

## Editorial

The 6<sup>th</sup> Ad Hoc Committee Meeting of the UN Convention of Rights of Persons with Disabilities is scheduled to be held in early August, 2005. Articles 15-bis to 25 are scheduled for discussion at this meeting. These articles relate to children with disabilities, education, participation in political and public life, accessibility, personal mobility, health and rehabilitation, right to work, social security and an adequate standard of living, participation in cultural life, recreation, leisure and sports and monitoring mechanisms.

After the Tehelka expose about an Agra Mental Hospital psychiatrist committing fraud in the certification process, there is now the story of a fraud committed in the marriage registration bureau. Two young lovers applied to the district wedding officer in Agra for a license to get married in the month of June. Instead of being united in marriage, the officer sent the couple to the Agra mental asylum. The girl's brother reportedly influenced the officer, who unduly harassed the couple in order to dissuade them from getting married. The brother deposited an affidavit certifying that the girl was mentally unsound and incapable of taking such decisions. Why the boy also was sent to the asylum remained a mystery. The couple was independently examined by the Agra Hospital doctors, who reported findings of sound mind! The admission to the hospital was made under provisions of the Indian Special Marriage Act 1954 section 4(d) and the Indian Lunacy Act. Was the officer from the marriage registration bureau aware of the Mental Health Act? This instance once again is evidence of the many yawning gaps in law concerning those alleged to be mentally ill in our society, allowing easy institutionalisation. [*ISI-Human Rights News Bulletin*, June 29, 2005. [www.isidelhi.com](http://www.isidelhi.com)]

FDA intensified its activities relating to the risk of suicidality in *adults* being treated with antidepressant medications. Several recent scientific publications suggest the possibility of an increased risk for suicidal behaviour in adults who are being treated with antidepressant medications. The FDA has begun a complete review of all available data to determine whether there is an increased risk of suicidality in adults being treated with antidepressant medications. In the meantime, the FDA is highlighting that

⇒ Adults being treated with antidepressant medications, particularly those being treated for depression, should be watched closely for worsening of depression and for increased suicidal thinking or behaviour. Close watching may be especially important early in treatment, or when the dose is changed, either increased or decreased.

⇒ Adults whose symptoms worsen while being treated with antidepressant drugs, including an increase in suicidal thinking or behaviour, should be evaluated

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## Editors

Bhargavi Davar  
Sadhana Natu

## Contact Address

Center for Advocacy in  
Mental Health  
B1/11, B1/12, Konark  
Pooram, Kondhwa Khurd,  
Pune- 411048.  
Phone: 26837647/644  
Email: [wamhc@vsnl.net](mailto:wamhc@vsnl.net)

*Aaina* is a mental health advocacy newsletter.

*Aaina* is an opinion-making and opinion-leading newsletter, with a consistent message of user empowerment, good practice, policy, legal and social reform in the mental health care sector in India.

*Aaina* covers issues in community mental health, the role of NGOs in mental health, self-help and healing, the use of non-medical alternatives in mental health, human rights issues in mental health, institutional reform, ethical dilemmas, policy discussions, and the mental health needs of special groups (young people, women, the poor, sexual minorities, persons with a disability, etc.).

*Aaina* covers themes related to disability caused by psychiatric drug use, and long term institutionalization. It has a great interest in how much money pharma companies are making by pushing hazardous drugs onto poorly informed communities.

*Aaina* provides a forum for users to express their problems and dialogues with the mental health service system, and their demands for change. It also addresses issues of social living for persons with a psychiatric disability, stigma, discrimination and deprivation of the right to life and liberty, especially of the poor and the homeless.

If you wish to make a donation to *aaina*, please make a DD or a cheque in favour of "*Bapu Trust for Research on Mind & Discourse, Pune*" and post it to our mailing address.

by their health care professional. The list of drugs which this will apply to can be found at : [www.fda.gov/cder/drug/antidepressants/antidepressantsList.htm](http://www.fda.gov/cder/drug/antidepressants/antidepressantsList.htm) Also look for similar review of pediatric usage of antidepressants at [www.fda.gov/cder/drug/antidepressants/default.htm](http://www.fda.gov/cder/drug/antidepressants/default.htm)

A national consultation on Urban poverty was held in Delhi, organized by Action Aid India along with Aashray Adhikar Abhiyan, a campaign for housing rights, which is reported in this issue of *aaina*.

The Draft National Policy on Disability, put out on the website by the Social Justice and Empowerment Department, elicited some response from carer's groups, but otherwise went unnoticed in the Mental Health sector. Once again, we felt the need for a cross disability dialogue.



By the roots of my hair some god got hold of me.  
I sizzled in his blue volts like a desert prophet.  
The nights snapped out of sight like a lizard's eyelid:  
A world of bald white days in a shadeless socket.  
A vulturous boredom pinned me in this tree.  
If he were I, he would do what I did.  
-Sylvia Plath  
"The Hanging Man"  
(A poem about her experience with electroshock therapy)

.....  
 The list of side effects of psychiatric drugs is increasing day by day with increased scientific knowledge. However, the information does not "trickle down" to the level of the patient, or even the carer. Who all are responsible for this gap, and how can this gap be filled? An anguished carer demands accountability from MNCs and greater responsibility from the treating doctors, about the risk of glaucoma with the use of Topiramate. Should the Indian Psychiatric Society or some independent regulatory authority issue letters to treating doctors about such warnings when up to date information is made available on side effects?  
 .....

### The need for knowledge of Black Box Warnings of side effects of drugs

**I**t was a routine check-up for my daughter to fix a new pair of spectacles. The eye doctor found some increased IOP (intra-ocular pressure) during the preliminary investigation and advised us to do the Humphry's field test. As the nursing assistant touched her head, my daughter did not fully co-operate with the testing. Anyhow, the IOP was found to be only marginally higher. We just forgot about the whole thing. The time was November 2002. Her maintenance dosage after her 4th relapse was 800mgs of SIZOPIN (clozapine) and 200mgs of TOPOMAC (Topiramate) daily from march 2002.

As I was watching a TV show in CNBC TV 18 "Awaaz" I noticed that the anchor was discussing the side-effect of the drug Topiramate on a young bipolar patient. The report was on how the drug increased a patient's IOP and how she almost went blind. What irritated me during the programme was the attitude of the lady doctor (a high level health department functionary) who was constantly blaming the patient and her carer, for not bringing the IOP increase to the notice of the treating doctor. As if one feels the increased pressure in the eyes! During the programme, it was also mentioned that the marketing drug multinational, Johnson and Johnson, did not include this warning about increased IOP in the DRUG INSERTS. These inserts accompanied all drugs sold in India during the introduction of this drug. Such warnings had been included in the DRUG INSERTS released in the

USA and so the information was available at the time.

