It Is Complicated Episode 15 - Mental Health

Transcript

(Intro music plays)

Josephine: Hello and welcome to It Is Complicated, the podcast where we answer every single question with It Is Complicated, including the title which is It *Is* Complicated. Today's episode is a little bit special and we are going to start with a sort of content notice about some of the thing we are going to be talking about, because we are going to be talking about issues related to mental health and all the things that can go with that which can include issues that are difficult, that can be challenging, that might be upsetting for people. So, we will be including discussions of self-harm, of suicide, of depression and anxiety. Is there anything that I'm missing, Dr J?

Dr J: PTSD

Josephine: PTSD, certainly.

Dr J: Yeah. If you're impacted by anything that you hear here, or you're listening to this and you're like, "this isn't the time for me to listen to" … totally understand. Turn it off and get yourself in a good space to listen to us talk about stuff that is really difficult for both of us to talk about. And, is also going to be really difficult to listen to. This isn't a "in the background while you are driving," kind of episode. This may bring up thoughts and feelings for yourself and if they do, go with them, feel your self-care. And there's also places like Mind, there's people like the Samaritans that you can get in touch with in the UK, and I'm sure there's the same globally – there's The Trevor Project that you can get in touch with in the US, which is an LGBTQ focused mental health support line. So, find those, we'll make sure they're in the description as well.

Josephine: Absolutely.

Dr J: Because we are responsible when we discuss these things, because we don't want to spring this shit on you.

Josephine: Definitely. And we may also speak with a sense of (sigh) humour. And perhaps even very dark humour. Two of the way that Dr J and I (Dr J laughing) discuss these things (Dr J laughing) is yeah… well, there you go.

Dr J: Dark humour. Dark humour, I am dark humour. My dad was dark humour. We basically sat there and built our lives on dark humour.

Josephine: Well, we'll talk about that a bit I'm sure because… one of the ways in which Dr J and I have bonded over the years is through our appreciation of very, very, very dark humour

when it comes to very difficult topics. And I've been a performer and done these topics on stage and I can tell you, I often deal with these things by making them funny. So, we are not making light of anyone, least of all ourselves, and certainly not the very serious conditions which we do take very seriously. So, please keep that in mind as you listen.

Dr J: I was going to say, this is our coping mechanism when that pain gets too much, one of the ways I have learned to cope with it is to laugh at it.

Josephine: With that in mind, welcome to you all, as always, it is an absolute pleasure to have you here. Dr J would you like to introduce yourself?

Dr J: I gave myself the job title, Harbinger of Change, because ThoughtWorks allowed me to do so. I gave myself the gender, transgressive non-binary genderqueer, because the New Zealand government allowed me to do so. I am what happens when you allow queers to self-define. I am also a trouble-maker and a #queernuisance. And to add to this, I have had diagnoses of depression, anxiety and PTSD. When I say I've had those diagnoses, that's perhaps something we could get into as to what it means to have those diagnoses, but I just thought it's good to be clear and upfront as to the bits what I know about. (Both laughing)

Josephine: Okay.

Dr J: The bits what is me.

Josephine: I can probably do something similar. My name is Josephine Baird, I'm an independent scholar, activist and artist. I like to make a spectacle of myself on the stage, and also to draw funny pictures and put them on the Internet. Many of those instances of performance have to do with dealing with trauma, dealing with anxiety, dealing with the absurdities of living in a world that is so against people being different. And I'm different in many ways. In this particular arena, I have a background in psychology – I studied it at university. My first degree is in psychology. I have worked at some point as, weirdly enough, a peer-support worker, I have given training to psychologists and working clinical psychologists. I've also spoken at the British Psychological Society, and lead group therapy sessions. So, in some ways I have that angle. The sort of "behind-the-scenes" therapy and psychology angle. And myself I have also been… depression and anxiety to begin with, but then raging complex PTSD. So, that's my background. And it's hard for me to talk about that, because I don't talk about it very often. So…

