On Remaining Sane in Insane Systems

Lewis Edwards

Fourth Edition.

For my mother, who taught me that patience is a virtue with blood, sweat and tears.

Introduction

Lived Experiences

Most of these essays are written about, or pertaining to, the lived experiences of myself or others close to me.

I’m not the only one in my family with psychiatric diseases. I can’t tell you all of the story, because not all of it is mine to tell, but this is first and foremost the parts of it that we all really needed to know 20 years ago.

I particularly hope this can reach anyone who is around that point — when you’ve realised that something is very wrong, and are rapidly realising how big the gaps are between medical capabilities, societal beliefs, and the reality of what you’re going through.

For psychiatrists: this is my feeble attempt at bridging the gap between a group that is multiple decades of experience away from normal in one direction, and a group that is multiple decades of experience away from normal in an almost-polar-opposite one.

The most important experience here is quite rare: the feeling of coming out of psychosis and panic and disability and into most peoples’ idea of normal functioning, and realising that it’s frankly even more insane.

Mainstream society is still just as crazy, it’s just in a more standardised way.

Trust me on that one. I went mad once or twice.

Disclaimers

I am not a doctor. I am not your doctor. This is not medical advice.

I'm going to be saying a few things that sound *kind of* similar to some anti-psychiatry crap that is popular at the moment.

I've been through the system, and come out with more functioning than the majority of people in that situation, and consequently might have a useful perspective regarding what is good and bad about it.

And make no mistake, there are some very big problems with the way we do psychiatric treatment at the moment, as any sufferer can tell firsthand. I want to help improve this system.

It doesn't help anyone to lie about the fact that there are problems in psychiatry. Let's help fix them.

Regarding rigor

This is not an academic whitepaper. This is not an argument in a political debate. This is a bunch of unusual perspectives and experiences that may be useful to the people going through the same.

I'm freely mixing my own experiences, my own perceptions, the experiences of friends and family, and my own understandings of topics. Where there’s a statement that is straightforward to back up, I’ll make a point of providing a source, but I’ll be playing fast and loose with evidence in general.

I have no interest in convincing anyone of anything, and these days, detailed and well-thought-out arguments are a poor way to do that anyway.

In any case, a fairly large chunk of the things I’m going to be saying are going to be statements that could never be rigorously backed or refuted by a study. Feel free to take them for what they are; giving sufferers, carers and laypeople useful perspectives does not have to entail winning debates.

Clarifications and Misconceptions

“Everyone has issues”

The most problematic framing of psychiatric conditions is (that they are) exaggerations of normal experiences.

It is a universal part of the human condition to experience frustrations, resentments and injustices throughout our childhoods, and most people never fully process these experiences, resulting in emotions and sensitivities the person wishes they could eliminate.

Children have a minimal ability to change their circumstances, so the difficulty in dealing with them almost always carries on to later life when they do have more power to improve their situation. This is normal. These are “issues”.

These are not the same thing as psychiatric conditions.

An “issue” is something that happens *in* your mind. A psychiatric condition is something that happens *to* your mind. These are medical problems that have a broad, lasting impact on the process of your thinking and emotions, and many of them get worse over time if not attended to competently.

Efforts to resist these forces through willpower are not only futile, but in many cases make the disease process accelerate. That doesn’t mean give up; it means simply trying harder is usually not the answer.

This misunderstanding is made substantially worse by descriptions published of common psychiatric conditions. Here’s an example of a symptom list for bipolar disorder:

- not sleeping (the most commonly experienced sign)
- agitation, irritability, emotional intensity
- energised with ideas, plans, motivation for schemes
- fatigue
- staying up late to watch TV or work on projects
- feelings of sadness or hopelessness
- loss of interest in usually pleasurable activities
- loss of concentration

(source: [1])

An individual that looks at a list like this without knowing anything about the disease is unlikely to remotely grasp the nature of the illness. These are all perfectly normal human emotions and experiences that everyone undergoes during their lives. Someone does not have a disease because they have experienced these, and the disease does not simply consist of all of these normal experiences. It does not even consist of more of them than normal, or of worse severity.

The effect of psychiatric diseases is that these normal human experiences happen at completely the wrong times, at completely the wrong intensity, and have an incorrect response to the forces that should normally influence them.

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[1] https://www.blackdoginstitute.org.au/clinical-resources/bipolar-disorder/what-is-bipolar-disorder

This has absolutely nothing to do with anything happening *in* the person's mind. These are emotions and experiences that the disease process has simply invented.

It is normal to feel rage in response to seeing someone deliberately harm a loved one. Take that exact same rage, and have it literally appear for no reason at all, with things that should calm it doing the opposite.

When that happens, the problem with this response is not one of intensity or regularity. It becomes a problem of its nature: it is the wrong thing at the wrong time. This is a disease.

It's worth clarifying how I'm using, and will continue to use, two terms which are generally considered to be synonymous: "mental illness" and "psychiatric disease."

For the purposes of what we're discussing, a mental illness is an illness of the mind, meaning beliefs, habits, personality, memories, etc. A psychiatric disease is a specific type of process which *causes* illness of the mind.

Increasingly, medical technology is able to track the structural brain changes that accompany these processes. They are real.

It was surprising and shocking to learn firsthand that the actual psychiatric disease process can sometimes be stopped dead, and that reorienting and rehabilitating the *mental* issues that result is a completely unrelated effort.

“An orderly room is an orderly mind.”

I’ve seen a few people walk into my room and comment on the state of its messiness. Most people just don’t care, but there’s a small group of people who will vocalise the idea that they feel the state of a person’s room is a reflection of their state of mind. If the room is orderly, so are their thought processes.

Empirically, they often seem to not be people who have actually experienced having a disordered mind.

I think a person’s environment is reflected by their state of mind, but psychiatric diseases are so complex and counterintuitive that the relationship between those two things is also complex and counterintuitive.

Someone who is very depressed will probably neglect their surroundings. And as they get better, they will probably maintain them a bit better.

But someone who is hypomanic might obsess over them. Or they might not. They have all this energy, and they might not know what to point it at. They might point it at cleaning for a while, then neglect. Or they might do it consistently. Or they might create a giant mess and leave it. It depends.

Interestingly, as a person comes down off that high, it’s quite likely they will simply stop giving a fuck about the state of their room. This may or may not increase the actual level of cleanliness, as they may have been giving too many fucks about it and this got in the way of meaningful cleaning.

The point is, cleanliness in a person's environment is a function of the person's overall energy levels, but it's also a function of what that energy is pointed at. There is no linear relationship here.

People with psychiatric conditions almost universally have problems with self-care. But these problems are not necessarily a lack of it.

"Mental Health Consumers"

There's a trend at the moment to bowdlerise the terminology that is used to refer to sufferers of psychiatric conditions. Currently the preferred term for them seems to be "mental health consumers."

I reject all parts of this.

The use of "mental health" is misleading here. An impact on mental health is the *consequence* of psychiatric conditions. That consequence is serious, but in the context of recovery we care much more immediately about the diagnosis, treatment and management of the disease, not the mental illness. There is a disease process that needs to be stopped and reversed, and there is nothing "mental" about that process[2].

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[2] There is now data suggesting that the blood of a long-term bipolar sufferer is measurably toxic to healthy neurons: https://www.sciencedaily.com/releases/2016/05/160531104421.htm

The use of “consumer” is equally objectionable. I believe that psychiatric patients should be referred to in the same way as *literally every other branch of medicine*. It is a disease. It causes suffering. It can be managed and treated. A person should not be branded with a special “consumer” status because of the type of disease they have.

The “consumer” term is supposedly about emphasising the equal relationship between the health provider and health consumer. But it does the exact opposite: a *patient* who needs a heart transplant is well within their rights to decide to leave hospital and go home to die.

A very sick mental health *consumer*, on the other hand, does not have this right; ironically, even one with an actual heart condition as well. So now we’ve created a completely unnecessary division and judgement with a special-purpose term originally intended to emphasise equality. It really does not help.

It’s understandable to want to get away from the stigma of “psych patient” in the medical system. The way you get away from a dysphemism like that is not by inventing a brand-new dysphemism to replace it.

Dramatic Hallucinations

Hallucinations are what happens when you experience sensory input that does not map to the physical world. What seems to be much less common knowledge is that there are a lot of different kinds of hallucination, and they all behave very, very differently.

There’s visual snow and tinnitus, which are very common even among the healthy and generate a background level of noise in your visual and auditory fields.

They’re usually harmless; these are failures of your brain to filter out extraneous stimuli. There is some evidence that failures of this filtering are correlated with psychiatric disease.

There are the hallucinations associated with psychedelic drugs, which usually take the form of fractals and kaleidoscopes and other pretty geometric figures.

The person is, in general, aware of what is happening and of the fact that they’re on a drug.

There are the hallucinations associated with delirium, which can be caused by anything from a severe fever to a bunch of medical conditions, to a type of (non-recreational) drug.

These are more complex in nature, and affect a wider range of the brain’s systems. Usually the person experiencing them is barely conscious, so pinning down their mode of operation must be done from the outside. Delirium is not psychosis.

There are also the hallucinations caused by psychosis, which I’ll get to in a minute, because there’s also the hallucinations people *think* psychosis causes. This is a totally, completely unrelated concept to the hallucinations it can *actually* cause.

It’s an old forensic psychologist’s trick to ask a question like, “Do you see the words I’m saying spelled out in front of me?” or “Have you ever been sitting around and have the building you’re in suddenly collapse, then realise none of it was real?”

I’m unaware of any record anywhere of any psychotic person ever stating, unprompted, that things like this have happened.

But a layperson who is attempting to appear psychotic will not know that. They just want to appear that they’re out of touch with reality. If you ask enough of these questions mixed in with others, sooner or later they’ll endorse one of them. Any genuinely psychotic person would be confused by this.

My personal experience is that there are only two kinds of hallucination that psychosis is likely to cause:

1. Prototypical hallucinations that the disease directly causes, and
2. Hallucinations that tie into a delusion.

The first category is mostly fairly well known, things like hearing voices, seeing shooting stars, stereotypical stuff like that. As a side note, what’s a little less well-known is that the sense of smell is usually equally affected: it’s very common for a psychotic person to sense a smell that isn’t there.

Generally, for me these are threshold hallucinations; various forms of noise in quiet/dark situations.

The second category may be a little less obvious. Consider that psychosis re-orients someone's belief structures and how they interpret the world around them.

It is my belief that the hallucinations created by this process are an artefact of this interpretation: they have taken an ordinary experience, interpreted it through a lens that completely changes the meaning of that experience, and generated memories and reactions that correspond to that meaning.

This is a completely normal process that everyone does — it's how humans work — but it is now operating at a right angle to what is expected.

I don't know that this is something that could ever be meaningfully proven, but a study that comes up with a method to do so would be very interesting to see.

All of these hallucinations work very differently. They sound like the same concept, but they have completely different mechanisms and completely different dynamics.

"Therapy and medication"

Just about anyone who even recognises that psychiatric conditions even exist will know how to treat them. And they'll tell you - any time you mention that you have one and don't know what to do. It's exactly the same line, over and over and over again:

"Therapy and medication."

Yes, you *will* need therapy and medication, in the same sense that a broken-down car needs maintenance and replacement parts, or a failing shop needs changes in its management and products. Technically entirely true, but completely unhelpful when it comes to actually solving the problem. It doesn't explain even the basics of what is actually involved with either of them.

"Therapy" is not a product that you consume. It's not something where you pay a therapist to give you something, and that something improves your health. People frequently state that "therapy is long hard work", but even that understates how far off the mark this understanding of it is.

Therapy is a place. It's a platform on which you can explore your thoughts and experiences. It is not and cannot be the only place where you do this exploration, and the fact that you're turning up and saying words for an hour per week does not in any sense prove that you're actually doing it.

The process of doing therapy means integrating and understanding the mechanics of how your past influences your current thought patterns, and this is something you do 24/7. The actual sessions are more like an opportunity to share this progression and get outside feedback on it.

They're not even necessarily an inherent part of this process in every case - though they can be a great force multiplier. This process happens across every area of your life, in every situation you find yourself in, and the idea that "therapy" entirely happens in the therapist's couch doesn't help you do it. It is a process of integration.

“Medication” is similarly problematic. People who have not used a variety of psychiatric medications seem to assume that they’re all fundamentally the same type of thing (though they usually seem to be a little unclear on what exactly that type of thing is). Take the pill as directed. Health improves.

Psychiatric medications are used to push your brain’s state in a certain direction. There is absolutely no guarantee whatsoever that that direction is actually the one you need to go in. A psychiatrist can make an educated guess, but ultimately the only person who is capable of knowing which direction they need to go in is the patient themselves.

Doctor Google and Doctor Wikipedia genuinely matter a lot here. Being able to pitch an idea to a psychiatrist is actually important, because their main source of evidence is your personal experience.

Ironically my initial diagnosis of bipolar disorder came from me outright saying I thought I had it. And I was very much right, because the highly stimulating antidepressant I was prescribed around that time (reboxetine) caused an uncontrolled hypomania.

If the patient takes a medication that is doing the opposite of what they need, they will get worse. In some cases, the medications can make them *much* worse. Even a medication that *was* pushing them in the right direction can rapidly become the opposite of what they need later on. Unless the patient can recognise this and suggest a change of tack, the psychiatrist can do nothing.

The core thing that has to be understood about both “therapy” and “medication” is not that they *require* constant work on the part of the patient. It’s that they’re *made of* constant work on the part of the patient.

The role of a professional is limited in scope here: they can prescribe, and suggest, and listen, but ultimately the patient is the only one who has the capacity to make them work. A patient who is not being actively involved and included in their own treatment process is a patient who is not being treated.

On terrorists and serial killers

I’ve had one, maybe two incidences where people found out I had bipolar disorder, and were immediately terrified.

These were people whose entire contact with this disease was reading a couple of news articles about serial killers or terrorists or whatever. Thankfully people who have such a poor understanding of it are rare these days, but it’s surprising to see firsthand that a non-zero number of people have absolutely no clue whatsoever — other than what sensationalist media says.

I’ll refrain from giving details on account of not wanting to embarrass the people in question, but suffice to say that on one occasion the host of a party was really, *really* iffy about giving me a steak knife to eat my steak with.

I’m guessing the line of thinking goes “bipolar disorder” -> “psychosis” -> “psychopath”...?

So, just to clarify: anyone intending on doing some horrible crime will almost certainly find that bipolar disorder will get in the way of this, in the same sense arthritis or blindness would. This is not a disease that takes a perfectly normal, capable person and gives them evil intentions: it’s a disease that takes a normal person and makes them disabled.

The one good thing about this group is that they usually haven’t had very much contact with people who have these diseases. Simply interacting with them normally in a social setting for a while consistently makes them realise that their schema for the disease is completely wrong.

Because of this, ironically this group is one of the easier ones to deal with. When they realise that you’re just a normal person with a health problem, they’re likely to express relief.

This group is far easier to deal with than the ones who think, despite never having had your condition, that they fully understand it and know how it should be handled.

People who think your mind is utterly alien and unstable can fix that misconception with about an hour of talking to you. People who have no understanding of the disease at all, but believe they do, are much harder to handle.

Bipolar, schizophrenia and split personalities

“Oh yeah, I haven’t seen you since high school! So, what have you been up to?”
“Around the time I was supposed to graduate I developed bipolar disorder and had to quit.”
“I see, got a bit of a split personality, then?”

What he said wasn’t offensive, but it feels slightly condescending to even discuss it. That said, it was an actual conversation that happened, so there are very clearly a non-zero number of people who are failing to understand how bipolar affects your sense of self.

Bipolar disorder is usually described as a disease of mood. I don’t buy this. Bipolar disorder is a disease of *engagement*. A sufferer will go through periods of extremely high engagement with just about everything — everything is exciting, everything is compelling — and periods of extremely low engagement. Usually these periods are in the order of months.

While the person will be noticeably different in those two phases, they will be the same person, with the same identity and the same memories. The variable factor is engagement.

But here’s the thing. I was looking through some old journals:

> *“This is like being Dr Jekyll and Mr. Hyde, except I’m not sure which is which.”*

Engagement levels are one of the things that comprise your personality. Changing those levels can result in changes to just about all of the important things that result from it.

Someone who is uncontrollably, unavoidably engaged with something they are not normally interested in may be exactly the same person — but from the outside, every measure of their “self” appears to be different. Their beliefs, actions, appearance and objectives are mutable based on this, and that changes where they’re going in life.

As that excerpt implies, it is sometimes difficult to know which state is more “well”. Living in a world where you’re unbelievably excited and enthused to get things done actually *can* have a positive material impact on your life circumstances. You do have, actually, a right to enjoy life and work towards achieving the things you want, despite having a disease.

You also have a right to do it sustainably.

The damage uncontrolled (hypo)mania can do has the ability to prevent you doing that, too. You have to manage it.

The Pit of Despair

The field of animal models of depression is, perhaps surprisingly, quite mature. There are quite a range of apparatuses that can reliably and replicably generate a state of major depression in laboratory animals.

It might be surprising to discover that simply inflicting pain or other adversity on the animal is not usually enough, no matter how severe that pain or adversity is. As long as the animal has some measure of control over its circumstances, it will probably not become depressed.

On the other hand, if an animal has no control over its circumstances, nothing it does will have an impact on its suffering, even if that suffering isn't actively painful. It'll thrash about for a while trying to find something that works, and eventually give up and learn to be helpless. This is depression.

The first notable example of this type of experiment was known as the Pit of Despair, and the apparatus was not misnamed. I recommend not googling it[3].

Depression is what happens when you feel like nothing you do makes any change to your situation. The situation does not have to be painful or bad in any way — the brain can invent that just fine. But this raises an interesting thought:

The opposite of depression is not happiness.
The opposite of depression is agency.

In fact, something similar to depression is quite common among those who have everything that most people traditionally think of as creating happiness. You can have all the wealth, security, power, stability and luxury in the world, but if your actions have no impact on your situation, you will become depressed very quickly.

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[3] Or literally anything else invented by its creator. Seriously. It only gets darker from there.

And when you’ve reached that degree of success, just about the only thing that will make any meaningful change (albeit negative) to your circumstances is wasting money en masse.

There’s a recurring theme among successful entrepreneurs. They’ll start their company, grow it, and then exit in an acquisition. They’ll have a couple of years contractually obliged to work under the acquirer, then quit and be free to move to Mojito Island and drink cocktails on a beach for the rest of their lives.

What actually ends up happening is that after about 6 months of unbridled hedonism, they get utterly bored and dispirited.

They’ll consistently endorse the position that they were much happier when they were fighting tooth and nail to get traction, and now that they no longer need to, there’s no point in doing it again. In short, they were exerting agency over their situation at a high level: rapidly changing their circumstances with a sheer effort of will. They had purpose.

When someone is depressed, the most useful activities for them are not ones that make them happier or give them pleasure. They are ones that help them exert agency: ones that actually make a meaningful, permanent difference to their lives, no matter how small.

The best kind of impact is passive: things that require little or no future maintenance effort, but which will still have an impact regardless. Things that they can do that will result in change forever.

That’s what makes depression so hard to deal with: by definition, it feels like nothing will result in change. That is the key even more than the actual state of your mood.

In the West, we are socially programmed to believe that our objective in life is to maximise pleasure, and that we can do this by accumulating material wealth. This is probably one reason midlife crises are so popular.

The way to lead a fulfilling life is not to finish with the highest score in your bank account. The way to lead a fulfilling life is to know which things you care about, and to maximise your agency over them.

Madness in mass media

There’s really only one psychiatric disease that gets invoked in mass media.

The usual approach for looking at these diseases in film, TV or games revolves around ideas like “madness” or “insanity”. These are not psychiatric conditions, and they are not synonymous with psychosis.

“Madness” and “insanity” are social concepts, not medical ones. They represent a view from the outside of the sufferer, a perspective where the person’s beliefs, words and behaviours do not make sense to others. You certainly don’t need to have a psychiatric condition for this to be the case, and having one does not guarantee that you'll be seen this way either.

There's a common thread among the depictions of these concepts in mass media, though, and it's one that almost everyone will experience at some point: fear of going mad.

It is almost universal to feel afraid at the prospect of going mad, and almost universal to feel at times like you're not that far off it. But the operative word here is *afraid*: this is not psychosis. This is not the beginning of psychosis. This is *anxiety*.

Unlike psychosis, anxiety is nearly universal. *Everyone* feels inappropriately anxious at some stage in their lives. It is part of the human condition. Being inappropriately anxious about your own mental state and ability to think in a way that makes sense is extremely common. Far more common than actual psychosis, in fact.

Ironically, fears like that of losing control, or being overwhelmed and losing your ability to cope, or of something somehow damaging your mind beyond repair — are usually exactly that: fears.

Funny story — when I was in TAFE I was working on a 3D graphics renderer in between classwork. I'd successfully gotten part of it rendering, but there were some issues with the virtual camera[4]. Turning the camera caused it to go out of control and spin faster and faster.

I was staring intently at this scene as it spun faster and faster trying to work out if the rotation was at least continuously in the same direction, when my teacher who knew very little about my health issues spoke up:

“Hey, do you have schizophrenia?”
“Huh? Uh… no…?”
“Reckon you could give it to yourself if you stare at that long enough.”

That teacher was a laugh[5].

Symmetry and Suffering

Culturally we like to represent happiness and sadness as a symmetric duality. We have an equal capacity for both, and our lives are a balance of things that give us pleasure and suffering.

For people who have not experienced trauma, this is a plausible and digestible worldview.

The most horrifying thing that trauma does is that it makes you aware that, unlike our capacity for happiness, the human capacity for suffering is unlimited: that even after you’ve lost

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[4] Modelview matrix, if you are that way inclined. This was in the OpenGL1.1 stone ages, though if I remember correctly, I was trying to build a software imitation of that architecture.

[5] He also successfully convinced a classmate the moon was made of cheese, a fact which I never let either of them ever forget.

everything, you still have a lot to lose, and even after you've hit rock bottom, you've got a lot further to fall.

My experiences, and the experiences of friends and family, suggest that all psychiatric disease is inherently traumatic. Like all traumatic experiences, they permanently shift your perspective.

We live in a world where policies and systems are almost invariably developed by people who have not had that perspective shift, and who pride themselves on being "reasonable" and "prudent" about their failure to solve the problems that result.

It is difficult to even convey the scale of the suffering that these diseases can cause, purely because it is so far off the scale of anything you could normally experience.

Fatigue and brick walls

It's a very popular activity to ridicule chronic fatigue and fibromyalgia sufferers these days.

Insurers and evaluators like declaring that they're not real disabilities, (some) doctors like declaring that they're not real diseases, and politicians like funding studies that say sufferers are "just deconditioned."

You've probably heard the spiel before that these are hugely disabling and very serious diseases, and anyone who has either problem can tell you. I don't have either of these diseases, but I have two cents to throw in. I have some conditions and treatments which are chronic, and which cause profound fatigue. In the very literal sense it is a *chronic syndrome of fatigue*, but I wouldn’t meet the criteria for CFS.

My other health battles surround things like psychosis, panic attacks, developmental problems, anxiety, depression, hypomania and mania. What these all have in common is that they are variable: they can be worked on. They can be improved; you can experiment and find new medications and new methods and new ways of looking at the problem. They are complex and traumatic to work on, but if you have the support it can be done.

Fatigue doesn’t work like that. Fatigue is a brick wall. You can bang your fists on it as much as you want, but it isn’t moving. The effort of banging your fists will make you more tired, in fact. Fatigue is just utterly static and immutable and unmovable. There is nothing you can do with it.

Most people, when they hear “fatigue”, think of what they might experience after a 10-hour day at work with an hour bike ride each way.

This is a completely unrelated concept: when you have a normal amount of energy, and are simply soaking it up with lots of activity, you do not have fatigue. You are just busy and tired.

Tiredness is not fatigue. They’re completely different, not just in severity, but in nature.

Fatigue in the medical sense is when you have no source of energy to start with. Maybe caffeine gives you 20% more energy, but 20% of zero is zero.

It’s crushing and overwhelming. Even your thinking is affected: certain lines of thinking take more effort than others, and when you have fatigue, all but the lowest-effort lines of thought are utterly impossible.

In short, despite all of the problems that I’ve had, fatigue is actually the most disabling one. All the disordered thinking in the world can be improved with hard work and the right support, but when you’re utterly incapable of putting effort into anything, you stop dead.

You have no options. You have nothing in the tank and the tank isn’t refilling. And there’s no reason to believe it ever will.

It might be a little surprising to consider that the vaguest symptom in the world, one which sounds like a completely normal experience, is actually a very specific and severely disabling problem.

Fatigue does not simply add a barrier to you functioning, but entirely eliminates the resources with which you overcome those barriers as well. You cannot overcome this by trying harder.

“A combination of genetic and environmental factors”

If you search for information on the causes of bipolar disorder, you’ll usually find something like this:

> *“Bipolar disorder does not appear to have a single cause but is more likely to result from a range of factors that interact.*
>
> *Some studies have suggested that there may be a genetic component to bipolar disorder. It is more likely to emerge in a person who has a family member with the condition.*
>
> *Environmental factors: Abuse, mental stress, a "significant loss," or some other traumatic event may contribute to or trigger bipolar disorder.”*
>
> (source: [6])

There are a thousand variations on this spiel, but most people will find all of them unsatisfying. More importantly, they imply that we do not know much more than the fact that certain criteria are associated with an increased risk of developing the condition.

I think we know a bit more than that, but it is likely to be necessary to combine the data with a direct understanding of

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[6] https://www.medicalnewstoday.com/articles/37010.php

the condition to get the whole picture. So, the real question: what causes bipolar?

What starts a forest fire? Is it the dryness, hot day, the wind, an ember in the wrong place? Some of these are necessary conditions, some are intensifying factors, and one kicks it off. None of them are sufficient to start the fire on their own.

A person's genetics are estimated to comprise 60–85% of their risk of developing bipolar[7]. That's already a very large number, but it raises some questions:

- It is even possible to develop bipolar disorder entirely due to one's life circumstances, without the relevant genetic configuration?
- Is it impossible for this configuration to occasionally arise in people with no family history from unexpected combinations of otherwise innocuous genetic material?
- For every case where one identical twin develops the disease, is it (invariably) possible to induce the disease in the other twin through environmental circumstances?

