

MY JOURNEY

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Reflections by Jagiellonian University students and
teachers on mental illness and university education

Kraków 2011

Editors: *Ireneusz Białek, Dr Hubert Kaszyński, Marta Bylica, Dagmara Nowak-Adamczyk, Urszula Szczocarz*

Cover graphic concept: *Przemysław Stachyra*

Drawings: *Lucyna Małgorzata Szk-Ciechacka*

Translation: *Mikołaj Sekrecki, Dagmara Wolska, Agnieszka Ziajka-Matecka*

Proofreading: *Martin Cahn*

Typesetting and formatting: *Marta Bylica*

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As teachers, counsellors and representatives of institutions we must make sure that for students the world is open and we cannot close it. We are responsible for opening up the world; for giving our students opportunities rather than blocking them. In this sense, their freedom lies in our hands. They must take responsibility for it but we have it in our hands. We can make the world broader or narrower. We can even close it off.

Willy Aastrup

Introduction

As Jagiellonian University Vice-rector for Education I often come across the problems encountered by students with various mental-health difficulties. It is typically hard to sense whether, by way of support for a given person, it will be sufficient to help them resolve some University-related problem, or whether maybe they should be referred to a specialist. I am aware that my predecessors in this function faced similar dilemmas.

For some time now, the number of students with mental-health difficulties at our University has been growing and this very publication offers an extensive overview of the problem. Due to this fact, a year into my tenure as Vice-rector, I asked the Head of the Disability Support Service – which reports to me – to submit proposals for solutions. In this way the idea was born to develop an adaptation programme for students with mental-health problems known at the Jagiellonian University as Constellation Leo, aided by a major financial contribution from the European Social Fund. We hope, thanks to this scheme, to learn how many students experience difficulties of a mental health nature, what kind of support they need and what is their academic situation. This knowledge would help plan long-term and effective support for such students. It might be necessary to amend

the existing procedures and rules so that they are more flexible and take into consideration such circumstances.

The broad dissemination of information about the project has met with massive interest amongst the academic community and the media. This is a welcome development as we want to initiate an open discussion concerning mental illness and university study so as to minimise a number of harmful stereotypes about those affected. Such stereotypes make students live closeted lives without help, human or medical, for fear of such disclosure condemning them to exclusion and discrimination. In turn, their unwillingness to seek assistance exacerbates their problems, which may well transform into advanced illnesses making it considerably harder to pursue university study.

It is our intention to break this vicious circle. To make it happen, much courage is needed from the students affected themselves, and from their families, friends and partners. Courage is in equal measure required in order to conduct a debate on the issue in the broadly understood academic community and, above all, to create an open attitude to such debate and the diversity of the problems that we will need to resolve as a result of it. That is however indispensable in order to create a socially responsible University, an academic community where we all feel safer in the knowledge that in extreme situations other members of the community can be counted on.

I do hope that this publication will help us all understand the challenges we face on this path. I thank the Jagiellonian University students and lecturers who have agreed to share their reflections in this book. Having read them, I am even more convinced that the path taken is the right one.

*Professor Andrzej Mania
Jagiellonian University Vice-rector for Education*

The Journey Begins

‘This field of study is not suitable for cripples,’ I once heard an important person at one of the Jagiellonian University’s popular faculties announce. That peculiar diagnosis was expressed back in 1999, when I was just appointed by the Rector and only beginning my work as University Disability Coordinator. I had asked that person to talk to me about a problem a student had. The issue at stake was the replacement of a written examination with an oral one; today the Jagiellonian University disability consultants typically deal with such things by just writing a single letter. I still remember the harsh statement and think that as a disabled person, and also a graduate of our alma mater, I found it very painful to hear. We would now call such an attitude discrimination, and fully open at that, but back then I was rather looking at it as one of the difficulties I was to face working in my post. I also think that undertaking that mission I felt lonely and although I knew that an important social concept was at stake I did not really believe in its success.

I have heard many times that I support special privileges for people who do not really have what it takes to be university students but use their disabilities to ask, via my agency, for various concessions and so make other students feel disadvantaged. It was not of much help to

explain to such interlocutors the meaning of equal opportunities, an idea which involves the university first adapting itself to the needs of persons with various disabilities and only then requiring them to fulfil their duties to the same extent as is required of the other students. The reverse sequence maintains the vicious circle where persons with disabilities shun university study as they do not want be part of an institution which is not sufficiently adapted to accommodate their needs. My assumption was, of course, that some students with disabilities might use their condition to extort disproportionate advantages but this does not mean that one should not strive to offer educational opportunities to those who, whilst having some physical limitations, meet all the qualitative criteria to pursue university study successfully. Incidentally, eliminating various forms of abuse is a matter of the correct balancing of the support system and procedures; besides, the problem does not concern people with disabilities alone.

