Contents

Navigating Psychopathology

Please note, I have had to include each journal entry as screen grabs as the formatting when uploading to Tabula made the work unreadable. I have included the word count on the right-hand side to ensure that I have kept within the 5000-word limit.

The phenomena of the mind

Week 1

The first part of week 1 was all about the concept of interdisciplinarity: a wonderful idea which witnesses the synergy of academic disciplines to provide a more holistic understanding of the world as we know it. Without going into too much detail, the picture below – I believe – sums up the concept of interdisciplinarity very elegantly. A variety of different-sized elements all entering the same pot in a range of different angles, altogether producing a result that is simply wonderful and well rounded. Although this albeit an odd way to define interdisciplinarity, I see it as an attempt by my conscious self to bridge the gap between my heavily linguistic background and the many other academic paradigms which exist. I enrolled on this module for two reasons: i) I have always been interested in the mind, psychosis and mental health, ii) I saw this module as a challenge for my self-proclaimed stubborn academic nature to relinquish some of those prescriptivist views and realise – much to my amazement – that there is a world beyond an English Language textbook! Must I say, what a cathartic experience it has been so far.

Starting with a pre-lecture activity, we were provided with a series of images and asked to explain our feelings and attitudes surrounding what we believed they stated about mental health, and how we felt about these assumptions. With some discussion from Viv and my peers, I have come to the following agreements:

- mental ill-health is not something you simply do or do not have
- normal is not a sign of positivity
- 'normal' is only at the discretion of the individual in which the label be applied.

The assumption which took the greatest amount of time to process was the notion of normal not being a sign of positivity. Being brought up in the generation in which places social media on a pedestal, I have seen first-hand the correlation between being 'on-trend' and an increase in 'likes', positive comments and popularity on social media. Those three things sound pretty good to me!

Only when I read a piece authored by Rosenhan and Seligman (1989) detailing seven behavioural characteristics in which people could demonstrate to suggest a Failure to Function Adequately (FFA), and therefore abnormality and poor mental health, (unpredictability, maladaptive behaviour, personal distress, irrationality, observer discomfort, violation of moral standards and unconventionality) did I realise that, depending on which discipline you use for assessment, everyone is considered 'abnormal' in one sense, cementing the notion of 'normal' as being wildly unachievable.

Although this may not seem like a drastic step, this has been a pivotal change in the direction of my thoughts surrounding mental ill/health, and I truly do not believe I would have reached this level of perceptual change without the conversations with Viv and my peers. I have already been overwhelmed by my interest in the other academic domains which I am fortunate enough to be able to work with, and I hope this feeling of great interest and enjoyment of the module continues.

Perceiving perceptions and seeing sights

Week 2

What do you see in the picture below? Do you see three infants carrying an abnormally large Coca-cola can with another infant on top? Good. Don't worry, you're not hallucinating! Or, are you?

This week in the materials, our main focus was centred around the idea of hallucinations and ways in which we can identify whether someone is really seeing something or whether it is in fact a hallucination. You may, just like me, believe that if you can see and touch something (direct contact) or hear or smell something (indirect contact) then the thing which is being sensed is actually there in reality (the Common-Sense View). The concept which I struggled with most during this week's content was the idea that just because someone senses something and strongly believes they have sensed it, this does not in fact mean that they have actually sensed it.

Coming from a linguistic discipline, it may be easier for me to normalise myself with the use of metaphors and other forms of figurative language, whereby people are using concrete concepts to explain abstract ideals. However, the concept of hallucinations poses difficulty in distinguishing metaphor and 'real life' experiences in literature.

Another significant moment from this week occurred in the Facebook group chat for my group. Within this conversation, my group members and I discussed specifically the Charles Bonnet syndrome, which is a syndrome that can occur the days and weeks during a significant loss of vision. A patient will experience bizarre and compelling hallucinations which, in some cases, are so convincing that it is hard to distinguish between fact and fiction. And, you may be thinking to yourself right now - just like myself at the time - that it would be easy for us, dare I say it 'normal people', to help these patients figure out what is going on in the world around them.