I have no way of proving this, but it's my belief that a person's genetics are a necessary factor (the dryness), a person's stress, trauma history and engagement levels are intensifying factors (the heat and wind) and a period of sleeplessness or excessive stress kicks off the process (the ember). It's not

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[7] Smoller JW, Finn CT. Family, twin, and adoption studies of bipolar disorder. Am J Med Genet C Semin Med Genet. 2003;123C:48–58.[PubMed]

meaningful to try to make a case for which of these “caused” the fire.

It is not a case of each of these factors simply increasing your risk by a certain percentage each. There is actually a structure to the process of the disease beginning - different factors matter more or less at different times depending on how they’re combined.

“Stay on your meds.”

There’s a well-known forum on the Internet[8]. Each post has an icon next to it, and when you post it you get to pick which one appears. There’s a fairly wide range for various circumstances, but there’s one that is particularly relevant here.

It reads, “OFF MEDS”.

Now, the forum administrators are being funny, and people usually invoke it when they’re doing something risky or generally unwise. But that’s exactly what is interesting: coming off medication is seen as an inherently unwise and dangerous thing to do. You’ll see this thinking very often when there is a tragedy committed by someone ill after they came off them. “Stay on your meds.”

What these people don’t realise is that staying on the *wrong* meds, or the wrong meds for their current state and situation, is frequently worse than nothing.

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[8] Unrelated: if you’re wondering whether or not there are stairs in my house, I’m protected.

These drugs are not cure-alls that solve all mental pathology. Each one is targeted to a specific problem and is only useful insofar as it is helping that particular problem. The wrong drug at the wrong time will push you in the wrong direction.

For something like bipolar or schizoaffective, drugs are the only way to actually slow or halt the disease process, so their use is absolutely essential. But it is also absolutely essential that the patient does not simply accept that doctor knows best and that their own experiences don’t count or matter.

That *will* eventually result in the patient stopping the drugs, because they will remain on inappropriate medication and consequently deteriorate until they are no longer able to continue.

The only way you can guarantee that a patient will keep taking their medication regularly for decades is to prescribe them the *right* medication regularly for decades.

Prescribing the right medication means not only listening to what a patient is complaining about, but actually setting the stage for them to think about how their medications interact with their biology, their activities, and their lives, and to help them learn to autonomously make choices about that.

It’s a long slow process of learning, healing and recovery, but the patient is the only one who actually has the ability to make these judgements, and once they’re stabilised, the psychiatrist’s main role in medication choice is to facilitate this and serve as a failsafe.

Here’s a story. I had read a while ago that a tech company had created an antipsychotic pill that would report to a worn electronic device and log with their treating psychiatrist that they had taken it.

The poetic irony of placing tracking devices on psychotic people aside, this is an unbelievably terrible idea. Every invention has value of some kind, but this one’s value is purely, exclusively to harm people who are already at their most vulnerable.

It shifts the power even further to the treating team and away from the sufferer. It makes the sufferer’s experience of their illness count even less to the treating staff, and instead evaluates their recovery in terms of compliance and obedience.

*This is the polar opposite of what is needed***.** Recovery comes from developing autonomy and judgement, and the primary role of psychiatrists is to support them to do that. Recovery does *not* come by conditioning someone to do what they’re told, even when it is harming them. That’s how people get sicker.

More importantly, that’s how people decide to stop engaging in treatment entirely.

The Rorschach Test

Probably the single most famous psychological tests for pathology is the Rorschach Test, known for its abstract inkblot patterns. Go and google the blots themselves if you’re curious.

To clarify: this is in general a *psychological* test, not a psychiatric one. It’s occasionally used by some fraction of psychiatrists in some very specific settings, but less often.

A lot of people who are peripherally aware of the test think it’s utterly bizarre and arbitrary that the blots could be used as a way of understanding someone’s internal mental state. This seems like voodoo and something that could not possibly be connected to reality.

In a sense, they’re right: you can’t diagnose someone’s psychological problems or psychiatric disease with them. This test does have some genuinely valid, evidence-backed value in treatment and diagnosis, though.

Most of the blots have interpretations that are much more common than others. Among a population, you’ll find several descriptions of most given blots that pop up much more than others. The divergence from these interpretations is one of the useful metrics. Questions from the subject regarding things like card orientation or how they’re supposed to approach it contribute to this.

More unusual answers are associated with more psychopathology. But they’re also associated with more creativity and higher intelligence. This metric can be useful, but only in context. Someone answering only unimaginative responses can also be conspicuous, depending on their situation, personality and mental state.

Some of the blots do not have any common interpretation at all, and some of them are abruptly different from the previous cards (example, some are coloured). This can be used to understand how the subject handles unexpected changes and unstructured stimuli, depending on their circumstances.

If you've noticed that there's a lot of "depending on" and "in context" here, that's extremely important: the cards themselves are a MacGuffin[9]. The objective of this test in an evidence-based setting is to provide clues as to how the person approaches a novel task, and they are arranged in a way that happens to provoke common responses in a well-studied way. They are not diagnostic on their own.

The main practical use of these cards in psychiatric medicine is to find signs of thought disorder in someone who refuses to open up about their own internal thought processes. Presenting the cards provides an external stimulus for them to talk about instead, and paying careful attention to their responses can elucidate information that the person refuses to put forward.

This is as much art as science, and the entire process is exquisitely sensitive to the circumstances and the person's state of mind. The days of "If you do not see a penis in this card, you have repressed latent homosexuality." are far past in the psychological profession.

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[9] A MacGuffin is a device for catching lions in the Scottish highlands. The astute will note that there are no lions there; in storytelling the term refers to elements that advance a plot while being entirely arbitrary and meaningless on their own.

Rather, the fact that responses for these cards have been studied for the better part of a century provides a useful statistical anchor from which to judge a person's behaviour when responding. It still takes skill and careful judgement.

These cards do not diagnose a person. They provide something unusual to talk about that psychological science has good data about responses on. For that, they have a (narrow, specific) niche, and some practical value.

Hardware and Software

Computers are marvelous things. You can buy a single piece of hardware for a surprisingly low price, maybe $200, and it will be able to run an extraordinarily broad range of software. The hardware is general-purpose, and in the absolute worst case if it has a challenge that's too hard for it, it will (mostly) do the same job as every other computer, just slower. The software and the hardware are completely independent, and with the right software, you can do anything.

One of the central questions that seems to come up when discussing psychiatric illnesses is analogous to this: is it a physical illness, or a mental illness? Is it something that is wrong with the person's brain, or something that is wrong with the person's mind? Is it the hardware, or the software?

The critical problem with this question is that it fundamentally misunderstands how the brain works. The human brain simply does not have a division between hardware and software.

Every single thought that you have causes lasting structural changes. Every action creates new pathways. In short, the content of what is happening in your mind has a permanent, physical impact on brain structure and functionality.

What's particularly frustrating about this is that most of the people who know this seem to use it as an excuse to be lazy or judgemental, or both.

If a sufferer perceives a physical symptom, this is not an excuse for assuming that there is a psychological cause for it. That *can* happen, but if they say it didn't, you have nothing else to go on but their word. Be careful about jumping to conclusions.

If a sufferer has a psychiatric problem, this is not an excuse for saying they need to find a psychological solution to it. The fact that the mind's actions affects the brain's structure does not necessarily mean that it is possible to solve their specific problem without something like medication. They do not have control over *how* their thoughts affect the brain's structure and functioning.

What it does mean is that the borders between psychological, psychiatric, and neurological conditions are simply nonexistent. By dividing these conditions up into separate areas, the entire medical and scientific profession is doing itself the highest disservice: it is clouding its understanding of its own field at the expense of its patients. It is simply not possible to have a psychological condition that does not have direct neurological consequences, or vice versa.

So how do we use this to improve our understanding of the patient’s situation? There is a very simple question you need to ask yourself:

“Is knowing there’s no boundary between physical and mental problems making me take their suffering ***more*** *seriously, or less?”*

There’s a right answer, and it starts from the right attitude.

“The trick is to push through it.”

This might seem painfully obvious and stupid to anyone with experience of psychiatric disease, but it’s one of the things that seems to come up time and time again in the general population.

It was a little surprising to hear all of these firsthand:
- “You’ll be fine if you just stop worrying.”
- “You’d have no problem if you calmed down a bit.”
- “I’d be depressed too if I was dwelling on this stuff.”
- “You’re sleeping all day every day? Whose fault is that?”
- “To get to sleep, just put your head on the pillow and close your eyes.”
- “Whenever you get caught in this loop, just take a step back.”
- “The trick is to overcoming these problems is to push through them.”
- “You can make this much easier by being less nervous.”

...and many, many more.

These are all saying that the solution to a problem is: to not have that problem.

They all came from well-meaning friends who wanted to help, which given how common this seems to be, is unfortunate: these are people who want to help and misunderstand the basic nature of these conditions.

Someone with insomnia cannot sleep by lying down and closing their eyes. Someone with hypersomnia cannot stay awake by keeping busy or drinking coffee. Someone with depression cannot improve their mood with enjoyable distracting activities. Someone with anxiety cannot stop worrying. Someone who is manic cannot calm down. Someone with any of these cannot simply keep trying harder until the problem clears on its own.

That is the reason they have a problem. These functions of their bodies and minds don't work anymore.

This happens in the inverse too. When I had improved to the point where I was able to handle a full-time job, I had more than a couple of comments that effectively translated to "It is so commendable that I overcame the disease through sheer force of will," and that "It made perfect sense that my problems were improving, because I'd finally taken control of my life."

Insofar as willpower was involved in this process, it was the willpower required to completely ignore the advice these people were giving.

These diseases cannot be treated by trying harder or other common-sense solutions. In fact, it is precisely the fact that common-sense and brute-force approaches do not work that makes them diseases, and not personality traits.

“Grow up.”

I had a look through the Facebook of an old friend who had gotten sick long after I saw them last. There was an entry which sounded quite grandiose and dramatic, making broad and serious statements. I think their last diagnosis was schizoaffective.

There was an interesting comment from someone I didn’t know:

“Grow up.”

To be honest I wasn’t entirely sure what to make of this. The writing they were responding to was quite obviously disordered, and even somebody who knew absolutely nothing about psychiatric diseases would still have a pretty good idea that something was very wrong.

It was a little disturbing to see someone attribute this type of thinking to a simple lack of maturity - that they were just choosing to be dramatic because they thought it was cool and edgy. To someone who has experienced psychosis, it was self-evident that there was a serious problem here.

I skipped adolescence. From ages 13 through 17 I was too sick to have a teenagerhood. It makes sense, then, that I would see such dramatic sweeping and confused statements through the lens of illness, but someone who had not been through that would see it through the lens of melodrama.

Stereotypically, even most healthy teenagers are fairly melodramatic and often act out with emotional outbursts and sweeping grandiose statements. It actually makes sense that people who have only been exposed to that one type of prose wouldn’t realise that the other even exists.

People who have psychiatric illness don’t say and do these things for attention or to shock people, or because they’re not mature enough to know better.

They say and do these things because *they really believe and feel them, because they’re sick*. One of the common threads among most psychosis is a feeling of “largeness” - even when it isn’t grandiosity per se, there’s still a theme that the things the patient is concerned with are large and scary.

This is not because they haven’t learned perspective, or any other developmental milestone like that. It is because this is a direct effect of the disease process. The most intelligent, mature person in the world is still utterly helpless against a biological process that changes the way they think.

It’s quite striking to see that some people who have never come into contact with psychiatric conditions firsthand simply see a person’s behaviour as part of their personality regardless of any disease process. That’s an easy position to hold until someone close to you develops one of these conditions.

“You shouldn’t be doing a PhD, you should be in therapy!”

A while ago I was browsing an online discussion among postgraduate students.

One of the people in this forum stated that they were struggling with schizophrenia while doing their PhD, and the first response to this was frankly shocking:

> *“Schizophrenia? PhD? You shouldn’t be doing a PhD! You should be in therapy!”*

Uh, okay, and the objective of that therapy is to get them able to do what…?

After recomposing myself I realised I’d seen this attitude before in person, too. There seems to be an implicit impression among some people that “therapy” is a near-full-time occupation that you engage in as a primary activity in life until you’re “fixed”.

There might even be a hint of pre-deinstitutionalisation thinking here, where the objective is for psychiatric diseases to be Someone Else’s Problem, and if asylums can’t provide that, then maybe therapy can?

The unfortunate reality is that even when it is anomalously successful, the treatment process for severe psychiatric diseases does not output a normal, healthy person who is ready to fit in where anyone else could.

More often it will output someone who has utterly lost their confidence, has alienated most of their social circles, and is the better part of a decade behind on conventional life milestones.

There is nothing that can happen in a therapist’s chair that could ever help that. The way you build confidence is to gradually achieve things you don’t think you can in your own time. The way to rebuild a social network is to regularly interact with people regarding things that are meaningful to you and to them. The way you catch up on conventional life milestones is to gradually chip away at them until they give.

In short, if something genuinely gives the patient meaning and purpose in a way that matters to them, it’s by definition the most effective rehabilitation measure available. There is nothing therapy could ever do that would substitute or approximate this. That’s not what it does. That’s not what it’s for.

The uncomfortable part of this is that the people involved with the activity in question have to deal with the fact that someone they’re doing it with has a psychiatric condition. They can’t fob it off to a psychiatrist and say to come back when they’re cured. The process of recovery requires that “normal” people go through it with them in “normal” settings. *Of course it bloody does, how else will they re-learn what normal is?*

I think a big part of this is (once again) mixing up “issues” and “diseases”. The logic is that if they put a large amount of effort into preventing their personal issues leaking into their professional or social lives, that someone with one of these diseases should do the same. If they can’t do that, they need more treatment until they can.

Psychiatric diseases are not personal issues. They can cause personal issues, and they can be set off by personal issues, but they are a fundamentally different concept. They are diseases. These diseases require special consideration and support in professional and social environments. Providing that support is not connected in any way whatsoever to opening the floodgates on whatever personal crap others are dealing with. They are a separate and different case and need to be treated like it.

Suicide ideation hierarchy

When someone says that they “feel suicidal”, people tend to be scared and confused and hurt. It’s easy to make knee jerk reactions that make matters worse.

It might be surprising to find out that “feeling suicidal” is not just one thing. It’s a whole spectrum of things, some of which are much better or worse than others, and the presence of one doesn’t necessarily imply the presence of others.

One (arbitrary) list you can construct looks like this:

Death indifference
“I don’t care whether I live or die anymore.”
Passive death ideation
“I hope the next time I cross the road I get hit by a car I didn’t see.”
Passive suicidal ideation

“I wish I could bring myself to attempt suicide.”
Active suicidal ideation
“I intend to attempt suicide (and may have some ideas about how and when).”
Planned suicidal ideation
“I intend to attempt suicide, and this is how and when.”
Suicidal intent
“I’m going to attempt suicide.”
Death intent
“I’m going to attempt suicide, and I am going to succeed.”

It’s worth pointing out that each grouping of severity filters out a large number of people. Very few people who intend on making an attempt actually do, and very few people who actually make an attempt are actually determined to succeed.

The overwhelming majority of suicide attempts are not successful, which tallies with *actual* death intent being quite rare. People overwhelmingly choose methods that are likely to fail.

It’s also critical to understand that these are not *stages* that a *person* goes through. They’re categories of thought types, and it would be singularly unlikely for all of one person’s suicide-related thoughts to fall neatly into one category exactly.

The usual diagnostic indicators for it are premeditation; that is, whether the person has set their affairs in order and has a specific process in mind for ending their own life. A person presenting with that to a psychiatric evaluator will generally result in a hospitalisation, which may or may not help in any way.

This is not precisely reflective of the group that actually intends to succeed. But it’s hard to tell them apart until it’s too late.

Severe depression

It may surprise many people to learn that after “acutely suicidal with a plan and intent”, there’s actually a whole galaxy of worse forms of depression.

Estimating the severity of a depressive episode is difficult at the best of times, because there are psychological tricks the disease plays to mislead you.

By the time someone even qualifies for the diagnosis of major depression, they usually have such a profoundly negative outlook on their life that it is well past reason. Part of this negative outlook is almost invariably the feeling that everything just keeps getting worse and worse.

A patient who has begun to get better almost never says that things have improved in the beginning. Instead, they’ll gradually reduce the magnitude by which things are getting worse. By the time things are breaking even and not getting better or worse, their negative outlook is largely gone and their health has usually improved dramatically. They’re better, without their life ever actually getting “better”.

This distorts their perspective of how severe their depression is. When you start from someone who no longer has anything at all to live for and is seriously intent on ending their life, how much worse can it possibly get?

Much worse.

The next step after this is to start developing quasi-neurological effects from the disease, which is then followed by *actual* neurological effects.

This process is referred to in psychiatry as psychomotor depression. The person’s rate of speech and movements slow down dramatically, and they begin to have unexplainable difficulty engaging in straightforward tasks. Eventually their rate of thinking slows, too, and they can eventually stop moving and speaking at all (akinetic mutism) and become non-responsive.

This is not something to spend time worrying about: very few sufferers of depression progress to this extent, and if you’re worrying, it’s a pretty clear sign you’re not going that way. It doesn’t “just happen.” But it’s important to be aware that this is what is at the extreme end of the depression spectrum.

A patient who intends to harm themselves is still functioning at a certain level, because they’re trying to make changes to their life (albeit negative). As psychomotor depression progresses, they will lose the ability and interest to even do that.

All depression is severe, in the sense that it is an unreasonable and inappropriate set of emotions and thought processes that the disease thrusts upon you. But there are many kinds of severe, and not all of them show up in mainstream discussions.

Advice for Carers

Black humor

You can’t look death in the face every day for years at a time and not develop some gallows humor. Get used to it. It might be scary, but try to recognise that they’re at least having a laugh about something.

“It’s real to them.”

Seeing someone go through a psychiatric crisis is very challenging, even if you’re not close to them. And even harder if you are.

The initial response from well-meaning people with no experience often seems to be rejecting the person’s interpretation of the world around them, and coming up with an explanation for why they see it that way. Few people can deal with a loved one being delusional.

When you’ve seen a loved one either lose contact with reality completely or utterly lose control of their emotions, it seems to split off into two basic responses: either reject their experiences entirely as disordered, or acknowledge that while their beliefs and experiences are not real, they are “real to the person.”

“Real to the person” is a step up, but I think it’s still a little misleading. The most important part of this entire experience is one hundred percent tangible:

The suffering is real.

And the suffering is the part that matters. The suffering causes them to thrash about trying to improve how they feel, and this thrashing is usually what damages their supports and life progression. You stop the suffering; you stop the damage.

Looking back at journal entries after my hospitalisation in 2006, what is most surprising about them is how little they change. The distorted thinking and grandiosity and all those other fun mania things are still there.

This is actually a little surprising, because my experience of it was completely different: after my hospitalisation, I was on the right medication, and the suffering largely stopped overnight.

Judging by these entries, it took another 6 months before my thinking had mostly returned to normal. That was extremely surprising to discover: the part you remember is that you are no longer suffering.

If a person has unusual behaviours, thought processes or beliefs, but is not suffering or progressing, they probably don’t have a psychiatric condition. The term for this group is “eccentric”. It is certainly possible to be both eccentric *and* have a psychiatric condition, but these are two completely independent traits.

There’s exactly one psychiatric problem where the person doesn’t seem or claim to be suffering: hypomania. Anyone who has been through it can tell you that they have simply deferred the suffering. It will catch up with them. Guaranteed.

Psychiatric diseases are made of suffering. Don’t miss the forest for the trees.

Low expectations

This is not something I have as much firsthand experience with, because once I was stabilised I immediately got the hell away from all this. That may have been part of why I recovered so well. Nonetheless, it’s something I’ve observed over and over again from friends and family who spent years in it.

What I’m referring to is the support infrastructure that is provided to people with psychiatric conditions after they’ve stabilised and are looking to recover functioning. Therapy groups, employment and education assistance, things like that.

The problem with these supports is that they usually seem to have spectacularly low expectations with regards to career and social success, and this often becomes a self-fulfilling prophecy. In most cases they treat full-time work at a supermarket or petrol station as better than could ever have been hoped for, and the thought that someone can hold down a job that is even slightly above that is considered absurd.

Most people would consider working at a petrol station for the rest of their lives soul-crushing and depressing.

Is it really that crazy to consider that the same experience would be equally depressing for a person with a psychiatric condition, but with the added bonus that they have repeatedly had it drilled into them that they can never do better and this is the best that any work (employment or creative or otherwise) can ever be for them?

Worst of all, now all your peers are counting down the days until you collapse and have to fall back to the supports, like everyone else they know who tried to do this. Do you think that is an environment conducive to finding your calling and creating meaningful fulfillment?

Perhaps it shouldn't be much of a surprise that the people with these conditions don't usually do much better. Because they've been set up for failure and then told that anything bigger is far beyond them.

The irony of the situation is that people with psychiatric conditions are usually very creative. Creative people do not do well in jobs that mostly consist of pointless drudgery. Creative people do well in jobs where they have the ability to invent and create, and to have ownership of their creations. If the supporting staff aimed to place them in challenging roles where they actually had intellectual stimulation, it's likely they would actually do much better.

Jobs and activities which are also meaningful and mentally stimulating are easier, more enjoyable, more fulfilling, and more sustainable long-term. Especially if you're someone whose thought processes are divergent and creative compared to most.

And, I hate to say it, but workers who do jobs like that are often treated better and given more flexibility.

Though I’m sure it’s with the best of intentions, our system has inadvertently been set up to discourage the people that need those positions more than anyone.

I work as a software engineer. It’s a highly-paid, high-impact, intellectually demanding role. I can do it. I am doing it. Guess what? I would not be able to work as a laborer or a supermarket box stacker. Not because I don’t want to do such a boring job, but because *I am not capable of doing a job like that*.

Next time you see a recovering patient struggling to do a soul-crushing low-skill job, consider that it is not because they are not well enough. Consider that perhaps what you’re asking them to do is bullshit and they know it.

Personal responsibility

"I have a really interesting political point of view, and it's not always something I say too loud at dinner tables here, but you can't go from a $2,000-a-night suite at La Mirage to a penitentiary and really understand it and come out a [progressive]. You can't. I wouldn't wish that experience on anyone else, but it was very, very, very educational for me and has informed my proclivities and politics ever since."

~ Robert Downey Jr

This quote is from a man who reached the lowest lows of society, as well as the highest peaks, and believes that anyone who goes through that and understands it cannot under-emphasise the importance of personal responsibility.

I honestly think my life is a mirror image of that. You cannot go from florid psychosis, rebuilding a life from scratch, being fully housebound from agoraphobia for years, and then recover to the point of having a professional job and marriage - and really understand it - and come out a conservative. It is not possible.

The reason is nothing to do with opinions or beliefs or anything like that. It is the result of knowing viscerally and firsthand what is absolutely, unconditionally required for someone to go through that process and be able to not only survive it but reach quasi-mainstream thresholds of functioning afterwards.

This is incompatible with most conservative ideologies because they broadly emphasise that personal responsibility is the core element which is required for all positive change.

That’s a perfectly reasonable belief for someone who hasn’t experienced firsthand the fact that there are some problems that absolutely nobody can ever take responsibility for, no matter how much they want to. Problems that affect every area of your life.

Psychiatric diseases simply cannot be handled in this way, and attempting to do so is likely to make them worse. These are diseases that are far, far beyond any concept of “responsibility”.

What is needed is unconditional patience and acceptance. If the carers and treaters consistently handle a severely psychiatrically ill person through the lens of personal responsibility, *they will never recover, period*.

The process of stabilisation is mostly centered around the use of medications, and without those the person is simply not capable of being responsible for their actions. But once they're stabilised, they still have a long way to go.

They need years of recovery, and of said unconditional acceptance and patience. Obsessing (even silently) over their inability to be responsible is an outstandingly effective way to halt this process. Until all of your interactions are coloured with genuine acceptance and patience, nobody is improving.

At the end of that, you can *start* to help them take on responsibility. When *they're* ready to.

None of this is an opinion or a belief or anything like that. This whole understanding of the process is the result of me spending over a decade going through it and coming out the other side. You absolutely cannot go through that process and not come to this conclusion. It's not possible.

You wouldn't hold a tree to account for falling down on someone during a gale. You do not have the right to hold a psychiatrically ill person to account for their behaviour while sick. All that extreme behaviour? That's caused by extreme suffering. This is a gale that healthy people are entirely blind to.

"What part of this is difficult?"

People with psychiatric conditions almost universally have problems with activities that are considered basic functioning for a human. It's practically part of the definition.

It’s particularly upsetting when the thing you’re unable to do is literally as simple as walking down a street, or sitting in a room with people you don’t know for a brief period, or having a ten minute conversation about some basic procedural parts of life like paying bills.

Here’s an important message for anyone who has to take care of a person who can’t do things like this:

They know perfectly well that these are normal human activities.
You don’t need to tell them that and you ***certainly*** *don’t need to give them shit for it.*
They are guaranteed to be already giving themselves more shit for it than you can imagine.
More pressure and more shame are literally the two last things they need.

This is a particularly interesting topic to me, because I’ve been on both ends of this. On my end, panic disorder is an obvious one: when you’re basically unable to move around in public places without panicking, it makes doing pretty much anything very difficult.

I got to return the favour to the same person who cared for me through that — they spent a while vigorously avoiding some standard adulting activities.

They know perfectly well it would have taken less than 10 minutes to sort out those activities. I know perfectly well it takes less than 10 minutes to walk to the corner store. The fact that either or both of these are easy for one person doesn’t make it any less impossible for the other.

In both cases, there was a big mess to clean up. But this put us in the unique position of both having cleaned up an avoidance mess, and having had our own avoidance messes cleaned up.

What I’ve learned is this:

Dealing with someone who is not able to do simple and basic everyday things due to psychiatric illness is *unbelievably* frustrating. There are no words for how infuriating it is to try and get someone to do something extremely simple and necessary, and having them completely and utterly avoid anything connected to it for an extended period.

