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Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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Resolving mental illness stigma: should we seek recovery and equity instead of normalcy or solidarity?

I am grateful that the editorial by Professor Corrigan[1] has raised highly important issues regarding discrimination against people with experience of mental illness like myself. I hope that I will be able to enhance this by adding a slightly different perspective on the problem, based on my own experience of stigma. In short, I would like to suggest that the concepts of 'solidarity' and 'normalcy' are not the most effective and appropriate ways to address the problem of discrimination.

From my point of view, the concept of 'normalcy' in approaching mental illness is very vague and does not reflect the real state of affairs. First, since there is a broad continuum between mental health and mental illness, the heuristic boundaries between normality and abnormality are very unclear and difficult to address with anti-stigma interventions. Second, seeing mental illness as like any other illnesses was described as one of the 'lost paradigms' of anti-stigma interventions.[2] Indeed, the public is deeply aware that mental illnesses are not like any other and is not prepared to see them as a part of 'normal' experience, and therefore will hardly be able to accept us as the same.

The concept of 'solidarity' in tackling stigma is also controversial. Self-identification with mental illness (and with a group of people with mental illnesses) is a difficult endeavour, requiring a long journey through the personal narrative of illness[3] which may easily lead to depression in some circumstances.[4] The positive effect of identification with a group presented in the editorial by Corrigan is hardly applicable to mental health-related stigma: African–Americans and women are African–Americans and women throughout their whole lives. On the contrary, mental illness is not a lifelong disability, as 'normal' people often see it.[5] Mental illness often occurs only at a certain point in a person's life, and it can be coped with through recovery. Efforts can be directed towards obtaining quality of life equal to that of the rest of society, including a happy family life instead of isolation, properly paid work instead of social benefits, and enjoying comfortable accommodation instead of sheltered housing. Besides identifying with mental illness and searching for solidarity, it is crucial for people with mental illnesses to be able to identify themselves with mainstream society and to feel eligible for the same life opportunities.

Based on the aforementioned considerations, instead of searching for a better category (of 'normalcy' or 'solidarity') in approaching people with mental illnesses, I would rather welcome those initiatives focused on acceptance and equity that were absolutely necessary to me in breaking down my self-stigma and coming back to society. Fighting structural discrimination and searching for better access to life chances and equal opportunities, provision of appropriate patient-centred care and focus on full recovery would probably be more beneficial in terms of demonstrating the equity of people with mental illnesses and promoting their acceptance by other members of society.

1 Corrigan PW. Resolving mental illness stigma: should we seek normalcy or solidarity? *Br J Psychiatry* 2016; **208**: 314–5.

2 Stuart H, Arboleda-Florez J, Sartorius N. *Paradigms Lost: Fighting Stigma and the Lessons Learned*. Oxford University Press, 2012.

3 Lysaker PH, Clements CA, Plascak-Hallberg CD, Knipscheer SJ, Wright DE. Insight and personal narratives of illness in schizophrenia. *Psychiatry* 2002; **65**: 197–206.

4 Krupchanka D, Katliar M. The role of insight in moderating the association between depressive symptoms in people with schizophrenia and stigma among their nearest relatives: a pilot study. *Schizophr Bull* 2016; **42**: 600–7.

5 Schulze B, Angermeyer MC. Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. *Soc Sci Med* 2003; **56**: 299–312.

Dana Chrtkova, Junior Researcher, Department of Social Psychiatry, National Institute of Mental Health. Email: Dana.Chrtkova@nudz.cz

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Author's reply: Thanks to Dr Chrtkova for an insightful letter about my editorial contrasting normalcy versus solidarity messages in order to change stigma.[1] In my editorial, I recommended replacing messages meant to erase the public stigma of mental illness based on normalcy ('People with mental illness are just like me') with messages of solidarity ('I stand with you where you are at'). Chrtkova and I disagreed with the notion of identity as it applied to this distinction. She said that group identity does not fit well with mental illness, at least not compared to lifelong conditions such as being female or African–American. I believe that identities come from significant life experiences as well as genetic endowment. I viewed myself as a dad when my son was born, and as a psychologist when I earned a doctorate. Some may argue that a person need not identify as 'mentally ill' throughout life, because recovery is a reality in which mental illness might be left behind. I agree; this is a reality for some. But for others, the experience of mental illness – its symptoms and challenges – and/or the experience of mental health treatments, marks them. This mark is not always negative; people marvel at their journey, recovery and achievements, often embracing their mental health identity with pride.[2]

Consider an analogy with the gay community I have made elsewhere.[3,4] Stigma and discrimination against lesbian, gay, bisexual and transgender (LGBT) people has greatly decreased over the past 50 years in the Western world. Not so long ago, a gay man trying to escape stigma might have said, 'I am just like straight people': a variation of normalcy. At its most extreme, this might mean the person passing for straight, thinking he escapes homophobia as others do not know he is gay. Nowadays, this is likely to be viewed as a problematic message. 'Passing' implies ideas of keeping one's sexual orientation hidden. Instead, gay pride celebrates a message of who one is. In this celebration, members of the LGBT community expect others to join with them in solidarity.

Dr Chrtkova has lived experience of mental illness and talks about 'breaking down my self-stigma'. I thank her for the courage of her message; we share a fundamental perspective for understanding stigma. I have come to identify as a person with mental illness after 40 years of diagnoses, medications,

hospitalisation and recovery. Somewhere in the journey, I realised that I am a person with mental illness – that it is as much a part of my identity as fatherhood or professionalism. I am proud of all of these identities. I do not want to have to keep any of them a secret by passing as normal. Instead, I expect others to join me where I stand.