Unsurprisingly, you and many of us would be wrong in that assumption as brain imaging technologies such as FMRI and EEG reveal to us that the same brain cortices activated during a hallucination would be activated when someone is truly sensing something.

This really was the first time that the idea of interdisciplinarity connected with me. Although biological/neurological technologies are extremely useful, when an issue arises which is qualitative in nature and is captured mainly through narrative means, a more social scientific approach is far more suitable in understanding the nature of the issue.

Neuro + Science = Neuroscience

Week 3

This week in navigating psychopathology we were lucky enough to be able to receive a lecture from Dawn. Now you may be asking yourself 'who is Dawn?'. Well, to help me remember who Dawn is I made her name into an anagram: Dat Amazing Woman in Neuroscience. I really wish I was lying about that, but my memory is so awful and that is the only way I will remember the lecture content.

That quite smoothly brings me onto my first point of discussion from this week. After having a brief overview of the basics of the nervous system and the brain, in the seminar we quickly moved on to discuss **neuroplasticity.** From A-Level psychology I originally thought that this wonderful term meant the birth and death of neurons, however it has far more to do with the strength of electrical signal between cells and neurons rather than just the cells in their own individual right. Increasing the **strength of the signal** can make the signal transmission stronger or weaker. Increasing **synchrony** between cells (firing at the same time) in the same network makes a stronger signal that is more likely to be carried to the target region without loss of clarity. So, how does this link in with memory? The picture to the left was taken of me in summer 2019. Can I remember what I was looking at? Of course not. I have not mentally rehearsed the memory, therefore the signal in my brain attached to that memory is not strong enough for me to retrieve the visual input. Following some wider reading later in the week and a fairly mellow group discussion within our Facebook chat, my group and I were able to outline some issues in real life scenarios (especially linked to mental health) where this particular concept in neuroscience can be pivotal in understanding ones mental state and the things they can remember.

The first was posed by a fellow linguist in the group who suggested the idea of 'overthinking' (later forming delusions) which seems to be a symptom in many mental health conditions. They argued that if one is to focus entirely on a thought which is negative in nature (eg. everyone is out to get you (**delusions of prosecution**)) then the signals transmitted through the brain to retrieve other memories will become less rehearsed and will be harder to access as the signal is weak.
Following on from this, a psychologist in our group then explained the importance of Cognitive Behavioural Therapy in dealing with these retrieval failures. CBT (thought to be a working example of neuroplasticity) has a primary goal of changing the direction of cognition in our brains – it challenges our beliefs. Although through prolonged practice this method of psychotherapy can prove to be very useful in reducing the symptoms of mental health problems, neuroplasticity can be extremely detrimental where accurate memory retrieval is vital (eg, eyewitness testimony), especially when the lag time of sensory input (the event) and sensory output (reporting of the event) is extreme.

Ignorer c'est reconnaître

Week 4

This week in navigating psychopathology, we narrowed our focus onto the psychological explanations for mental health problems following on from the neurological perspective offered by Dawn previously. The way in which we chose to navigate this issue was through the controversial topic of shell shock during WW1. The second half of this week's content surrounded Bowlby's attachment theory. Although I also have many comments about this content, I view it as less critical in terms of new knowledge for me, therefore my focus will remain on shell shock.

Mott (1916) played a significant role in enforcing the diathesis-stress model in his approach to explaining shell shock. The diathesis (biological predisposition) which he believed to be an "inborn tendency for neurosis" (p.448), combined with the stressor (environmental influence) which he identified as "active service ... repeated and prolonged exposure to shell fire and projectiles containing high explosives..." demonstrated how a potentially sound individual can develop shell shock.