Let us have a closer look at other attitudes which should also be mentioned here and thanks to which I can now write these words, 'You know, when I was a student I had a blind friend who achieved success in their studies, although that was in the 1950s; I am sure that nowadays things can be organised much more easily; what you are planning is very important and I am going to assist you in your endeavours,' which the then Rector of the Jagiellonian University said some time after installing me as his Disability Coordinator. Soon afterwards one of the university institutes, in defiance of the procedures and previous arrangements, did not agree to extend the time allowed to blind students for taking their entrance tests. The Rector intervened to the benefit of those candidates. I had already heard the well-known slogan 'Nothing about us without us,' which is an inspiration to movements for the participation of people with disabilities in social life, from

my direct superior the Vice-rector for Education at the first meeting when I was presenting the ideas behind the operation of the Disability Support Service to her. And so that is how things really went forward as the range of services that the Disability Support Service offered to students radically expanded. From that time onwards we have managed to change our office into a larger one and created advanced technological support facilities unparalleled in the country. In 2012, we are going to enlarge them much further in a brand new University building called Collegium Paderevianum II, a result of our good co-operation with yet another vice-rector.

One more event has stuck in my mind. One day the Service was visited by a University professor, in no official capacity and with science as his research area. And so I was interested to see the direction our conversation would take. 'I spent ten years in Sweden and I know how important the things you deal with are. I would like to be of assistance', he started off. Several months later, together with a team of his people, we were testing a training programme for academic teachers¹ aimed at improving their disability awareness using very modern training methods, tested on the British market with great success. Now we offer such programmes on a regular basis and we are the only Polish university implementing such courses.

A decade has elapsed since the function of University Disability Coordinator was created. We currently make up a team of more than ten staff members with full technological support facilities and a wide range of specialist services equalling those offered by many excellent European universities. That is because the University authorities have

¹ Training courses for academic teachers enhancing their disability awareness developed as part of the European DARE project (www.DareProject.eu).

been consistent in implementing the policy of equal opportunities and an ever-growing group of keen enthusiasts of the socially responsible University have shown their own determination. Looking back at the past decade I still ask myself about the sources of such bias and stereotypes shown by people who in principle are so well educated. There are probably many answers, but one seems quite vital at the moment: the bias and stereotypes resulted from the fear of the 'Other'. When disability becomes our daily business it ceases to be sensational, something rare, unusual and unknown which must be made familiar. When it turns out that a student with a disability can be educated just the way all the others are, only adopting a methodology or using some specific technologies, the process is not cumbersome any more but becomes a fascinating teaching challenge. The number of students with disabilities is growing as the University is opening up to them. Being different has become daily business, something common, the standard has changed and the vicious circle has been broken.

There are and there always will be problems to be solved, yet the University fully deserves to be called an institution operating in compliance with the very restrictive Article 24 of the United Nations Convention on the Rights of Persons with Disabilities. All that is true, however, for 'traditional' disabilities, if that is the right word to use here. We are facing now yet another great challenge related to various mental-health difficulties, the number of which is growing amongst our students year on year. My current superior Professor Andrzej Mania has decided to embrace this challenge asking me to develop a programme the implementation of which would provide us with answers to at least some questions concerning the reasons why the number of students with mental-health issues is growing so rapidly and would allow us define key action priorities. It would be worthwhile

to answer the question whether daily academic life does not generate a climate that may be conducive to illness, whether the existing procedures are flexible enough to take into account the presence of students with mental-health conditions and facilitate their daily lives at University without necessitating them dropping out. And finally, whether we can offer such students something from us, regardless of where on a daily basis we are in the University structure.

I do hope that this publication offers answers to at least some such questions. It has been compiled for all those who feel that the idea of creating a socially responsible University is close to their hearts: a supportive rather than excluding University, open to the challenges of the contemporary world rather than an ivory tower. With all those, that is the majority of our community, in mind we have created Constellation Leo. It is a programme not only for those who need assistance, but also for those who wish to fight their fear of yet another 'Other', students with mental-health difficulties, learning something more about them and trying to understand them.