But I also learned that being the person unable to do it is equally, if not more frustrating. And you don’t get holidays from it: other people can walk away — even if briefly — and while they’re away it’s not immediately affecting them. The sufferer, on the other hand, does not get breathing room: their condition affects them every minute of every day.

This type of disability is multilayered and overwhelming. It’s a suffocating, pervasive form of shame that infects every corner of the person’s sense of self.

The more you try to shove someone like this forwards, the more you’re shoving them backwards.

If you’re wondering whether or not a sufferer is aware that the things they can’t do are actually easy, the answer is simply: they’re more aware of it than you’ve ever been of anything in your entire life.

Bipolar - Type I vs Type II

Ostensibly there are two basic types of bipolar disorder. There are a range of atypical presentations that suggest other types, and much academic debate about the nature of these variations. But let’s focus on the classic two types.

The DSM and most other mainstream psychiatric sources differentiate the two by the distinction between mania and hypomania. Type I has mania, a more severe and obvious form with outright delusions and psychosis, while Type II has hypomania, a less severe form that allows a patient to still mostly function.

That’s kind of right, but a little misleading. I prefer to think of it like this:

Type II has episodes that are self-limiting, and type I has episodes that are *not*.

A bipolar type I episode, whether it’s manic or depressed or mixed, will just keep getting worse and worse, and is usually agonising. This is a blessing in disguise: these episodes will rapidly escalate, and it will become obvious, extremely quickly, that this needs treatment *now*. In fact, the sufferer themselves is more likely to seek it, even if indirectly, because episodes this severe are just about the most psychologically painful thing it is possible to experience.

Type II is not necessarily less severe. It’s just less acute. The problem is that because it does not rapidly develop into a severe and painful state, it usually goes untreated for much longer. It is still perfectly capable of causing psychosis and still perfectly capable of causing dysphoric (hypo)mania, but these states do not happen as the result of a single very severe episode - they result from a large number of much less unpleasant episodes summed over time.

When those episodes are summed over multiple decades, by the time the sufferer experiences explicit psychosis it is likely that the disease has already caused much more extensive damage to their memories, belief structures and thought patterns. In that sense, type II is actually *more* severe: if a person has many years of emotionally charged experiences associated with their beliefs it is going to be much harder to willingly reject them and seek treatment.

There are medications that can completely halt the disease process of full-blown mania in the space of a couple of days. This is quite a bizarre experience; I described it at the time as feeling like “my brain was melting.”

I don’t know that such rapid turnaround is common among hypomanic patients, and it seems likely that the slightly more insidious nature of this process means that treatment both happens later and causes less immediate improvement.

I’m increasingly believing that if you treat bipolar effectively and quickly, remarkable improvements are possible in time. The disease getting much worse very quickly can actually make that easier, because frankly there are only two options: treat or die.

“When are they going to improve?”

Your loved one has had their crisis, and they’ve been stabilised. They’re out of immediate danger, they’ve pulled out of anything challenging or stressful, and they’ve got the biological part of their disease - if not sorted - at least not clearly deteriorating. You’ve tried acceptance for [weeks|months|years], but they’re still just sitting watching TV or playing computer games, all day every day. So, the questions you can’t help but ask are:

“When are they going to improve?”
”When will they do something with themselves?”

They are best answered with another question:

“Are these things that someone who has genuinely and unconditionally accepted that they must take their time would ask?”

This acceptance colours every single interaction you have with the sufferer, and the sum of those interactions forms one of the necessary conditions for recovery. Necessary, but not sufficient: there are several pieces to this puzzle, and they all have to be in place for an extended period of time.

How would you behave if the whole self care career progression personal growth thing simply did not apply to them at all, and it was perfectly okay for them to continue as they are for the rest of their lives? Would it make a difference to how you interact with them - both on the small scale and large?

“I will try this for a while and see if it works” is a very, very different attitude to “This will take as long as it takes, and I’ll be there regardless” which is different again to “Just do whatever, it’s your own fault if you don’t deal with this.” This very different attitude alters (consciously or otherwise) the way you treat them, which changes the way they treat themselves, which changes the outcome of their recovery.

The moment you start truly accepting them (and their illness) is the moment they *start* being able to regain functioning. And it’ll be tentative. They’ll be gun-shy and scared, because they’ve almost certainly been bitten repeatedly on this front - which is probably the whole reason they’ve shut themselves off from it in the first place. But everything in recovery comes from this start.

Your job is not to shove them forwards - they’ve usually spent years having nothing *but* people trying to shove them forwards. And it’s certainly not to stand there impatiently, waiting for them to get on with it. Recovery can’t happen until they’re ready to step forwards on their own instead, and that’s something they are only able to do when they are *extremely* sure it’s safe to try.

Next time you find yourself thinking these thoughts, perhaps replace them with:

> “If we had literally all the time in the world, how would I be treating them, and why?”

“If improving functioning simply didn’t matter, how would I be thinking about them right now?”

This approach can never guarantee improvement in someone whose illness is too severe to allow for it. But what it can guarantee is that the carer and the various other supports will not be blocking the recovery process. Nobody can *make* someone get better. But they *can* avoid getting in the way.

“Pay attention, you’re being rude.”

You have a loved one with a psychiatric condition, and you’re going to a social do of some kind. Maybe a family thing, maybe meeting an old family friend. Whatever.

They seemed fine when they got into the car. When they meet the people, they seem to just stop caring. Their eyes droop and become unfocused, they start constantly yawning every time anyone says anything, they stop talking and gaze off into the distance. They have no awareness of the social setting around them or the fact that it’s important that they’re properly present.

So, you tell them to pay attention. Nudge them under the table.

You’re hoping to jolt them back into life, so they start paying attention again and interact with the situation they’re in. Give them a bit of a nudge, and they’ll stop being so rude. Are they overmedicated? Have they not been sleeping well? Do they feel uncomfortable engaging with these people? Do they not realise people notice that they’re not paying attention? Do they simply not care?

Uh, no.

They are *anxious*, and you are making them *more* anxious.

In popular culture when you say “anxiety” most people think of someone who is visibly externally nervous, and there are easy-to-recognise physical signs of this, like being shaky or fidgety or jumpy. This often bears little connection to reality. There are many other manifestations of anxiety.

The other people at this social engagement may not know that, but that would be a good reason to *not make the problem worse*.

The central theme of anxiety is not nervousness, or fear, or worry, or anything like that. Those are all things that perfectly normal people with no conditions experience frequently.

The central theme of anxiety is avoidance.

A person who has had severe anxiety for a long time will go far beyond avoiding specific people, or situations, or locations, or the like. They will find that in situations which generate anxiety, their brain simply begins to stop accepting certain types of stimuli to protect itself. It is avoiding these inputs.

When a person has had severe enough anxiety for long enough, it is quite likely that their brain will literally stop accepting sensory input when they’re feeling sufficiently uncomfortable.

They are not capable of absorbing all the sights and sounds of the situation they're in, no matter how hard they try. In fact, trying makes it worse, which is why telling them to pay attention is doubly bad: you've made the problem worse yourself, then put urgent pressure on them to do the same.

The correct course of action is to genuinely accept that they are unable to fully engage with the current situation, and to maximise their enjoyment of it regardless. Once the pressure is *genuinely* off, they'll realise it's okay to let their guard down.

Drop the impatience. Drop the concern about being impolite. Just try to focus on things that actually help.

The risk of recovery

Let's talk about perspective.

Specifically, the perspective of someone who did *not* go through what I did: who finished high school without any problems, completed their university degree, and settled into their middle-class job by age 22ish, and didn't have to contend with serious psychiatric diseases in the process.

This is the perspective of someone who has met societal standards of functioning their whole lives. It is not difficult for them to keep doing their day job and gradually progressing financially and career-wise, because it's what they've always been doing. They just need to continue. It's their baseline.

From the perspective of someone who has that baseline to start from, the actions of someone who is attempting to recover from a major psychiatric condition while going through important developmental steps are likely to seem alien. Just keep doing what anyone would do, right?

The core issue is that everything that the functioning person does, and has always done, and has never had issues doing — these things are *risks* to someone who has the disease.

Applying for a university course is a risk. Going in to it is a risk. Completing it is a risk. Apply for a driver's license is a risk. Actually using it is a risk. Moving out of the parents' house is a risk. Starting a relationship is a risk. Getting married is a risk. Applying for jobs is a risk. Accepting one is a *big* risk.

I don't just mean in terms of losing formal or informal disability supports — though that is a substantial problem that needs to be taken seriously — I mean in terms of the effect on the person's mental health.

All of these are efforts that require a person to commit to reaching a certain standard of functioning, and if they fail to meet that standard, there are consequences. The missing step that the functioning person doesn't understand is that there is a substantial chance the sufferer will suddenly deteriorate for reasons completely outside their control, and dealing with the stress of these commitments is likely to increase the chances of this happening.

The temptation for observers is sometimes to minimise the risks and try to emphasise the fact that *they can do it*. This is generally not helpful: the risks are real, and need to be taken seriously.

Encouraging the person to block them out entirely does not help mitigate them, and *certainly* doesn't help your relationship with the person. That doesn't mean don't encourage them. It means do it intelligently. Don't just push them forward blindly.

Approaching this situation from the perspective of a person who never had to take any risks to do these things is not likely to be enlightening. Such a person never had to weigh up the danger that failing at one of these commitments would entail: they were able to do it, so they did it, and that was their life.

Failing a course, or getting fired from a job, does not simply mean they don't get the degree or paycheck. It means they've failed, and that failure has consequences for their mental state.

Someone with a psychiatric condition is not being lazy or defeatist when they refuse to take a step like this. They are actively weighing up the risk of failure and the consequences if they do fail, and they're the only ones who can possibly know what the odds or consequences are. Take them seriously.

How to deal with a friend doing badly

Among people who have an acquaintance or friend who has contracted a psychiatric condition, it is very common to simply not know how to deal with it. People who are not carers, but want to do the best they can to make matters better.

This is a new type of problem that they have not dealt with before, and the instinct of many people is to try to find a specific procedure to go through that will improve the sufferer. Whether they attempt to work it out on their own, or go to some resource in the hope of finding the answer, that's what people usually try to do.

There *is* a specific thing you can do, and while it sounds kind of dumb to say it:

You have to be kind and patient with them, and not take it personally.

That's it. You do not have to fix them. You do not have to put in unusual deliberate effort in the hope of making a difference. You do not have to find a specific magical sequence of actions that will mechanically cause some kind of improvement.

You certainly don't have to put on a big fake show of how great you think they are and their life is. That will last about until you realise it isn't working, and they know it, because they've seen it before. Many times.

You literally just have to treat them like a human being who is suffering, and understand that while your work in comforting them won't fix things, it will set the stage for them to eventually come out of that pit.

In short, it will form the background to recovery when they're ready. Your efforts have to be sustainable: things you can keep doing without wearing yourself out.

If you press a point and do something that is unsustainable in an effort to make a difference, consider that you are damaging something that is scarce and valuable to them, something that they're going to struggle to rebuild: your relationship with them. Neither of you gain anything in return.

Treat them like you would want to be treated after a majorly traumatic experience. If they lash out, treat them like you would someone who lashed out after a serious tragedy: with patience and tolerance. You wouldn't berate someone who exploded at you after their parents just died. Don't berate someone who has developed a psychiatric disease and is exploding at you. Pick up the slack when you can.

You *can* relate to their suffering. You've suffered before in your life, just for different reasons. These are the same feelings, just happening at completely different times and in completely different circumstances. It's a disease, but the part that matters here is that it causes emotional pain.

Your handling of the sufferer and behaviour towards them should be things that you're able to do indefinitely. You will not have to do them forever, as long as you're prepared to do them forever.

Pushing peoples' buttons

When someone overreacts to something minor that annoys them, it's broadly socially acceptable for others to engage in mild-to-moderate teasing and to deliberately exaggerate that annoyance as a form of humor.

Don’t do that crap to people who are suffering because of psychiatric diseases. It’s not funny. It’s not clever. It’s abusive, and it will affect the trajectory of their illness. Yes, really.

It might seem surprising that the progression of a major disease like bipolar or panic disorder can be influenced by something so small.

What you have to understand is that doing this is not simply creating irritation. It’s a threat: it’s proving outright that you can and will cause emotional harm any time you like, and that this fact is funny to you.

In short, it’s taking someone who is vulnerable and, in many cases, who can’t get away from your behaviour, and deliberately making it very clear to them that you have no regard for their feelings and even find it amusing to harm them.

They can’t just laugh it off like anyone else, because *they are suffering more than you’ve ever suffered in your life right now, and you are actively making that worse because you think it’s funny*.

Cutting someone’s hands off wouldn’t be so funny, because you wouldn’t deliberately make someone permanently disabled for a laugh. So please be aware that’s what you’re doing.

This is not a reason to avoid humor. It is a reason to be sensitive to whether you’re making their mental state better or worse with it, and not double down when the answer is “worse”.

“You get better when you’re forced out of your comfort zone.”

A very common occurrence when observing a loved one who is chronically ill is when some unexpected circumstances come up that force them to confront their illness *right now*.

This is particularly salient for anxiety sufferers, for whom avoidance is the central problem: sometimes there will be a deus ex machina that will force them out of their comfort zone. And usually they will improve and say “oh! That wasn’t so bad.”

After you’ve seen this a couple of times, it’s extremely likely that this will change how you perceive the illness. You know that they *can* do it, and you’ve seen that when they’re really pressed they can *make* themselves do it. So, should you push them, too?

No.

For the love of god, do *not* push them unwillingly.

There are two simple reasons for this:

1. It won’t work.
2. It will damage your relationship.

A person with an anxiety disorder is usually entirely capable of completely ignoring it on occasions when they *know*, for *sure*, *factually*, that there is no other choice and the consequences of not ignoring it are unthinkable.

Engineering the situation they're in to induce this response, or even just saying "Your safety net is gone? I guess this'll be good practice then!" - are monstrous betrayals of trust. And when - *when* - the person finds out what you've done, all of those gains will completely collapse and be replaced with distrust and anger.

You are not helping them, and you are *certainly* not helping your relationship with them. *They* will decide when a good time to practice is. If you're shoving, then now is *not* a good time.

In any case, someone cannot recover this way. These exceptional events follow the law of diminishing returns. The more it happens, the less the person will be able to use it.

Now you have three new problems, and no way to fix any of them:

- They've reduced their ability to step outside their comfort zone of their own free will (because the only times they improve are when forced);
- They have further internalised the idea that their disease must be fought and not worked with; and
- Worst of all, when there's a *real* emergency, they won't be able to ignore their anxiety anymore.

You have now, despite having all the best intentions, dug them into a hole that is even harder to get out of. And damaged your relationship with them in the process.

Anxiety disorders cannot be helped with fighting and forcing and pushing, or even just nudging. They are helped with acceptance and patience. Actual acceptance and actual patience. Meaning, you let them do it when they're ready, and if you're even wondering when they'll get it done, you're doing it catastrophically wrong.

Sitting around impatiently waiting for them to get on with it is a great way to completely halt their progress. That impatience bleeds into their mindset too.

If you just accept them as they are, and under the belief that they might be like this forever, "forever" will become sooner than you think.

Drugs and Medication

Regarding psychiatrist-patient relationships

“As you may be aware, [he] has very clear ideas about treatments.”
~ Letter from my psychiatrist to a new GP

My relationship with my psychiatrist is a bit unusual. But the outcomes we’ve generated between us are also unusual, and it seems likely that there’s a connection there. Most patients are not actively engaged with understanding their medications and how they work, and, well, most patients have poorer outcomes too.

Any discussion about medications necessarily has to be done in this context. I am not a doctor. I am not your doctor. I am not qualified to give medical advice at all, ever.

I can, however, do two things that may be useful:

- Provide my personal experiences with certain medications; and
- Explain some fundamental aspects of these drugs that seem to get confused in the general populace.

Increasing a patient’s engagement with and understanding of pharmacology is something that can only be positive. These drugs are usually one of the most important planks of your treatment, and the more willing you are to learn about them, the better informed you’ll be to make decisions about them.

I think every patient needs to learn a bit about their drugs. At the very least, it's worked for me. Every drug talked about here is one I've either taken or am still on.

Prozac and Valium

Medications and methods used to treat psychiatric diseases change on a yearly basis. There's one bit of confusion that seems to have been around since about the 1960s, though, and is still going strong.

An alarmingly huge number of people don't understand the difference between Prozac and Valium[10].

Prozac is a brand name for a drug with the chemical name fluoxetine. It's an antidepressant. If you take it once, it will have almost certainly have no noticeable mental effect on you whatsoever, even if you take quite a lot.

If you take it every day for a month, you probably still won't notice much. But your energy levels are likely to subtly improve, as is any anxiety or worrying. If someone taking only fluoxetine has a rapid or drastic change in any way it's a red flag that something is going very wrong: this drug's purpose is to subtly pull someone's mood trajectory upwards a little.

If it suddenly shoots upwards or down this is a sign of uncontrolled bipolar, which requires a mood stabiliser

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[10] I'm using the brand names here because these are what people recognise, but it's important to note that these are my experiences with fluoxetine and diazepam of a range of generic brands.

to go with it. Outside of that and some rare metabolic and common sexual problems, it’s a fairly safe drug. And, in case it wasn’t obvious, it isn’t “fun” in any way.

Valium, on the other hand, is a brand name for a drug with the chemical name diazepam. It’s in the benzodiazepine group.

Pharmacologists in the audience have permission to cringe, but what I’m about to say is around 80% true: it’s alcohol in a pill. Mostly.

Some people enjoy it. I don’t, and I *like* alcohol.

Like alcohol, it will calm you down, reduce anxiety, relax muscles, suppress seizures, impair coordination, impair memory formation and impair judgement (the exact proportions of these are different to alcohol, but are mostly in the same ballpark).

And like alcohol, it will do these things *right now* as soon as the drug is in your body. And, once again, like alcohol, you rapidly get a tolerance and nasty addiction to this drug. Also, combining it with *actual* alcohol causes a multiplier effect, which is a dangerous combination.

That is not to say that Valium does not have a place in medical treatment: there is a range of situations where you need to get results in one of these areas *now*, and for that, drugs of this type are sometimes the only game in town[11].

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[11] The memory impairment effect is commonly used for day surgery.

But, once again, like alcohol, they can reduce your inhibitions, and if someone is acutely sick those inhibitions might be the only thing holding them back from doing something extremely dangerous. This is a drug that needs to be treated with a lot of caution.

That’s why it’s so important to understand that not all psychiatric medication is the same, and that if you use the wrong one at the wrong time it can be harmful or even outright dangerous.

A large chunk of the population barely recognises that these two drugs are even different to one another, but anyone who mixes them up during a mental health crisis is going to have a very bad time indeed.

Antidepressants, benzodiazepines, antipsychotics and mood stabilisers are all four very, very different types of thing.

You cannot just expect that someone can take a prescribed pill as directed and that will automatically improve their mental state. You have to use these drugs intelligently and understand what you’re actually doing.

Chemotherapy for the Mind

Usually when someone comes off antipsychotics it’ll be stated that they did it because of the side effects. Things like tiredness, lack of motivation, apathy, anhedonia - these things are the price of remaining sane, and not everyone is willing to pay that price. People stop because of these side effects.

Sorry, I don’t buy that. The reason people come off antipsychotics is because of their *effects*.

Chemotherapy is a great analogy here. When someone has cancer, it is not a foreign entity that has invaded their body and must be eliminated or expelled. It is their body itself that has created the disease, and it is very difficult to distinguish between the diseased and non-diseased parts of their body because they’re fundamentally the same thing.

So, we treat cancer with drugs that kill everything in someone’s body, but which kill the diseased cells slightly faster than the rest of the person. If we get the dose just right, and continuously monitor the amount and type needed, we can leverage that small gap and kill more and more of the cancer while the person gets better and better.

The drug will kill any fast-growing cells in the body, so things like the stomach lining or hair will probably not do too well for a while. And frankly, there is probably not a single part of their body that will thank them for introducing this poison into it. But they can survive as a result. Hair regrows, eventually.

Take that entire story. Now tell it again, but in the mind instead of the body.

Antipsychotics kill all your thoughts and feelings. They kill all your motivation, they kill all your excitement, they kill everything that makes life worth living. But they kill psychosis slightly faster.

Those fast-growing cells? Those are your really clever thoughts. Those are the ideas that help you recover functioning or achieve great things. They will come back, but only if you moderate your choice of drug and dosage extremely carefully. You may have to sacrifice them occasionally to kill the cancer.

It’s fairly well known that antipsychotics cause a slight degradation of brain volume. When you look at it this way, it makes perfect sense: *that’s why you take them*. You *want* to disrupt the pathways that the disease is pushing your thoughts towards, and you *want* the anatomy of your brain to reflect that.

The critical thing to ensuring this process works is not simply that you take your meds. The critical thing to ensuring this process works is that you take your meds *intelligently*.

You need to have a rapport with a psychiatrist that you trust, and equally importantly, that trusts you. You need to have a psychiatrist that you can say you need a higher or lower dose to, and who will trust that you know yourself better than they do. But also, one who will have the courage and judgement to step in when they know you’re *really* making a mistake.

This is not a common thing to have, which is a tragedy, because this is one of the factors that is absolutely critical for recovery.

Psychosis is extremely painful.

Managing the disease requires fully integrating that fact, and being aware that you want to avoid it. And it requires trust that the medication will eliminate it, and being given autonomy to declare that when you *really* need to adjust it, and your psychiatrist respecting that, unless you’re making a major mistake.

When you have all those pieces, only then are you in a position to manage your disease.

And frankly, having someone else try to manage your disease for you is almost guaranteed to fail in the long run. They’re not the ones who are suffering.

Tall tales about lithium

I’ve been on a bunch of drugs over the years that people have misconceptions about, but the number one example that people seem to have very strange ideas about is lithium.

Lithium is literally just that: elemental lithium, bonded to something like chloride or carbonate to make it less reactive[12]. Your body treats it as a salt, replacing some of your sodium but having a slightly different effect on your nervous system.

Because it replaces some salt in your body, you need to pay attention to your fluid intake, as well as how much *actual* salt you’re taking in.

It’s used to stop the cycling and degeneration of bipolar disorder, and for reasons that are still mostly unknown to

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[12] Once you’ve adjusted for dosage, the only material difference between the different instant release lithium salts is how they taste if you accidentally bite into a pill. Which, for all of them, is some variation of terrible.

medical science, it is one of the most effective ways to do this. There's data on a range of other mood stabilisers, but none seem to be quite as effective for Type I Bipolar.

I've been on it for 13 years, and it has served me exceptionally well in that period. But it seems to be a popular one for strange beliefs. So, here are some of the weird beliefs I've heard about it:

"Lithium gets you high."

Particularly shocking is the fact that I've heard of police and border security believing this. Lithium would be a very poor drug of abuse, first up because its ability to affect your mental state depends on how much sodium it's displaced in your nervous system.

Aside from the fact that this must be carefully calibrated to prevent things like organ failure, it also takes several weeks to build up enough to do this.

More importantly, even after a few weeks of taking it every day, it has no obvious mental effect on a healthy person at all. You might notice some minor side effects like shakiness or a changed appetite, but you certainly won't see any euphoria: this is not a drug to take for fun. It just doesn't do that. Increasing the dose won't achieve anything except organ damage.

"Lithium in drinking water can make the population more compliant."

This is mostly referring to studies that correlated trace lithium compounds to things like suicide or murder rates, then proposed to increase the concentration of these minerals in drinking water. These studies are a popular target for conspiracy theories.

So, first up, I take *more than ten thousand times* the doses they're talking about on a daily basis, and (unfortunately for my wife) I assure you it does not make me even slightly more compliant.

My experience is that lithium helps your body regulate day-night cycles, helps prevent your emotional state getting out of control *when you don't want it to*, and reduces distress.

You still have the full range of emotions, and your natural ability to make your own choices as always, even on the vastly higher dose.

To be perfectly honest, these are all things that the general population would probably benefit from in small amounts. Probably more trace lithium in the drinking water would be a net win for most people.

"Once you come off it, that's it - going back on it can kill you."

No idea where this one came from. In fact, I don't think this is true of basically any drug used in modern psychiatry. There are certainly drugs that can cause withdrawal, but lithium arguably doesn't even fall into that category — the most likely outcome of coming off lithium is simply that your disease will come back. There is certainly no permanent inability to use it ever again.

I have a slight suspicion there's a tiny tendency among the medical profession to resist outright debunking this kind of belief, because it seems like it'll push people to stay on it. This is misguided, because it just makes lithium sound scarier.

"Lithium is the most dangerous psychiatric drug."

The drug's fearsome reputation among some people isn't completely undeserved. If a patient using it becomes sufficiently dehydrated, the proportion of lithium that has replaced salts in the body changes, and as aforementioned, that can result in serious morbidity. You can absolutely die from it[13].

Avoiding dehydration is the one and only cardinal rule of taking lithium. Luckily, the drug also tends to cause a pronounced thirst, so most people will become unbearably thirsty long before they're in any danger. You'd better like water more than Michael Phelps if you take it.

If you can do that, lithium is actually relatively benign. It won't cause noticeable sedation or intoxication unless your levels are much too high. In fact, in most cases it won't have any noticeable effects at all, apart from halting the degenerative cycling of bipolar disorder. The patient will still have all of their normal emotions, but the out-of-control feedback loop where they completely stop sleeping and eating won't happen. That's pretty much it.

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[13] You'll probably die from dehydration eventually anyway, funnily enough, but lithium makes it happen sooner.

Personal experience of zolpidem

Zolpidem is the scariest drug I’ve ever taken, by far. No contest whatsoever. I find it horrifying that this drug was ever approved for prescribing, let alone substantially successful and common.

So, first, a bit of background. For many years the standard of sleeping pills was the benzodiazepine family (benzos for short). These work broadly like alcohol, causing relaxation, tiredness, loss of motor control, impaired memory and judgement — the usual suspects.

Like alcohol you can develop a tolerance to them, and the resulting addiction/withdrawal/etc can cause serious problems.

Zolpidem is not a benzo. Instead, it belongs to a group informally referred to as Z-drugs: they’re related to benzos, but only affect a subset of the receptors benzos do. The theory was that the designers could selectively eliminate the addictive or intoxicating effects to provide a “cleaner” sleeping pill.