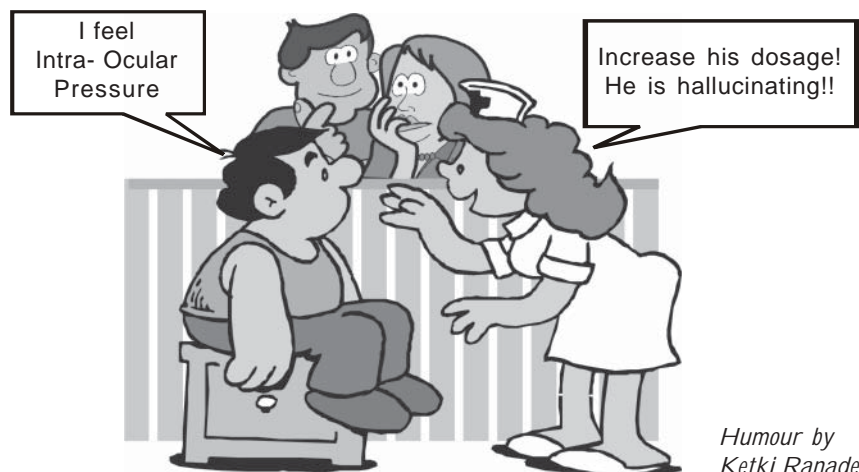
As a carer, I felt that the drug MNC has kept the Indian psychiatric community in the dark for a long period after the introduction of the drug. I sent a routine email to all carers / professionals who might be using this drug in India, stating the obvious. A fellow carer forwarded this mail to the Ethics Committee of the Indian Psychiatric Society, expecting it to be followed up. I expected that the Society will ask its members (the treating doctors) who are prescribing this drug to ask their patients to carry out a check of IOP, as we do a blood check up in clozapine use. IOP cannot be felt like the rise of glucose in blood unless it reaches a critical level.

The new drug insert of 2005 compared to the one I got it in 2002, during the introduction of the drug, has added warnings about acute myopia and secondary angle closure glaucoma. It has even mentioned about SUDEP (Sudden Unexplained

Death in Epilepsy), which is not included in the insert of 2002. Drug inserts are often the only guide for registered medical practitioners. The culpability is not solely of the MNCs. It is the *duty* of doctors to educate the patients. The MNC, whose duty it is to inform about the added warnings to the doctors, the MNC just washes its hands off, by saying they have given the necessary DRUG INSERTS. When such added warnings are given by the Drug company in the USA, as mandated by the FDA, they have NOT ONLY to issue the necessary BLACKBOX WARNINGS. But they also have a responsibility to educate the doctors about them. I do not know that any psychiatrists / neurologists have been educated about these warnings in the black box.

The FDA in USA has mandated that the whole lot of SSRI anti-depressants like SERTRALINE, FLUOXETINE, PAROEXETINE, MIRTAZAPINE, NEFAZODONE etc

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Humour by  
 Ketki Ranade  
 aaina

## “Who am I” A mythical question

P. Ramakrishnan

This note is in response to the heartrending expressions “Who am I?”, as appeared in *aaina* (March 2005). At the outset I am keen to clarify that I neither want to pontificate nor I desire to be judgemental about the issue discussed herein. I only would like to explore the issue with an unbiased alert mind, so that we can expose all the nuances of this issue that are both obvious and hidden.

In a nutshell the essence of the narrative is the issue of “self-identity”, rather, the crisis of “identity”. Arun Dohle has singularly confined his entire research for self-identity to finding out the biological parents and the natural family. This aspect of self-identity is his crisis. It would indeed be an unpardonable blunder on my part if I attempt to trivialise that search. I am deeply sensitive about the issues enumerated. Emotional pangs of human beings are excruciatingly hurtful of our body-mind equipment. Nevertheless, we could journey further to explore the whole issue of “self-identity”.

Immaterial of widely differing life-situations each human being is placed in daily existence. All of us without an exception are in endless search for our self-identity. Whatever the facets of identities our “self” already is in possession, it seems to be not quite fulfilled by them. Hence it looks for newer and newer facets of identities. Through ever multiplying relationships and innumerable material possessions, all of us are constantly struggling to reach the plateau of everlasting self-identity fulfilment! It is universally evident that nobody has ever succeeded in this gruelling search. Each one’s self-identity remains

incompletely patchy. Whereas, hardly few would have realised the futility of such a search by unravelling their own mind-mechanism that compulsively and also vainly indulges in this self-defeating endeavour.

The whole purpose of human existence is to take the initiative to explore relentlessly within oneself for one’s sense of “SELF”. Each one’s “World” spins on the axis of one’s notion of “myself”. This bedrock notion of “myself” is never ever questioned or even reviewed by us. It is taken absolutely for granted that “myself” is not a notion, but a concrete certainty! All other concepts and values that motivate and govern our living are structured firmly on this and also out of this bedrock notion.

We never pause in our maddening rhythm of living to reflect or wonder that *if* the very fundamental factor of self-identity, i.e., “myself”, is itself only a *notion*, then what creditability can there be for the subsequent super structure of concepts and values that have cluttered our existence? Is it not essential to dispassionately enquire, “WHO” and “WHAT” is this “myself”? One needs courage in its true sense to conduct this relentless inner enquiry.

All the while in our life, our questions and search for self-identity have been aimed at the outer world. In spite of innovatively coming up with newer solutions and answers in our above search, we still feel awfully incomplete in establishing an everlastingly fulfilled self-identity. There is a nagging sense of void in us. The anxiety belonging to this mindset prevails in us.

This is the sorry state in which the

humankind are found living both in the past as well as in the present. This being the case, the future cannot be any different for us, unless we set aside our time worn search for newer and newer illusory identities and question the very notional central “entity” of the psychological “Myself”.

We all have an unquestionable sense of “Myself”. Hastily many of us take it to be our spiritual-centre! It is generally taken for granted that one’s sense of identity, the “myself” is an unbroken continuity. This naïve belief makes us give to our sense of self-identity a status of an individual entity. A notional identity is perceived through confusion as an individual ENTITY. Whereas, nature has endowed in each human being a vital clue to crack the enigmatic code of “Myself”!

Without an exception, all human beings experience the discontinuous nature of “Myself”. The irony is that we never take note of this factual experience. Every day, each human consciousness experiences three states of consciousness: waking-dream-deepsleep. Each has a sense of “Myself” in the wakeful hours with its one set of reality pertaining to wakeful situations. Challenges perceived by the wakeful “Myself”, and the corresponding responses, can be called as “Waker”.

When sleep takes over, initially waves of dreams tumble into and flood the consciousness. In the dream state, there is an exclusive sense of “Myself” identity, with its own peculiar challenges as well as responses. The “solidity” of the world that belong to the wakeful period is quite different from the stark “realities” of the dream-period. Our

wakeful world's problems and as well solutions do not apply to the needs and fears of our dreamtime problems and solutions. The "Myself" identity experiencing dream-time realities is the "Dreamer". It is a fact that the "Waker" and the "Dreamer" are not compatible in any given moment. Experientially in their respective realm they both cancel the "Other" out!

Subsequently, the state of deepsleep takes over the consciousness. In this state, amazingly both the identities of "Waker" and "Dreamer" dissolve into the state of absolute "not-knowing". Even this "not-knowing" is only "known" after the consciousness manifests three starkly differing identities of "waker", "dreamer" and the "deep-sleeper".

Thus, it is immensely evident that our intimate sense of self-identity is not after all a seamless continuous single reality. On the contrary, it is an ever-changing discontinuous notional image. It is like the images imprinted in a motion-picture film. Each one of these images is only a series of separate and discontinuous still-pictures. The "motion" that is perceived is only an illusion. Motion is only a notion. Earth's rotation round the stationary sun, makes the cannot-be-doubted reality of 'sun rise' and 'sun set'! In like manner, endless repetition of "waker-dreamer-deep-sleeper" cycle in our mind gives rise to the notion of "Myself".

