paper defines constructs that comprise stigma (e.g., attitudes, stereotypes, prejudice, discrimination), discusses the harmful effects (e.g. label avoidance, public stigma, self-stigma) and presents factors that may influence them (e.g., concealability). The paper focuses on intersectional stigma and on the complex relationships of race/ethnicity, gender, class, religion, and health status among Muslims."*

This article is complex to read but provides the reader with a rare review of existing studies on stigma and explores the intersectionality of racial identity and mental illness.

3.

Epstein M., (1995) A Consumer Activist's Guide to Mental Health in Australia: One Stigma or Many; http://www.takver.com/epstein/articles/one_stigma_or_many.htm

Abstract: *"Stigma is often based on ignorance. As individuals we form our belief systems and values from the experiences which have made up our lives. We have no other easily accessible tools with which to made sense of the multiple realities which surround us. Thus, as we move through the world we 'see' it through eyes which we sometimes believe see 'facts' but which actually sieve all our experiences through our internal meaning systems which are, of necessity, limited. Therefore, if we have never been really depressed (or lived closely with someone who have been really depressed), for example, it is very hard for us to understand the awful reality of such an experience."*

An accessible article to read. The Consumer voice is ever present. It provides a rich analyse of the current situation of Stigma in all forms and provides the reader with challenges as we all stigmatise.

4.

Holley L.C. et al, (2012) Reconceptualising Stigma: Towards a Critical Anti-Oppression Paradigm in *Stigma, Research and Action* Vol. 2(2) <http://stigmaj.org/article/view/46/pdf>

Abstract: "Informed by critical theories and oppression literature, this paper offers theoretical arguments for replacing the current stigma model with a critical anti-oppression paradigm. This paradigm expands our lens to emphasize transforming the power dynamics inherent in system-level arrangements and structures that privilege those who are perceived as not having mental illnesses while disadvantaging others who are perceived to have mental illnesses. We conclude with implications of this paradigm for practice and research."

A good article on the intersectionality of power, privilege and stigma. It is a very academic article and the references are extensive.

5.

Lee Teh J. et al, (2014) Self-Stigma, Anticipated Stigma, and Help-Seeking Communication in People with Mental Illness, in *Journal of Multidisciplinary International Studies*, vol. 11(1), January <http://epress.lib.uts.edu.au/journals/index.php/portal/article/view/3295/4366>

Abstract: "This study aimed to determine the strength of correlation between the two types of personal stigma in PWMI and their willingness to communicate for help. Anticipated stigma was more prevalent among respondents than self-stigma, but the latter is more closely linked with decreased willingness for communication about mental health issues. While there are campaigns aimed at changing negative public perceptions about mental illness, more effort should be directed towards helping individuals cope with self-stigma, thereby enhancing help-seeking communication."

If you are into statistics, this is interesting research into the impacts of anticipatory stigma and self-stigma on a person's willingness to seek assistance with their mental health issues.

6.

Martin N., (2013) Empowerment, Disclosure and Group Identification on Reducing Self Stigma, Discrimination and Enhancing Social Inclusion; National Network for Mental Health, March 27 <http://www.slideshare.net/neasa56/nnmh-policy-paper>

Abstract: "... emerging research is increasingly confirming what consumers have long known: that recovery is possible and is enhanced by peer support. That peer support is an effective and efficient resource, which fosters recovery and protects people from self-stigma, and that addressing self-stigma is critical to recovery. Consumer-led support plays a contributing role in reducing self and public stigma, in support disclosure and empowering consumers through positive group identification."

This academic article is well researched, easy to read and provides very concrete analyses of ways we can reduce stigma by the community and self-stigma.

7.

Our Community, Tactics for mobilising and developing grass roots action; http://www.ourcommunity.com.au/advocacy/advocacy_article.jsp?articleId=828

Abstract: "An advocacy campaign is nothing without support from some quarter. For most campaigns, this means support from the ground up - broad community support - and so you'll need to engage in exercises that provide an opportunity for people to get involved. This will raise awareness of your issue and generate debate that you hope will influence decision-makers."

A summary of key tactics in organising for social change.

8.

Rosen A., et al (2000) Combating psychiatric stigma: An overview of contemporary initiatives in Australasian Psychiatry, Volume 8(1) http://www.wpanet.org/uploads/Education/Contributions_from_ELN_Members/combating-psychiatric-stigma.pdf

Abstract: "Psychiatric stigma is the false and unjustified association of individuals who have a mental illness, their families, friends and service providers with something shameful. It is often deeply hurtful. Sometimes fanned by the media, the ever-glowing coals and brand of stigma foster hostility in the community and negative discrimination by services and employers. Stigma stirs up fears and discourages people who suspect they may have a mental illness from seeking appropriate and timely help. The following paper summarises recent initiatives to counter psychiatric stigma that are relevant to or emanate from Australia and New Zealand." (Page 19)

An academic article that evaluates approaches to reducing Stigma. It is very dense. Some might find it very difficult to read. Focus of the article is on practitioners in the field, not consumers.

9.

Poole, J., (2014) Sanism at TEDx, <https://www.youtube.com/watch?v=hZvEUbtTBeS>

Jennifer Poole is an Associate Professor, School of Social Work, Ryerson University.

This is a good place to start to understand Sanism; a very accessible presentation exploring it as the root cause of stigma. Stigma is a symptom of sanism. Poole talks about her own mental health and that we have been taught by friends, faith communities, by TV, schools etc. that mental and health is synonymous with problems. Such teachings are part of a larger belief system, named Sanism, which is a form of oppression experienced every day as thousands of everyday insults.

10.

Simmons University, Boston, Simmons Library Guide, Anti-Oppression: Anti-Sanism (2018 - last updated) <https://simmons.libguides.com/anti-oppression/anti-sanism>

Abstract: *"Sanism (also called mentalism) is prejudice plus power; anyone of any neurological condition can have/exhibit neurocognitive-based prejudice, but in North America (and globally), neurotypical (<http://neurocosmopolitanism.com/neurodiversity-some-basic-terms-definitions/>) people have the institutional power, therefore Sanism is a systematized discrimination, antagonism, or exclusion directed against neurodivergent people based on the belief that neurotypical cognition is superior."*

A really good summary of the key terms and links for further reading; a good starting place to explore and learn about Sanism and oppression.

11.

Sweeney, A., (2016) Why Mad Studies Needs Survivor Research and Survivor Research Needs Mad Studies, *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity and Practice*, Vol. 5(3) St. George's, University of London

Abstract: *"This paper [is] ... exploratory rather than definitive, with the aim of considering points of intersection between Mad Studies and survivor research, why we should foster a strong relationship, and some of the key issues currently facing our fields. The intention has been to open, rather than close, dialogue. ... Ultimately, the aim of considering these and similar questions is to strengthen our ability to develop and explore our own theories and knowledges about madness and distress in a scientific and cultural climate in which biomedical psychiatry rules."* (page 56)

This article explores the value of greater linkages between Mad Studies and Survivor Research. The language is that of academia and seems to be focused on the academic reader.