Judging from my own experience with it, here are the ways in which they failed:

- Zolpidem is actually much *more* potent at preventing you forming memories, meaning you usually won’t remember what you do while you’re on it;
- It’s also much more potent at impairing your judgement, meaning you’ll do extremely stupid and bizarre things and not remember;
- It causes hallucinations and distorted thinking; and

- It does have a tolerance mechanism, but in my experience instead of causing withdrawals when you take it long term, it will instead start to cause those memory blanks and bizarre behaviours while you’re not even on the drug.

A few public figures have done inappropriate things on zolpidem and then cited it as a reason later. The public has broadly responded to this with skepticism and shaming, and this is screwed up: if anything, these people are understating the danger of this drug.

This really is a drug that can cause people to do things they would never otherwise do, and not remember it the next day. Accountability is important and all but *the drug really can do this to someone*.

I woke up many times after taking it and found my room had been utterly trashed, or I’d said something extremely inappropriate to someone the night before, or that I’d given out secrets or destroyed personal items.

Yes, I was sick at the time, but zolpidem made me completely unable to control or remember my behaviour. Benzos did not have the same effect.

There’s a specific kind of anxiety that is completely normal and healthy and required for you to not do utterly stupid and dangerous things, and zolpidem sometimes removes it.

This is a drug that can be far, far more dangerous than the benzodiazepines and needs to be treated as such.

Antidepressants and first-episode (hypo)mania

A large proportion of first (hypo)manic episodes are triggered by antidepressants.

The usual story is that a patient walks into their GP’s office and complains of depression, anxiety, or both together. The standard response (medication-wise) is to try and nip it in the bud by prescribing an antidepressant on the spot.

Most of the time this works. Basic antidepressants have a pretty reasonable success rate against these disorders, and their tolerability is usually also pretty good. There is a high chance that this will subtly improve matters and avert a crisis before it begins.

Speaking to the patient — and carer(s) — directly, you also have to be aware of the risks. If you have bipolar disorder that is beginning to emerge, these antidepressants are likely to make things much worse. This is surprisingly common.

Bipolar disorder is very sensitive to antidepressants. They can be used for it, but only once the mood cycling is well and truly controlled — and even then, the jury’s out on whether they’re a net win in the general case. If they’re used when the mood cycling is *not* controlled, you can trigger a hypomania or mania, which can be dangerous.

Recognising this accurately requires a medical professional, but there's one giveaway. If it's not there, that doesn't prove anything either way, but if you see it, you need to get them medical attention *now*.

Pay really careful attention to the sufferer's sleep cycle.

If their waking hours are substantially widening (most probably, staying up late doing things) then that should ring alarm bells. For most people, goal-directed behaviour is a tell — if they're staying up to work on something consistently then you should get help ASAP.

A common occurrence with anxiety sufferers is staying up all night worrying, often about their own (mental or physical) health. This is different. I'm talking specifically about staying up *with a purpose*. Hypomania is about *doing* things, not worrying about things.

If you have someone who has just started a new antidepressant and is not on any form of mood stabilisation/antipsychotic, and who has suddenly started staying up very late doing things, then it's time to call whoever prescribed it as soon as humanly possible. Don't assume that stopping the drugs will solve anything. Get medical advice. Right now.

Olanzapine

There's one drug which gets a particularly bad rap among many groups (medical professionals, patients and support groups). But it has saved my life literally a thousand times over, and it's one of the absolute foundations of the successes I've had. So I want to share why it's so important.

Olanzapine is an antipsychotic. It is notorious for inducing three things: the hunger of a thousand starving famine victims, sleeping 18 hours per day, and utter apathy towards the world around you.

And yes, it *does* make you uncontrollably hungry. And it *does* make you sleep. And it *does* make you utterly apathetic.

In many cases, it can also end extremely severe and complex manic episodes in a matter of days, and also often rapidly improve a range of other unrelated psychiatric conditions.

Like all of these drugs, there is a range of conditions that it makes worse rather than better. But if you are in a severe and complex mental health crisis, this has a very high overall success rate, at least in the short term.

Psychiatric wards love it for that reason[14]. It has an uncommonly high likelihood of solving episodes of the most problematic conditions in one go. Even when it doesn't, it will usually reduce the amount of distress and agitation in the patient, which is the next best thing that can be hoped for.

The flipside of that is the fact that this process will almost invariably involve long periods sleeping punctuated by gorging on high-calorie foods (it not only directly messes with your blood sugar, but your appetite and insulin sensitivity too).

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[14] Apparently as of 2018-2019ish it's starting to fall out of fashion there.

By the standards of someone who measures functioning based on things like going to school or work, this is probably not going to seem like a net win.

But a carer or psychiatrist that measures functioning in that way is not going to get very far. When someone is in a crisis, you have to measure their functioning in terms of suffering. If their suffering is going down, you're probably moving towards improvement. If they were suffering, then their "functioning" probably wasn't sustainable.

Despite the common wisdom that a fundamental part of (hypo)mania is "elevated mood", it is in fact an extremely painful experience. The confusion about this probably comes from *where* that pain is directed.

Someone who is hypomanic is likely to say they feel fantastic and they're doing better than ever before. But little things which bug them are vastly amplified, and things which are genuinely disturbing become colossal and life-endingly traumatic. They will snap and vent and rage and pace and generally be uncontrollable. And if you ask why, they'll say it's because of someone *else's* behaviour.

The moment where I realised that all of those emotions are not real, and that something like olanzapine can rapidly eliminate them, was the single most pivotal part of the recovery process for me.

What does it feel like to take a psychiatric medication?

What does it feel like to take psychiatric medication? Antidepressants, antipsychotics, mood stabilisers?

This is actually a pretty common question when people find out I’m on them, particularly among people who are beginning their own treatment. It’s also kind of based on a false premise.

When people try to answer this, they mostly think of what recreational drugs are like. Things like cannabis, opiates, amphetamines, even caffeine. This is really misleading.

These are drugs that you consume for their *acute* effects. You smoke weed once, you get high once. Asking what “being high” feels like is an interesting question, but not wholly relevant.

What would happen if you smoked weed every day?

I haven’t tried doing that[15]. But my understanding is that regular use of it tends to sap things like drive and motivation, reduces engagement with difficult tasks, things like that. These are the *chronic* effects.

With most psychiatric drugs (benzos being the main exception), you don’t care at all about the acute effects. Those are the short-term feelings that the drug causes that don’t really help you in any meaningful way. They’re generally not fun at all and

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[15] I’ve tried weed a couple of times, and never really enjoyed it.

for the most part you just want them to go away already. You can even frame them as side effects and not be wrong.

The reason you take most psychiatric drugs is for the chronic effects.

The thing with the chronic effects of psychiatric drugs — just like the chronic effects of recreational drugs — is that they creep up on you. You do not connect the effect of the drug to how you feel, because it’s the same drug you’ve been taking every day for the last few months without incident.

But because of this, you are no longer connecting the changes in your life to the pills you’re popping once/twice a day. You are connecting them to, well, the changes in your life: your thinking is starting to correct itself and see the normal everyday experiences of life in a new light. That’s the whole point.

There are some particularly potent antipsychotics that have acute and chronic effects that smoothly blend together. But after a month or two on them, you’ll tend to adapt and take them for granted. In any case, those are not usually the first drugs someone is prescribed — most people who ask this question are referring to things like SSRIs that don’t have this issue.

So really, when people ask this, the best answer is: if you’re noticing it, it’s probably just a side effect.
Wait it out and see how your life unfolds on this drug.

Unfortunately, anyone who is being prescribed a drug for the first time should (in most cases) just take it and see what happens over the next few weeks to months. You’re going to need to gather some data on how it affects you, and the only useful way to do that is to try it and see. This is equal parts art and science, and in the beginning, your doctor has the science part down.

By far the most important part of how a psychiatric drug affects you is how it affects you over the course of weeks to months. Days is not enough data.

Demographics and medication choice

Choosing a psychiatric medication to start on is difficult, but there are some tricks you can use to improve your odds.

There are a few general rules of thumb with regard to choosing, based on things like the average efficacy for a given condition vs the average tolerability of a drug. Some antidepressants are more activating than others; some antipsychotics are more sedating than others; some mood stabilisers have better odds vs different variants of different diseases.

It's also worth pointing out that there are patterns connected to the demographics of patients.

For example, olanzapine tends to have poorer tolerability among younger female patients. This may be connected to the fact that it causes metabolic derangements along with a demonic food-lust, and concerns about weight are endemic to that demographic. But it's also likely there are some other mechanisms that are causing this group to not tolerate the drug.

Another example is escitalopram among teenagers. This is an easy one: escitalopram has a very short half-life, and missing even a single dose can cause withdrawals. Teenagers are not well known for doing anything consistently, least of all something a doctor told them to do.

Valproic acid derivatives tend to have poor tolerability among middle-aged-and-older male patients. These drugs tend to have a detrimental effect on overall energy and vitality levels, both sexual and in terms of physical activity. Among a demographic that is stereotypically particularly concerned with their vitality, it makes sense that this drug would go down poorly. Also, it can worsen hair loss[16].

What I'm getting at here is that there are the biochemical variations among different demographics — which are not to be sneezed at, because people from a different genetic background or with a different biological configuration are likely to respond very differently — but there are also behavioural and sociological dimensions to these factors.

This is not, at all, to say that these drugs can't or shouldn't be used in these demographics. But when choosing which medication to start with, demographics are a useful factor.

A drug is tolerable or intolerable *in the context of a person's life*. There is no possible way to isolate purely biological factors in this decision.

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[16] Or make it go curly. Curlier, anyway. Speaking from experience.

Stories of Serotonin

Most misconceptions about drugs and mental health have apocryphal roots. It’s not at all common for a myth of this type to have a single, easily traceable source. There’s one really common one that does, though:

> *“Depression is an imbalance of serotonin (ie not enough of it). Taking a drug that gives you more will treat it.”*

This story was broadly invented by a pharmaceutical company’s marketing department to sell fluoxetine, the first “modern” antidepressant.

All things considered this was probably a net win: the public at the time simply did not have a frame of reference to understand the drug’s effects, other than the “chemical lobotomy” that Thorazine and other early antipsychotics provided.

Unfortunately, this campaign caught on a little too well, and even to this day a lot of people still believe that this is a useful model of depression or the treatment of it.

The first problem with this model is that SSRI antidepressants usually cause an increase in synaptic serotonin levels in a matter of hours, which is reflected by the side effects. These levels (and side effects) do not generally increase further as treatment progresses. But therapeutic benefit to depression or anxiety do not occur until weeks to months have passed.

Serotonin is very clearly connected to the improvement, but there are other mechanisms that happen in the meantime.

The second problem with this model is that there is a range of drugs that clearly have an antidepressant effect, but which also clearly have no activity at serotonin receptor sites. We have effective antidepressants that hit norepinephrine, dopamine, melatonin, NMDA, mu-opioid and several others.

The third problem is that there are drugs that actually *enhance* the reuptake of serotonin, causing serotonin to be cleared from synapses faster and doing the exact opposite of what fluoxetine does. Nonetheless some are of comparable efficacy as antidepressants.

The truth is that the creators of that campaign never actually believed the naive monoamine hypothesis verbatim — the idea that depression was directly caused by a lack of activity on the part of pleasure-producing neurotransmitters.

That whole story was a PR campaign from the beginning, so it shouldn’t come as much of a surprise that there are gigantic holes in that story. The truth of the brain’s functioning — and, in the case of psychiatric disease, malfunctioning — is far more complicated.

Bullshit in treatment

The state of inpatient care in Victoria

You still occasionally hear laypeople jokingly allude to “committing” people who they see as difficult or dangerous, as if that was actually something that can happen in Australia these days.

You will overwhelmingly find that someone who is acutely ill is largely unable to find any useful form of care at all.

When I needed inpatient care, I received it at a roughly appropriate time and (to the credit of Orygen) was for the most part treated okay. I should have been in hospital years earlier, but had okay outcomes regardless.

These days the only material evidence of my stay there is the towel I stole from my (private) bathroom. I sure showed them.

I am the only person I know who has had this experience: being treated at the appropriate time in a public ward, being treated humanely as an involuntary patient, and recovering as a result.

Among friends and family, the most consistent outcome I see in our public system is that people are utterly excluded from inpatient care for years to decades, and it’s only when this causes them to sharply deteriorate and are in acute danger that they are sectioned.

The treatment that these people then receive is often not just against their will, but against their interests too. Years later, many have not recovered from it, let alone from their disease.

This is in stark contrast to private clinics, where you are a customer first and foremost, and they make money by ensuring you are comfortable and happy. The difference is night and day. Public hospitals are not just worse versions of private ones. The outcomes you will get from them are fundamentally different.

Consider that, in Victoria, whether or not you pay for private health insurance is the sole factor that determines whether staff are legally permitted to use physical violence[17] on you when they feel it's necessary.

That's not an exaggeration or overstatement; it is literally what the legislation says. Public wards are allowed to use force on patients when they feel it necessary, and private ones aren't.

There is no disease that could ever aspire to this level of madness.

Waking up, and regretting it

My one stay in hospital was short and ended with dramatic recovery. There's still one thing that stands out in my memory though, which I don't think I'll ever forget.

Waking up in a (public) psych ward, and regretting it.

There's something oddly unique about regretting waking up. Everyone has days where they know something challenging or bad is going to happen, and wish they could not have those

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[17] If you object to the use of the word "violence" here, perhaps you should try asking the patients in question what they would call it.

days happen. But the experience of waking up and realizing where you are, and feeling like you'd give just about anything to go back into a dream — even a nightmare — is something you can't forget.

Hospitals are intended not to be actively offensive places to be. While they often fail to reach that ideal, even when they do, it is a very poor ideal to aim for. A place that is not *actively* offensive, but in which there is little to no positive stimulation of any kind is bad enough.

Add bizarre power structures preventing you from leaving under your own power, and frame your inability to leave as your own fault — that is its very own special kind of hell.

Everything is so slow. Your options for passing time are drinking tea, reading magazines, watching TV, and talking with other patients. That's it. Some places have table tennis and Connect 4 too. Even your engagement in those activities has to be very carefully chosen so nurses don't use your behaviour against you when trying to move forward on release.

For a lot of people, it probably sounds nice to be able to utterly escape your problems and go to a place where you'll be cared for 24/7 for free and have basically no responsibilities at all. My advice to those people is, “Be careful what you wish for.”

The boredom is overwhelming and crushing and oppressive. The only meaningful change you can make to your life is to be released, and the entire system is oriented towards that process being only possible if you’re able to match the recovery narrative that the treating team are expecting.

You will wake up every morning and wish you could be anywhere else. That’s hard enough for a healthy person to deal with, but forcing people who are sick to contend with it is outright *wrong*. This is not how you treat these diseases.

White lies in recovery

There have been a number of people throughout history who have experienced severe mental illness, then recovered and gone on to achieve phenomenal success later.

If you look at the mass media depictions of them and compare them to historical data, there is a very clear trend across the depictions of these peoples’ stories.

They are full of lies.

Not big lies, not dramatic lies, but small over-corrections that were generated with the best of intent. These are white lies. They are attempts to misrepresent the truth of that person’s recovery for the benefit of the lay reader who does not know the whole story.

It is not universal, and it is not a grand conspiracy to censor these details, but it is a very common trend that affects quite a lot of the public-facing versions of these biographies.

The central theme of these lies? Keep taking your meds, and do what your psychiatrist tells you.

The part that makes this difficult is that in the small scale this is usually good advice. But if a person internalises and accepts this as an overarching theme throughout their lives, it can result in a net harm to them, and to the field of psychiatry.

You *do* need to stay on the (correct) medication. And a good psychiatrist *is* an expert on these conditions and should be able to direct you usefully.

But lying about the circumstances and nature of the exceptional cases — the ones that recovered far beyond what is expected — is a highly effective way to ensure that those cases remain exceptional. You will overwhelmingly find that these cases diverged from the generally accepted best practices and could not have had a good outcome if they hadn’t.

These cases are exactly the cases the field should be studying and paying attention to. If someone has found a way out of an incurable disease, understanding how and why that happened should be priority #1 of the specialty in question.

And these are precisely the cases that seem to reliably attract not-entirely-honest representation, as well as a strong tendency of drawing attention away from the actual important bits. The public needs to know about these too, because the public is where these stories originate. They won’t come forward if they feel like they won’t be believed or taken seriously.

A popular story to tell among the general public is that someone they know had all kinds of horrible diagnoses and were prescribed all kinds of medications. But then they stopped the drugs, started meditation and church and exercise and capoeira and fire cupping and their problem went away! Those meds were poison!

We’ve all heard crap like that.

It’s critical to differentiate those stories — stories which basically just want to conclude that psychiatry is evil — from ones where a person really did have a serious condition and really did recover in an unexpected way.

These diseases are still relatively poorly understood. It is not outside the realm of possibility that diseases we don’t understand can have nuances we also don’t understand. And that there’s a way out we don’t understand.

Unfortunately, neither the public nor a large proportion of doctors seem to have learned to differentiate the two types of story.

It seems extremely likely that there have been many other, less famous stories of unexpected recovery that remain largely untold because of this.

It’s easy to dismiss these cases as a misdiagnosis or neuropsychological fluke. But doing that makes it trivial to defend evidence that these diseases are lifelong and incurable, and vice versa with misdiagnosis: it’s a systemic No True Scotsman fallacy.

A story of a suicide attempt

I wrote a note. It is probably not what you would think of as a typical note for a serious suicide attempt, but because it is largely concerned with people I knew at the time, by the time I removed all the personally identifiable details there wasn't much left.

Six grams of sodium valproate is enough to put you into a coma, and for all the flippant and childish language of the note associated with it, I really did take it, and yes it really could have killed me.

Not long after taking it, I'd approached my parents with the empty blister packet simply because I didn't really care what happened next and was curious to see what would happen.

They called an ambulance, and I was carted off to the emergency department. The first one we went to supposedly didn't have a toxicologist, so they carted me off to a different one.

It doesn't make sense to me that an emergency room wouldn't have any toxicologist they could consult, and I'm also aware that the second hospital had the only adolescent psychiatric unit in the region at the time (ironically this was Orygen, but I was not admitted this time). But that may or may not be related. They may have wanted a specific expert on hand just in case.

I spent about the next four hours drinking a large amount of a disgusting like-orange-lucozade-but-far-worse electrolyte mix, and shitting out slightly-brown-tinged water. Not long after I finished the lot and they stopped giving it to me, I suddenly felt that I really, *really* wanted to go to sleep right now, so I did.

Waking up was an interesting experience.

First off, being casually told, “Oh, you’re awake,” which was then followed by “Your heart almost stopped.” Uh, thanks? Apparently, I’d been asleep for the scary part.

It kind of didn’t bug me: I was so sick at this point that I didn’t really mind whether or not I’d survived it, as long as I wasn’t going through the suffering of the disease anymore.

When recovering, the most unsettling part was the coldness. Usually, when someone’s cold, it’s either because their environment is a lower temperature than they are, or because their internal thermostat is set high because they have a fever.

This was a completely different and unique experience. The internal heat source that normally provides the driving force for your re-warming efforts was gone. There was no fire inside me. For a couple of hours, I was utterly cold, not just to the bone, but to the heart. No amount of piling blankets on top of me would help, because they reflected heat that wasn’t there. There is no experience quite like this. It passed overnight.

The next day, the doctor who saw me gave me the most minimal psych evaluation I’ve ever heard of:

"Are you going to do it again?"
"No."
"Good, life is precious."
He then turned to my parents.
"There's nothing more to do here, take him home."

The possibility of being hospitalised wasn't even brought up. I probably would have taken it if offered, and I probably would have benefited, too. I probably *should* have been offered it.

For about a month afterwards, my mental health was fantastic without any drugs at all. Maybe this worked as a form of shock therapy. Anyway, after that month, it all went south again.

As an aside, there is now evidence that therapeutic doses of valproates can activate neuroplasticity that can re-open critical skill learning age windows for things like performing music and second languages[18]. As far as I know, nobody has studied the effects an overdose would have on this.

Psychiatric admission

I've only been in hospital (involuntarily) once, and it was a brief stay. I don't think that necessarily discounts me from being able to talk about the experience of hospitalisation: we can compare my own experiences with those of close friends and family of mine who were in-and-out of hospitals for years or decades. Of which there are quite a few.

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[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3848041/

These experiences, combined, have largely convinced me that there is exactly one right answer to who should be in hospital:

Almost anyone who wants to be in hospital should be, and almost anyone who does not want to be in hospital should not be.

There are exceptions, but *far* less than most would think.

In other words, hospital admission needs to be something that is available whenever you request it, which you are not forced into, and which you can enter or leave at any time for any reason.

These elements interlock. You need all of them. You can’t make small policy changes and do one of them at a time, or do it partially.

One fear a lot of people have with this kind of policy is that patients will go into it willingly and become dependent, not bothering to live their own lives and instead just being taken care of for the rest of their lives.

The truth is that the only reason people actually become dependent on care in that way is because they’re afraid it will be withdrawn.

If you can prove (over and over again) that the care will be there whenever they need it, and they can depend on it being there no matter how bad things get, then eventually the person will stop worrying about survival and start thinking about the things they actually want in life.

They will have a bedrock that they can build a life on. Eventually they will get bored, and not just because they're being cut off from entertainment. They will start thinking about what matters to them, and how to do it.

This is the best possible sequence for recovery; having the security to become bored with their situation means they'll actually *want* to do something with themselves. Wanting to do something productive is infinitely superior in every way to being threatened into it.

At the other extreme is the fear that very sick and potentially dangerous people will not recognise that they are ill. That they'll refuse to accept care, or will wander out of the ward and do something horrible.

The problem with this is that very sick and potentially dangerous people only avoid psychiatric treatment because they know they won't be able to get out of it once they're in it. They may be sick, but they aren't stupid.

If you operate your emergency treatment systems less like prisons, and instead work on proving that you're going to *help* (and that they don't have to take that help if they don't want it) they are going to be much more likely to seek this help.

Psychosis is extremely painful. If treatment reduces their pain, they will not avoid it. Many avoid it now because they know inpatient treatment will increase their pain substantially. And frankly, because on average public wards will probably make their disease worse, not better.

The actual problem with actually implementing a regimen like that is less to do with the actual medical outcomes and more to do with public policy.

It would have a high initial cost - in the short term you’re going to have a rapidly expanding psych ward system and rapidly expanding financial costs. And it sounds like a PR nightmare, the kind of policy that is implicitly discarded as absurd.

But to be perfectly honest, those downsides apply regardless.

Any useful attempt to improve the system will inevitably have to confront those two issues. They are irreducible problems, because patients are being under-treated and over-coerced.

We simply have to confront these problems, like it or not, and trying to kick the can by finding an answer that doesn’t confront them will just drag this out.

Informed consent

The entire basis for all involuntary treatment and restrictive practices rests on the notion that some patients are so sick that they are unable to consent, so a doctor can do it for them. This is the linchpin that holds together literally all of our involuntary treatment ethics and laws, so it had better be solid.

The threshold for ability to give consent to a medical treatment in Victoria is to pass four tests[19]:

1. The patient is able to understand medical information given to them.
2. The patient is able to make decisions based on that information.
3. The patient is able to remember the decisions and information they were based on.
4. The patient is able to communicate their decisions.

This is not a high bar.

Note especially that they don't have to do any of this particularly well. They don't have to understand the specifics of the medical information, or make particularly good decisions, or remember anything more than a vague outline of what they decided, or express those decisions in anything but the most basic form.

If the patient is capable of doing those four things at the most rudimentary level, they are able to consent, and able to decide that they do not want treatment right now and would like to go home please.

It strains credulity that all but the very sickest of psychiatric patients would not be able to do these. Even among the very sickest, you're still pushing it.

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[19] https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/recovery-and-supported-decision-making/presumption-of-capacity

It is likely that if you genuinely applied this test in its literal form, you would find that the overwhelming majority of patients in involuntary care are perfectly able to consent and are simply choosing not to.

There are laws specifically regarding psychiatric diseases that specifically empower treatment teams to detain patients with those diseases, with different criteria for these powers. Psychiatrists can, for example, detain a patient who (because of a mental disorder) is likely to harm themselves.

But think about what that power is based on: a lucid patient with kidney failure is perfectly within their rights to refuse all treatment, even if the act of doing this will mean harming themselves. Legislation which precluded this would be close to impossible to defend and enforce.

Medical practitioners have no power over such a patient, so what actually gives them these powers over psychiatric ones? Declaring that a patient is not able to consent. Nothing more. All of those additional powers come from this one source.

It might seem broadly a good thing that this policy is not obeying the letter of the law in this regard, because in many cases patients can be a danger to themselves or others while still being able to consent. But the basis for involuntary treatment of such patients - almost certainly the overwhelming majority of them - is dependent on a fantasy with little if any connection to reality.

This state of affairs is particularly problematic because if the treating teams are operating with a questionable basis when deciding on a patient’s basic circumstances, it implies that other aspects of how the patient is treated probably have a questionable basis too.

The entire structure of involuntary treatment law rests upon a premise that almost invariably fails to meet its own formal definition in most real-world cases. Something is very wrong with the foundations, so it seems extremely unlikely there isn’t something very wrong with everything built on them.

Inpatient treatment teams are granted exceptional powers to act in patient’s interests when the patient is unable to. While staff broadly try their best to do this, resources are so limited that it is not always possible. And some staff are more enlightened than others.

There are many tales in the public system of treating teams doing things which are outright against the patient’s interests, and even my extremely limited time in it was still enough to witness this firsthand.

If you have a loved one facing hospitalisation, you should move Heaven and Earth to ensure it happens in the private system, where they’re a customer first and foremost.

“We make it unpleasant, so they won’t want to come back.”

This is a line that tends to pop up among staff in public psych wards, and I’ve heard it from one person or another quite a few times. There are private clinics with much better standards of treatment, but you will not, ever, hear this line uttered in them.

It’s kind of horrifying that anyone ever said it to start with, but the regularity with which it appears in peoples’ experiences is even worse. This is a common thing to hear.

The quote effectively summarises the fundamental problem with that form of custodial care in one go.