Dr J: And that's why I'm hoping this feels like a safe enough space for both of us to talk about these things. I am just off the back of two-and a-bit years of therapy. Possibly when this comes out, I will have had my last session with my therapist and have officially been released into the world as a brand-new being. (Both laughing) That has taken… but that has taken a lot of work. And I kind of almost wanted to start from the start. And explain even what it was like as a teenager, or some of the family stuff that builds up to this, from my perspective. So, my grandmother suffered badly from depression. And had a massive breakdown when my

grandfather died, and ended up in a mental hospital – and when I say mental hospital, we're talking old style institution for multiple years. When I was about eleven, onwards, 'til I was about fourteen – especially in New Zealand you are transitioning from primary to intermediate to secondary schools during those times. So, you are constantly having reinforced social groups and there would be lots of jokes about people being "mad" and being in the mental institution called Kingseat, and that was where my grandmother was. So, kids at school would tease each other about being sent to this place and my grandmother was there so I spent a lot of time hiding that fact from my peers. And it was not something talked about massively with any of our family friends. She recovered from that and she was able to live the next fifteen plus years… I will say quite happily, while being medicated. It was a really important thing to see. So, the other side of the family suffered from anxiety. And I recognise that now looking back, at the time you don't notice, you just see somebody reacting to things. So, both those meant that I grew up in a family and in a space, where mental health was there and wasn't great, but also wasn't talked about. When I did start to go to therapy, my dad's comment to another family member was, "yeah, it's only really people like J who need to go to therapy." It didn't need to happen to any of the men in the family or anything like that, which is a very "of-his-time," "of-his-space." And one of things that I have had to come to terms with is that my grandmother was essentially a third parent for most of my life, while two of my three parents had mental health conditions, they were also cis-, heteronormative-, white people in a system without any other complications really impacting on them. So, there was a lot of stuff that they got a slightly easier level than what I did, perhaps if you think about it that way. So, I can recall about twelve or thirteen, running knives down my arms, and knowing how to kill myself from there. And struggling with that. (exhales) pretty much all the way through until well into my thirties, and even my forties. Just those constant ideas that there was a way of ending the pain that I was in. There was a way of doing it, and if I just did it, this would all stop. Which is really hard. And it's about understanding how much pain you're in, that your peers may not be experiencing. Or that your peers are experiencing in different ways. No-one at school seemed to notice that I would occasionally be incredibly withdrawn and tearful and then I'd be fine, and a couple of weeks later I'd be bouncing back, so it was always described as manic depression. Because you spend so much time masking the depression, you go completely manic until you run out of energy and then you crash. Also, as an aside, I grew up as a teenager in the 80's, I understood nuclear war, I understood what it would mean, I understood that it was imminent, and I understood that I would die at any moment. And that was just rooted inside my dreams, my anxieties – I would wake up screaming, from about ten, eleven; kind of that time when you're not a little kid anymore, you start to be exposed more to the world, you start to try to think more about what's going on. And my fear of nuclear war really never went away until this last breakdown. So, about just over two years ago, I broke completely. I'd been at Thoughtworks for eighteen months, which meant that I hadn't been bullied, so all of the workplace bullying that I'd experienced, that had built up a large amount of PTSD – unrecognised by myself and so many people – suddenly, it was all of these protective things were there and there was nothing to protect me from. So, I was constantly waiting for the foot to fall and just getting more, and more, and more anxious. I literally was psychotic; I could see things falling from the sky. I was so suicidal that going to work was the only thing that stopped me from sitting there obsessing about how to kill myself in a way that

wouldn't upset my partner. And also, how to survive the nuclear bomb that was about to fall. And how I would get myself, my crippled arse, not-very-healthy self, from where I was to where my partner would be. Because those are the two things to think about, obviously. One is how to kill yourself, and the other one is how to survive a nuclear apocalypse. I would wake screaming most nights because I couldn't control the anxiety, I wasn't sleeping. I was eating horrendously, self-harming and trying to kill myself through food. Which is actually a recognised thing and once I recognised what I was doing, it was good… well, it wasn't good, but once you know the coping behaviour, you can start to work with it. And understand why it is there and start to manage it and address the underlying issue so you no longer have that coping behaviour. So, here I am now – an amount of time into 2020 – a lot of it has been spent under lockdown, completely in some kind of isolation fear, in a way that should be inducing in me a massive anxiety breakdown. And I have been mostly fine. I've had one nightmare in about a year. But the way to that has been putting in a lot of work. So, that is my background in a précis – I am not sure how précis that was. Josephine has been nodding at me like a very good therapist. (Josephine laughing) And I don't expect Josephine to have to give exactly the same, because this is all about how much we are willing to share. And how far we are willing to push our boundaries and how safe we feel. I almost have no boundaries, in some ways. (Both laughing)

Josephine: And as your "therapist," I should tell you that that's not a good thing. (Both laughing)

Dr J: Yeah, I don't have boundaries around this information. I will quite happily share pieces of information like this – I do have boundaries and set them quite… quite well at the moment I believe.