The mother of all concepts "Myself" takes possession of our consciousness. Yet it is a deluded state. This delusion, as a parasite, occupies and confuses our consciousness. Our bodily existence is not dependent on this notional self-identity. Quite frequently, this "Entity" only creates problems through illusions. The human mind staggers and its innate intelligence gets clouded by this sense of self-identity. All shades of psychological fears and desires

belong to this self-identity delusion. Though as a part of humankind all of us are born with this delusion and learn through social conditionings to lead erroneous life of conformity, we can also *unlearn* this hoary distraction and regain the purity of consciousness. Through appropriate scientific insights if we can correct our imperfect perceptions of Reality in the Outer space and as well in the sub-atomic state/realm, our psychological can also be corrected and set right by deeper insight into our own body-mind mechanism. This realm of intelligence is known as *spiritual* intelligence.

Purified consciousness lives moment-to-moment in a here-and-now state of response. It does not grapple with the dead past, which is operating as a "Myself" identity. The contents of "Myself" is nothing but the dead past events of our life. Freed from the burden of a false sense of "Myself" identity, the pure consciousness does not seek fulfilment through the endless arrays of deluding identities. It learns to treat all forms of identity as tentative co-ordinates to conduct oneself in collective living. It has clearly realised that identities are no more the fundamental certainties to base one's very existence on them. For peaceful existence, really, there is no necessity for any type of identities. Identities such as: family, religion, caste, creed and even nationality need not have an absolute importance for peaceful existence.

It is everyone's everyday common experience that 30 to 35% of our lifetime is spend in sleeping. In childhood and old age the sleep occupies almost 40 to 50% of time in a day. Thus in a lifespan of say 75 years, in all we humankind spend almost 30 years in sleep! Hence, if one says that he/she has suffered one's entire life, it only amounts to 25 years less suffering than previously assumed.

Let us investigate a little further. Even

in our wakeful hours, to what extent can we be continuously focused, exclusively on our misfortunes? At a stretch never more than a few minutes. Time and again our attention wanders away distractedly. These moments of preoccupation without thoughts or misfortune would be less than 20% of our entire lifetime. Be it sorrow or joy, our body-mind mechanism cannot bear to stay put with one thought for more than a few seconds at a stretch. Hence our self-conscious "Myself", repeatedly gives exaggerated importance to bolster its built-up identity, to our bygone unfortunate events. It also *arrogates* itself with pride, boasting its fortunes. The lasting cure from this malady of make-belief self-identity is only possible if we care to delve deeply into our own body-mind mechanism. If one can dispassionately observe one's own life, it is quite evident that the content therein is nothing but the anguished demands of one's self-identity. Both self-esteem and self-pity are two sides of the same coin of one's illusory self-identity.

One's make-believe centre needs both type of experiences. One's chest swell with pride and also correspondingly when this gratification is denied, the chest should sink in depression. This is the reason, Buddha described the whole of human life in just one single word, 'DHUKKA' (sorrow). For us the humankind, even our 'joy' also paves way only to sorrow. This is because, without realising the truth of its own falsity, our sense of self-identity vainly demands constant mental pressure, movement. As this is not feasible in the balance of nature, the self-identity makes a showdown time-and-again by sinking into depression. All these are pointed out, so as to clearly perceive and profoundly grasp the question Dohle has raised in the article 'WHO AM I'? After realising the truth, one lives in the world and not of the world. Living based on false identities is only a dream, even a nightmare.

## “Building musical bridges: Drum circle therapy with autistic children”

at Prasanna Autism Center

A report by Zubin Balsara, Senior Therapist, WCCL Foundation, Pune.

Report authored by Nafeeza S. Pavri and Zubin Balsara

### WCCLF prayer:

May you experience  
 Music in your heart  
 Rhythm in your steps,  
 Song on your lips,  
 And poetry in your words.  
 For, the spirit needs only a few things  
 But all things need the spirit.

A quality of freedom awaits us when we diligently undertake the exploration within us to unravel the enigma of “Self-identity”. Raising critical questions regarding the way of our human world cannot resolve the conundrum of self-identity in which we are trapped. Each of us should get ourselves psychologically free and then perhaps try to put the outer world in order. Only when we are free, we can genuinely and fully help others. Attaining psychological freedom from the burden of self-identity is each one’s birthright.

**Contact:** P. Ramakrishnan, Sr. No: 163/3, Madhav Memory, Flat 2, D.P. Road, Aundh, Pune- 411007.



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must have blackbox warnings about the SIDE EFFECTS

- 1) increased suicidal behaviour and worsening depression
- 2) close observation for above if patients are given medication for first time and when dosage is changed.

My questions are, who is issuing these blackbox warnings in India and who are responsible for its implementation? Is it the patient / carer, as told by the doctor in CNBC TV 18? Is it the duty of Drug MNcs through their medical representatives? Or is it the duty of doctors, who must read the drug inserts and inform their patients accordingly?

Captain Johann Samuhanand, S/3, A/ block, Shantiniketan Appts, Arekere, Bannerghatta Road, Bangalore 560076. Tel: 080-26591615 (m) 09448459161

All back issues of *aaina* can be freely downloaded from our website:

[www.camhindia.org](http://www.camhindia.org)

The report describes the use of Drum Circle Therapy, pioneered by Arthur Hull and further developed by Heather MacTavish of the New Rhythms Foundation, USA. Zubin Balsara, of the World Center for Creative Learning Foundation, Pune, has been using Drum Circle Therapy with various groups including the mentally challenged children and children with autism. This report describes the work of WCCLF with children with autism. The report describes the application of DCT, emphasizing that the selection of drums and percussion instruments depends on the special needs of the client population being served. The report also talks about the “safety norms” of using DCT. The report refers to the literature on music therapy and autism. From this literature, it is clear that music can:

- ✔ facilitate and support the desire to communicate
- ✔ break patterns of isolation and engage the individual in external experiences
- ✔ reduce echolalic responses impeding functional language use
- ✔ decrease stereotyped motility patterns
- ✔ teach social skills and
- ✔ facilitate increased language comprehension

The report comprehensively describes the evidence base for the healing power of DCT.

The report itself is evidence of the effectiveness of DCT in the case of autistic children. The method was applied at the “Prasanna Autism Center”, Pune, as a research intervention. The study aimed to explore the use of songs, drums and rhythm based games for teaching functional and emotional languages for both verbal and non-verbal autistic children and breaks their patterns of isolation. Individual case studies are presented of ten children, and study findings summarised. A CD is provided along with, of the sessions.

WCCLF is planning a year long course on DCT and other art therapies from September, 2005, in Pune.