It *sounds like* it’s a positive thing to say. They should stay on their meds and engage with therapy, and we try to give them an incentive to do so by ensuring that the times they fail to do this are miserable. A patient that stays well enough to not need hospital is always better off, right?

What it’s actually saying to the patients is: if things get dramatically worse for you (likely through no fault of your own), medical professionals, as a whole, will not hesitate to kick you when you’re down, and in acutely traumatic ways.

People do not go (or are taken) to hospital because they decided it would be fun to stop taking their meds. They don’t go because they can’t be bothered with their responsibilities.

People go or are taken to hospital because they are suffering and vulnerable, and are in danger.

This is literally the last group in the Universe that needs to be punished for reaching out for help, or worse, for having help forced on them. You do not need to make these peoples’ lives more miserable. They’re plenty miserable already. *That’s why they’re in hospital*.

You need to teach them that medical professionals are there to help them, to reduce their suffering. You need to teach them that they can trust their doctors and be honest with them, and that doing so won’t be used against them.

In a public inpatient setting this is *not* what the profession is teaching them, so practitioners of it should not be shocked when the patient decides not to engage willingly with treatment. Who could possibly have seen that coming?

The patient needs to trust that when their disease gets dramatically worse, doctors and nurses will cut them slack and support them to recover, not deliberately make their life even more miserable. But trusting won’t help anyone if it isn’t true.

Ineffable, incurable, unexplainable diseases

Psychiatry is a field whose primary mission is its own elimination, but its track record for doing so is poor. The idea is that as the mechanism behind the diseases are better understood, they can be treated directly, rather than just suppressing the symptoms and slowing degeneration.

There have been a few diseases that graduated from psychiatric conditions to, well, *medical* conditions. Syphilis, porphyria and hypothyroidism are three high-profile examples. These were examples of low-hanging fruit: conditions that had a relatively simple cause once they were sufficiently well-understood.

Most of the common syndromes of psychiatric conditions — things like bipolar disorder, depression, panic disorder — do not have such a simple straightforward cause that's been found yet.

This is not a reason to give up and declare these diseases incurable or of occult cause. These are diseases that result from a process, and this process has a mechanism. *But a not-insignificant chunk of psychiatric professionals seems to have completely shut this out of their minds.*

For these professionals, these diseases are ineffable, incurable — diseases that cannot ever have a clear cause, and anyone who claims to have found a cause is a quack. Yes, there are plenty of quacks, but this group is actively shutting out any attempt to understand the process of what they're working to treat because of these quacks.

There's confirmation bias going on here. Psychiatric conditions are almost universally diagnoses of exclusion: they're supposed to be the last thing you consider after excluding any possible organic cause, and the first thing you cast doubt on when faced with a new problem or manifestation.

It might be tempting to assume that in every case of a person with a psychiatric condition, anyone requesting a check for a physical problem, is simply a hypochondriac. Unfortunately, I've seen a horrifyingly large number of doctors do exactly this.

Is it conceivable that the presence of a psychiatric diagnosis is liable to cause these doctors to simply fall back on that straight away, without putting any substantial diagnostic effort in?

Is it possible that in many, if not most of these cases, there is an organic cause to their symptoms that can only be found after digging deeply enough? Only their doctors never dig deeply enough to find out, because of the psychiatric diagnosis?

And if that really is the case, would we ever know?

If the presence of a diagnosis of exclusion consistently causes doctors to *stop* properly investigating a problem, is it completely crazy to suggest that a large number of people who have received that diagnosis have an actual, physical problem causing their condition that is being overlooked?

It’s more comfortable not to think about it, isn’t it?

Maybe that’s exactly the problem.

Security, bouncers and police

Public safety workers, as a rule, are pretty oblivious to psychiatric conditions. They deal with them on a daily basis, yet their understanding of them is extremely poor. But what might be surprising is that they’re orders of magnitude more oblivious to some conditions than others.

I’ve never really had an issue with any of them because of bipolar, whether it was depression, hypomania, or psychosis.

As long as your behaviour isn’t obviously bizarre these problems will largely fall within the margin of error for acceptable behaviour as far as they’re concerned.

Surprisingly, the one thing that consistently seems to cause problems with security guards and the like is anxiety.

Public safety workers are primarily on the lookout for two things: deception, and hostility. Most often, this means stealing things or starting fights. These workers form an idea in their mind of what people who do these things are like.

Someone with severe and uncontrolled anxiety can more easily match the patterns they’re looking for of a shoplifter, a meth user, a drunk looking for a fight, or a number of unspecified unsavoury groups associated with these. Someone obviously nervous and shaky and tentative and glassy-eyed could be any of these.

On the other hand, if you have friends or family who are able to vouch for you, these workers are usually very understanding. Even obviously disordered behaviour like walking into glass doors can be easily explained away by a companion.[20]

You’ll consistently find that these workers primarily want to respond appropriately to the situation. As soon as the framing of the situation goes from apprehension and punishment to aiding someone in need, their behaviour will become dramatically more appropriate and reasonable.

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[20] Speaking from experience on that one.
My friend smoothed it over by saying “he’s not drunk, he’s always like that.”

When this happens, they'll almost invariably express relief. You can talk to them about it. They don't usually mind telling you what they were afraid of once they realise it isn't true. You can get their impressions and concerns straight from the horse's mouth.

The fact that some security guards or police seeing someone visibly shaky and jittery immediately default to some permutation of "...ice addict, shoplifter, wants to start a fight" is honestly not fantastic. Anxiety is much more common than methamphetamine addiction, and by virtue of their profession alone, these workers absolutely owe members of the public the benefit of the doubt.

Public safety workers' treatment of anxiety sufferers in particular can be quite inappropriate, but they don't usually get to find that out. In most cases they only get to find out when their hunches are right.

Being well enough to lie

During involuntary hospitalisation, there is implicitly not just the expectation that you're well enough to behave in an orderly way, but also the expectation that you're well enough to lie.

When a psychiatrist in a hospital asks a patient "Have you been thinking about harming yourself?" they're not actually asking that. They're asking "Are you well enough to recognise that you have to lie about wanting to harm yourself?"

What's particularly sinister about this is that different people have different capacities to lie, and also different capacities to pick up on those subtexts. It's not their fault or a reflection of how sick they are. It's just their personal values.

Unfortunately, the truth is that being an involuntary patient in a hospital pretty much guarantees that you want to harm yourself, even independent of any psychiatric or mental illness. This is not the fault of the patient. This form of hospitalisation naturally inclines its recipients to this pattern of thinking: death is the only guaranteed escape from both the hospital and your disease.

The state health system likes to loudly advertise the fact that only a very tiny fraction of patients is actually involuntary.

There is a much larger subset of the population in hospitals that is currently voluntary, but only because they have not yet asked to leave. As soon as they do, they will become involuntary and subject to the use of physical force.

This is a group that is being lied to every day by their treating team, and the only way to avoid being physically assaulted and/or placed in solitary confinement[21] is to lie back to the treating team and say they're voluntarily staying.

The unpleasant reality is that a patient who is honest will almost invariably suffer much harsher treatment than a patient who has cottoned on to the fact that they must lie.

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[21] If you object to the use of the phrase "solitary confinement" despite its literal accuracy, I invite you to visit someone who's just been released from "seclusion" and try arguing that point with them.

Homeless shelters

I’ve never been homeless, thankfully. For this I’m speaking on behalf of a not-that-close friend who went through this.

Theoretically a psychiatric hospital is supposed to make decisions about admission based entirely on the person’s illness and risk, and the exact circumstances outside of that are irrelevant.

That’s not quite how it works in reality.

In practical terms, after a couple of months of being homeless, it usually becomes very close to impossible to secure admission.

There are a few programs for people who are at *risk* of becoming homeless, and sometimes they’ll admit people who have been homeless for short periods. But after any substantial length of time the support that is offered will dwindle, and people evaluating the patients will completely stop listening.

They don’t want hospitals to turn into homeless shelters. It sounds like it makes sense, too — the thinking is, all you have to do is cite a credible threat that you’ll kill yourself, and it’s self-evident that you need to be admitted. Free bed and board.

It’s implicitly believable that someone who has been homeless for any length of time probably wants to kill themselves anyway, so it becomes very easy for staff to ignore their plight.

This is complete crap. Never mind the fact that the majority of people who are homeless already *have* bed and board, and actual rough sleepers are a small minority even in that group.

It'd be difficult to prove, but it seems self-evident that the majority of people who are long-term homeless are in that state because they have uncontrolled (and possibly undiagnosed) psychiatric conditions. We have a disability support program for people who have such severe disease, but you'll note a substantial number of them are not on it[22].

In order to get onto disability support, you'll need a long-term relationship with a psychiatrist. The waiting lists for private psychiatrists are usually months to years long, and the waiting lists for public ones are usually even longer.

Either way, you're still paying out of pocket — despite our semi-socialised Medicare program, most psychiatrists must still be paid (hundreds of dollars) upfront on the day of the appointment. You get a partial refund *after* the appointment, as long as you have a clear medical indication for it.

Public psychiatrists *technically* can support someone to get on disability, but the sheer volume of disadvantaged clients they deal with means a patient's success rate with them will be much poorer.

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[22] Again, if you doubt this or intend on disproving it with statistics, please try discussing it with actual homeless people instead. That's not a rhetorical device, it's a literal invitation: you will get a much better perspective by going to them and seeing for yourself.

Theoretically the quick and cheap way to do this is to be hospitalised in a public ward and collect the necessary evidence there. But as aforementioned, public wards simply will not hospitalise most people who are homeless long-term.

They end up in a triple bind. They cannot afford the time or money needed to build a relationship with a psychiatrist. They cannot go to a psych ward. They cannot receive the public support needed to solve either of these issues because they don’t have a diagnosis yet. And of course, they haven’t got sufficient social capital to make these problems go away using friends or family. Around and around it goes.

This would be nearly impossible to deal with if you were healthy, but keep in mind *these people have to deal with all this while acutely sick*. Psychosis is ranked somewhere between blindness and quadriplegia in terms of how disabling it is[23].

Homeless people with psychiatric conditions have to navigate an impossible system while dealing with *that*, and with minimal social and financial resources. This cannot be described with a word any less strong than “cruel.”

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[23] Ustün TB, Rehm J, Chatterji S, Saxena S, Trotter R, Room R, Bickenbach J (July 1999). "Multiple-informant ranking of the disabling effects of different health conditions in 14 countries. WHO/NIH Joint Project CAR Study Group". Lancet. 354 (9173): 111–5. doi:10.1016/S0140-6736(98)07507-2. PMID 10408486.

Speaking directly to sufferers

It does get better, eventually

I firmly believe the pain caused by psychiatric conditions can be greater than just about anything else in life. Complicating this is the fact that for most of these diseases, there is rarely a quick-acting solution that is guaranteed to work.

So, when you're starting on a treatment and it isn't immediately working, it's very difficult to mentally reconcile your trajectory. You're already far past endurance, and there is no sign that what you're doing is helping in any way. You have no idea whether or not you're on the path to recovery, or how far away that recovery is, or even whether it's going to happen. You don't even know if you should be doing something differently.

It's a common refrain to hear that "This too shall pass" and that "Time heals all wounds". But getting worse takes time, too, so how do we know that isn't what's happening?

Here are my experiences.

Things do actually get better. But just waiting isn't always enough. It is a necessary component, but not sufficient. Improvement and recovery will take time, that's guaranteed. But you need to fill that time with some amount of action. No, you usually can't just solve it all in one go, either.

What's critical to understand is that almost everything that affects your mental health is a function of actions over time. Think of a rectangle: its height is the effort of action, and its width is how long you've been doing it. You care about its area.

In most cases, there is not a single one-off action that will make much of an improvement, no matter how heroic. Your rectangle has no area: it is tall, but so thin you can barely see it.

If you engage in an action which is more sustainable, you can keep doing it for longer. Maybe your rectangle is less tall, but it's much wider now, so you have many times the area. More area means better recovery. Time multiplied by effort.

If you gathered that this generally means a torturous cycle of working hard and waiting for ages and having no idea whether what you did was right or not, well, congratulations: that's it exactly.

It is certainly possible to come across a much better medication by luck and instantly turn your life around. But you have to be aware that trying and researching different medications takes long-term effort too, and muddling through the first few weeks to find out whether a med is right for you is sometimes extremely hard. And sometimes not sustainable to do repeatedly.

So, in short, yes, you need time to pass, and yes, you need to put in effort to try and improve your situation. Just be aware that one without the other isn't likely to help. As long as you keep trying and remain patient, things will eventually improve.

Bipolar and all-nighters

"The greatest trick the devil ever pulled was convincing you that this time, the "all-nighter to reset your sleep cycle" is going to work for sure."

~ Anonymous

I have actually successfully reset my sleep cycle with an all-nighter a couple of times. The success rate is poor, and it causes a range of other problems, but it can be done.

However, it can *not* be done while you have un(der)medicated bipolar disrupting your sleep-wake cycles. If you're in that situation, in the long term *nothing* you can do will regulate your sleep-wake cycles other than the right medication.

If you're in a situation where you're substantially tempted to do this more than rarely, that's a strong sign your medication regimen is insufficient. Regulating your sleep-wake cycle is arguably the single most important part of managing the disease; as a psychiatrist once said, "Bipolar is a sleep disorder with a mood component."[24]

It's a very difficult urge to resist, because it gives you an excuse to both go on a giant productivity bender *and* be responsible about your sleep problems at the same time. In practice, I usually find (if I'm not extremely ill) shortly after dawn it becomes uphill pedaling and only gets harder until I reach a time that is a socially acceptable bedtime. Of course, that's when you get your second wind.

The ability of antipsychotics to regulate night and day is *glorious*. If you take a moderate dosage, you will utterly lose interest in anything productive about an hour later. You will feel like "the party's over" and just want to rest. These drugs are

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[24] I'm struggling to find the source of this one.

probably the single most powerful tool a bipolar sufferer can have, because even when you're acutely unwell they can override the uncontrollable energy and tell your body and brain to stop running full-pelt.

I still want to stay up from time to time. And even more rarely, I do still do it sometimes. But interestingly my success rate has gone up: it has only ever worked when I was fairly well and able to regulate night-and-day in the first place. I've never succeeded in solving sleep problems from under-medication just by pushing through.

Standards of functioning

I want to specifically speak to the group of people that started experiencing severe psychiatric disease before they reached the conventional life milestones of graduating high school, university, and/or beginning their first full-time job.

The most important thing you can hear:

Relax.

A very common response to developing this kind of disease is to feel like you've failed at life and you're not good enough to be a part of society, because you haven't met the basic standard of adulting.

Here's the thing: the people that *do* meet these milestones don't do it by beating themselves up, or by letting other people beat them up. They don't do it by feeling inadequate and flagellating themselves until they meet someone else's standards. They do it comparatively effortlessly, because it was the next natural step when they were ready to move on.

The “basic standard of adulting” that seems so important is completely arbitrary and meaningless. The fact that a business will pay a liveable wage for functioning above this threshold may be materially significant to your life circumstances, but it does not actually reflect your progress or efforts.

As long as you’re looking at your own life in terms of the ways you’re not good enough, you won’t be good enough.

You might be 99% of the way there and not know it. Your (potential) employer might not even know it. It achieves absolutely nothing for anyone to measure or care which percentage of the way there you are. We live in a culture of standards and thresholds, and in which the mass media makes a big deal out of reaching the standard of “self-sufficiency”.

Guess what? *Nobody* is self-sufficient. Financially, everyone depends on their friends/family, employer, customers, and assets. *None of these are your self*, and equally significantly, all of them can be lost for reasons that were not in any way your fault.

Responsibility and self-sufficiency are not the same thing as possession of financial wealth and power.

Maybe there are some arbitrary differences in marketable skill that separate your abilities from those of the people who have more or better employers, customers or capital.

But you have to really emphasise the *arbitrary* part: this is not because you have come up against an *inherent* part of the world we live in. it's because you have failed to meet a criteria that a *market* has set a threshold at, through no fault of your own. You may or may not meet that threshold later. That's your business and nobody else's.

If and when you reach that point where you're able to meet societal standards of functioning, the most likely emotion you'll feel is outrage. I know it was for me.

The fact that so much fuss is made about the virtuous suffering of employment and other critical responsibility is frankly appalling: *when you're well enough to do it*, it's really not that much more difficult. Recovering from and managing your disease is much, much harder.

If you can't reach the point where you're financially able to take care of yourself, this is not a problem with you as a person or your skills as they are. This is a problem with the mapping of these traits or skills to the environment you live in. It's not your fault if they don't line up, and equally: it's not your virtue if they do.

You do you. If that matches your environment, great. If not, that's great too. If people that want to believe that there's something commendable about happening to have the right qualities for the current economic environment, good for them, but it won't help anyone else either way.

Advice on finding a good doctor or specialist

If you walk into a random clinic, you’ll find a doctor who is competent, but on average probably not much more.

If you have complex and difficult health conditions, like oh say — everyone who has a psychiatric condition — you’ll want to find a highly experienced diagnostician. You’ll probably also want someone who knows a skilled psychiatrist to refer you to.

Here’s one strategy for doing that.

First and foremost. Try to find the clinics attached to universities.

Normally when you say “teaching clinic”, people say “so you’re going to an undergrad student...?”
Yes, you’re going to an undergrad student — but when they can’t solve the problem, you’re going to their professors. Who know all the best graduate specialists, often decades later, because they taught them.

Similarly, it’s quite common for universities to have private clinics in the immediate vicinity. This is *really good* because the faculty in question often see the public directly from these clinics. Even if you’re not going to the professors themselves, you’re going to doctors who come into contact with the best specialists.

You want a GP that is connected to these people.

Do not assume that they will be prohibitively expensive or difficult to get a slot into. These clinics tend to be well-kept secrets. They often see students or the disabled/unemployed for reduced or waived rates too.

Similarly, the specialists with an exceptional reputation are not necessarily difficult or expensive to visit. You can usually get an appointment with a research leader in a field without too much difficulty. Do your homework and determine who you want to go to.

Having a specialist with a particularly good reputation does not guarantee that you'll get on with them, or that they'll be accurate or helpful — particularly for something as difficult and personal as psychiatric diseases. But it tends to exclude the possibility that they are oblivious to the nuances of the condition in question.

This is not going to solve all your medical problems. But it reduces the number of things that can go wrong when you're in trouble. The leaders of these fields tend to be more open to complex problems, and guess what: if you have a psychiatric disease, most of your problems are going to be complex.

Shame and self-hate: forgiveness and moving forwards

"Acceptance should be written on your heart."
~ Claire Weekes

You cannot build positive change on shame and self-hate. It is not possible.

The temptation for anyone with a psychiatric disorder — particularly a very disabling one — is to identify their disorder as *within* the ego boundary. As part of themselves.

You can argue to the end of time whether or not that's correct, but it doesn't help you get better.

In order for you to start building positive change, it has to have a foundation of acceptance. Acknowledging that *this is a disease* and *it's not your fault* is the first step. It's difficult to believe, but you're going to have to assume this — or a watered-down version of it — is true to improve.

Maybe start with "there's something wrong with my brain, and it's making this worse"...?

The truth is that you're just as worthy and valuable a person as anyone else in society. You have a disease that is injecting thoughts of the opposite into your head. There is no quick and easy way to stop this process, but recognizing that there are lies in your head through no fault of your own is Step 1.

There is no particular disease that causes this to happen. The classic example is major depression, but guess what? It applies to literally any psychiatric condition.

You are worthy. You are valuable. You are sick. That's not your fault. Forgive yourself when ***you*** *are ready.*

Learn to process it in your own time. Not anybody else's.

What to expect when you tell a GP you're depressed/anxious

This explanation will pertain directly to Victoria, Australia, but is likely to be analogous to other countries or states.

In most cases the beginning of treatment for a psychiatric condition starts when the patient reports to their general practitioner that they are depressed and/or anxious, or having trouble sleeping.

Even much more serious and complex problems quite often present in this way at first. For the major disorders, low mood and high worrying are usually the parts that cause distress early on, so that's when people tend to act to get help for them.

But these complex and serious problems are much less common, so the default response will usually be to take them at face value and treat for mild-to-moderate depression/anxiety.

At such an appointment, your GP has basically three things they can offer you.

First is advice on lifestyle modification. Eat well, exercise well, sleep well. Ease off on the alcohol and tobacco. Manage stress, spend time with friends, take care of yourself. They can write letters to universities, schools and employers too, if that helps — generally these institutions have to make any reasonable accommodation a doctor asks for.

Second is a mental health care plan. This entitles you to 10 free psychologist visits per year. Your psychologist will have their own approach, but it’s likely to include some form of brief counselling such as CBT where you’re taught various coping strategies. They may be willing to see you cheaply after your 10 sessions run out, depending on their own circumstances.

Third is drugs. This is most likely to be an SSRI or SNRI antidepressant, though they may prescribe a low-to-medium dose benzodiazepine for short-term or occasional use. None of this will be very drastic; think, “Take the edge off a bit.”

If there is clear evidence of a major psychiatric disorder, they can make a referral to a psychiatrist. This is a less likely outcome in most cases for a first appointment. What is much more likely is that these three things will be offered to you.

You don’t have to accept any of them, barring immediate danger. Each of those three interventions have comparable effectiveness for mild-to-moderate-depression-anxiety. While using all three is often even better, doctors are usually very aware that different patients have different treatment preferences.

Some patients might struggle to get exercise in and jump[25] at the chance to improve matters just by taking a pill. Others might be extremely averse to medication and will go to the end of the Earth to avoid having anything like that in their system. Totally okay. The doctor must respect both groups, and all in between.

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[25] Figuratively.

You will not be dragged off to the psych ward for talking about this stuff with your GP. In fact, you will probably not even be *able* to get admitted by talking to them, even if you want to. They're even usually pretty understanding about suicidal ideation, as long as there's no reason to believe you're in immediate danger.

If it struck you that these options are not all that helpful, well, you're right, they're not.

Doctors are under no illusions about the inadequacy of these interventions. They know perfectly well that they're a slap in the face of most people who seek help. But at the scale we're talking about, it is nearly impossible to mobilise the amount of resources needed for a more effective system with the funds available.

The resources of psychiatric systems are pretty badly limited, and they have to manage a large volume of people with complex conditions largely via public funding. This is basically the best that can be done with what's available.

It's really not good enough. But it's better than nothing. Kinda.

Personal experience of psychosis

Time dilation

Time dilation. You know, like in relativity, how time slows down more and more the faster you go? You might have heard of it as a scientific entity, but what does it mean in psychology?

We all know the feeling of having to do some incredibly boring chore that we really don’t want to do, and how it feels like it drags on forever. Or on how we have some moment that’s once-in-a-lifetime and incredibly valuable, and how it seems to flit by instantly, with no chance to savour it.

Take that phenomenon. Make it a thousand times worse.

When a person is experiencing a psychiatric disease (particularly a crisis in which they’re suffering) time slows down by orders of magnitude. These diseases have a particular way of extending the period of suffering — even if the disease is mild — gigantically. More suffering, more slowing.

When you’re really, *really* sick, the effect is has on your perception of time almost outweighs all other factors. Time just goes *so slowly* that you’d give just about anything to get it to start passing again, even without any actual symptoms.

Here’s an unusual definition of psychosis, which nonetheless is representative of my experiences:

When time slows down so much it completely stops. And part of you is stuck there forever.

There’s a part of me that is still 16, and will be forever: that was when I crossed that threshold. It’s not gone. It’s stuck. It’s not exactly something you can just forget. There is some non-zero part of your core self that will never move past that stage of your life.

This is an incredibly difficult concept to explain. It’s a little like how doing something every day for 30 or 40 years wears a groove in your brain, almost like a vinyl record that’s been played in one spot for too long. Compress those 30 or 40 years down to a much shorter period, and make the groove you’re creating pertain to a specific kind of experience, and you’re getting close.

Just about any minor irritation, extended for days to weeks, can be dramatically amplified. Now imagine what happens if they were extended *forever*.

Psychosis is a singularity, in the relativistic sense. Anyone who is dealing with a person going through it needs to understand this: normal concepts of time do not apply here. It is a disease of thought processes, and perception of time is one of those processes. The fact that it can break down so profoundly means that minor irritations can turn into torture.

Psychosis and memory

It’s fairly well established in the literature that psychosis impairs the sufferer’s memory formation. And that part is true.

The problem is that the impairment it causes does not map neatly to other forms of memory loss, like those caused by head trauma or ECT or alcohol or benzos. Psychosis has a powerful effect on how memories are laid down, but this effect is not simply preventing them being laid down.

Psychosis represents a dramatic upheaval of the sufferer's belief structures, the structures through which they interpret their experience of the world around them and turn that into a representation of what they believe. Its effect on memory, then, is the result of those belief structures shifting.

In the same sense that a healthy person is unlikely to be able to remember a 30-digit number they've heard once, there are a lot of things that a psychotic person will not remember for much the same reasons: they seem arbitrary or random or unimportant or just plain incomprehensible. When someone's understanding of the world around them has broken down in such a fundamental way, it is impossible to mentally record the significance of these things.

It is absolutely critical to understand that the things they experience that *do* map to these belief structures, will be remembered even more vividly than by a healthy person.

The problem with this is that psychiatric staff frequently rationalise the acts they're committing on psychotic people with the belief that they will not remember it later. Unfortunately, psychosis often manifests as some kind of paranoia: the belief that people who are powerful have a malicious intent.

Psychiatric staff generally have some form of power over the patient in question, and by doing things like lying to or physically overpowering them, they are directly placing themselves in the middle of that paranoia and lighting the fire at a very visceral level. They are explicitly proving that they are powerful, malicious and deceptive.

This is not something the patient will *ever* forget in their whole life, no matter how much their disease improves later.

In fact, it is extremely likely that they will remember it *more* than a healthy person. Aside from being an outright life-changing traumatic experience in its own right, it is one of the few things the sick person can actually make sense of. The central theme of their belief structure is being viscerally and immediately proven right, and in an intensely traumatic way.

How would you feel if a doctor found out someone had a life-threatening but entirely treatable disease, and when this was discovered injected them with a drug that did absolutely nothing to treat it, but which causes their body to reject the cure for the rest of their lives?