Josephine: I agree. I say that as a joke. And I laugh with Dr J about these… and I know we said it at the beginning – we deal with these things with humour – but we have also known each other for fifteen years and perhaps I should have included that in this. Dr J an I will laugh about the most apparently inappropriate things.

Dr J: Also, Josephine has been there, tag-teaming when I have been actively suicidal. Having to sit and almost ensure 24-hour care, of me, because I haven't been in any kind of functioning state to leave alone. We have been around long enough to share these things, but I am now actually feeling guilty that I may not have done the same thing of (Josephine laughing) of Josephine in the same way.

Josephine: That's okay! Oh god. That's not how this kind of thing works. No, but I understand what you're saying. I'm moved that you would feel that, but you show care in other ways. And that's the other thing about mental health that's… as someone who's studied it in an academic sense and a scholarly sense and having to have gone through it personally, is that it's relative. Like all things, mental health is a relative state. It is relative to what you consider normal. The way you have described that before, which I absolutely love, normal for a given value of normal. Right? But the assistance you have shown me, the care you have shown me, is equivalent as far as I'm concerned in magnitude and has meant the world to me, when you have helped me through other situations that may not have been immediately life-threatening, but were as

important to my live*lihood* and my liv*ing* state. You've also been there emotionally when I've had other issues and other times in my life when I have had very difficult concerns. And yes. The genesis of this podcast was in part, after a particularly rough patch for me. There was an incident that occurred that meant that I was particularly sad. That particular incident, I'm not going into detail. Yeah, so, J, in terms of relative assistance and support, I consider you kin, and family. In the most queer and wonderful way. And you have certainly kept me *well*. And I think of wellness that way. A notion of contentment is not the word, and I hear that sometimes, or "equilibrium," maybe? That's also not really something you and I live with (Both laughing) in any real sense. The other thing is of course, I've recently discovered that I'm neuro-atypical. (Both laughing) That means my world is often askew, in some fabulous way, and being queer-folk the way we are, we're often going to have to deal with things that would (sigh) be traumatising on a daily basis. So, we may never live in equilibrium. We may never be able to be content in that way, but a way we can live is in the notion of wellness. And security. And have saf*er* spaces, like the one J and I have created, hopefully, in this podcast but also for ourselves. So that we can sit here during lockdown, in this absolutely unprecedented, bizarre time called 2020, and deal with some of the things that we find particularly difficult, using the skills that we've both learned. And I think that is the difference for you J, when you mentioned that you are currently in a circumstance that weirdly enough, matches up to so many of your apocalyptic fears from the past (Dr J laughing). Right? And now you can cope with it, because you have actually had treatment for that. (Dr J laughing) I heard a good joke about that, I saw somebody wrote right at the beginning of all this, they said on Twitter, is like, "you know, the only people who are really coping with this panic well, are the people who have PTSD. Because they've all been worrying about this happening, so they've all been preparing." (Both laughing) And it's all true, I know what to do in this kind of situation, because I've been worrying about this for years! (Both laughing)

Dr J: And that's the weird thing. We're "preppers" but we're not preppers. We're not the sort of people who've got bunkers and things like that, we're the people who have mentally run through thousands and thousands… I mean, literally I have done *The Good Place* in my mind, on scenarios like this. Nightly. Which is also one of the reasons I love *The Good Place*. And I know Josephine hasn't finished it so we're not going to spoil it yet. But it's like, just running that scenario of, "oh so you've failed this time? Try it again. Change something." And you just constantly do that in your head. In my experience, me being a, "not quite competent," protagonist. (Both laughing)

Josephine: I love that. (Dr J laughing) What I think is so interesting is I have a very similar habit. And you have spoken about super powers that have been created by difficult and challenging circumstances. I believe that is one of the superpowers produced by PTSD, is this ability to very, very quickly predict the future by examining all the possible elements that could come into effect, or all the possible alternatives, all the possible influences. Basically, trying to predict the future through scientific mind… you know, mapping… or thought experiments. And J is nodding (Both laughing) You recognise this right?