We have found a slogan for Constellation Leo, 'Courage Helps'. How true it is can be discovered by reading the essays that make up this publication. Thanks are due to all the students and teachers who have decided to share their experiences here. Each of these stories is a subjective point of view expressed by a given person, his/her world, private emotions, tragedies and reflections. This is the way to appreciate these stories. This means that no-one wants to impose any viewpoint on anyone, just the contrary, but rather to inspire discussions, passing thoughts and reflections. The first such reflections came as we were distributing the mascot accompanying our programme, a cuddly little lion. Many University staff members would smile warmly at it and say: 'what you are doing is very much needed', 'finally a programme

like this, 'are you planning any staff support schemes?' or 'you have come up with something useful yet again.' The lion mascot has played its role well, inducing warm smiles and moments of reflection. The rest depends on the results the programme brings, the decisions and actions taken and possibly the consequences of this very publication. I do believe its potential is strong enough to make us take another step on the way towards being a responsible University.

*Ireneusz Bialek
Chief Coordinator,
Jagiellonian University Disability Support Service*

PART ONE

THE TEACHER'S PATH



Dr Hubert Kaszyński
Institute of Sociology, Jagiellonian University

Prevention in Mental Health

The difficulty in recovering mental health consists primarily in the elimination of the excessive tension that occurs in people as a result of a clash between the natural need to be healthy, which condition – very importantly – it is possible to achieve, and the social process of crystallising disability, which is founded on a lack of knowledge about the illness, stereotypes related to it, prejudice and discrimination. As regards mental health, the process involved in the social creation of disability is very rapid and results in effectively blocking or limiting the chance of returning to the world of healthy people. Disability as a social fact should be understood as the existence of unfavourable conditions in a given environment so that individual activity is restricted. This is related to the contemporary organisation of society which tends to exclude the existing or potential developmental abilities of particular persons, and so excludes them from participating in the mainstream life of society. In other words, this means worse treatment of some people – referred to as ‘others’ or ‘strangers’ – in the areas of professional activity, acquiring education, family life or, in broader terms, in their participation in the daily life of the community.

The opinions expressed by Poles show that such worse treatment also affects people with mental problems. It is a manifestation of a lack

of knowledge related to the words that evoke fear and incomprehension: schizophrenia, psychosis, bulimia or anorexia.

Research conducted by J. Wciórka¹ indicates that public attitudes towards mentally ill persons are characterised by stereotypical and untrue notions, emotions based on fear and constant readiness to avoid any joint action. The research cited shows that 83% of the respondents think that people who are mentally ill experience discrimination as regards their right to work, 67% highlight a lack of respect for their personal dignity, whilst according to 65% unequal treatment is also exercised towards them in the field of education. The attitudes towards persons with mental health conditions are a source of diverse psychological, social, legal and economic barriers which consolidate their disadvantageous position in society. What is of special importance in the process of moulding and maintaining these attitudes is a lack of direct contact with mentally ill people and the belief that illness is something shameful for the patient and his/her family and friends.

The accessibility of higher education for students with mental problems or, put another way, moving towards mental recovery, is also important for the larger group of people coping with other types of disability. My claim is based on the fact that the level of openness towards mental health issues reflects our readiness to accept other ways of experiencing and defining the world, the power of social bonds as well as responsibility for individual human identity. It is also a test of our working methods based on personal sensitivity, on the non-wounding emotionality necessary for the development of each human being. It is worthwhile undertaking the difficult task of reflecting on

¹ See Wciórka B., Wciórka J. (2008) *Osoby chore psychicznie w społeczeństwie. Komunikat z badań [Mentally Ill Persons in Society: A Research Report]*, CBOS (BS/124/2008), Warsaw.

the health status of the student community as this problem is, and will be, present at university and – whether we see it today or try to hide the reality which is not always comfortable – it is and will be part of our academic work².

I also wish to point out the broader context of the issue in question. In Poland, nearly 80% of people with disabilities do not work and more than 95% of those with mental health disabilities suffer from chronic unemployment. This is painful from both the human and purely economic perspectives. We all bear the costs of such an acute case of negligence and we also know that the key determinant of the status quo is the low level of education in the disabled community.

Mental disorders and mental illness

Mental disorders are defined as a special combination of mental and behavioural dysfunctions dependent on biological, mental and social conditions unique for a given person. In diagnostic terms, the traditional division of mental disorders is as follows: psychotic (i.e. states of illness featuring delusions, hallucinations as well as disturbances of consciousness, emotions and mood) and non-psychotic, including neuroses, mental impairment ('intellectual disability'), organic syndromes, profound personality problems, addictions to psychoactive substances and some sexual dysfunctions³.