This is exactly what is happening in psychiatric treatment around the world. Someone who has been lied to or physically overpowered by psychiatric staff while psychotic will never, ever be able to fully trust members of that profession again, even if they want to. *Of course they bloody can't, what on Earth were you expecting?*

Someone who's paranoid is scared that someone powerful wants to harm them. If psychiatrists and nurses prove that they are powerful, and can or will harm them, then the patient will never be able to freely access help again. The treating team have permanently limited the patient's access to treatment through their actions. There is no excuse for this.

Nightmares

I've never heard of anyone else saying this, so all I have to provide here is my own experience. The one reliable sign of psychosis for me is nightmares.

The interesting thing about psychosis nightmares is that they don't have content. I cannot recall a single detail, even vaguely, about exactly *what* is so disturbing about the experience. I could not for the life of me tell you even the approximate narrative of one of these nightmares.

But when I'm experiencing them, every night I'll go to bed absolutely dreading going to sleep, and wake up profoundly disturbed. It's not even an "I'm so glad that's over" feeling like with a normal nightmare - it's more like a feeling that the experience has deeply harmed you in some way and that it's going to be a very long time before you're whole again.

On a few occasions people have been sleeping nearby at the same time this has happened. In a couple of cases they reported that I was calling out in my sleep, but unlike how night terrors are described, there was no false awakening; the entire experience happened while obviously sleeping.

Because there's no actual concrete content to write about, I'll have to instead try to give you an idea of the emotional *flavour* of the feeling. It's a feeling that something very big, dark, and just plain wrong has violated you at a very basic level. It’s like your brain is infected with something that does not belong in this world, and is eating away at something very fundamental to your existence. If I had to pick a pop culture reference, think of Cthulu.

What is interesting is that this feeling was so profoundly disturbing that even when I was extremely psychotic my immediate response was “What the hell was that? That was messed up.”

This phenomenon seems to be completely different in its nature to the actual waking psychiatric presentation. If anything, the profundity of the experience was enough to distract me from the obsessional thinking and other hallmarks of psychosis - while I’m sure a neuroscientist would be able to make all sorts of interesting connections between shared underlying mechanisms, I was very aware that whatever happened while I was asleep was not a part of my (twisted, distorted) waking belief structures.

This is a useful barometer. The need for insight is a critical factor in identifying and treating psychosis, because its manifestations can be subtle and the nature of the illness tends to distort your thoughts about it. Handily, I have had these nightmares exactly twice since being stabilised in 2006, and in retrospect on both occasions I was starting to become psychotic.

In the future we’ll know that if they pop up again it’s time to rapidly and substantially increase my dose of antipsychotic. The last two times it was not done quickly enough, and my health deteriorated for a while as a result. But it was done eventually, and the problem ceased immediately.

I have no idea whether nightmares are a common signal of incoming psychosis. I have no idea whether the specific kind of nightmares I have are a common thing among people with psychosis spectrum diseases. And I have no idea whether there is *any* common signal that anyone can identify psychosis in for themselves. But maybe this will be an interesting piece of information for future study.

The Golden Metwand

It is a little odd to consider that the subject matter a psychotic person is obsessed with may have actually been one of the keys to recovery. I don’t know that this was the case, and I don’t know whether it even helped, but it seems reasonable when looking at someone who has recovered so well to look at what they were obsessed with.

For my entire life I have been absolutely obsessed with writing software, and I believe that, for me, this fact was one of the necessary conditions for me to recover.

Here’s a story.

John Nash was a highly successful mathematician who effectively founded game theory. In 1959 he gave a lecture that was supposed to present a solution for one of the most fundamental unsolved problems in mathematics[26]. The lecture was completely incomprehensible and made no sense to anyone who attended, even at the most basic level. Immediately his colleagues knew something was wrong, and shortly after Nash was diagnosed with schizophrenia.

This cannot happen in software development. If you are writing code that doesn't make any sense, you will find out about it very quickly. If it is obviously gibberish, it won't even compile, and you will know straight away. If the logic doesn't make sense, it won't function, and you will know very quickly. If the concept doesn't make sense, it will not do what you think it does, and you will also know very quickly.

Software development is a field with a "golden metwand" - a standard by which anything you create can be accurately judged (this is a legal term, referring to the idea that all people are judged by the law equally). No matter how crazy your thoughts or ideas are, if they are wrong, you will usually know in a matter of seconds to minutes.

And you can keep trying and experimenting and tweaking and get instant feedback - the compiler, and the runtime, are effectively arbiters that you are at least aware of rational thought. You cannot cheat them.

This is not to say that they will guarantee that your thinking is correct, or rational, or oriented towards any goal or concept that even makes sense. But they guarantee that there are some things you cannot delude yourself about. Psychosis can cause

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[26] The Riemann hypothesis, which is still unsolved and now attracts a million-dollar prize for a verified solution.

delusions and hallucinations, but I assure you it will never cause a belief that code that does not compile is working successfully.

The sufferer might believe that the CIA is deliberately messing with their compiler, or that when they get it working it will contact aliens, or that they are a universal genius who will solve all of humanity's problems with their work. But they will *not* believe that they have successfully built a program when the compiler in front of them clearly states that they haven't and points out why.

I think work towards mastery of a field where there is a golden metwand and a low cost of experimentation is one of the necessary components of a successful recovery process.

Software is a particularly nice example, because the cost of experimentation is zero, the cost of verifying a failure is also zero, and the value of a successful innovation is high. That said, I think there are many other fields that could work just as well.

If you consistently judge your thoughts against a standard that can always be trusted, properly treated psychosis can become creativity. Creativity of a kind that is simply not accessible to anyone else.[27]

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[27] Related story of a software engineer who experienced psychosis:
https://en.wikipedia.org/wiki/TempleOS
https://www.templeos.org/

“Every morning he gets up and uses my bathroom.”

The front of my parents’ house had an en-suite, but like most en-suites it was directly connected to the master bedroom. Because he didn’t want to disturb his wife with this, every morning my stepfather would get up early and use the only other toilet in the house — the one immediately next to my room — instead.

Not that it really mattered, but it was a little irritating that he did this. So I told the parents that I was annoyed about it. Pay careful attention to the wording:

> *“Every morning he gets up and uses my bathroom. Can he please use his own instead?”*

This happened around the time I’d just started to make meaningful recovery. I was post-hospitalisation and had just started doing TAFE and making friends. I’d largely recovered from the manic episode and my thinking was in the process of righting itself.

I found out much later that this statement had caused my parents to become incredibly worried, and question whether I was becoming psychotic again. They had heard “Every morning he gets up and uses my *password*.” As in, he’s getting into my personal files on my computer.

“Bathroom” and “password” don’t even sound particularly similar. But at that point they were both acutely concerned about my mental health and were terrified that things were getting worse again. So worried that their verbal processing was distorted. They heard what they were afraid of, not what I said.

I think there’s a really important lesson to be learned here: after going through something as traumatic as a life-threatening manic episode with psychosis, a carer is likely to be hypersensitive to any slight sign that the person’s health is slipping again.

When someone is this overly sensitive to another person’s thinking, you are going to get false positives. Even a perfectly normal and healthy person’s speech and mood naturally varies within a certain range, and when you’re *really* scared that it’s starting to move outside that range, it’s going to influence how you interpret their actions. Even to the point of dictating how you see those actions.

If you’re a carer, you need to be aware that there are going to be *more* miscommunications throughout the recovery process than there would be otherwise, not less. If you’re not sure, rather than assuming a disaster is happening, perhaps actively clarify with them. You can always just ask.

Personal experience of hallucinations

Auditory and visual hallucinations are one of the classic manifestations of psychosis. I’d like to provide my own personal experience of them, because it doesn’t tally with what I’ve been told on the topic by anyone else.

Everyone has a mind's eye, and a mind's ear, in addition to their physical eye and ear. The physical eye and ear are what you actually see and hear in front of you, and the mind's eye and ear are what you're imagining. Hallucinations can affect all of them, but in different ways.

The only hallucinations I've ever had from the *physical* eye and ear have been threshold hallucinations. That is, they consist of the brain attempting to fill in the blanks in a quiet or dark environment.

Interestingly, stress and fatigue seem to change that threshold. When I had just started to stabilise, and I'd started my trade school course, I had one day per week that was effectively eight hours long. It wasn't particularly stressful, but what is interesting is that at the end of that day I would go to bed and experience a most peculiar auditory phenomenon.

As I was starting to relax and wind down, I would hear (as in, *actually* hear) fragments of the speech I'd heard throughout the day, but chopped up and randomised. If someone I'd been listening to had a particular consistent mannerism or way of speaking, it would be reflected in that random content.

This sometimes merged into exploding head syndrome, the best named medical condition in history[28], as when I was drifting off sometimes one of these speech fragments would *yell* and I'd jerk awake, before realizing everything was silent and I hadn't heard any sound at all. My echoic memory was empty.

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[28] Close second is Jumping Frenchman Disorder.

The entire phenomenon was very curious, but the longer I continued on an effective treatment, the less it happened. It still pops up from time to time (minus the yelling) when I'm extremely stressed or sleep deprived.

Same for the visual effects, which are usually pretty boring and mostly just random noise. When I'm extremely sleep deprived or physically strained, these tend to become more prominent. These seem less like "seeing" things that aren't there and more like a partial breakdown of visual processing.

Interestingly, these hallucinations mostly turned up *after* I'd been very sick, when I'd gotten past the initial recovery and my thinking was starting to right itself. My theory is that these phenomena were artefacts of the recovery process — my thinking had improved, and that made me more aware of the disordered sensory processing.

The effect of early psychosis on the mind's eye and ear is completely different.

When I'm experiencing prodromal psychosis, it has a very interesting effect on my imagination. I think most people probably are barely aware of their use of their imaginations, because they have behaved exactly the way they would expect them to for their whole lives. We all use them, all the time.

It is a very difficult phenomenon to explain in words. During the process of forming a mental image of something (deliberately or coincidentally), there will be momentary flashes of the things I'm trying to put together blended with completely inappropriate things and concepts.

The images it generates in this manner are quite frightening and disturbing in quite a Lovecraftian/Uncanny Valley way, but they’re not fully formed, and I could never retain them for long enough to actually come up with a description. By the time the concept I’m after has actually formed, the image is long gone, but the reaction of “...What the fuck was that?” remains.

When I say the mind’s ear, I’m mostly talking about the internal monologue (your internal voice thinking your thoughts). The effect of prodromal psychosis on this is different again. You end up with the correct elements in your thought process but they happen in a more non-linear fashion and come out with the wrong structure.

This does not prevent you acting purposefully (albeit in a strange sequence) but it makes explaining your thoughts extremely difficult. It is a failure of structure, not of content.

You can kind of try to correct the structure. But sometimes the structure you’re correcting it with is wrong too.

Mania, hypersexuality, regret

There’s one effect of (hypo)mania that people tend to avoid talking about: hypersexuality.

This is particularly an issue for people who first contracted bipolar disorder in their teen years to start with. The average teenager would probably meet most of the criteria for hypersexuality, and having someone that has actual hypersexuality *on top of* the standard teenage deal is likely to always be intense.

Hypersexuality is a particularly sinister effect of the disease, because it is not something that the sufferer is likely to complain of itself. They're much more likely to complain about the lack of available sex, which unfortunately is a normal part of adolescence in itself.

It does not simply affect your thought processes in terms of what you are wanting of: it is a problem that affects the entirety of your thoughts. Your entire thought process is distorted by it in ways that can't be fully rationalised.

It'll probably surprise few people that between manic hypersexuality, lack of social development, and ordinary teenage problems I did some embarrassing things in this area when sick.

I don't remember doing anything that would be considered worse than "embarrassing", but they're still not things I'd have done if I'd been in control of my faculties.

But I wasn't. It wasn't me that did them. Simple as that.

Probably anyone who goes through bipolar crises for any length of time and then reaches something resembling recovery has to undergo this externalisation process.

It’s a lot easier when you have a treatment that causes a rapid and sustained improvement in the disease process. I have the nice and easy line in the sand that anything outrageous that happened between a particular set of years almost certainly falls into this category. I’ve had ins and outs on other occasions, and have once or twice acted in ways that weren’t representative of my personality because of it. But for the most part, most of the problems fit into one neat range of years.

If your uncontrolled disease wasn’t so neatly confined to one period of your life, this process of understanding what was and wasn’t your own actions is probably much harder. I don’t have advice for that situation, not having been in it.

Psychiatric diseases do not always entail a complete breakdown of a person’s decision-making ability. But sometimes they do, which is unfortunate for our beautiful and perfect socio-political models of the world, or for the people who are caught up in them.

As strong as the movement to make public accountability utterly inescapable is right now, severely sick people often do things that they aren’t capable of controlling. And you cannot plead insanity in the court of public opinion.

Panic disorder is awful

Perversity of panic

Panic disorder is not a disease that you get complacent about and slack off with.

Panic disorder is a disease that you *have to kill dead, right fucking now*.

It’s a disease where you can’t relax for a second, where your every waking moment has to be dedicated to analysing and finding a way to utterly destroy it. Where your energy has to be completely and fully and totally directed at this.

Because if you didn’t direct all your energy at beating the disease, you wouldn’t have it.

It’s only alive as long as you’re feeding it, and your deepest survival instincts tell you to double down and feed it more and more and more.

People who are slack and complacent don’t get panic disorder. Only the people who are genuinely determined to beat it actually get it.

Encouraging people to slack off more — that’s not in line with the modern world, though, is it? Isn’t laziness and lack of responsibility an epidemic in our society? Don’t we all need to buck up and pull our weight a bit more?

We all need to do everything better and faster and more efficiently, and take more and more responsibility for the consequences of failure. We need to push ourselves to reach other peoples' expectations at all times, and hold ourselves accountable when we fail to do so.

We call panic a disorder, but maybe it's actually a symptom.

"Don't have a panic attack."

I was having a casual conversation with a long-time friend of mine about something technical. He made a suggestion that didn't make any sense, so I playfully told him, "You're an idiot." His response was interesting:

"Don't have a panic attack."

"That's not a panic attack."
"It's… not…?"
"Not even close."

I think among some laypeople the term "panic attack" has been distorted in meaning, and nowadays often simply refers to any excessive emotional meltdown that the person experiences. It might be worth clearing this up explicitly.

A panic attack is not the result of an overreaction in the sufferer's mind. If they're having a panic attack, they're almost certainly well aware that the situation they're in is safe and unthreatening. If they could turn it off, they would.

In fact, in genuine emergencies, people who suffer from panic attacks tend not to have them. Not because they are choosing not to, but because their brains can recognise *actual* danger and prioritise.

A panic attack is what happens when your brain's emergency survival reflex kicks in, in response to you being afraid that your brain's emergency survival reflex is going to kick in.

This wouldn't be an issue if you could simply ignore it, but that's quite a lot harder than it sounds. This reflex is the most primitive and fundamental survival mechanism in the brain, and nobody can possibly be prepared for it.

It is by far the scariest thing you can ever experience, because it's your super-serious-mortal-danger-alarm stuck in a feedback loop.

Just to clarify. People who have been in hostage situations, or plane crashes, or have stood at the top of unstable towers with no safety line, or who were locked in snake-spider-and-scorpion pits, or who have run out of oxygen while SCUBA diving will all tell you the same thing: panic attacks are much, much scarier.

There is no contest whatsoever. Of course there isn't. By definition this feedback loop generates the maximum fear you are physically capable of feeling.

The intensity of this fear generally causes people to shy away from it, and that withdrawal response becomes deeply ingrained as a survival mechanism. This often manifests as claustrophobia or agoraphobia, where the sufferer is afraid to enter any situation they've previously associated with panic attacks that they can't get out of. Which causes a panic attack.

Despite "claustrophobia" usually being taken to mean fear of being in small spaces, and "agoraphobia" usually being taken to mean fear of being in large open spaces, they're fundamentally the same thing, just with different sets of triggers.

The irony is that when a friend or loved one has a panic attack, the temptation is, well, to panic. The sufferer's fear reaction will make them respond as if they're in mortal danger, because that's what their brain is telling them they're in.

It's very usual to feel like there must be some very specific course of action that's needed that you don't know, but if they aren't actively asking for something, the most useful thing you can do is act as if it wasn't happening — just with consideration and awareness and patience.

There's no danger. Fear never hurt anyone. The panic attack is incorrectly signaling from their brains and does not represent any actual form of danger. Understanding that is generally the first step of treatment.

The way out is to understand that the panic cannot *make* you do or not do anything. That actually, despite the extreme intensity of the feeling, it can't make you unable to function. That you can keep going despite it.

If you fully take in everything that your body is throwing at you, experience and feel it fully, and do nothing about it, it'll pass.

But that’s something the sufferer has to learn firsthand in their own time, not something you can impress into them from the outside. Telling them to do that won’t help. All an outsider can do is not give them more things to worry about.

Benzodiazepines for panic

Panic attacks that are happening *right now* are usually treated with benzodiazepines. This is because unlike antidepressants, they have an immediate effect, generally in under an hour.

They’re often treated as a surefire cure in the short term, because they have a high success rate and can be used as a one-off if needed. They impair emotional memory formation, so they cannot be used as an aide to cognitive treatments, but as far as getting someone out of the panic state *right now* goes, they’re the standard.

So, are they always guaranteed to work?

No.

Depending on how determined you are to beat the panic.

At the peak of my panic disorder I went to the local plaza with my partner to get a chicken schnitzel. I was panicking at the drop of a hat, so I took a fairly large dose of diazepam about 45 minutes before leaving.

It was too much. I got into the building okay, but I was extremely drowsy. While waiting in line, while half asleep, I started getting anxious.

Being someone who is utterly incapable of giving up when it comes to things like this, I was so determined to use my cognitive techniques to defeat it that I was able to have a full panic attack while half asleep from sedation.

I was so profoundly determined to win this battle and function that I was able to push through the strong sedation, and panic anyway. And consequently struggled to function.

Truly a bizarre disease.

Meditation and astral projection

During my initial CBT treatment for panic disorder I was instructed to try mindfulness meditation. Meditation doesn’t usually achieve much for me. But I did it anyway, and gave it a good solid shot. I was not entirely convinced by what I’d read indicating that this was an evidence-based therapy.

Something unusual happened. You know when you’re half asleep in the morning, drifting in and out of consciousness? You can almost tangibly feel when your brain is actually communicating with your physical body, and when that connection is severed and your brain is instead communicating with itself in a dream.

So, after 20 minutes of meditation that link got completely severed, but I was fully awake.

This is a strange and disconcerting feeling. I lost any sense of my body — I think part of my brain thought I was asleep — which was actually quite frightening, but my motor function wasn't connected either. I was able to move, but only after rousing myself out of this state.

I'd describe the experience as dizzying and disorienting — not unlike you're falling or tumbling down a dark hole.

My therapist asked if I'd fallen asleep, and after coming out of that state I said "Uh… I lost contact with my body…"

She laughed and said "Astral projection is not an evidence-based therapy."

Guess meditation was a wash.

In any case, apparently there's now evidence suggesting that meditation can have an actively harmful effect on people with psychosis spectrum conditions.

"Not that I don't believe you, but the timing is a bit convenient."

It's very common for agoraphobia to first strike around major life transitions. Things like finishing uni, getting your first job, getting married — stuff like that. I think there's a connection, but the truth is it's probably for the opposite reason most people think.

Agoraphobia first hit me badly towards the end of my Bachelor's degree. I was within spitting distance of completing it, I'd made a project prototype I wanted to sell and made some inroads on finding customers, I was ready to go. I was fired up. Then I started having panic attacks.

A few people close to me made the connection. They assumed that I didn't want to start my career, that there was some conscious or subconscious force that held me back from getting into working life seriously. That at some level I was scared and wanted an excuse not to do it. I told them this wasn't the case, but memorably one of them replied:

"Not that I don't believe you, but the timing is a bit convenient."

Looking back, I can categorically say that entering the workforce *was* the reason I started having panic attacks, but for the exact polar opposite reason this person had described.

In fact, it was because I was *too* determined to take responsibility for my career.

The critical thing in understanding panic disorder is that the harder you try to beat it, the worse it gets. Someone who has fully internalised the idea that they *must* meet a given standard of functioning and who tries extremely hard to do so is likely to get worse. The harder they push on through this, the worse their functioning becomes and the more debilitating the illness.

I was absolutely, 100% dead-set *determined* to kill this problem dead. That was what made the problem happen in the first place.

Ironically someone who is so-so about their career and life milestones is much less likely to be struck down by panic, because not caring is a much more effective way to deal with this type of disease. One of the classic ways of resolving panic attacks is to try and make them worse, and someone who genuinely would like an excuse to not put effort into something will almost certainly not find that excuse in panic attacks.

Someone who is having panic attacks around a major life milestone is almost certainly having them because they *really* want to move forward in life and are *really* determined to ensure it happens. If they were looking for an excuse not to do it, then they want to panic, and they wouldn't be panicking.

Panic disorder will not give you an excuse. It will only turn up when you're determined to overcome it.

Facing down panic attacks

A not-uncommon bit of advice given to people experiencing panic attacks is, "Try to make it worse."

If someone is *only* having panic attacks, and hasn't yet developed the avoidance behaviours of something like agoraphobia, this can actually work very well. Here's my experience with this method.

For a while after hearing about this, I tried to apply it using a method that was, in retrospect, bizarre. I'd go into a semi-uncomfortable situation in which I had moderate anxiety, and I'd say "make it worse" to myself while kind of bearing down on the anxiety I did have. I was not *actually* trying to make it worse, but more like over-focusing on it defensively.

One time, after trying this, the panic came home with me afterwards. A formerly safe place had become outright panic-inducing, and this itself was scary. I started to have an *actual* panic attack, and there was nowhere left to retreat to.

The possibility of calling an ambulance flicked across my mind, but I was very aware that it would probably make matters worse on all fronts. So, I did something stupid: I *actually* tried to make it worse.

This is an act of ultimate vulnerability: you're feeling like there's a mortal threat present, and you're actively letting it in. You're inviting it inside all your defenses to cause maximum damage. It has been described by some as "committing mental suicide", and that's not too far off the mark.

A moment later, I burst out laughing.

I couldn't help it. All of that tension and fear had instantly dissolved and turned into a pleasurable relief. It was a euphoric and exciting moment.

It turns out that if you go all the way, and invite in maximum damage from the panic sensations, your body is able to recognise that there's no threat and resolve the fear. All that adrenaline stops being turned into fear and starts being turned into euphoria.

This didn't cure my agoraphobia. I'd spent years building up layers of avoidance behaviours, and had internalised the idea that I wasn't able to go out on my own. But it was the first glimmer of a way out.

I still struggle with it, because panic turns up at the moments you want it not to. The most inconvenient times possible. But it's nice to know what lies at the end of the worst possible panic attack, and even nicer to know it's actually quite enjoyable.

Medicinal kava for panic attacks

The problem with using something like alcohol or benzos for anxiety is that the brain adapts to them. Their effects are a result of making your GABA[29] receptors more sensitive, and your neurology responds to this by downregulating (making less of) them.

Kava is a Pacific Island drink made from the root of a specific plant. In the mass media it's usually dismissed as "equivalent to alcohol" and most coverage of it assumes it is basically the same thing with the same problems. This is ridiculous, because kava is nothing like alcohol.

One theory for its mechanism of action is that rather than making your GABA receptors fire more easily, it induces upregulation: it tells your brain to make more of them. This means that your baseline level of arousal will be lower, but

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[29] Gamma-aminobutyric acid. Your brain uses this chemical to regulate alertness and anxiety.

without intoxication. The most you'll get is feeling slightly jolly, without actually being drunk.

There are a number of TGA-approved kava products on the market, and most are available without a prescription. If you're going to mess with it, you need to clear it with your doctor, particularly if you're already on other meds. The drug's pharmacology is complex and atypical, and there are risks associated with doing this.

For me, kava products were one of the breakthroughs that allowed me to function again. They were associated with such a dramatic improvement in my anxiety that I was able to go from housebound to working a full-time job in person.

It's not for everyone, and there are certain risks associated with this approach. But very few psychiatrists are even aware of this drug, and it's one of the things that's given me my life back.

How not to do CBT

"What's the LD50 of trying too hard?[30]"
~ Anonymous

The gold standard of treatment for panic disorder and agoraphobia is cognitive-behavioural therapy (CBT[31]). This is a talk therapy that involves a standardized process for introducing the patient to concepts in a specific way.

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[30] LD50 = Lethal dose in 50% of subjects. A simple measure of a substance's toxic dosage.

[31] When researching this therapy, make sure to use the full name, not the abbreviation. Trust me on this one.

Unlike pharmacotherapy, it’s supposed to teach you methods which you can use anywhere at any time, granting you a higher degree of freedom over the disease.

My attempt at doing CBT took me from moderate anxiety when on buses to being completely housebound and unable to function at all. As much as I had a go at her over this, it was not the fault of the therapist teaching me, but a consequence of my fundamental approach to doing this type of therapy. Here’s what I did wrong, so you can avoid doing it too.

My objective was to kill the panic dead, and I was not going to let anything in the universe stop me from achieving that. I tried to use CBT as a weapon with which to do this. This is not what it is or what it’s for.

I was taught a range of relaxation techniques and then told to gradually work my way up from less-challenging environments to harder ones. Systematic desensitisation.

I started in a comfortable environment, was okay. Took the next step to one that caused mild anxiety.

What I *should* have done was acknowledge the anxiety and realise that it didn’t really matter and wasn’t worth worrying about, and come back tomorrow. Instead, I doubled down: I declared that I wasn’t going to move until it was *gone* and remained in the situation for multiple hours.

Acceptance wasn't what I was doing. I was going to defeat this, and was ready to do whatever was needed to do so.

This approach was just another form of fighting the anxiety, but with the added bonus of iteratively going through situations I used to be able to handle and making myself less and less comfortable in them. It was, in effect, systematic *sensitization*.

It shouldn't come as much of a surprise that I got dramatically worse in a very short space of time and didn't really start to recover until I completely scrapped this approach.

If you're trying systematic desensitization, be aware that your intent is a key part of your outcomes. If you're using it as a method to kill the panic, you're going to get worse, not better.