**Contact:** Zubin Balsara, WCCLF, A/4 Hill View Residency, Baner, Pune 411045, Maharashtra, India. Tel: 020-27898066 Email: [wccl@vsnl.net](mailto:wccl@vsnl.net)

## Drug Tracks

*Aaina* readers will be aware that governments in many developed countries have issued warnings and directions in the use of anti-depressants for children. AW Mathews and H Tesoriero of *The Wall Street Journal*, July 1st, reported that the FDA has recently taken a harder line on suicide risks for adults taking antidepressants. The agency issued a new warning that adults taking antidepressants should be closely watched for suicidal tendencies, citing publications that suggest an increased risk among patients taking the drugs. In March 2004, the FDA asked that several antidepressants get labels noting that all patients should be watched closely for signs of increased depression or suicidal leanings. Later, the agency called on manufacturers to add a strong “black box” warning about the link between the drugs and suicidal tendencies in children. Eli Lilly & Co.’s *Cymbalta*, being tested for stress-related urinary incontinence, was remarked to have a “higher-than-expected rate of suicide attempts” in the clinical trials findings. (Reported by Dr Harish Shetty, Mumbai). The warning is posted on the FDA website.

*A welcome ECT verdict:* A woman from South Carolina became the first survivor of ECT to win a jury verdict and a large money compensation for extensive permanent amnesia and cognitive disability caused by the procedure. Peggy Salters sued Palmetto Baptist Medical Center in Columbia, as well as the three doctors responsible for her care. As a result of an intensive course of outpatient ECT in 2000, she lost all memories of the past 30 years of her life, including all memories of her husband of three decades, and the births of her three children. The jury awarded her 6,35,177 USD in compensation for her inability to work. The malpractice verdict was against the referring doctor. The first lawsuit for ECT amnesia, Marilyn Rice v. John Nardini, was brought exactly thirty years ago, and dozens of suits have followed. While there have been a few settlements, including one for half a million dollars, no former patient has won a case until now. Psychologist Mary E. Shea presented extensive neuro-psychological testing proving to the jury’s satisfaction that Ms. Salters suffers dementia due to ECT brain damage. 13 shocks were given in 19 days, instead of 26 days as is usual. The doctor’s allegation concerning Mrs. Salters’ severe suicidality could not be substantiated by the medical records. For the past three decades, the report says, defense attorneys have won case after case by the same strategy: browbeating the jury with the plaintiff’s psychiatric history, playing upon the prevailing cultural notions that mental patients are incapable of telling the truth and doctors don’t lie; even claiming that mental illness causes amnesia and brain damage. In India, we are still arguing whether direct ECT (that is, shock treatment without anesthesia) is good or bad! Doctors regularly deny any side effects of ECT. Indian courts should pay heed to the arguments and the outcomes of this case. Case No. 03CP4004797, Richland County, South Carolina. Peggy Salters vs. Palmetto Health Alliance, Inc. & 3 doctors (News from Linda Andre, a survivor of ECT, for the Integrative Psychiatry e-group)

*More on suicide risk of anti-depressants, and how the pharma cheat the public:* District Court Judge, Minneapolis, James M. Rosenbaum rejected Pfizer’s effort to dismiss Kimberly Witczak’s Zoloft-suicide lawsuit. Mrs. Witczak asserts that Zoloft induced her husband, Timothy (“Woody”) Witczak, to commit suicide after suffering severe adverse reactions to the drug. Mrs. Witczak claims that Pfizer fraudulently marketed Zoloft as safe and effective and failed to provide warnings about Zoloft’s propensity to induce suicidality, despite Pfizer’s knowledge of the risk, as evidenced by internal memoranda and studies obtained through discovery. In an effort to prevent this evidence from reaching a jury, Pfizer sought to dismiss the case, arguing that Mrs. Witczak’s state law claims are “preempted” by federal law. Pfizer argued that, since the FDA approved Zoloft and did not, until recently, require a warning about suicide risk, any lawsuit blaming Pfizer for failing to warn about the risk is legally impermissible. Judge Rosenbaum, however, refused to accept Pfizer’s argument, stating that “FDA regulations allow drug manufacturers to strengthen warning labels ‘in the interest of drug safety’ at any time without FDA pre-approval precisely so that the warnings can be ‘placed into effect at the earliest possible time’ and ‘to enable prompt adoption of such changes.’” Judge Rosenbaum stated that the “crucial flaw” in Pfizer’s argument is that “Congress certainly did not intend to bar drug companies from protecting the public when enacting the [Food Drug and Cosmetics Act]; its goal was to protect the public ... Any contrary interpretation of Congress’s intent is perverse.” Mrs. Witczak has a website devoted to her husband’s memory and is raising awareness about the risks of Zoloft and similar drugs: [www.woodymatters.com](http://www.woodymatters.com). Full judgement at: <http://www.baumhedlundlaw.com/media/ssri/Zoloft/Witczak/Witczak-Preemption-Ruling.pdf>

## Knowledge building on mental health

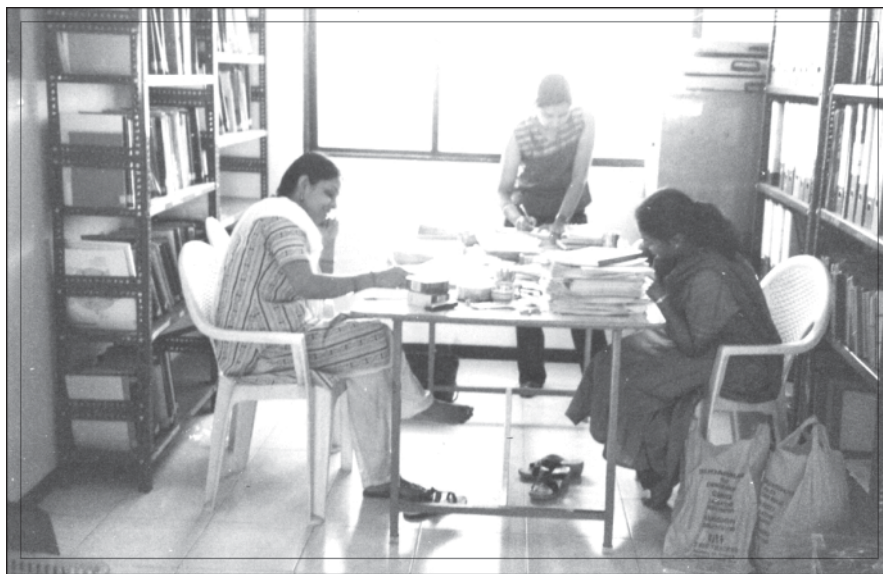
Library, documentation services & archives  
Center for Advocacy in Mental Health

**H**ealth, both physical & mental, forms an important aspect of our lives. We take care of our physical health because so much information is available about the importance and implications of physical problems and well-being. Once persons enter the psychiatric domain, not much information is forthcoming to them either about mental health in general or their own 'diagnosis'. Another reason is that there exists a lot of stigma about mental health in our society. It is not easy to get information about mental health aspects. People need the right kind of information to take active steps in their own mental well-being. The CENTER FOR ADVOCACY IN MENTAL HEALTH library aims to be such an open forum, for information and awareness building in the mental health area.

### Objectives of the resource center

The objective of the resource center is to present expert information in a form that lay people can utilize in their day-to-day care of themselves or of their mentally ill relatives. No doubt medical libraries exist in Pune city, filling an important gap. However these libraries are too technical and do not serve the purpose of community education. Our resource center is four years old, and in our experience, is a very important instrument for information sharing, opinion building & stigma reduction in the area of mental health. Our resource center exists in order to fulfil the following functions.