Dr J: I'm laughing because I've heard it as sto-chi-atric? (stochastic) I think it is. Because I've done it for share-prices for somebody. And used the past, but I'd not heard it talked about this way, I thought it was a mathematical term. Or a shares-ey, financial, economist term – who are all turning around going, "fuck whatever predictions we came up with, oh my god, throw them out the window, start again."

Josephine: Yeah, they were not prepared (Dr J laughing) whereas you and I are. Because we've been disaster thinking (Both laughing) for so long that we actually know – "No, no, no, this is not a problem, we know how to deal with this, because we've emotionally gone through this process so many times." The problem with this superpower dear listener, however, is that by continually trying to predict the future, your brain is constantly overheating. It's like working at 150%, trying to imagine all the possible outcomes of anything that might happen. And you only need one of them. Or not even that one, because of course, the thing about disaster thinking is you're always looking for the next disaster. Now, predicting what that might be, often is going to be wrong. (Both laughing) Because it is unlikely that the 1200 disastrous notions that you have thought of will happen. But because of some of the ways in which someone who has had that experience, or is in that particular condition, thinks, is that way – to try and look for danger. Because your brain has tuned into that notion to such a degree, you are constantly seeking out potential threats. And weird enough, I think, that partly gives you a superpower and having gone through the process of managing that, and learning the tools with which to cope, has given a secondary element to that, which is a notion of control. Now you can control that superpower. Another superpower for someone who has PTSD, is the ability to disassociate. Which means you can effectively leave your body when something is happening to it that is unpleasant. So, if for example you're at the dentist, and your tooth is getting drilled, and you don't particularly want to feel that, you might "space out," sort of disconnect from your reality. And then when the horribleness is finished you can come back. Wonderful superpower, it's like leaving your body. It's amazing.

Dr J: One of things from mine is a constant flood of cortisol to my body. Which over the years has wreaked all kinds of havoc upon parts of my body. I've got a tendency to put on a nice little belly, simply because my body is just going, "there is something about to happen! Quick, if we're not directly under threat, store it as fat because we're going to need it very soon!" But what it also means is that I feel pain in a slightly different sense, because cortisol allows you to kind of walk around pain a little bit. What it doesn't do is help your body fight inflammation, it doesn't help your body fight infections. And it's kind of coming out of the other side, and going, "okay, how do I find ways to – in the midst of this craziness – take all of the cortisol out of my body and how do I find ways to ensure my body is not producing it." Which is another whole set of skills that may come in useful for other people.

Josephine: The thing about those superpowers, like any superhero story, the problem is they are out of control. Think about the superhero story, any superhero narrative, think of a movie, comic book – the presumption about that narrative might be, person wakes up with superpowers, does amazing thing, end of movie, end of story. Right? That's the sort of narrative.