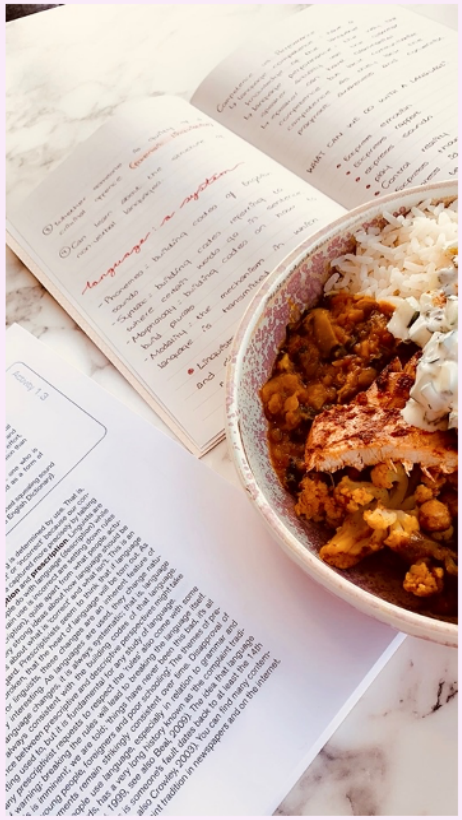
Just two years later in 1918, Rivers used a psychological approach to explaining shell shock in soldiers, demonstrating how the use of repression (actively reducing one's memory recall of a specific event) as a "necessary element in education and all social progress" (p.173), and also as a way of preventing further cases of shell shock.

Much to my delight, we then moved on to look at the poem Dulce et Decorum Est By Wilfred Owen. This poem encompasses a first-person account of Wilfred Owen's experiences in a World War One trench. *Dulce et decorum est pro patria mori (Latin)* means it is sweet and proper to die for one's country. This is particularly relevant as it is clear through the language used by Owen that he believes the contrary to be true. Although many would write this off as simply sarcastic, at the time of production of this poem sarcasm was not as rife as it is in the modern day, so it would be inappropriate to assume this was the desired effect.

If one is to look at this statement from a psychological approach , the title which is then repeated at the end of the poem can be seen as a window into the vast amount of political and societal propaganda in which Wilfred Owen has been subjected to. He has become deluded as a result of the environment he is in and cannot control these strong feelings of patriotism. This poem is clearly antagonistic to Rivers' perspective of dealing with mental health problems. Where Owen is focusing on voicing his experience of shell shock, Rivers sees it as a necessity to remove these memories through repression. However, I am a strong believer in the art of silence, whereby it can often have greater power than words themselves. If society was simply to repress all of its problems, then we are inevitably going to give it more attention later in life when it manifests itself in adult hood. After all, ignorer c'est reconnaitre.

Understanding the unexplainable

Week 5



After the seminar on Tuesday it's fair to say that my brain was in a bit of a pickle... I take that back – not a bit of a pickle, I gave it the nickname 'Branston'. As having no experience in Philosophy prior to the session, I found it difficult to try and visualise the broad meta-concepts of **explaining** and **understanding**, and how they are so interdependent yet so independent at the same time.
You may be wondering what relevance the picture to the left has – this is how I spent the rest of my week after confessing to Viv how utterly confused I was and making myself look like a right fool in front of ten other students; head buried in a textbook and attempting **Jaspers** (2013) for a sixth time.

The first idea I managed to understand (if understanding is in itself possible) is the concept of having to experience an idea or event as an individual to ever reach a level of maximum understanding. Although first troubling for me to understand, I do believe by linking this concept with those suggested by Swiss Psychologist **Jean Piaget** (1896-1980) in the manner that he believed children need to take an active approach in learning to reach a certain 'knowledge equilibrium' ("a state of balance between individuals' mental schemata, or frameworks, and their environment" (Beauchamp (2016)) that this has aided my understanding, not just of this distinction, but of the content in week 2 where we looked into hallucinations.