- ◆ The resource center first & foremost acts as an information dissemination center and an education center for the community, for users, caregivers and families; NGO's, academic institutions, departments of psychology,



counsellors, other mental health professionals etc.

- ◆ Families and individuals using psychiatric services have a right to understand and to give consent for the treatment that they are undergoing. For that, they need to have free access to reading material that will educate them in non-technical terms about the various aspects of mental health and good practices therein.

- ◆ The public needs to be educated and be aware of mental health issues. This could help bring it up to the level of a community movement in which opportunities of employment, self-help & social support are maximized and stigma against mental illness removed.

- ◆ Researchers who are doing research work on the area of mental health as well as students could make use of the reading material and references on mental health from the CAMH resource centre.

### Collection of our resource center

Our resource center specializes in

the area of mental health. We have a unique & interesting collection of locally as well as internationally published books. We have collections of our project reports, personal stories, photographs, legal case papers & various NGO's study reports, annual reports and government documents. Our resource center stocks books and reports in the following areas of mental health:

- ⇒ Archives
- ⇒ Communication & media
- ⇒ Colonialism & after
- ⇒ Culture & the disciplines
- ⇒ Curriculum & training
- ⇒ Development & society
- ⇒ Feminism
- ⇒ Health
- ⇒ Literacy in health & mental health
- ⇒ History of science
- ⇒ Law, human right & mental health
- ⇒ Literature
- ⇒ Advocacy in health & mental health
- ⇒ Psychiatric ethics
- ⇒ Methodology
- ⇒ Community mental health
- ⇒ Mental health of women
- ⇒ Positive mental health





- ⇒ Psychoanalysis
- ⇒ Psychiatry
- ⇒ Anti-Psychiatry
- ⇒ Psychology
- ⇒ Psychotherapy & counselling
- ⇒ Philosophy
- ⇒ Sexuality
- ⇒ Social movements
- ⇒ Self help in mental health
- ⇒ Violence

Our resource center offers a very special collection on alternative mental health as well as positive mental health, policy papers & documents on mental health, & self help material on mental health.

Our resource center subscribes to 14 journals on general health, mental health, law & other issues related to health & mental health.

Daily newspaper & magazines are rich sources of collecting material on mental health perspective. We employ these resources with research papers; compiling together all the mental health material from local, national newspaper and magazines. CAMH subject files contain clippings from 4 newspapers & 3 magazines. We have stocked newspaper clippings collections from the year 2001. Case studies (e.g. on Erwadi) have also been compiled and stocked.

Now a days, the Internet has become

an important part of our life. We can get a lot of information through the Internet on any subject. Our center also offers study materials & resources drawn from a range of websites. Research papers from other libraries and research institutes from around the world also make an important contribution to our collection. These include an inclusive filing system composed of a comprehensive list of eighty categories.

We have a small but growing collection of films, documentaries & audiovisuals.

We also stock various files on training and capacity building in the mental health sector, for community use.

#### **Other activities of our resource center**

- ◆ To compile a list of books, reports, files & other material, acquired by the library, every 2 years.
- ◆ Publish a mental health advocacy newsletter "Abhiyakti", in Marathi, every six-months.

#### **Users of our resource center**

Our library serves as a community resource center and is widely being used by teachers, students, lawyers, counsellors, mental health

professionals, activists, development workers & trainers working in the mental health or related areas, and students from MSW colleges.

#### **Systems**

No organized work is possible without organized systems. Every library has to follow certain system (i.e. classification system, yearly stocktaking system etc.) for their daily work & development.

Every library catalogue tells its own story, it's special interest, and it's value system, the scope of activities and substance. We have looked at several library catalogues, including the standard international catalogues, the Akshara classification system and other variations that are used in documentation centres in Bombay and Pune. But the space and interest given to mental health and to our special advocacy interests in mental health have been minimal. So we decided to evolve our own.

#### **Computerizing of resource centre**

For computerizing of resource centre we use CDS/ISIS package. We make database of our library collection through CDS/ISIS package. CDS/ISIS package is a DOS based package, developed by UNESCO for libraries.

We keep our accession register's softcopy on Microsoft access, and use Microsoft excel for filing cabinet indexing.

For more information of resource center, visit our website [www.camhindia.org](http://www.camhindia.org). Our library holdings and new additions list are uploaded at our website.

#### **Contact:**

Aparna Waikar, Librarian,  
**Center for Advocacy in Mental Health,**

A research center of Bapu Trust  
B 1/11 and B 1/12, Konark Pooram,  
Kondhwa Khurd, Pune 411048  
E-mail: [wamhc@vsnl.net](mailto:wamhc@vsnl.net)



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 The World Association for Psychosocial Rehabilitation and the World Health Organisation, had organised a Consumer Conference in the second week of June at Milan. The World Network of Users and Survivors of Psychiatry, after a great deal of discussion within its Board, agreed to participate. Sylvia Caras reports. Her full report may be obtained by writing to her.  
 .....

## Mental health: the consumer's view

■ **June, 2005, Milan**

**Sylvia Caras, PhD, writes**

I was asked to be on the advisory committee for this conference organized by World Association for Psychosocial Rehabilitation and WHO, and then invited to come and present. The purpose of this international conference was to organize Italian consumers to create self-help, social employment enterprises, and to help the system continue to improve. By the time we started the conference, about 45 minutes late, people were sitting on the floor leaning against the walls, about 400 people, 75% users, 15% professionals, 10% families. We began with a welcome from Angelo Barbato. He noted that there was no pharma funding and there was considerable audience applause.

Then Benedetto Saraceno (WHO, Director, MH and Substance Abuse) spoke. He was part of the Italian psychiatric revolution in the 70's. He talked about the relationship between the WHO and users, noting that the history of WHO's attention to the relationship is poor. For instance three boxes of ignored letters had been found. This became the "Voices from the Shadows" – a WHO publication project, a resource which may be available through a google search. More involvement is necessary. In the last five years, WHO held a stakeholders meeting in Geneva during the WHO mental health year, which was open to different perspectives; has done systematic consultation with users; aimed to, but didn't, establish a parliament, a Global Council, though three preparatory

meetings were held (parliamentarians, family, users); and has promoted the user movement for instance by giving an African user, Sylvester, the founder of the Pan-African group part of a precious 30 minutes during a health conference; and will publish a resource book about mental health legislation (I've seen drafts; it will include suggestions for use of force). Saraceno reiterated the WHO approach to developing nations, including the accent on meeting unmet needs. He talked about creating a global atlas of the movement, and that there was a need to organise in the developing world, to treat in the community and that ECT is controversial. WHO will be hosting a global service users convention in 2009.

Next came a world wide perspective roundtable, me, Elena Chavez, Mary Nettle, Sylvester Katontaka, Chris Hansen. We all were well received, reinforced each other, made good and different points. Perhaps 200 attended the afternoon research panel. Falloon represented the mainstream view of good "evidence" that treatment works, that there is an effective treatment for every mental illness but people don't get those treatments. The issue is not the science (good) but the application of the science (bad). He talked about educating consumers in best practices so that they can insist and direct their treatment. He was the most provocative of the panelists. According to one question, there's some momentum to stop using the diagnosis of schizophrenia.