But it isn't. That's not the narrative. The narrative actually is this, person wakes up with superpowers, cannot control them, often causes significant problems for that particular character, learns to control them, does very spectacular thing, and then goes off to use those superpowers for good. Right? That's the mental health journey. Hypervigilance is a word which means that you are constantly looking out for danger – really useful if there is a danger. Exceptionally useful. Being able to produce cortisol in massive amounts. Really useful. Hyper-healing, very, very useful. Except when you don't want it to do that. Because actually the problem is, is that it has a down side. So, hypervigilance is constant mental effort. And exhaustion. And constantly being in a state of anxiety and fear. Constantly looking for danger. If you are doing it all the time and you can't control it, it will start damaging you. And it will start having a very real physical and mental effect. So, like the superhero story, what you're doing is learning to control it. So, that's the second element, that is the factor of learning these skills or having these tools, so you don't have to do it all the time. But… these things are not broken… in you. They are habits that you formed, consciously or unconsciously, to survive. Your brain has been trying to help you this whole time. Often the narrative with mental health is, "oh, you're broken or there's something wrong with your brain," no, no. Your brain has been trying to *help* you in situations that it knows you are having trouble surviving in. So, it's going to do all these things to try and help you survive. But, of course, unfortunately it can't always predict what's going to be useful or important. So, it's going to do the nth degree. And eventually that may end up causing harm. So, you learn tools, you learn systems, you learn ways of being, to manage that really, really, really good thing you learned to stay alive, and use it only when you need to. That's part of that particular journey, that I know J has gone through and I have too. There's more to it than that. But that's one aspect of it. And sometimes I think that is a really useful way to look at this. That means that, the emotions that were part of that particular state of mind don't rush at me in the way that they used to. They don't just fly at me. However, I will never be entirely free from that experience. And also talking about it as a notion, even abstractly, will bring that emotion up. We've discussed that before in episodes like this. That (sigh) topics are going to bring up emotions, and we refuse to (Both laughing) try and be these objective characters and discuss issues without the emotions that they elicit. That's… that's ludicrous. So, just talking about the subject is going to bring up difficult emotions. And the secondary element of that, is that as queer people – and we talked about this in a special episode – that we're often feeling the (sigh) requirement not to share pain and trauma because we feel that we are under attack. And that our faculties are constantly being measured and taken to be some sort of indication of our mental health. I mean, I'm trans and I'm gay. These are things that not that long ago were considered mental health conditions in themselves. And having additional mental health issues of any kind can even impact one's diagnosis as trans, because trans was also a diagnosis. Only very recently it changed. And that was literally in terms of the ICD-11, happened this year. It was officially changed that gender dysphoria is no longer considered as some sort of pathology. But if you have "another" mental health issue, your classification as trans officially may be impacted. So, we're often in this horrible position of somehow needing to justify our mental health, "we're perfectly fine and we can choose… (intake of breath) … you know… with sound mind and body, that… we're trans or queer. And this constant onslaught? We can defend ourselves. We're robust." So, admitting to any mental health issue in that context can feel

especially vulnerable. And it is also a potential political problem. If one is, say, an activist, or an independent scholar, and someone does a lot of work on this in their area, and yet the notion that I could somehow be trans and gay and queer in this culture, and *not* have raging PTSD (Both laughing) seems entirely unlikely. And so, recently I've come to the conclusion (Josephine laughing) "show me a queer that doesn't have PTSD, and I will be astounded." Because how on earth can you live in this culture and not suffer from trauma and thus suffer from the characteristics of trauma, is astounding. I don't want to go into the specifics, I can probably say without making myself too vulnerable, that some of it most certainly has to do with violence and threat of violence as an adult. Being openly trans and queer does bring that about, and I have certainly had those experiences. But weirdly enough, I was able to cope with them much better than most, because I had had those experiences also earlier in my life. And those are the instances that I won't talk about (sigh) not right now. I may in the future. So, for all those reasons, and more, it's extremely difficult to talk about this topic. It causes genuine pain and consternation, but also a fear of what might come and how I might be judged in future because of it. Because we don't, as a culture, entirely accept mental health issues as a legitimate and perfectly normal response to trauma and therefore accept it like any other ailment. I was told by my partner, when I was worried, and she said, "but if you had a broken leg, would you expect me to have that reaction?" And I said, "no, of course not." She was like, "it's the same thing." And she said, "it's not the same thing, of course," but in terms of her reaction to it and in that sense, I really love her, and you, Dr J, and others, who hold that perspective. And I am well. And I feel in control of those superpowers. Those characteristics. I don't want to call them symptoms, and I certainly don't want to call them problems. I spent too long believing I was somehow broken. That I didn't function properly. That there was something wrong with me. Well, no, there wasn't anything wrong with me. If you look at the factors that lead to certain things, it is a perfectly normal sort of knock-on. All the things you do are a natural consequence of those things happening. So much so, that we can produce a narrative result and say, "if you do this to someone, at a certain age, in a certain way, the likelihood is this." Because of course it is. How can you not be traumatised by living as queer in this culture? By constant messages that you're not valid? By constantly being told that you are somehow misguided, or you *are* having a mental health issue because of your mere identity or being physically attacked or constantly being under assault, emotional, physical sexual? You name it, it happens. And you are constantly afraid of it. Of course, that leads to certain sets of behaviours. Constant vigilance being one of them. You know, forgetting traumas being another. Trying to just survive, a sense of humour! Being another. You're constantly covering this up with humour. And it works, because you're funny, really funny. You're really good at this. "It's why so many of ya are comedians."

Dr J: Yeah. It's what we do.