² In the light of the report entitled *The mental health of students in higher education* ((2006) London: Royal College of Psychiatrists) around 20% of students suffer from broadly understood mental health disorders, mainly phobias, anxieties and neuroses; in recent years, the number of university students with profound mental health difficulties like schizophrenia, depression or eating disorders is growing.

³ See Pużyński S. (1993) 'Zaburzenia psychiczne' [Mental Disorders] in idem (ed.) *Leksykon Psychiatrii*, Warsaw: Państwowy Zakład Wydawnictw Lekarskich.

The most profound mental problem is diagnosed as mental illness (like acute and temporary psychotic disorders, delusional disorders, schizophrenia, schizophrenia-like syndromes, episodes of acute depression, psychotic affective disorders and eating disorders). It is a state where the clear boundary between the real world and a world of delusions and hallucinations is blurred, a state of disintegration of the boundaries of one's own self accompanied by serious emotional disorders. The illness entails a powerful need of withdrawal from the social contacts previously entertained as they become too much of a burden. In isolation, the ill person tries to regain the lost control over his/her life and ineffectively searches for the cause of his/her deep depression or wild mood swings. People who experience mental disorders need treatment suited to their health status as well as appropriate psychotherapeutic and rehabilitative influence. Of particular importance for the recovery of good health are all the stimuli designed to establish various forms of social support in the ill person's residence. Thanks to them and his/her efforts the person taxed by a mental crisis may gradually return to active life; he/she may work, study at university, function well at home, have friends, or – generally speaking – participate in social life with a relatively high sense of security.

In mental healthcare, the social orientation draws on the 'susceptibility to falling ill/social stress' model which prescribes that outbreaks of illness are brought on by the social stress linked with important life events, described by the ill persons as unexpected and unforeseeable situations, which also entail a sense of inability to put them in order or to ascribe to them an adequate meaning and hierarchy of importance. Three basic factors may act as deterrents to illness. First, the ability to cope with the daily problems acquired

prior to the crisis. Second, emotional, informative or financial support provided by the family and other social groups. Thirdly, a friendly environment open to otherness and criticism featuring mutual trust and readiness to co-operate. That is why programmes of support for people with mental problems prominently feature psychoeducation, directly targeting them and those around them: family, friends and other important social circles (like employers, academic teachers and healthcare personnel).

Importance of contact with mentally ill persons

A humanist from Kraków and the author of some classic scientific works on psychiatry Antoni Kępiński has ascribed a special role to the person with mental disorders, that of ‘a patient and a teacher’⁴. He claimed that professionals offering treatment and therapy as well as providing help should be also be able to learn from the ill person about their needs. Following this perspective, the daily practice of a therapeutic ‘meeting and conversation’ is an attempt to understand something more beyond the mental health deficiency, possibly the value of a social bond, a link between strong and weak people, ill people and healthy ones. The therapeutic method developed by Antoni Kępiński has consisted of working on the patient’s intellectual insight into his/her own experience of illness, that is working on learning about the potential causes of his/her health problems and ways of solving them. In his working method, the key role was played by providing the patient with the experience of an emotional bond in their relation with the doctor, as in his view that

⁴ See Kępiński A. (1972) *Schizofrenia [Schizophrenia]*, Warsaw: Państwowy Zakład Wydawnictw Lekarskich.

relation had a positive influence on the way the patient experienced himself/herself and others. The last element of his therapeutic method was having a dialogue with the patient concerning values, the meaning of life and the often painful existentialist search undertaken by them as well as his/her own role as a person with a disability⁵.

Building a relationship with an ill person may be described referring to the claim, commonly made by practitioners, that regardless of how typical the symptoms of an illness may be, an experience of it is always manifested by a specific person and his/her specific social circumstances. In consequence, each time we help an ill person, we can see an exceptional manifestation of the symptoms. Stressing the individual in the patient's experiences, attitudes and abilities is a vital antidote against the tendency, dominant in the medical world, to treat people with the same diagnosis as if they had many more common features. Essentially, any therapeutic and rehabilitative action must be based on the individualisation of the circumstances of each patient, looking for the meanings that the clinical manifestation of the patient's experience has for him/her as well as discovering how such experiences are linked with his/her earlier and present existence in the world.