Recovery parallel session - what helps and what hinders:

Farkas, from Boston University noted that "recovery" means taking back one's life. To be "symptom free" was an inadequate goal. Rehabilitation may or may not contribute to recovery. Begone from EUFAMI gave the carer's perspective.

Mary O'Hagan from Australia talked about the continuum between institutionalized services to recovery services. Recovery services have a philosophy of self-determination, that the user knows best. They have a purpose of recovery; a view of madness as a crisis of being; that meaning and value are crucial to recovery; that services must be broad, including peer support, complementary treatments, psychotherapy, or whatever else it takes. She emphasised leadership by users. There must be no force, and users take responsibility with chosen supports.

Iris Hoelling from Germany talked about **helpful** factors in the process of recovery: the *absence* of psychiatry, and of drugs; the attitude of supporters towards the person in crisis; full legal capacity at all times and without any exceptions; and **harmful** factors: psychiatric drugs, psychiatry diagnosis, lack of independent full information, lack of choices, lack of user-controlled spaces. Following psychiatric labelling, it can be a lifetime struggle to re-appropriate one's own life. Often people have good reasons for going crazy. Iris is calling the medical interventions violent. The concept of violence is comfortable for me, more than that of torture.

Talbot, a professor of bioethics was

## Homeless mentally ill and urban poverty

excited by consumer-run services. He used a medical experience of his own to compare what helped and what hindered. He talked about the importance of non-medical personnel, faith, religiosity and spirituality. Farkas noted that recovery is not linear. It is individual and unique even though there are techniques and themes that help. He talked about the need for a core set of values - person-oriented services, partnership, choice and self-determination and hope. The notion of "partnership" versus "leadership" was discussed. Users were invited to come, speak, tell their stories. When a user gets stuck at the microphone, comrades in the audience applaud for a bit, which gives support and some time to focus. It was startling the first time, then was very good to experience.

Tina Minkowitz (America) and Gabor Gambos (Hungary) spoke about the UN Convention work, including issues and monitoring. Jose Bertolote spoke once again about WHO initiatives, noting that WHO is interested in promoting user groups in developing countries.

Other speakers included David Oaks and the Secretary of WFMH. At least 100 stayed to the end. I put a web page of conference related resources for them at [www.peoplewho.org/wapr](http://www.peoplewho.org/wapr) and there is a link from there also to my presentation ([www.peoplewho.org/wapr/remarks.htm](http://www.peoplewho.org/wapr/remarks.htm))

WHO is planning to develop a **global atlas** of the movement and information about existing national organizations. The WHO will also be hosting a global service users convention in 2009. Conference related resources [www.peoplewho.org/wapr](http://www.peoplewho.org/wapr). There is a call from WNUSP, Mind International, and other user groups to strengthen advocacy and plan the process for the WHO 2009 event.

Sylvia Caras, one of the founders of the WNUSP, can be contacted at [sylvia@peoplewho.org](mailto:sylvia@peoplewho.org)

Aashray Adhikar Abhiyan [AAA], along with Action Aid International, New Delhi, organized a "National Consultation on the Urban Poor" at the Indian Social Institute in July, 2005. Many sessions focused on the plight of the wandering mentally ill people. Justice Krishna Iyer's note of felicitation talked about how globalization and privatization have created the disease of "afflu-enza", leading to the mass creation of the "wretched of the earth". Milind Kothari, the UN special rapporteur on housing rights, talked about the UN report on homelessness. The enormous play of power in private land, land theft, land grabbing and the injudicious policies of the government favouring the privatization of land was questioned.

AAA is involved in the enormous task of mobilizing the homeless, and several testimonies presented here spoke about the atrocities committed by authorities administering the Bombay Prevention of Beggary Act (BPBA), especially the police. The moving testimonies described - the beatings, the risk of life to self and family, police *hafta*, the loss of dignity in the process of arrest, the appropriation by the police of personal belongings, the struggle for housing and economic rights, a life of degradation and neglect in the beggars' homes, fraud or arbitrary arrests, the sexual exploitation of women by officers, the use of women in custody for personal work (maalish, etc.), the loss of child when in custody, the corruption in the admission and discharge procedures, the demand of bribe for release on personal bond and the daily abuse (foul language, beatings, etc.).

A panel on the BPBA pointed out that the Act was not picking out the professional beggars, but only innocent people, many of whom were in fact earning their daily bread through honourable means. This Act was a left over from the colonial period, which made institutional arrangements for all peoples not seen as a part of the productive, industrious, work force. Beggary was made a crime in the 1940s. The AAA experience also noted the enormous number of mentally ill people held in custody in the Beggars' homes in Delhi. Their legal aid program also pointed to gaps in justice administration of the BPBA through the beggars' courts. Among the many "adverse" remarks that the beggars' home authorities may make in the Social Investigation Report, "mentally not found to be fit" is also one, making it very easy for the homeless mentally ill to be apprehended and arrested by the police. There was a demand to repeal the BPBA. The role of international law and jurisprudence was brought to bear on the topic of vagrancy.

Experiences from MAITRI project, involving de-institutionalisation of persons in the Ranchi mental hospital, were shared. The untenability and tentativeness of psychiatric labeling of institutionalized persons as "manageable", "untreatable", and "incapable" was described. When doctors say that someone has a "poor prognosis", how is this conclusion arrived at? The vegetative states that people are pushed into, especially the long stay, "certified" cases, due to medical neglect, ECT abuse and overmedication was described. Whether a determination of mental illness was based on science or personal judgment was discussed, especially in the context of women. Discussion centered around the role of mental hospitals in mental health care, the steps that needed to be taken to prevent people from reaching the institutions, and the creation of programs in the community. The IHBAS experience showed that such initiatives are possible.

The Banyan experience talked about the right to care, and described their

*continued on page 14*

# Mental Health Act Amendments

Proposed by Laila Ollapally and Nirmala Srinivasan  
Action For Mental Illness, ACMI-Bangalore\*

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Many groups of stakeholders, including psychiatrists, carers groups and user support groups have been discussing the need for bringing about amendments in the Mental Health Act. So far, we have not heard of demands to repeal the Act from any interested group. The note below comes from a Carers group. It is interesting that areas relating to involuntary admission *per se* are not being contested. Reforms are being sought to make the procedure easier. There is the suggestion even to expand the scope of involuntary commitment to staff handling ambulatory services.  
.....

## Why amendments?

1. The legislation needs to be amended to suit the current needs of the mentally ill persons. Currently, the institutions are non-existent; instead it is the family (not community as in the West) that is the mainstay in India. Not a single word in the legislation mentions family care and needs of the care givers to protect the human rights of the mentally ill, ensure their safety and that of their property.

2. The advent of new medicines has made treatment possible on an OPD basis. But support systems for families and patients to access such treatment are not enacted as a rule. As a result, many go untreated.

3. Right to health and rehabilitation besides right to privacy / safety and dignity must be made fundamental rights in the MH Act.

4. Rights of the patient under lucid moments must be emphasized and spelt out clearly. Presently, this is not there. However, a few patients reach a stage of functionality when they are capable of self care and management.

5. Rights of family care givers needs attention too.

6. A separate human rights decla-

ration is sought based on the "International Covenant for Civil and Political Rights and International Covenant for Economic and Social Rights".

## What is to be amended?

**2.1** - definition of "mentally ill person". This definition needs to be looked into to make it more inclusive of all major mental illness other than Schizophrenia.