From time to time I tend to get really bad insomnia: I can go days without sleeping which can, you guessed it, lead to a considerably bad mood and hallucinations. Only by experiencing that one small hallucination that I had was I then able to understand the fear, confusion and helplessness behind them. I believe this is me possibly trying to find the silver lining within the insomnia, but by having this experience nevertheless it has armed me with personal experience in which, Jaspers would agree, has aided my understanding of hallucinations.

The content from this week also allowed the other linguist in my group and I to discuss how this relates to our department. Within the study of language there are two opposed ideals: i) **linguistic relativism** (the idea that our language is shaped around the environment we are exposed to), ii) **linguistic determinism** (the idea that our language shapes the way we perceive and view the world and we are unable to think outside of the language we know).

And, again, how does the above link in with understanding and explaining? Well, there is a thought that during **language translation** a significant amount of pragmatic context is removed from language. As a result of this, the explaining of language becomes flawed in terms of all of the connotations which go along with particular words, phrases and sentences, therefore understanding of those words, phrases and the sentence can't ever reach its climax and true understanding from one language to another can't ever be achieved.

Recording mental health...

Week 6

This week's materials bought a sense of anger out of me. Some reasons for this could possibly be:

- The sentence "everyone is mentally ill to some degree" by the director of Donnie Darko
- The fact I have let the above phrase hog my memory for a whole week after reviewing the materials
- The concept of mental health films as a generalism

Let me explain.

"everyone is mentally ill to some degree"

If this sentence is taken at face-value, implying that no one is perfect, then this sentence provides a significant degree of comfort and rapport between the producer of this utterance (Richard Kelly) and the receiver of this utterance (the audience). It allows us to feel a sense of unity in a world of mental health which is often so isolating. I have to take issue with this sentence purely because of its assumption that perfect - in terms of mental health - does exist. In order for someone to be ill, there must be a version of perfect health, which I simply do not believe exists. As this concept of perfect has not been distinguished, I do not believe it is fair to reference it.

Another thought which plays in my mind regarding the sentence is at what point as a society do we change the boundaries of 'normal'. If so many people, for example, have depression in a given society, can it actually be concluded having depression is normal and not having depression is actually abnormal?

Hogging my memory

Although the approach I have taken seems very nitty gritty and reductionist, and although I am very consciously aware of this, I believe the way that I have been taught to look at language is through a very careful lens. Being unable to focus on language in this way can be very debilitating and often leads me to miss out significant details as I'm focusing on the finer things... a bit like this week. This is really something I am trying to tackle throughout this module and is one of the main reasons why I chose to enrol on an interdisciplinary scheme.

Mental health films

As part of the content this week, Viv asked us to watch a film which relates to mental health. Mental health films are a very clever way to provide explanations of mental health problems and truly encourages audience connection with the issue. I understand their role in removing mental health stigma in the 21st century but I find it difficult that years of struggle felt by an individual who has a mental health problem can be shortened effectively into two hours. Although one of the main aims of mental health films is to normalise mental health issues and symptoms in society, the extremifying of symptoms for dramatic effect does the opposite for society. It is for this reason that I chose to listen to other people's reflections rather than make my own.

(p.s. my pets have made an appearance to simply cheer me up)

‘Have some rest, Deer. It will be fine.’

Week 7

I liked this week’s content for many reasons, the main one being set the reading from Charlotte Perkins Gilman. Charlotte was an American author /feminist/activist who wrote ‘The Yellow Wallpaper’ released in 1892. This extraordinary piece of literature was one of the first pieces of feminist workings in America, and the psychological realism / gothic fiction genre as well as being written in the first-person perspective allows us to explore the reality of slipping into psychosis.

I shan't give a chronological recount of the events in the narrative, but I will (attempt to) provide a critical overview of the main issues.

Throughout the narrative we are exposed to Charlotte’s husband, John. She explains how he, as a physician, loves the art of numbers and binarity. In regard to her treatment for depression, John suggests she remains sedentary and emphasises the importance of rest for physical and mental recovery. Despite this going against her own wishes, Charlotte does her up-most to follow his advice but remains secretive about her desire to write and keep a diary of her feelings.