Josephine: (big sigh) I apologise for the monologue. Much like J, I feel that I'm spilling my guts. But it's that thing of, sometimes it's not easy to begin talking about, so you just start. And what comes out, comes out. And my professional interest in this, is in part because I have been trying to understand it all my life. And trying to understand my own mental processes, because I had known that I was different in some way. All my life. Obviously, I knew that I was trans. I didn't

know I was neuro-atypical. That's new. (Dr J laughing) Yeah, I know! You're laugh (Josephine laughing) because of course you did. Yeah, I'm the last to know. PS I am also the last to know I was trans. Everybody seemed to know before I told them. Really, really annoying. (Both laughing) "We knew!" and I was like, "How did you know?!" "How did we not! Jesus Christ! You've been screaming it at us in every way! For years!" And of course, I didn't know that. Of course, I couldn't cope with that. Because I thought that my history was such as shameful, shameful secret. And of course, it's not.

Dr J: It is probably going to be a set of monologues from each of us. But this is part of the other person giving space, and holding the other person while they're talking. Which has been a lot of what we've been doing when we've been talking to each other. I know that I have a habit of, when I'm getting deep into some of this stuff, I can't meet somebody's eyes, I've got to look off and look away and do things. And that's simply to control what's inside my head a little bit. I have had breakdowns and stuff in workplaces for… well, quite a while. We'll just go for "quite a while." And every single time, until Thoughtworks, the narrative was, "shut up about your mental health. Quick quiet about it, that's private, you've got to be more private about that." So, what that meant was there was a sense of shame around the struggles that I was having about my mental health, there was a sense of, "if only you tried harder to be more normal, then you wouldn't be like this." And that comes all the way through from when I was a kid, even though I have two of my three parents very obviously having mental health challenges to deal with. There was always a narrative that this was something shameful that you couldn't talk about it with anyone. I couldn't tell anyone that I had been attempting suicide, and one of the things that I will say here and I don't know whether my New Zealand crew are listening to this, my whānau. One of the reasons, I am here today is that when I had the worst of my breakdowns, some of my friends literally did not leave me alone and at the time they got me into the mental health system in New Zealand as an out-patient quite quickly, got me on some medication that at least took some of that urgency out of what was going on and gave me space to at least consider. Because one of things that I found was that all I needed was the space from the screaming inside my head to figure out what was causing the pain. For me, the suicidal ideations that drive to make it all stop isn't about a desire to die, it's about a desire to stop the pain. You've got that running on, while you're trying to get through your everyday. That is really, really, really difficult. I look back and think about how I was in New Zealand at various points and I don't know how I made it through. I literally don't know… what kept me not driving into the barrier.

Josephine: I think you do… I think you do. I think you told us… the chosen people in your life. You told them… you told us exactly how did it. You had those chosen people in your life, and you sought out help, and you got it, from them and from the institutional places that you needed it from. You learned about your own impulses – where they came from, and why they exist. You know exactly how you survived. (Dr J laughing) I am completely baffled by human beings. Almost on a daily basis. So, the ways in which I learned about them, was by literally studying them. (Dr J laughing) Going like, "okay, let's figure out what these people keep doing!" It's made me understand that psychology is logical. Almost always. When somebody wears tinfoil hat on their head, and says, "it's to protect me from the alien rays." They're acting logically, if their

assumptions are correct. If you said, “actually, there are aliens in the sky and those aliens project a ray and tinfoil bounces those off,” that person is now acting rationally. The only difference is, the aliens aren’t there. But the behaviour is logical. The same thing happens with self-harm impulses, with suicidal ideation. Self-harm is often misunderstood as self-destruction – doing things that would seem to the outside world to be completely unfathomable, that’s why mental health issues are so scary to people, because they’re so incomprehensible in some regards. They seem so counter-intuitive. (sigh) but living in a world, that is so constantly traumatising, might want to make you feel like exiting the situation. Which is logical. It is a logical extension. If you were in a world that is constantly traumatising you and causing you pain, you want that pain to stop. You don’t want to not live. You don’t want to die. If you were given another option that said, “we can take away that pain *and* you get to live,” you would take it immediately. This is logic. Psychology isn’t mythical, it’s not. You’re predictable. Because you’re logical. And because you’re logical, and predictable, it can be assisted. It can be helped. *Because* you’re logical. *Because* the things that you do, the reactions you have, the coping mechanisms you create in this culture, are predictable. And that’s what’s so upsetting about discrimination and (sigh) oppression. We know what happens when you systematically discriminate against someone and oppress them. *This* is the kind of thing that happens. And yet we still let it happen in our society. We’re okay, in some regards, because if you say to someone, “well, are women treated worse than men generally in this society?” they might say, “yeah, generally, you know, I can predict that.” It’s like, “okay, go do something about it.” “Yeah… no. It can’t be that bad.” And it’s like, (Dr J laughing) “you know causing this behaviour causes this logical outcome, why would you do that to people?!” And you start to realise the phrase “it takes a fool to remain sane,” starts to make much more sense. Because this culture is absolutely… bat shit!