**2.q** - definition of "psychiatric hospital and nursing home – including convalescence homes" must be expanded and made explicit to include all psychiatric facilities such as Day care centers, Half way homes etc. wherever the mentally ill are detained and looked after other than their own family homes.

**2.t** - substitute "relative" with "family care giver or natural care giver".

## Mental Health Authorities – Central and State

⇒ **3.3 d** – Their major responsibility is to ensure implementation of the National Mental Health program from district to state level; states to central level. It is not necessary to waste meager resources like MD Psychiatrists to be the Secretary. Any MD or a senior level medic in the State must be allowed to do this responsibility.

⇒ It is necessary to include a new clause for spelling out the composition and membership of the Central and State Mental health authority. Only one-third must be mental health professionals. Others must be drawn from family support groups of parents, guardians and active care givers of the mentally ill persons, legal profession, engineers, Rotarians, PG students, police etc. There must be one member to represent the exclusive interests of mentally ill women including women prisoners.

⇒ **Sec.6** – Drop the word "asylum". Definition of care / convalescence homes must be more precise. All such facilities must obtain license under this Act.

⇒ **Sec 6** – Only those who have had a proven track record of having worked for the mentally ill or having cared for them as a relative must be allowed to start homes so that commercial interests and mercenary expectations are reduced.

⇒ A clause must be included that all psychiatric facilities be they treatment centers or care and convalescence centers must get license to practice strictly under the Mental Health Act only. No other Act or certificates or licenses can supersede this legislation. They may get additional licenses but

\*ACMI stands for Action For Mental Illness, Bangalore, India. For more information on ACMI, visit our website [www.acmiindia.org](http://www.acmiindia.org); E mail is [acmi@vsnl.net](mailto:acmi@vsnl.net)

license under this legislation is mandatory because it is subject to inspection by the Board of Visitors. Such a provision endorses the UN principle of right to supervised care for the mentally ill persons.

⇒ It must be made mandatory to display the license in a place that is visible to clients.

⇒ All general hospitals and nursing homes need not obtain license but is enough if registered. However, for psychiatry patients, it is desirable for them to include Occupational and Therapy facilities as part of the treatment package.

⇒ **Sec10** - Spell out what the phrase “prescribed conditions mean.” Substitute this with “Human rights”? The State of Karnataka by the recent notification has notified ‘in exercise of the powers conferred by S.10, read with S.94 of Mental Health Act, 1987, Karnataka with S.94 of Mental Health Act, 1987, Karnataka Psychiatric Hospitals and Psychiatric Nursing Homes (Conditions and Maintenance) Rules 2004. Wherein the minimum standards as to the living conditions in in-patient settings are set out. The Karnataka Psychiatric Hospitals and Psychiatric Nursing Homes (Conditions and Maintenance) Rules 2004 is pending clearance from GOI).

⇒ **Sec13**- Inspection records are not confidential documents (but patient records are) and must be accessible to public. Reports on inspection and filing of reports on the conditions at the State run hospitals, Institutions including those that come under the purview of the Central government are to be accessible to public.

⇒ **Sec14** – All OPD facilities should be given license only if they have ambulatory services for shifting patients to hospital or nursing home in a crisis or emergency situation. If they do not run ambulance service

directly, they must at least be linked to such facilities so that the patient and the care givers have easy access to treatment. Such cases will follow same rules as under Involuntary admission in order to protect the ambulance staff and others from legal hassles. Doctors who have clinics at home must provide information to family care-givers as to how to shift and where to shift in case of crisis.

All third party insurance must cover psychiatry consultations contrary to the present practice because it violates the right to health.

#### Ch. IV

**Part II, Sec 19** on admission of mentally ill person under special circumstances – Admission and Detention issues are to be worked out by simplifying these procedures.

**Part III Sec 20** on Reception Orders – Many families are made to run around for reception orders though it is neither necessary nor is their responsibility. It is the responsibility of the authorities to procure Reception orders. But just because of the problems involved, patients are sent out without admission.

For exercising his decision to detain a mentally ill person under Sec 20, the definition of who is mentally ill, is important. There are mentally ill persons who have 100% insights into their problems- for example, OCD patients who may have strong harmful impulses but may not be considered mentally ill by law! So how to decide on admission. Hence MI needs to be defined precisely as to what it includes. The advantage of leaving it ambiguous as it is in the present form may also be helpful to give it broader interpretation.

**Sec 23 .3** – Duties of the Police needs to be clarified. It says that “every person .....shall be produced before the Magistrate within a period of twenty-four hours“. This duration is too long a waiting

period if the patient is genuinely ill. For both the family members and for the patient, he or she must be produced before the magistrate immediately or any first aid help is to be given. Cases of incarceration must be avoided.

**Sec 25** - Ill treatment and care of mentally ill in police custody can be avoided if this legislation makes it mandatory to introduce a chapter on “Mental illness- Clinical, Social and Legal aspects” in Police training syllabus for constables and officers a swell. The Police must be updated on treatment aspects and family sensitivities.

#### Ch.V

**Sec 37** – Composition of the Board needs to be looked into. There is no point recommending mental health professionals because the desired numbers are neither available nor do they have time to do monthly visits. So one medical officer, MBBS from government, one social worker (not necessarily a NGO), one lawyer (retd), one Rotarian or Lions Club member, one educationist, and one care giver representative from a care giver lobby ( SHGs as different to NGOs). None of the members of the Board of Visitors shall have any formal or informal contacts or interests in the institutions that they visit for inspection. Even the family member must not visit the institution as a member of the Board if his or her ward is admitted in such an institution. (It is worth mentioning here that in Karnataka, some rehab. institutions had appointed their own psychiatrists and Social workers as members of the Board of Visitors for their own institutions! This is presently under the scrutiny of the High Court). A Psychiatrist must be available for consultations only.

The Board of Visitors must be given a format prepared by the Central Mental Health authority under this Act as to the items to be made part of the check list. Besides simplifying

procedures, this will also demystify inspection from its present status of a secret privilege of a sacred few. The process is to be more democratized and more transparent especially to care givers and patients or consumers as primary stakeholders.

### Ch.V –Part III

Leave of Absence and Bonds are not to be enforced on family caregivers in a country such as India where there is no crisis management and emergency services. Similarly, when the patients are taken from rehab. centers for a weekend leisure, the family has to give it in writing that it is their responsibility to get them back. This is also not fair because patient may not like to get back to the facility.

### Ch.VI - Judicial Inquisition

This entire chapter needs to be completely and thoroughly revamped to disorient itself from the mindset of the Lunacy Act 1912. Lot of fundamental changes as suggested below are required.

One of the vexed issues for the families concerned, has been regarding the options and lack of the same with regard to guardianship of their relative who is under treatment for mental illness. Here the rules have to be made on par with the care givers and guardians of mentally retarded. They have full rights to appoint guardians of their choice and inform the District Collector / Commissioner under the national Trust Act. A similar law can be introduced here as well. There is no need to even seek the approval of the DC because he has no time and cases keep pending for years waiting for his/ her signature. So it is enough if the present care givers during their lifetime appoint guardians of their choice and mention this on a notorized stamp paper.