The method that does work boils down to "...absorb all the fear, feel it all fully, and do absolutely nothing about it." Learning to do this in the face of overwhelming mortal danger is the hard part.

Feeling useless

There's one thing that just about anyone who experiences panic attacks goes through at some point. This is particularly relevant to agoraphobia and claustrophobia, but it applies very much to social anxiety and many other forms of it.

It's usually expressed as something like:

"I feel so useless."

This is present in depression and a lot of other diseases, but severe anxiety seems to have a particularly strong and disturbing effect with regards to this feeling.

Speculation time. If you were literally, physically unable to take care of yourself, it would probably be slightly less difficult to allow other people to do it for you. It'd be challenging; you'd feel terrible about it at the start, but sooner or later you're going to stop caring, as you realise that it's not your fault. You're simply unable to do it and you'd do it yourself if you could.

An agoraphobic, on the other hand, feels like they *can* and *should* take care of themselves. And they would absolutely do it in a heartbeat if it weren't for the anxiety. The anxiety is considered a part of themselves that they *should* have control over but don't.

This is what makes it so hard. They *know* they're able to do the things needed to take care of themselves. They've done it before. But they can't bring themselves to do it… because of something in their brain that stops them, which they can't control.

This is way, way harder to live with than it probably sounds.

Understanding this is critical for carers and any other non-sufferers who come into contact with agoraphobics. The disabling part feels like it's *inside* their ego barrier, even as they're fighting it with everything they have. And ironically this fighting is what causes the disability.

The cruelest, most evil thing you can do to someone in this situation is to hold them to a “normal” standard of functioning and shame them for being unable to reach it. They’re already doing that to themselves, and that process is incredibly painful. They want more than anything to be able to live normally like everyone else.

The converse of this is that the best form of support you can provide is giving them opportunities to be genuinely useful and providing genuine appreciation for this value (while still acknowledging that if they can’t handle it right now, that’s not a problem). The more they can learn that they are still valuable and useful, the further they get towards the first step of recovery.

The claustrophobic driver

I think this happened in 2017. I was at the peak of my agoraphobia and had absolutely no useful way of dealing with the condition. I was having panic attacks so much as walking past the mailbox, and there was no real end in sight.

I was still able to take ride-share services to a small list of places that I knew well, as long as someone was able to meet me there who could take me back if necessary. That was about the extent of my mobility, and even then, the slightest spanner in the works would totally throw me. I was so unnerved by open spaces I couldn’t even have a car window open for long periods.

I was taking a car to my psychiatrist, and when the driver arrived, he had all of the windows in his vehicle all the way down.

I hop in, and politely request that he closes them. He sweats a little. Fumbles. Says he can do it, as long as he can have his own window open. He likes the fresh air, keeps his face cool.

I'm okay with this for now, so we start on our trip.

About halfway I start to get shaky and nervous. He was letting the outside in: there's a lot of noise coming in from that window and a lot of open space on the other side of it. I ask him to please close it.

Eventually he comes clean:

“I had to quit my last job because I can't handle indoor places. I get really panicky when I'm in an enclosed space and don't have an easy way out. I can only drive passengers around because I can open the windows.”

The severely agoraphobic passenger got a severely claustrophobic driver on his way to treatment.

We have a bit of a back and forth negotiation trying to work out a compromise that works for both of us, and end up with all of the windows just a crack open. He still gets his air, but most of the sound of outside is blocked out.

“Where are you going, anyway?”

“To my psychiatrist, to get treatment for my panic attacks.”

“Hrm.”

He pulls in. As soon as I get out, he immediately winds all the windows down all the way and spends a minute or two taking some big deep breaths. Then he leaves.

There’s a name for that

Akathisia

Most psychiatric medications have a certain chance of causing a troublesome side effect: akathisia. Though it can certainly pop up in psychiatric conditions that have never been medicated anyway.

The chance of this occurring — and its likely severity — varies depending on the type of drug, the dosage, and the amount of time using it. Most antidepressants and benzos have a relatively low chance and severity, while mood stabilisers have moderate and antipsychotics the highest. Using these drugs at higher doses for longer times increases the risk of developing it.

Akathisia, at its most basic, is a constant compulsion to move. Unlike a dyskinesia[32], this movement is still a voluntary, conscious choice. Unlike a tic, it is not a compulsion to do a specific act. The compulsion akathisia causes can certainly be ignored, and it's not usually aimed at any particular type of movement.

You would think, then, that you can just ignore the compulsion, and if you continue to ignore it for long enough, you'll adapt and learn to be still.

Wrong.

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[32] Dyskinesias are an occasional effect of long-term antipsychotic use. They occur when the drugs affect your motor neurons, causing you to be physically unable to stop moving, usually your face and hands.

The way I’d describe it is this. You have a natural baseline amount of movement that you tend towards. In the absence of external stressors, if you relax and let go, you’ll move towards this baseline level. In an ordinary, healthy person, this baseline level is very low — so low that they don’t look to be visibly moving.

Psychiatric diseases and medication change this baseline level. They don’t just change the amount you want to move in the short term — you can adapt to that — but they change the point to which your body seeks homeostasis. The very resting point that you fall back to is no longer one of stillness.

A left-handed person can sort of learn to write with their right hand. And in the same vein, an akathisic person can sort of learn to make it look like stillness is their default. But it isn’t. They can’t change that. As long as they’re experiencing akathisia, they will always ultimately default to moving.

Normally, when someone is listening to another person and moving their body constantly, it’s a sign that they’re not interested or that their attention is wandering. As a result, a few people have said that they’ve found talking to me quite jarring at first: someone who is *constantly* moving throws this perception off, and they have to adapt their reading of body language to this. But they can adapt, and I can’t.

There are a few lurid descriptions of akathisia in the literature, describing it as a constant, unrelenting torture that drives many to suicide.

Maybe these people have it much worse than I do. But I definitely experience akathisia, and I would absolutely not characterise it as torture. Torture if I’m forced to stay still for an extended period, maybe, but for me it’s mostly just a moderate restlessness that sits in the background.

My wife sometimes finds it torture to watch though.

Dysphoria

Everyone knows what euphoria is. There are a thousand things that can make you feel excited, enthusiastic, content, and happy. Usually when people talk about the opposite, they assume we’re talking about sadness, disappointment, frustration and despair. These are not the opposite of euphoria. They’re emotions that can invoke its opposite.

The actual opposite is dysphoria.

Dysphoria is an acutely physical, acutely unpleasant feeling. It is not really possible to describe it, because it is irreducible. It’s one of the most fundamental building blocks of human emotion. It’s the common ground between every negative emotion or sensation; it’s the feeling that they all invoke.

It’s a little unfortunate that the entirety of contact that most people have with the word “dysphoria” these days is in the context of gender dysphoria. Which is a legitimate, serious problem that needs to be handled with treatment and consideration, but it’s really critical to understand that dysphoria itself can be caused by many, many other things.

Of particular relevance is the fact that just about every psychiatric disease has it as a central feature. In fact, you could make an excellent case for the notion that it's a defining characteristic of that category of disease.

Uncontrolled mood, anxiety or psychotic disorders are all perfectly capable of causing dysphoria even without anything else obviously wrong. This is particularly frustrating for the sufferers of these diseases and their carers, because at this point all they can do is say that they feel… bad. Their inability to match how bad they're feeling to any meaningful symptom is not something anyone, even a psychiatrist can do much with.

The one good thing about this is: a sufferer can usually tell whether a treatment is working for them or not — sometimes even before they show any actual symptoms. This is not a learned skill; it's something the sufferer will gladly tell you if you ask.

Dysphoria is an absolutely critical, fundamental sign of psychopathology, but most of the tools in a psychiatrist's arsenal are utterly useless without more clues to attach to it.

That doesn't make it any less critical to pay attention to.

The Call of the Void

You've been going for a walk around a lighthouse as part of a holiday. When you get to the top, you notice there's a gap in the railing, and you're standing right in front of it. For a moment, you want to jump, and you're acutely aware that there's nothing in the world stopping you. But you don't.

This experience is disturbing, common, and completely normal. It's the Call of the Void.

The urge to jump is the most famous version of it. But it can turn up in virtually any area where you're aware that small actions can lead to serious, irreversible consequences.

It certainly can appear with regards to social interactions and relationships. In many social settings, harshly rejecting someone (particularly someone with some kind of authority over you) you're just starting to get to know is a small action that can completely and permanently destroy your relationship with them. These are like little social cliffs you can throw yourself off, but generally choose not to.

A lot of people get anxiety about this phenomenon. Commonly, they're afraid that they're losing their mind and turning into some kind of psychopath that would actually do these things. Or they're afraid that sooner or later they're going to let their guard down and actually do the things without thinking.

The critical part of that last sentence is "let their guard down". Think about that for a second.

The Call of the Void is your brain's way of recognizing that you're in a situation where small changes to your behaviour can have lifelong consequences, and makes you extra, *extra* conscious of that. It's a mechanism to ensure that those all-too-easy mistakes are at the forefront of your mind when you're navigating the situation.

In short, it's a mechanism that is designed to make you keep your guard up in these situations.

All of those cognitive and behavioural adaptations are the consequence of that. All the worrying and what-ifs are a natural consequence of a system whose reason for being is to remind you that you are potentially in danger, and that you need to be mindful of your actions.

This system cannot possibly preempt what your cognitive processes will make of it. Your higher thought processes can generate any interpretation of it they want. It shouldn't come as much of a surprise, then, that it's very common for people to interpret these thought processes as dangerous, scary, pathological, as a sign that something is wrong with them and with their thoughts.

The Call of the Void is perfectly normal, perfectly healthy, and not a sign that there is anything wrong with you or your thinking at all. It's just your brain trying to remind you to be careful. Sometimes brains don't quite know how to effectively communicate with the people living in them.

Ambition and creativity

Learning to Code

I’ve been developing software in one form or another since 2000ish, and occasionally people ask me what the best approach would be to learn.

To that I say: I have absolutely no idea. The way I learned was unusual, and few can follow that example by choice. I simply do not have experience with any other method. I’m happy to explain exactly what that process involved, just in case it helps someone somehow.

I knew from the get-go that software development was my calling. Until mid-primary-school the problem was simply that I didn’t have access to any means to do so. Towards the end of primary school, I’d finally gotten access to some substantial tools and information and started actually building things.

By around about year 8 my bipolar had started to get out of control. I started going through periods where I was too sick to go to school, and this continually deteriorated over the next 4 years. By the time I was in year 10, I was pretty much incapable of normal functioning. My body clock was freewheeling and had no connection at all to the time of day.

So what did I do with myself? I wrote code. Obsessively.

During these years I would regularly set very difficult targets and then just sit down and say to myself, “I’m not getting up until either it’s done or I’m done.” I’d go multiple days continuously writing code without eating or sleeping, then crash and pass out for a few days.

Peculiarly, this experience actually *did* result in a meaningful project output. It wasn’t simply a case of me being psychotic and writing confused nonsense. By the time I was hospitalised at the age of 17, I’d single-handedly built an entire playable 3D first person shooter game using an original C++/OpenGL engine. Hell, most professional developers can’t do that.

Towards the end I started getting so sick that I couldn’t even do this. I still had the grandiosity and energy, but had become disorganised to the point where I wasn’t able to be productive.

During that period, I built skills that would contribute to the entire rest of my career so far. So, there was an actual upside.

Thankfully there’s not usually much need to tell people not to do this, because it is not an approach that most people would even want or have an opportunity to take. If you don’t have bipolar disorder, you can’t do this. The caution I would give to someone who *does* have bipolar matters more.

Your illness will naturally push you to pour all of your energy into the things you find rewarding. It was a fluke that mine was aimed at something that actually moved me forwards in life. This story is *not* a reason to dump the treatment, give in to your illness and just go nuts with one thing. Every part of my story would have come out better if I’d had effective treatment earlier.

But it’s worth sharing a story where all that energy was aimed at something that actually turned out to be useful.

Dark and disturbing works

I know a lot of people who have psychiatric problems and are also quite creative.

A lot of them, myself included, have created works which have been quite dark in character. Having gone through the experience of this profound suffering gives you a lot of content and perspective that you can use in your work.

It might surprise some people to learn that these works, no matter how disturbing, are almost invariably created when the person is actually doing very well.

Creative energy is positive energy. Creating something dark and disturbing is still a positive and affirming act, and is generally only possible when you are in a positive mind space to start with.

Periods of severe depression or despair or psychosis or whatever can certainly change your perspective and certainly give you more to work with. Having this breadth of experiences means you’ll have more things you can talk about from your firsthand life history… when you’re better.

These periods of despair are almost always low-productivity. Experiencing and expressing are two different things.

Bipolar - risk and reward

What do you think of when someone says “high-risk, high reward?”

There’s a famous Silicon Valley entrepreneur who started his career as a law student. He made many interesting decisions aside from not attending a single class, like taking $20,000 from his student loans and trading shares with it.

He took high-risk high-growth shares, then borrowed more money with those shares as security, and bought more shares with the borrowed money. This magnified his profits; he repeated the process until rich.

This is not illegal or fraudulent, but that doesn’t make it a good idea. The value of those shares peaked at $12 million, then crashed. He ended up graduating $4 million in debt. His magnification had also magnified his losses to thousands of times his starting capital. Definitely not a good idea.

What would you do if you had graduated with that much debt? How does “...max out your credit card to buy a $25,000 share of a new tech startup” sound? Well, I guess by then he didn’t have much to lose. Luckily for him, that startup turned out to be Twitter. He came out ahead.

I am not, in any sense, suggesting that this person has bipolar disorder. It’s quite likely this man is/was simply a (lucky) idiot. But this story is very relevant to the disease.

People who are manic or hypomanic have an intense orientation towards goal-directed behaviour. The goal in question is not always financial wealth or social status, but it is usually connected to them. They are far more motivated to these ends than a healthy person ever could be, and frequently this motivation hangs around after the episode ends.

Taken along with the excessive overconfidence, this classically manifests as the person taking extremely unwise risks, much as in the story above (albeit usually without the successful Hail Mary at the end).

Personally, I don’t believe that there is any way to temper this risk-taking without actually treating the disease. Until the disease process is halted, the person will continue to believe that the risks of these actions are minimal and the rewards are all that matters. You need to treat it, and you need years to let your thinking come back to normal.

What nobody seems to be discussing is what to do with all that motivation and ambition *after* the person has largely recovered.

Any person who has been (hypo)manic has dreams of greatness burnt into them. It is not something anyone can ever get rid of. But the vision of recovery presented by most treatment teams is one where the patient rejects these dreams as grandiose and unhealthy, and where they set their sights much lower; lower even than their healthy peers.

It shouldn’t come as much of a surprise that they tend to not accept this vision of recovery, but not having been provided with any other possibility, the only other alternative seems to be to quit their treatment entirely. And again, it shouldn't come as much of a surprise that that's exactly what happens in many cases.

It's my belief that no successful treatment for bipolar disorder will ever happen without reconciling that ambition to a person's realistic situation and abilities. Those dreams are what keep patients going, and pushing them to just give them up is not a useful way to get through to the patient.

Businesses and psychiatric disease

A lot of people nurse visions of starting a business. I suspect that among the psychiatrically ill, the proportion is drastically higher.

It's easy to sell the idea that this is because they're feeling grandiose and want to achieve something greater than their wage-earning friends (and nurses, and doctors). It's true that a business does not have a salary cap, and that there is no limit to the amount of income (and power) that the founder can gain.

It's also easy to sell the idea that this is because there is no required qualification. Just about any other job has a barrier to entry, even a low one. Someone who has failed at every stage of their life still has the potential to start a business that can grow large.

You can start from nothing, and shoot for the stars, with a lot of risk. So many people's instinct is likely to be to assume that the sufferer is being grandiose and unrealistic.

This is particularly problematic, because many people with psychiatric conditions have skill sets and talents that are outside what most employers expect. When we should be encouraging people with these diseases to find alternative and unusual ways to contribute to society, we're instead shoving everything they're incapable of doing down their throats.

People with disabilities are absolutely more suited than anyone to unconventional employment. But the one surefire way to guarantee they don't reach that level is to constantly find new ways to threaten them with ruin.

Rocket fuel

Let's talk about rocket fuel.

Over the years there's a bunch of different substances that have been used for it. Nowadays in hobby rocketry they mostly use some chemicals that are fairly stable and not tremendously toxic. They can do this because performance is not the top priority — safety comes first. It's not worth dying over a hobby.

During the initial development of rockets during World War II, they had other priorities. A rocket that could go 20% further was worth developing, even if it meant using some really nasty chemicals, because the people handling them would be trained anyway and this whole war thing was life-or-death to start with.

Hydrazine was one example. If you get it on your skin, it will start corroding that skin. If you inhale its vapour, it'll attack your lungs too. Regardless of how it gets into your system it'll start affecting your nerves, resulting in a range of fun effects like blindness and seizures. If you come into contact with enough of it your organs will start shutting down one by one. In short, you don't want to be near this stuff if you can possibly help it.

But it can get you to the Moon where nothing else will[33].

Psychiatric illness is similarly painful, dangerous and unpleasant to be around. It hurts your relationships, it hurts your health, and it can damage just about any area of your life.

But similarly, it can also give you a near-unlimited pool of drive and inventiveness that crosses the line to obsession.

You don't want to leave rocket fuel just lying around. Dealing with a psychiatric disease means crisis management, it means managing emotional capital, it means working smart-not-hard and acknowledging that the explosive thrust might happen when you're not expecting it. And it also means knowing when to say "I will try again tomorrow."

I really believe that anyone who has to deal with all that just to survive, and who also has the unlimited pool of drive and creativity, has the potential to do things that are utterly impossible to a healthy person. They didn't get to the moon by just spraying fuel everywhere. They got there by channeling it carefully and intelligently, and knowing when to take or not take risks.

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[33] Yes, the rocket that went to the Moon used kerosene, not hydrazine. Please stop ruining my story.

And they did not get there with fuel that burns poorly.

Power and skill

The loud and visible part of the entire civil rights movement and latter spinoffs is the transfer of power.

And in a very straightforward way, all people with psychiatric conditions are personally beholden to that: it was less than a generation ago that deinstitutionalisation began, and before that someone with just about any such diagnosis didn’t have the power to live a life that was in any way free or normal.

Every now and then you see writing that celebrates that members of such a group (or other disadvantaged groups) have gained “power.” “Power” in this context is generally taken to mean social power - the ability to draw upon social resources to actualise your intent.

Few argue everyone should have the same amount of power, and in some ways its allocation is a zero-sum game; ie. where each bit of power one person gains, another person loses.

It’s possible to argue that there’s a natural power gradient, and that the allocation of power should reflect a person’s acts of contributing to society regardless of things like race or gender or disability. Anyone who’s spent much time in environments where meritocracy is fetishised will know how this pans out.

But why do we even care about power?

At its heart, the concept of social power boils down to “my intentions matter more than your intentions, because of my social circumstances,” and *I don’t think that’s something to celebrate*.

I think *skill* is something that should be celebrated.

Skill is your power over the natural world.

You can be granted a better or worse environment in which to develop it, and you can have a better or worse natural aptitude for specific skills.

But all the mentoring in the world will not help you if you aren’t prepared to actually develop the skill. The core of this progression comes from inside you, not from what others give you. This is where you’ll find growth.

I think this skill dynamic matters far more than the constant power struggles in society. Those will never end: as long as there are two people alive in the world at least one of them will try to be in charge.

The rest of society can have fun with its power struggles. I am developing skill.

Concerning The Lunatics Running The Asylum

Terminology of public support

“Welfare” is the US word for income support payments. Its increasing use in the Australian mass media over the last two decades has been used to lift-and-shift the entire American clustering of arguments against it into our discourse. For that reason, I reject its use.

In Australia, we believe in compassion for other people, and we support people who are sick or otherwise unable to find or do work. Income support payments are one means by which we do this.

Doing nothing is difficult

What does a person who is on a disability pension and not engaged in work, study or anything like that spend their time doing?

Nothing?

There was a period of about two years in which I did “nothing”. I’d crapped out of my first degree attempt and hadn’t started my second at that point.

“Nothing” in this case largely meant going to computer game meetups and parties on some weekends, and kinda working on personal programming projects in between. If you picked up that those don’t cover the equivalent of a full-time occupation, you’re right: there were extended periods of trying to muster up the energy to do something productive and invariably failing.

For people who have done day jobs all their adult lives, it’s really easy to imagine someone your age sitting on a beach drinking cocktails all day (*with your money!!!!*) and be appropriately outraged.

Here’s the thing:

Doing nothing is incredibly difficult and depressing.

Even if I had actually been on a beach drinking cocktails, the pleasure in doing that would have worn off quick smart. The truth is that there’s no need to punish the people who are in a situation with no responsibilities because *that situation is already a punishment of its own*.

Even my personal projects, which were always strongly self-driven, suffered enormously from being in this state. It is — in a very literal sense — a situation where you lack agency, simply because having no responsibilities means nothing you do will actually impact your situation. It’s very difficult to pursue your passions in this state.

It is incredibly shocking to me that in our culture, it is implicitly believable that a large chunk of the population, given the slightest opportunity, will become so complacent and lazy that they will just not bother to do anything at all. People seem to strongly argue for this being true based on nothing at all.

Virtually nobody from the poorer classes ever actually has the chance to do this, but it’s repeatedly hammered into us that it’s true anyway. Take it from one of the rare few that actually has had the chance to do it: this is complete bullshit. You will go mad, and surprisingly quickly.

Ironically all the push to get income support recipients to apply for jobs, do nonsense activities, meet up with Job Network Providers and all that crap — is keeping them busy and giving them something to do. It makes being unemployed an occupation that requires effort. A pointless, humiliating one, but one that is *more* sustainable to do long term than actually doing nothing. It gives you something to occupy yourself with.

The greatest incentive to get a job you could ever give an unemployed person is, ironically, exactly what they're asking for: give them enough money that they're able to survive securely, and leave them alone to do whatever they want.

Speaking as someone who has been in that situation, very few people could go a full year without absolutely begging for something challenging to do. They will *want* a job, which is infinitely better than any amount of external pressure. And less people will slip through the cracks to boot.

Even when you have money, not having to work is absolutely not just a big long holiday.

The covenant of deinstitutionalisation

The state I live in was a bit late to the deinstitutionalisation party, with the final wave happening in the late 80s and early 90s.

People of a libertarian inclination are usually inclined to frame the process as one centered around the improvements in treatment. People with psychosis couldn’t function because of their disease, and now we’ve improved antipsychotics to the point where they can. So, as long as these drugs are available, there is no longer a need to lock people up. Give them their drugs and let them do whatever.

The story sounds nice. But that’s not how it played out.

Deinstitutionalisation is really an agreement — a covenant between society and people with severe psychiatric disease:

“We will no longer keep you in institutional care, but instead, we will provide comparable care in the community.”

The total institution, while functioning in some ways as a prison, did at least guarantee a basic standard of living conditions and treatment. When you remove that guarantee, you’re creating a population that is potentially unable to care for itself.

Once they’re free, it’s now possible to make the argument that their situation is their own fault, rather than a consequence of their confinement.

For all the bad things our Federal leadership did in the 90s, they at least understood this: this government expanded the disability support program dramatically to ensure that, in the short term at least, there was not a sudden outflux of severely disabled people who could not afford to fend for themselves.

Similarly, at the time, there were mostly enough resources dedicated to public psychiatric services that it was viable to care for these people when they couldn't afford to pay for them themselves.

This whole state of affairs makes our dominant party's constant attacks on medical and disability funding particularly sinister.

When deinstitutionalisation started, they removed most of the institutional support in a short period, with the promise that they would care for the patients in the community instead. And in the beginning, that's… *mostly*... what happened.

But over the last few decades, our legislature have continually eroded these supports, until now when they've been ground down to almost nothing. We've gone from shock therapy to death by a thousand cuts.

And because of that, they now sell it as a productivity, drug, poverty and crime problem, to be solved with law enforcement and deregulated markets, rather than what it really is: the direct and predictable consequence of our leaders reneging on their deal.

Long-term hospitalisation was abolished with the promise that patients would still be taken care of. That is, increasingly, simply not the case.

Drugs, drips and fountains

Drug abuse and psychiatric illness often go hand in hand. That shouldn't be a very controversial statement. It's usually framed as a coping mechanism - as self-medication. A person is suffering, so they immediately go for the only thing they know that might reduce that suffering.

I think this is more right than it is wrong, but it might be more productive to think of it instead as a *survival* mechanism.

You've gone two and a half days without water. You're severely dehydrated, and your body is beginning to shut down. You need water right now, or you're going to die.

A doctor pops up and say they can provide you with one drop of clean drinking water every 20 minutes. This, they proudly proclaim, is exactly enough to maintain hydration and survival for a healthy person.

You are not a healthy person. You are on the brink of death. You need *lots* of water *right fucking now*. But that fact apparently passes right by the doctor. There is a right amount, and it's the same for everyone. One drop every twenty minutes is the correct amount regardless of circumstances. The textbook says anyone who ever drinks more than that will overhydrate, which is dangerous.

In the distance you see nirvana: a fountain! Endless flowing water. As much as you could ever want.

The fact that there's a small sign saying that this fountain has been known to carry salmonella is probably not the first thing on your mind. Honestly you probably didn't even notice it. You're just glad to have an answer, and to not have to deal with the idiot who will probably kill you of dehydration.

So that's the problem with the psychiatric field's approach to recreational drug use.

You need food and water to live. You need emotional capital to *want* to live. If you don't want to live, no amount of food or water or money or anything else will help you.

You can be severely deficient in emotional capital, just like you can be severely hungry or thirsty, and this is an acutely visceral experience. It is painful. And like being so hungry or thirsty, it compels you to solve it as quickly as possible.

Recreational drugs, in general, do not help you recover from psychiatric illnesses. They're usually likely to cause a net harm. But I think for a lot of people with these diseases, they provide some form of hope: even if the person has never actually taken such a drug, just the knowledge that something merely *exists* that would be 100% guaranteed to cause them some kind of pleasure - this will orient their thinking and goals.

This thinking and these goals will harm them in the long run. But from their perspective, they know that there's a flowing fountain of (slightly poisoned) water at the end of these goals. As far as they are concerned, this is the path to surviving.