Dr J: Absolutely, and I think you make such a valid point there. If we are examples of what happens when you have people who are systemically discriminated against – what was the word I cam up with the other day, historically-not-included – then you end up with your mental health issues become so much exacerbated.

Josephine: Yeah. And those cycles perpetuate. There’s a thing that happens in LGBTQ politics where… I have often seen this from people who don’t like trans people, for example – they’ll say, “look at the statistics, trans people are statistically much more likely to have mental health issues, that must *mean* being mentally ill is part of being trans.” That is, if you are a philosophy person like me, a post hoc ergo proctor hoc mistake – after, therefore because of – or more specifically, causation is very rarely two things go together. It is often correlation. Correlation in this case might be, you’re trans in a society that doesn’t like trans people very much, which *causes* mental health issues.

Dr J: And it’s one of the things that comes out in research. That the more you affirm young kids’ ideas of gender and sexuality, the more you affirm their self-identity, the more you affirm who they are, the happier they are.

Josephine: Sometimes people sort of laugh at studies that come out that prove the blindingly obvious. Right? And it is sort of like, “you know, the university of obvious things, why on earth are you giving money for that to be figured out?” Well, because some people just don’t seem to f… take the fucking clue. You have to just literally give them a bit of paper that says, “Look! This works!” So yes, there have been several studies that show (sigh) if you recognise a child’s gender, and their name, they are much more likely to not have significant mental health issues that they have concerns or challenges with. That they’re going to be happier. That they’re going to be well. That it’s going to help them. Now, they don’t have to do anything else, this is just… just validating their sense of self. Because of course, it would. Again, it comes back to that notion that psychology is logic. (Sigh) PTSD is a funny thing. “Post-traumatic stress disorder,” I hate the word disorder, it always annoys me. But, let’s just keep it for now. Usually what happens is, a traumatic event happens, you make an association, an anxiety, that goes with it, you can’t process it correctly and you re-live it over and over again. That’s post-traumatic stress disorder. When it was initially discovered, in a study, it was usually related to things that *had been* discrete. As in it had a beginning and an end. Say, for example, a car crash. You were in a car crash, it had a beginning, it had an end, after it had ended, you developed this anxiety reaction that caused a problem to your daily life, and we are now treating that. You were in a war. These things caused prolonged traumatic events, but there was a discrete beginning and there was a discrete end. Living as queer, or different, or being Black, or a person of colour, or being disabled, being different in this culture is a constant trauma. Complex PTSD is a condition that has recently been discovered and is about people who have traumatic events happen in their life constantly. Over, and over, and over, and over again – often very similar, perhaps perpetrated by the same people, abuse for example – over a long period of time. Or constant stress, that never ends. That is the life of anyone who lives in a culture that discriminates against them. You are constantly being traumatised. Therefore, how can you survive this world without developing the coping mechanisms that are characteristics of complex PTSD? I have no idea. One of the coping mechanisms that is very popular for people who have PTSD is over-work. As in, you distract yourself with everything and anything. You cannot abide a quiet moment, because if you stop, you start to remember and you start to think and you start to feel. And because you can’t cope and it’s so overwhelming, you try to fill your day from beginning to end so that you fall asleep exhausted and never have to worry. Culture values that over-work, and it doesn’t value self-care, and it doesn’t value reflection, it doesn’t value, “hey, you’re living in this society in a really traumatic way, maybe you should have some time to deal with that?”

Dr J: I’m lucky because, as a workaholic – because that is one of the side-effects of this, of “you pour yourself into work, you get your validation from work because you can’t get it from the rest of society.” As somebody who naturally… is quite a workaholic… are you okay? I can stop for a minute.