1 Corrigan PW. Resolving mental illness stigma: should we seek normalcy or solidarity? *Br J Psychiatry* 2016; **208**: 314–5.

2 Corrigan PW, Kosyluk KA, Rusch N. Reducing self-stigma by coming out proud. *Am J Public Health* 2013; **103**: 794–800.

3 Corrigan PW, Larson JE, Hautamaki J, Matthews A, Kuwabara S, Rafacz J, et al. What lessons do coming out as gay men or lesbians have for people stigmatized by mental illness? *Community Ment Health J* 2009; **45**: 366–74.

4 Corrigan PW, Matthews AK. Stigma and disclosure: implications for coming out of the closet. *J Ment Health* 2003; **12**: 235–48.

Patrick W. Corrigan, Illinois Institute of Technology. Email: corrigan@iit.edu

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Stephen Potts' review of *To Fathom Hell or Soar Angelic*

I am saddened to see the wholly negative review of my novel, *To Fathom Hell or Soar Angelic*, in the June 2016 edition of the *British Journal of Psychiatry*.[1] Obviously, I open myself up to opinions and critique when publishing anything – and especially on such a controversial subject as this – so my grievance is not about the reviewer's overall appreciation of the book, which he is obliged to state. Rather, I felt the review published in the journal was markedly unbalanced and unprofessional.

Completely disregarding the fact that the book itself is a work of fiction, and missing entirely the point about my intentional use of character stereotypes to get across the complexities of the subject, the review reads as an unnecessarily personal attack on my approach to psychiatry and medicine itself. I clearly do not hold views of contempt for psychiatry or indeed medicine, as the reviewer suggests. I have been working quite happily and successfully as a mainstream doctor for 20 years using mainstream methods. In stating otherwise, the reviewer betrays himself as irrationally fearful of exploring – or even considering – alternatives to the current medical models. It is extraordinary how a work of fiction could have stimulated such a defensive reply.

The review was riddled with misinterpretations. I object strongly to the reviewer erroneously accusing me of acting irresponsibly, by his cherry-picked and biased reporting of the facts as they appear in the book. The reviewer is forgiven for not understanding the complex pharmacology of psychedelic drugs; those of us in this field have become used to weathering such mistakes made by others regarding the risk–benefit ratio of these substances, albeit such errors are more often heard from the tabloid press than from medical professionals.

As a result of the reviewer's biased approach, he made no attempt to represent the other side of the debate regarding psychedelic drug research; rather, he simply stated his own personal opinions and used the review as platform to make his views heard. He stated his objection to the caricatured description of the novel's protagonist as a stereotypical establishment psychiatrist, yet appeared to miss entirely the balancing descriptions the book offers poking fun at the equally ridiculous drug-addled hippies. I can only assume the reviewer did not even read the book in its entirety.

I have written a number of book reviews myself over the years and I do not always agree with or necessarily like the book I am reviewing. However, I am always vigilant of the necessary guidelines around how to write a balanced review: to avoid being swayed by personal bias, to present the facts clearly and – crucially – to avoid unnecessarily inflammatory remarks. In this respect, I am surprised the review was considered to meet the usual expected standards of the journal.

1 Potts S. Book review: *To Fathom Hell or Soar Angelic*. *Br J Psychiatry* 2016; **208**: 596–7.

Ben Sessa. Email: bensessa@gmail.com

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Author's reply: I know from experience that negative reviews can sting, and it is tempting to lash out and shoot the messenger. I explicitly reviewed Dr Sessa's book as a work of fiction, but he objects most strongly to what he calls 'cherry-picked and biased reporting of the facts'. What should we make of 'facts' voiced by a fictional character? Dr Sessa gives no example, but on page 72, a leading character – presented as a hero – lists psychedelic drugs as 'not just LSD. Also psilocybin, MDMA, ketamine, Ibogaine . . .' and goes on to say that 'they are extremely safe. They are totally physiologically non-toxic'.

If this is a fact, it is simply false: ask any emergency department doctor (or, in the case of ketamine, a urologist). Is it cherry-picking to focus on this? Any balancing statement is deeply buried. Is it irresponsible to make such an unbalanced claim about non-toxicity? In my view, yes – although I am happy to be guided to the contrary by toxicologists. Is it unprofessional to point it out in a review? I'd say it was obligatory.

On page 283, the authorial narrator – not a character – describes an identifiable National Health Service general hospital: 'A more decrepit hell-hole masquerading as a clinical setting is hard to imagine . . . overflowing bags of discarded clinical waste – also known in the profession as patients – wait for collection by absent stoned porters.' I may be biased, having once worked there, but I expect the porters and professional colleagues employed at this hospital today would also see this description as contemptuous.

Dr Sessa stands by his novel. I stand by my review. Presumably, the journal stands by its decision to publish it. Perhaps we should all agree to let readers judge for themselves.

Stephen Potts. Email: stephen.g.potts@btinternet.com

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How much of ketamine's antidepressant response is shared with ethanol?

In the informative review by Schoevers *et al*[1] about ketamine's potency in the management of pain and treatment-resistant depression, the authors perceive a latent risk of ketamine misuse resulting from these treatments and forecast that misuse will become more prominent if ketamine is used broadly in clinical practice. At this juncture, it should be emphasised that acute ethanol shares some pharmacological features with ketamine, all being parts of a cascade that precipitates enhanced synaptogenesis and connectivity in cortico-limbic networks:[2] non-competitive

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