Firearms and mental illness

In Australia, like in almost every country, someone who has been diagnosed with a serious psychiatric condition cannot get a gun license. If they get a license and later develop such a condition, they must surrender their firearms. People with these diseases, after all, can go through periods of suicidal or homicidal intent at unexpected times.

This makes absolute perfect sense until you think about the implications this has.

Unlike, say, the US, we don’t have too many gun fans here. So the sample size that I’ve met is fairly small in comparison. But I’ve met and gotten to know a few here and there.

It’s scary enough that this was said at all, but downright terrifying that it was said by *several* of them:

> *“I know something is seriously wrong with me. But if I get help for it they will take away my guns.”*

Our policy regarding mental health and firearms has not only failed to prevent dangerous people obtaining firearms, but it has *actively pushed them away from getting treatment*.

Armed, unstable, and untreated people will go to the ends of the Earth to avoid discussing any mental health or psychiatric problems with a professional as a direct result of a policy that was intended to keep the public safe.

I don’t have an answer to this. You can’t exactly declare that people can own guns as long as they weren’t diagnosed *before* getting a license. But there is a gaping hole in our firearms policy that could very easily result in deaths, and it simply isn’t discussed.

This is not something that can be solved by more “awareness” about mental health, because their fears are entirely accurate: so much as a diagnosis of mild depression (something that just about anyone could receive easily enough if they frame normal experiences in a certain way) is more than enough to have their license lost.

Yes, they “should” do the responsible thing and seek help. But from the perspective of someone who sees owning guns as a way to guarantee their autonomy, it’s a lose-lose proposition: with a gun license, they probably see themselves as having an above-average ability to assert themselves in a conflict. By becoming someone with a psychiatric diagnosis instead, they are likely to believe they’ll become below-average in their ability to assert themselves instead.

This is a hard enough sell even for someone who is thinking straight, let alone someone with an untreated psychiatric disease. Seeking treatment has non-trivial consequences for them, and spreading awareness will just make them more aware of that.

I do not have any idea whatsoever of a way that this could be solved or even improved. It’s a very, very difficult problem. But it seems like it should be worked on, because the stakes are so high.

Insanity defence

If you look through the comments of some of the center-right news outlets on articles for things like shootings, terrorist plots, or whatever, you'll consistently see things like this:

> *"They'll probably just say they're mentally ill and get a slap on the wrist."*

Statements like this break down into two basic assumptions:

1. It is easy to fake mental illness, or to exaggerate mild illness.
2. People who do so are exempt from the criminal justice system.

It might surprise these people, then, to learn that the entire system has been warped and twisted by generations of politicians, journalists and voters who believe these assumptions, and that as a result the opposite is now true.

In fact it is usually fairly straightforward to identify this category of malingerers, and a lot of academic effort has been dedicated to doing so[34].

It is now nearly impossible for a mentally ill person who has *not* been previously diagnosed to use an insanity defence. And even among the people that have been diagnosed, the bar for a

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[34] This kind of thing: https://www.tandfonline.com/doi/abs/10.1207/s15327752jpa5202_13

successful defence is much higher than simply being mentally ill. And even among the people who successfully make this defence, the effect on their freedom is no less substantial than a guilty conviction.

We have *one* forensic psychiatric facility in Victoria: Thomas Embling Hospital. Because of the political unpopularity of the insanity defence, it is very difficult to allocate resources to expanding it. As a result, spaces there are filled as quickly as they are vacated.

The patients who successfully make an insanity defence but don't have a spot? They're in prison, often for months to years. This latency period has been increasing steeply in the last few years, too[35].
It's worth reminding the reader that these are people that were found innocent.

The threshold for a successful insanity defence is that the accused:

- Was too sick to understand what they were doing was wrong; and/or
- Was too sick to be able to control their behaviour or actions.

This is an incredibly high bar. For serious crimes it is unlikely that it would be met by someone who did not have years to

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[35] https://www.forensicare.vic.gov.au/wp-content/uploads/2018/10/FC17-FC-Quality-Account-2018-V11-WEB.pdf

decades of documented psychosis behind them, and even then it wouldn’t be guaranteed.

Also, remember that bias at the start — the bias that the insanity defence is too lenient and too easy to use? The jury has that bias too.

If a person successfully pleads insanity, it means that they were able to overcome all of those layers of bias against the defence and still convince a group of the general population that they didn’t even understand what they were doing was wrong.

That does not happen easily. Successful insanity defences are rare and exceptional. Courts and juries do not hand them out lightly, and the defendant invariably ends up with a large amount of time detained regardless.

In Victoria, Community Treatment Orders are sometimes used as a diversion for minor crimes, and in this case form an alternative that has a much lower burden of proof.

But in general, they can only be used where a Community Correction Order (the usual diversion) would have been used anyway if they didn’t have the psychiatric condition. This is not an insanity defence and shouldn’t be regarded as one; it’s a diversion, but with treatment in the place of community service.

These orders are increasingly being made on people who have not committed any crime at all. While ostensibly it’s to guarantee the person’s safety, nowadays it’s usually more for the patient’s ability to access treatment: CTOs are the only bulletproof way to guarantee a patient will have access to a psychiatrist. It’s a sad indictment of our system when the only way someone can reliably access treatment is through an involuntary court order.

“It scares me how easy welfare is to get.”

There is a sector of society that *wants* to believe that income support payments are too unconditional, too generous, and too easy to get.

I’ve talked with a few people like this. Some are better informed than others, some actually understand the bureaucratic policies and others don’t, and some have actually spent smaller or larger amounts of time on this assistance.

They all have something in common:

> *This belief is constant, regardless of actual policy changes.*

Their opinion is utterly immutable in the face of means and participation tests, in restrictions on the person’s use of the benefit, and proving the circumstances required to access it.

This is a group that spends a lot of time hearing extremely tall tales about how the government will gift things like houses or luxury cars to anyone — usually a Muslim asylum seeker of course — who approaches them with a sob story[36].

And it’s a group that spends a lot *less* time interacting in any meaningful way with the actual people accessing support.

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[36] Seriously. People believe this shit.

It’s not harmless. Much like the insanity defence, the fact that this segment is so large and insistent has continually pushed our social security system to become the opposite. We now have a social security system that increasingly has this bias built into it.

This has a purely pragmatic consequence you need to be aware of.

If you have a psychiatric condition, buying into this crap is overwhelmingly likely to end really, really badly.

All communities have a responsibility to take care of members that are incapacitated through no fault of their own. If their condition improves to the extent that they’re able to operate at the same capacity as anyone else, great.

If not, that’s not their fault, and nobody has a right to give them a hard time. It helps nobody and prevents them putting forward the things they *can* contribute.

If you have a severe psychiatric condition, there is a very high chance you are going to go through substantial amounts of time where you have to depend on public support. If you’re ashamed about this, guess what: that’s just added a large and unnecessary impediment to becoming independent.

Throw away any center-right tabloid newspapers that are around, and never read them again. Say this with me:

You are sick. This is not your fault. You have a right to access support without having to fight for it.

Using it is fair and reasonable, no matter how long you need it.

You deserve to be taken care of, just like anyone else. There is no shame in that. You can only get better in your own time.

The less you let this crap get to you, the sooner you'll be able to move on and be more independent.

The people who think psychiatric sufferers shouldn't receive this support are also nearly universally people who wouldn't hire them in a thousand years. They like the idea of sufferers having jobs, just not at *their* workplace. These peoples' opinions can do absolutely nothing good for you. Ignore them.

Crisis support, CAT teams and liability

Reliably, whenever any talk of self-harm comes up in public media, there will be a disclaimer saying to call a crisis helpline if you are thinking about hurting yourself.

This is first and foremost a typical liability dodge. If everyone does it, and it's the most that can be reasonably done in public media, then nobody can really cause trouble regarding publishing an article about self-harm. They Did The Right Thing.

This occasionally rubs off into informal settings (read: social media), as people seem to have gotten the idea that posting the phone number is a way to advertise that you care and are doing everything you can to help them — without actually having to do anything much.

The problem is: do they know what actually happens if you call one of these numbers?

In general, there are four things that can happen, and they are each approximately[37] separated by an order of magnitude of probability:

- 90% chance: You'll spend an hour or so talking to a sympathetic and reassuring ear, then get some advice on how to get a referral to a psychologist/psychiatrist.
- 9% chance: You'll get a visit from a Crisis Assessment and Treatment (CAT) team, who will hang around for a couple of hours, maybe give you some benzos, and give you the phone number for the nearest psych ward triage just in case. Be advised that calling it is unlikely to achieve anything.
- 0.9% chance: The operator will look up your address from your phone number and send an ambulance and/or the police. You'll spend a night or two in Emergency and then be sent home.
- 0.09% chance: The operator will send ambulance/police to you, you spend a night in Emergency, and get admitted to a public psych ward. You spend days to weeks (couple of months in the extreme case) sedated and then go home, or in rare cases, to a halfway house.

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[37] This is not empirical, just a general guide to what to expect.

The remaining 0.01% was supposed to represent the chance of long-term hospitalisation or other drastic interventions, but nowadays in the public system that's so rare that you won't even find useful statistics on its occurence.

Long-term hospitalisation has become an exceptional tool for singular circumstances, usually because a major PR disaster is imminent, and not something that ever really happens in response to a phone call. In almost all cases the long-term involuntary patients are being cycled out, not in.

The entire crisis support process is largely optimised for people who do not have chronic psychiatric diseases. This is a system to manage risk in people who are basically healthy but have been overwhelmed by something like a breakup or being fired. If it can stop them doing something stupid over that, well, great.

This is a mental health service for people who have *mental health* problems. Any of these four outcomes has a fair chance of being unhelpful for people with *psychiatric* problems.

What's particularly sinister about this is the fact that crisis support is usually a regulated service. Providing it is a legal nightmare and the danger of liability means that it really can't be done usefully at scale outside of this mechanism. Any public-facing form of support basically has to refer anyone who mentions suicide or self harm to a regulated helpline and not touch the case with a 20 foot pole — or end up facing charges.

In short, there is usually a formal legal impediment to providing useful crisis support to *the group that is actually the most likely to seriously harm themselves*.

Suicide is particularly touchy because of the severe impact it has on the surviving friends and family close to them. I feel like that impact has eclipsed creating a crisis support system that actually works in the cases where it is most likely to happen.

Taking suicide more seriously does not mean freaking the hell out every time there's a hint of it. It means not only making useful treatment more accessible, but also not giving them a reason to consider it in the first place.

Services and charities always present a completely different face to the people giving them money versus anyone who actually comes to them for help, but the problem is particularly acute when the people asking for help are in an unpopular and powerless demographic.

People in a crisis can't vote with their wallets. If you *do* have that luxury, it's worth doing your homework on how the organisations you're supporting actually treat the people who seek help.

My personal story

This story might actually be particularly useful to sufferers and carers themselves. This is what the recovery process looked like for me, and seeing echoes of this in your own stories might be instructive.

The first signs of disease

I had a trouble socialising with my peers when I was very young, but at the time this didn’t seem severe enough to warrant professional intervention. As far as the teachers were concerned, I was the model student: I absorbed everything they said and did everything they asked perfectly.

The fact that I did it without looking anyone in the eye or meaningfully engaging with my peers didn’t set off any alarm bells at that stage. Later I’d receive a diagnosis of Asperger’s (and bipolar, and eventually panic and agoraphobia), but apparently, I was functioning well enough that none of the adults really considered that there might be a problem.

Primary school was interesting, with highlights including a complete nose reconstruction after taking a wooden bat to the face, but outside the scope of what we’re discussing.

High school was where things became acutely problematic.

Initially I had trouble attending due to anxiety, and started having what I later learned were called panic attacks. This was a problem, but it was rapidly eclipsed by a much bigger one.

By the time I'd reached my second year of high school (year 8) my thinking started to become disordered. I started to have trouble sleeping, became extremely irritable, started coming up with weird beliefs, and basically stopped interacting with my peers altogether. This was my first taste of bipolar, it would only get worse from there.

At this point I was still able to pass for okay to most adults. Surprisingly, it was my peers that noticed something was wrong, and the only thing they really knew how to do was to avoid me.

I was pretty unhappy at my local high school by then, and I had a friend who had applied for an elite selective-entry public school in the city. I thought, hell, I should give it a shot. Maybe the demographics there will be better. So I applied too.

What deterioration looks like

I passed the test for the elite high school by a fair margin. Great.

The problem was, by the time I reached year 9, I was starting to get *really* sick.

In terms of memories, ages 15 through 17 inclusive for me are a giant mess. My thinking was so disordered that it's difficult to piece together exactly how things happened. But I'll try my best.

Those ages happen to be really critical for personal development. These are the ages where teenagers get through adolescence and become adults. I did not get to do this at the time. Instead I had to deal with something that would overwhelm most adults, let alone a teenager.

By the age of 15, my body had pretty much completely stopped trying to regulate any kind of rhythms. It wouldn’t provide cues for things like sleeping or eating, and in any case, I had no interest at all in these things. I would pretty much just stay up for days at a time working on projects until I basically passed out from exhaustion.

My thinking had almost entirely broken down into incoherence, and there wasn’t much functioning I was able to do at this point. Even self-care was largely impossible.

This process is acutely physical and has no connection whatsoever to your psychological thought processes. For all the blurred lines between psychology and psychiatry, mania really is a neurological/chemical disorder; acts which would have been considered superhuman feats of determination among healthy people became acts which I was simply compelled to do and could not resist.

These feats were almost effortless, in a weird way. They kind of happened whether I wanted them to or not. But equally “effortless” were the obsessive ruminations and bizarre thought processes.

The dysphoria grew more and more as this was happening. The longer I went untreated, the worse it got: by the time I was 17 it was pretty much continuous, unbearable torture.

A relative of mine had recently been diagnosed with bipolar disorder, so thankfully I was pointed straight towards a free clinic for adolescents.

Early Intervention

The clinic I went to (PACE) happened to be a world-leading pilot for the early intervention model. So far I'd only had some SSRIs for depression-anxiety, and they recognised that something was wrong.

After playing with a few different antidepressants, I told them the whole story and just outright said that I think my highs are too high. They took me at my word and prescribed a mood stabiliser. Sodium valproate.

So yes, this particular drug was no good for me. My anxiety was still out of control, my thinking was still skewed, and now instead of being uncontrollably overactive I felt extremely sick and exhausted. That led to the suicide attempt previously mentioned.

By this point I was not really capable of taking care of myself in any meaningful way, let alone attending school. It took a large amount of care simply to keep me alive, and things were looking pretty bleak.

Turning around

At the age of 17 I was hospitalised at Orygen, as previously discussed, and while I was there happened upon the exact combination of drugs that largely resolved my disease.

The experience of going from outright psychosis to being basically lucid in the space of a week would look incredibly intense to an outsider. It's a mindfuck of the highest order that is possible. But I *did not care*, because the suffering had stopped.

I improved to the point where I was able to pick up a TAFE (trade school) IT certificate course. I'd pretty much written off high school by this point, which turned out to be exactly the right move.

The next year and a half that I spent doing TAFE were some of the best of my life, and I made friends that I keep to this day. This was before TAFE got trashed, so the standard of education was actually good.

Myself and two friends formed a bit of a clique that wreaked a bit of mischief here and there[38], but somehow managed to complete our courses without getting kicked out.

Through these people I got involved with various computer-related clubs and ended up having a pretty great social life.

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[38] We found a way to remotely reprogram all the printers to display the text "INSERT COIN TO CONTINUE" despite not having a coin slot. We also figured out a way to make the teacher's projector display flip upside-down halfway through each class.

Early degree attempts

I started a computer science degree. This meant going into the city, which meant being in spaces (trains, lecture theatres, etc) I couldn’t easily leave with large numbers of people.

Those panic attacks that hadn’t been a problem for a while? Yeah, they started being a problem again.

I was able to get through two units (albeit I was able to get a perfect score on one of them) before I crapped out again and had to quit. Fuck crowds.

The next two years, as previously mentioned, were a depressing mashup of various failed attempts to start degrees remotely and long periods of being unable to get myself to do anything at all. If I’d been forced to look for work in order to survive, I wouldn’t have been able to.

An unusual approach to rehabilitation

The next thing I did was slight lateral thinking, but it paid off. I ended up enrolling in an audio production degree. You can study part-time on disability, which is probably better for someone recovering anyway.

It’s an expensive degree, and doesn’t demonstrate to most employers that you actually have skills they need. But, critically, it has very small class sizes, has a large latitude for creativity, and is low stress.

In short, the role of this degree was not to teach me marketable skills. The role of this degree was to rehabilitate me.

Not that I wasn’t interested in audio. I’d been doing music production for fun for some time, and was keen to learn more about the technology and theory. But the most important thing that came out of it was not that: it was rebuilding the confidence and social skills needed to work together with others.

Ironically, it was a much better way to do that than a computer science degree ever could have been.

I had a bit of a pet project: every time they introduced a new piece of audio technology, I would challenge myself to try and write it in software, and I ended up finishing my degree with an entire software mixer that was used by some of the game development students. It was also fun to interface my code with the school gear.

This was around the time I moved out of my parents’ house for the first time, into a nearby rental owned by the parents of a good friend. Which surprisingly wasn’t a problem at all.

This was also around the time I met my girlfriend, at a LAN, by crashing her computer with a poorly written piece of software I’d written that was being shared around[39].

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[39] It was in fact a cascading collapse and caused several dozen computers to fall over all at once.

Then, Tony Abbott

Towards the end of my degree we had a change of government. We changed from a progressive centre-left government to one led by a man that was about as hard-right as could possibly be accepted from an Australian prime minister.

Abbott attacked the disability pension as much as he was able.

His party did not have a majority in the Senate, so they couldn’t actually pass legislation, but they did repeatedly use any by-law they could to make life harder for people who were disabled. He aggressively pushed the “mutual obligations” and “programs of support” along with “rolling reviews” from government-approved doctors to make it nearly impossible to get or stay on it[40].

He repeatedly announced that he was “cracking down” on people with disabilities, and that they should not expect to have payments for much longer.

This did not motivate me to do something with myself. I was already doing something with myself. Instead, this caused me to have an outright breakdown.

The panic and agoraphobia that had been mostly dormant became orders of magnitude worse, and because of this bullshit

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[40] He also put limitations on the amount of time disability exemptions could be used for unemployment payments, meaning that people trying to get on disability would be forced to try and do things they’re not able to do, then be told they’re not disabled because they tried.

I felt so forced to beat it and become more functional that I became completely disabled.

It is ironic, because someone who really was able to work would probably be quite complacent and relaxed about it.

It is also ironic that if these attacks on disability support had never happened, I would have entered the workforce a couple of years earlier and been much less disabled when I did.

But the person that legitimately did struggle with their health and was doing their best despite that got struck down by it.

The more you fight panic, the worse it gets. I was fighting so hard that I became unable to get to the letterbox out the front of the house on my own without being overwhelmed by panic.

Around now, I was probably the closest to suicide that I'd been since that failed attempt. I could not see a way forwards or out, and as far as I could tell this would just keep getting worse.

My psychiatrist was acutely concerned, but had limited options to help. He'd hinted that if I didn't improve, temporary institutional care might be necessary.

I told him that this was not going to happen[41].

I was going to find my own solutions.

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[41] Those are not the words I actually used, but I don't think I'd be allowed to publish those.

I somehow managed to scrape through the last two units of my degree, by negotiating with the institute and occasionally being driven in when my presence was absolutely necessary.

Things got better, but in a weird sequence.

Meeting standards of functioning

My now-fiancee and I got married, and we were somehow able to orchestrate a wedding where the groom was basically unable to go outside except under very specific conditions. It was kind of a miracle of logistics that we pulled it off at all.

Having finished my degree, I managed to pick up some work-from-home contract jobs. It is incredibly difficult to find this type of work, but having built a high level of skill as a software developer, I was in the fortunate position of being in one of the very few well-paid professions which is both talent-starved and remote-capable.

It was still very difficult to land them, but I got through those critical few years this way. The overwhelming majority of people in similar situations would not have that chance.

This loosened the noose greatly, as knowing that there is *some* way I can survive without having to actually leave the house makes life much more tolerable.

It was around then that I found a medication that actually could reduce the panic, and my comfortable range improved to the point where I was able to start applying for actual, in-person full time jobs (albeit by taking a private driver to them, but whatever). And what do you know, I got one. I’ve been at it for over a year now.

There’s still a lot of everyday stuff I can’t do, but in just about every measure that matters, I (and my wife) are doing better than most people we know. It is possible to make it.

I have no doubt I (or we) will crash again. These things come in cycles. But every cycle, I’ve moved forwards and gained functioning overall.

I like to believe I’ve hit bedrock, and that my body and brain have run out of problems to throw at me. That may well be wrong, but at the very least, having gotten on top of four major illnesses so far, I’m in a good position to handle yet another new problem.

But… nobody should have to go through this.

Takeaways

For sufferers

These diseases are singularly terrible and harm your ability to use the very resources you solve problems with. But they can get better eventually — with time, patience and effort.

Your suffering is real. If you're mistreated, you have a right to be outraged just like anyone else. And you have a right to stand up for yourself just like anyone else.

Learning to believe your own experiences, despite a system built around institutional gaslighting, is a precondition to receiving meaningful treatment.

If your treatment is consistently making you feel worse, not better, you should not just accept it. You should negotiate, and make your case heard with your treating team. If they're not listening, they're not really treating you, are they?

It's healthy and appropriate to have ambitions — or to not. You can actually aim to achieve the things that matter to you, if you have such things. It's also healthy to ask for support when you can't.

The support you ask for, or the goals you do or don't set, are nobody's business but yours. Nobody has a right to hold you to an arbitrary standard of functioning, and nobody has a right to punish you for not meeting it.

You have the right to try and reach any goal anyone else can. Those are *your* goals, and not anybody else's.

For carers

To carers, I’ve basically just said “...unconditional patience and acceptance” in several dozen ways.

That is the core of what is needed: if the person you’re caring for understands that you’ll accept that they move forward when *they’re* ready, and that you really will accept them and support them no matter how long it takes, then you’re doing everything you can.

You must eliminate the concept of “tough love” and realise that if your loved one asks for concessions; they are often not simply an indulgence but a structural component of their recovery.

At some level, they know what they need to recover, and both of you learning to listen to this is a critical part of the process. But you need the foundation of acceptance and patience to hear it.

Over time they can build autonomy, judgement and dignity on top of it. Their success in doing this will be directly proportionate to how resolute and unyielding the foundation is.

For the general population

Among people who do not have much direct contact with psychiatric illness, I’m hoping I’ve given you a glimpse into its world, and some firsthand insights into things that aren't talked about much in the public discourse.

The most important thing to get across is the notion that these diseases are just that: diseases. Someone who has never had schizophrenia knows as much about the experience of having it as they do any other random disease they've never had.

I'm hoping that having learned a bit more about the experiences of sufferers, this group of readers has grasped the fact that these diseases create processes that have nothing to do with the person's choices or decisions; that it's not simply a case of a normal person choosing to reject reality.

I'm hoping this group understands that these diseases cause a profound and complicated form of disability that does not map in any way to normal human experiences. It is truly an exceptional class of problem, and requires special handling at every level of society. No ideology can ever change that fact.

For psychiatric professionals

For all the rich history behind the "talking cure", talking the talk is not enough. You need to walk the walk too.

All the carefully chosen words in the world will not improve someone's situation if you aren't genuinely willing to go above and beyond to help them.

You reap what you sow, not what you say.

An easy litmus test

The next time you're not sure whether something is reasonable or unreasonable with regards to how a person with psychiatric disease is treated, ask this simple question:

If this person was a young person whose only health problem was cancer, and they were treated in the same way, would it cause a giant media frenzy and end a dozen careers?

It's become acceptable even among medical practitioners to use the category of disease a person has to justify doing profoundly screwed up things to them that will permanently harm their health.

It is a disease*. They need to be treated with the same respect you'd give anyone else who has a disease that causes suffering. One that makes them particularly vulnerable at that.*

For everyone

Psychiatric diseases are a special case and require special handling. But this handling is part of a bigger underlying message: that our collective quality of life is a function of how kind, forgiving and accepting we can be.

Ultimately, I believe that's the core message of all the major political, religious and social movements, but we still see those movements used primarily as tools of abuse against one another. People sure do like coming up with excuses to treat each other badly.

At its core, the main reason our system fails people with psychiatric diseases is because of a lack of these traits being ingrained at a structural level. When the people that make up this system put energy into upholding kindness, forgiveness and acceptance, they're ground and broken down until they're unable to function as part of it.

They end up invalidating suffering, stripping autonomy, and suppressing recovery, not out of malice or ignorance, but because out of a lack of resources and executive foresight.

We end up with a system built on skepticism, doubt and exclusion by default, with gatekeepers allowing only a minority access to the basic supports they need to survive and function, and many receiving nothing at all.

Our mental health systems are truly insane, at a scale no psychiatric disease could ever hope to approximate.

Epilogue

Let's go back to when I was acutely sick. So sick that I wasn't even able to substantially take care of myself, let alone attend school. I was going days at a time without sleeping or eating.

Things were bad. Really bad. I was past even suicide being a meaningful option; my thinking was profoundly disorganised and the suffering was intense and constant. Every minute I was alive was painful, and this pain was so bad that I couldn't even act coherently. There was no end in sight.

After I crashed and the chaos subsided a little, my mother would go for a drive with me. We’d go through the KFC drive-through and I’d get a wrap. If this had been a reward, it wouldn’t have been for going off the deep end — it would have been for coming out of it alive. We’d go through the automated car wash.

First, it’d spray the car with soap foam, and rollers would scrub it into the car. Then it’d wash it all off with water. The water was a bit like rain on the windshield, and the sound was relaxing. The process would repeat, then it would cover the car in brightly coloured rainbow splotches of wax before washing it off one more time. Then it would spray the underside of the car with jets of water.

Most of the time, I was half asleep and delirious. Finally, being able to rest and eat, having a relaxing sensory experience, I had a little emotional breathing room.

It’s a completely silly thing, but these were among the few times I felt like I might be able to get through it eventually. There are a large number of people who don’t, which makes me doubly grateful for the fact that I was one of the lucky few who came out the other side.

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