It was clear from the seminar discussion and the extended group reflection in our Facebook chat, as well as some additional exploring I did on Google, that my interpretation was one of many surrounding this publication. One belief that we did all have in common, however, was that this story was a microcosm for society as a whole, where John played a particularly strong role in representing the beliefs of the late 19th century.

The work of Silas Weir Mitchell (the famous American physician and neurologist) was championed by John as he suggested that Charlotte was to enable recovery quickly by embodying Mitchell’s ‘rest culture’. This included complete rest; no stimulation to the mind or body as well as a calorific diet. Personally, I feel like I embodied this swimmingly throughout lockdown. Although at the time the idea of rust culture was the main form of treatment prescribed to patients (derived from other forms of self-help such as Asclepius’ Asclepeion from ancient Greece) the use of such remedies in the modern day are usually accompanied by the use of effective medications and other scientific procedures and are not used in isolation.

At the end of the narrative, we begin to see Charlotte’s significant decline into psychosis - she has freed the ‘woman from the wallpaper’ and begins ‘creeping’ around the house much to her husband’s despair. When her husband discovers this, he ‘faints’ at the feet of his wife to which she ignores and walks over him. Although when I first read this publication I was rather confused at the ending, vigorous discussions surrounding this week’s materials with Viv, my group and the rest of the students in my seminar revealed that this was in fact a larger metaphor demonstrating how dangerous it is to deprive women of their rights.

(my cat who significantly influenced this week’s discussion during my study)

Being the agent of agency

Week 8

In week eight we focussed on why agency and continuity are important and narrative as a diagnostic tool for mental health problems. Although I have already focused on narrative previously in my journals, I believe that my interpretation of the topic has changed and is worth noting.

Agency and continuity

Agency is the amount of control we believe we have over our lives. It is often the case in mental health disorders such as schizophrenia and depression that patients are left with a weak sense of agency. They are said to have an external locus of control and therefore rarely see the value in self endeavour. Alternatively, if someone had an internal locus of control, they are more likely to feel like their actions will influence their future and will be more motivated to engage in longer-term gratifications such as in University.

Continuity can also be seen from two perspectives: at the beginning of the materials, I was in strong belief that people with mental health problems would like to return to their original. However, after much debate between my group and I, I have come to realise that many people with mental health problems would find it detrimental to be called the same person as they were a year ago as it suggests a lack of recovery.

Narrative

Are stories relevant in an evidence-based world? Well, asking a linguist this question is going to yield an inevitable response, however I do see many different constraints and allowances by using stories as a diagnostic tool. Introspection gives us the greatest insight into the mind - conscious or unconscious. However, there is a distinct difference between the mind and the brain; the mind being more of an internal voice and the brain referring to the physical structure where the mind lives.

For mental health problems where there is a chemical imbalance or a biological predisposition, it would be most unreasonable to assume that we can understand the mental health problem and find relevant quarters for it without looking at the physical structure of the brain. Although storeys provide us with qualitative data, it is often quantitative data that allows the most effective treatment to be enforced. I'm running out of words so I will stop here, however I will continue this discussion in my summative assignment.

Hi, I care!

Week 9

Week 9 was one of the most interesting in the module so far. We focussed on criticisms of psychiatry, including key questions such as how do we care for people? Who can care for people? What is care? Below is a short summary of my thoughts, including some critical thoughts and new perspectives.

What is care?
Care is nothing more than a social construct that enables us to feel good about ourselves and others to feel good about themselves. But what form does care come in? I found the answer to this depends greatly on the age of the person who is being asked. For example, when I asked my 6-year-old cousin, care to them was a mix of how many biscuits were in the cupboard and how many sweets they could have during the weekly shop. University students were more likely to answer around the concept of kindness and respect, whereas my father answered diplomatically, focussing on the best for someone, even if it is not what they want in the short term.