Josephine: (quietly and audibly upset) yeah… it’s fine. It’s good.

Dr J: You sure?

Josephine: Yeah, no, no. Carry on. Just going to cry. Because that's a normal reaction to what you were talking about… this is the thing about what I'm trying to say, and that is what I am trying to normalise… this notion of mental health… is this is a perfectly logical and normal reaction to what's happened.

Dr J: Oh yeah.

Josephine: Trying to stay stoic. Trying to stay, um… (crying) unaffected, is actually really, really damaging. And it's not broken. It's just damaging. Neither of us are broken. We are simply reproducing perfectly normal reactions. So being sad and crying at the moment, because of what you were talking about, empathising with you, (sniffs) and the valuing of ourselves through our work, because we aren't valued by the culture that we live in… is a normal reaction – is to be sad (crying more). And I'm sad. So, please carry on and I'm just going to cry and that's okay.

Dr J: That's okay. I'm just making… I'm just checking in.

Josephine: No, you are a good person.

Dr J: One of the things that I wanted to touch on here – it's come to mind simply because talking about finding that way back – I got to a certain point where I was on my way back, I was starting to come back, and then my ex-partner decided to kill himself. And succeeded. And I add the "and succeeded" because like myself, there had been more than one attempt. At various points. And that was hugely traumatic. For myself, for my partner. For a group of us. And I think that has a big thing to do with queer and mental health and things like that – we unfortunately have too many people who we lose to suicide. And it's huge. And it often impacts us and we don't talk about it. We don't sit down; we don't do those mourning rituals together. And I mean those rituals around grief and despair and reflecting and understanding, because there is a lot of anger, there's a lot of shame, there's a lot of "what if's," there is a lot of, "I should have's," there's so much stuff that comes up when somebody kills themselves. And our community doesn't quite know how to deal with it, despite it's been a constant… I can think of it being a constant thing ever since I came out. That's more than what people outside of our community have to deal with, and yet because we're trying to be stoic, we don't talk about how shit it is to live in this society when you are historically-not-included. How shit it is to be part of this group that is historically isn't included in even discussions about ourselves, even discussions about our own lives.

Josephine: What I was going to say, and I've finished crying now, so that's good, I can probably say this without breaking up as much as I was. What J talked about is really important. The astounding capacity of the human mind to accept things as normal… to accept abuse as love, as normal… to accept discrimination as normal, to accept rampant cultural violence as normal. To accept suicide in our own community as "normal," to accept (sigh) this political imperative to seem stalwart as normal. One of the ways in which you survive trauma, if it's ongoing, is to somehow get your brain to accept that this is normal and okay. Because if you didn't, you wouldn't be able to cope and you would die. Your brain wouldn't be able to cope and it's trying to

save you. So, one of the solutions to that when the normal that you are accepting is unacceptable, is to change what is normal. To change the normal. To change the *normal* response to the normal. To accept that a mental health issue is a *normal* response to *normalised* oppression. Normalised discrimination. Normalised notions that certain people are not included, will lead to a *normal* response, which is a *normal* massive health issue. That comes from massive mental health challenges. That is normal. To grieve in our own community is normal. To insist that the world see this, recognise what *it is doing*, to us, and make *that* normal. For Black Lives Matter to be made normal. For people to be accepted, to be given access to society, should be normal. And then, our mental health issues that are normalised in our community might not be there, in the same way.

Dr J: You've said it all.

Josephine: Thanks. (deep sigh and crying) and I'm sad. But I'm happy. And I'm okay. And it's okay to be sad. (exhales) I'm sad but that's okay. And I am okay… I don't think we can do our usual joke – although maybe we can, to break the tension of our anxiety and sadness, to make ourselves laugh again, because… I'm a silly creature, and I can't help myself, so (Both laughing) that's just how I am so, Dr J what are we going to talk about next week?

Dr J: Should we discuss her? Next week? I'd rather go off and have a wonderful, pleasant life, feeling like I'm included as part of society, thank you very much.

Josephine: And good night.

Dr J: And good night.

(outro music)

Dr J: This was good. Are you okay?

Josephine: No. But that's okay. I'm okay… I'm, I'm normal for a given value of normal. (Both laughing)

Dr J: of normal.

Josephine: Actually, I'm well. How about that? I'm well.

Dr J: So am I.