The mentally ill must also be given rights to self care and self

management including right to sign cheques, hold bank accounts or transact money matters etc. during their lucid moments. This also includes right to bequeath property.

**Sec 50.5** on Exemption from personal Appearance - This privilege must be extended to all mentally ill persons- not just the Purdha clad women. In fact, the mentally ill must not be allowed to disclose their identity in public on account of their vulnerability.

### CH VII

A national trust similar to the one formed for the MR/CP/Autism must be immediately formed for the MI as well.

### Ch VIII

1. This is the most important chapter, i.e. on Human Rights. This needs to take into account the following rights drawn from the the International Covenant for Civil and Political Rights and International Covenant for Economic and Social Rights”.

>right to vote; right to marry; right to have children and to maintain parental rights; right to own property; right to work and employment; right to education ;right to freedom of movement and choice of residence; right to health;\_right to fair trial and due process of law; right to sign cheques and engage in other financial transaction; right to religious freedom and practice; right to privacy to be qualified by car giver rights; right to bequeath property etc.



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*continued from page11*

institutional services being offered including 24 hour emergency services, free OPD, follow up, supply of medicines to the families, vocational training and relocation.

The Bapu presentation focused on why there were so many mentally ill in the beggars' homes, sharing experiences from Maharashtra and Gujarat. A history of human rights activism in the 1990s against the “wrongful confinement” of homeless mentally ill people in West Bengal and elsewhere, has led to the resistance of mental hospitals to admit these people. Families are now finding ways of admitting their unwanted relatives into the beggars' homes, instead of the mental hospitals, as they would have done earlier. Corrupt officers in these homes are making these admissions even though there is no provision in the BPBA for voluntary admission or admission by families. The presentation emphasized the anti-therapeutic nature of the Mental Health Act, which results in the involuntary admission of people into a custodial regime.

NGO solutions to this, such as the Lok Adalat, being followed in the South of India, only exemplify the “paradox of legal aid”, that providing legal aid enforces a bad law. Much discussion happened about the right to care versus the right to liberty, and whether it is constitutional to forcibly commit a wandering homeless person without her informed consent, as this takes away their right of liberty altogether. It was questioned whether moral arguments alone (e.g. risk of abuse) were enough to relieve women of Article 21. Whether NGOs should have the authority to function as a quasi legal entity by bringing the magistrate *in situ* was also questioned.



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## The diagnosis myth

By Eric Shapiro

Although I risk dissension by doing so, I must say something that I think many of us in the mental health community have acknowledged for quite some time: every single diagnosis of a mental disorder is fallible.

Before I proceed, I should note the value of diagnoses. They are immensely useful categorical tools. The human being cannot productively navigate the uncertain tides of reality without the use of symbols and structures. Symbols and structures allow us to determine where our glasses end and our tables begin. Accordingly, when Patient A is compulsively cleaning her apartment and Patient B is speaking to invisible demons, it is important to have the words "Obsessive-Compulsive Disorder" to describe the former and the word "Schizophrenia" to describe the latter. Categorizations such as these not only help us to distinguish between ailments, they also assist us in making reliable behavioural predictions and selecting appropriate modes of treatment. I have no intention of ignoring these facts.

However, two unsettling flaws consistently accompany diagnoses of mental disorders.

When one breaks an arm and is diagnosed with the linguistically sophisticated ailment known as a "broken arm," there is finitude on display. Witnesses could line up from the patient's bed to the hospital parking lot, and they would all agree that the patient was suffering from a broken arm. The Law of Averages insists that one or two jokers would, due to rebelliousness or sheer foolishness, concoct some other diagnosis, but I believe that my point is clear: physical diagnoses are

better suited for objective consideration than are mental ones.

Despite the probable existence of Patient A and Patient B, the mind is a realm of liquidity and abstractions. Absent are any features remotely approaching the rigidity of a bone. Even for its most stubborn bearers, the mind is a place of motion. When it is possible for a Depressed patient to shift from numbness to panic to auditory hallucinations within the space of a single afternoon, of what ultimate use is the "Depression" label? To be sure, some symptoms achieve prominence within some minds, but all minds, we must acknowledge, never stop shifting, advancing, reversing, and flowing. Every mental disorder is therefore an abstraction at best.

I have been diagnosed with Obsessive-Compulsive Disorder. This seems about right, but what am I to make of my occasional bouts of Panic? Are they "part of" my O.C.D., or do I also have Panic Disorder? And, further, what am I to make of the one or two professionals who have said that I may have Attention-Deficit Disorder? Is my A.D.D. an offshoot of my O.C.D. or does my O.C.D. stem from my A.D.D.? Which of the two shares a stronger bond with my Panic? Even more confusing: as part of my O.C.D., I sometimes obsess about the possibility of becoming Manic. This obsession seems to tangibly alter my moods, but am I authentically Manic, or am I merely Obsessed? I feel like panicking.

We must admit that all mental disorders, however distinctive their given names, are members of one large dysfunctional family. This family is so huge that I question the merits of memorizing all its members' names and faces.

The second inevitable defect of a mental illness diagnosis is the fact that Its Recipient Is Also Its Source. In other words, because the mind of a diagnosed patient is the seat of her affliction, knowledge of a diagnosis can provoke greater mental distress. Said distress can arrive in several forms. The patient's symptoms may increase due to her renewed awareness. The patient may develop an Inferiority Complex (yet another disorder!) or drift into a state of panic. Most troubling, the patient may adhere so strongly to the notion of being SICK that her mind will never trust itself to part with its imbalance.

I can sense the "nay"-sayers closing in on me. You likely think, "The patient will surely never improve if she's ignorant about the existence of her disorder!"

I agree wholeheartedly. Acknowledging the presence of a problem is the first step toward solving it. Nonetheless, our collective perception of mental diagnoses is ripe for a change. Not only do these labels fail to holistically summarize the people they're attached to, they also tend to make said people feel stuck.

Upon being diagnosed with a mental disorder, a patient should regard her diagnosis as a handy signpost en route to treatment and recovery. Regarding such disorders as fixed, deep-rooted states is a terrific way to make them hang around longer and sink in even deeper.

Eric Shapiro is the author of "Short of a Picnic," a collection of fictional stories about people living with mental disorders. He can be contacted at:

shortofapicnic@aol.com

## Behind the walls...



Behind the walls inside the chamber  
 There is the same sunlight the same thunder  
 The same rain that inundates all  
 Everything's the same, except this wall...

The scorching heat that filters through this grill,  
 Must be the same, which travels on the hill.  
 But I know not the warmth, I know not the heat  
 Because I am cold from head to feet.

Behind the walls, when the rain drips  
 It's just another feeling like the tea one sips  
 Nothing is different, nothing is new  
 It is a feeling understood by few.

Behind the walls, the dreams I see  
 Of living on my will, of living free,  
 Behind the walls, is my fantasy,  
 To live like the person that is inside of me...

### S. Anuradha

*Anuradha has worked on a study of the Quality of Care within institutions in the State of Gujarat.*

*She can be contacted at [anu4480@yahoo.com](mailto:anu4480@yahoo.com)*

Aaina, a networking and opinion sharing newsletter in mental health, is for private circulation only. It is sponsored by Bapu Trust for Research on Mind & Discourse, an organisation committed to mental health literacy and advocacy. The views expressed in the newsletter are however not those of the organization.