Such an idea is particularly relevant when in reference to mental health problems. Patients who suffer with depression may believe the best thing for them is to stay in bed all day and lay quietly. In reality, external influences such as family and friends could look past the mental health condition as they are emotionally distant, so encourage the patient to go outside, eat healthily and seek further guidance.

An interesting seminar discussion which was yielded by this surrounded the role of doctors in caring for their patients. If a person is held against their will as they are believed to be a threat to the community around them, is this still care? Of course it is; there is just a focus on the wider good as the doctor also has a care responsibility for the public and not just the individual. By detaining the patient, it also protects the individual from harming themselves too.

The most pivotal moment for me this week, and a concept which has dramatically changed my perception of psychiatry as a whole, is the assumption that psychiatry is objective and scientific, even though it uses diagnostic techniques such as behavioural observation and introspection. Although fMRI and EEG are used to try and aid diagnosis from a scientific perspective, using these technologies successfully is based on the assumption that all metal health problems can be detected in the brain. This is fundamentally flawed as mental health conditions are as much to do with the environment someone exposes themselves to, as well as a trained cognitive pathway than the blood flow to various brain structures which can very rarely be tested in isolation. I will touch on this in more detail next week, but the highly technical, scientific, objective discipline I thought psychiatry may not be as salient as I first thought...

Psychiatry: subjective objectivity

Week 10

Week 10 saw a more in-depth discussion of the criticisms of psychiatry. One of the most interesting things we discussed this week, from my perspective, was the classification and diagnosis of diseases. Now you may be asking yourself 'why is this a problem when we have references such as the DSM 5 and other useful diagnostic tools? Well, although these diagnostic tools are supposed to provide the diagnostic process with the level of objectivity, their classification of symptoms is lacking in salience.

One example of this can be demonstrated through hearing voices. The DSM 5 may state that a (positive) symptom of schizophrenia is to hear voices and, in an attempt to operationalise this symptom, psychiatrists would need to use their 'common sense' and experience to identify when these voices are acceptable and when they are not acceptable.

If you were sitting in an exam hall, it is very likely that you will talk to yourself in your head. However, if you are walking through town or doing other day-to-day tasks, the chances of hearing voices compared to a person without schizophrenia is a lot lower.

But this generalisation cannot be extrapolated over all cultures, races and ages. The very pinnacle of psychiatric diagnosis (one example being the DSM five, as mentioned earlier) is fundamentally flawed as it attempts to apply a set of governed rules to individuals.

I noted in the seminar and some conversation in the Facebook group chat which followed on from our discussion that quite a few of my group members found trouble in this argument as they believed the role of psychiatry and other social scientific / neurological diagnostic tools were having their relevance downplayed. I do believe that there is a time and a place for such medical focus, however when dealing with mental health problems, it is far more about the individual and less about one rule fits all - something that binary medical diagnostic tools and manuals simply cannot understand.

Moving away from the diagnosis of mental health problems, later on in the seminar we also discussed recovery as a concept. I believe that we are bought up to rationalise recovery as an endpoint - a state to be desired. In reality, I have now adjusted my perception of recovery to include two discrete categories: long term and short-term recovery.

The next analogy came to me in the dream I had following on from this seminar (yes, I had a dream about the seminar).

If a car is to literally be recovered from the side of a motorway, it is out of danger and cannot cause harm to anyone else or itself. But the car still has a problem. It may not be on the motorway anymore, but it still cannot start and still has two flat tyres which can only be fixed over a period of time. But the car's off the motorway, so it's recovered, right? Of course not. And the same applies to mental health. Just because you stopped hearing voices does not mean that you are recovered, and psychiatry cannot always explain this.

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And other acknowledgements

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A special thank you to Vivan who really has made this module as enjoyable as possible. Everything from the layout of the module, to the explanations of the topics were genuinely very interesting and seemed to work very well for me. Again, a big thank you and hopefully we cross paths in the future.