What matters in treatment is the ability to differentiate between the form and content of a mental disorder. For a psychiatrist, the form – a pattern of behaviour or showing emotions – is of key importance because it leads to a diagnosis. Yet the socially-oriented approach necessitates that attention be paid also, or maybe primarily, to the content of the disorder. The form leads to the diagnosis of an illness and determines a plan for future treatment. The content, in turn, points

⁵ See Kokoszka A. (1999) *Jak pomagał i leczył profesor Antoni Kępiński* [*Professor Antoni Kępiński's Advice and Treatment*], Kraków: Medycyna Praktyczna.

to specific difficulties faced by the ill person, specifies therapeutic priorities important from his/her perspective, contains information on social situations that are particularly difficult and determine the course of the illness or make it more acute, as well as pointing to determinants of recovery. Analysing the content of a mental disorder we learn what meaning it has for a given patient, his/her family and friends. We also learn how they try to explain the loss of good health in the simplest, most straightforward way by referring to what took place in the past. The description of the 'meaning of the illness' usually contains a wealth of information concerning the emotions, conflicts, mysteries and myths accompanying mental disorders. Undoubtedly, some particular circumstances related to the illness have an impact on the patient's participation in his/her own treatment, his/her attitude to the mental crisis and the power of the motivation with which he/she wants to change his/her own situation, that is to progress towards recovery.

In direct therapeutic contact it is important to see that the ill person is trying to control his/her emotions related to the psychotic experiences. He/she is fighting for his/her appearance as a normal person, trying to hide his/her emotions, opinions and ideas from the world fearing that the disclosure would terrify others and lead to social rejection, suffering or punishment. The ill person feels a strong need to 'fence himself/herself off' from other people who might learn about his/her secrets. His/her family and friends may call this state reticence, emotional closure or autism. The efforts put into this specific work on himself/herself in order to protect the self may be so enormous and extremely absorbing that the ill person becomes tense, irritated and, above all, restrained towards others.

Understanding their individual attempts at overcoming the illness-related symptoms is for all of us the precondition for making dialogue with ill persons possible. Dialogue is a fundamental value of good practice, not just in treatment or rehabilitation but also in our daily lives. Importantly, it is precisely the world of values that shapes the social perspective of work with persons with mental illnesses. It can be described taking into account the 'primary ethical principle' based on Immanuel Kant's philosophy and his categorical imperative prescribing that regardless of the circumstances, man is always to be the goal of our endeavours, never a means to that end.

The dialogue which makes it easier to become more familiar with how people who require our help function in social life is no crowning achievement of our professional activity but, on the contrary, rather a starting point for discovering a combination of complex links and broader circumstances of the ill person's presence in the world. Such an assumption entails the duty to have a multi-dimensional perception of the person and his/her problems as well as to look for solutions in all spheres of life, both individual and social. In other words, what is desired is practice focused on seeing more than just a pathology and medical diagnosis. Such practice takes into account the impact that relations with other people, poverty, unemployment, family disintegration, the maze of social law regulations or a poorly developed social support system have on the level of the (dys)functions. After all, it is possible to reach the upper threshold of what can be done to reduce a person's 'deficits', yet maybe something else could still be done in order to reduce his/her potential limitations by changing the external conditions.

Dialogue not only helps us understand our own experiences better but also lets us control them and transform them, thus opening up the possibility of changing one's current situation. This assumption

is the basis of the therapeutic process. Its initial phase, let us call it empowerment, is understood as moulding, in the course of relations with a person seeking help, the foundations for mutual trust and harmony, often called the therapeutic alliance. The consistent application of this approach may result in the needs of the ill person being fulfilled and his/her particular experiences related to coping with illness heard and understood. Ultimately, we can hope that support programmes will be, at least to some modest degree, not only created 'for' but also co-created 'with' their target recipients.

First-hand knowledge as a method of prevention in mental healthcare

According to a report by the World Health Organisation⁶ mental disorders affect 20% of the population and in the European Union alone as much as 27%. What is striking about Poland – against the backdrop of generally favourable changes in people's health status – is a considerable increase in the frequency of hospitalisation and out-patient counselling necessitated by mental disorders, in particular addictions. Prevention in mental healthcare, as well as improving the effectiveness of social campaigns promoting mental health in various social groups, including students at schools of higher education, has the prime role of offering direct contact with people who have overcome profound mental crises. Our attitudes towards ill persons, i.e. stereotype-driven and untrue ideas, fear and constant readiness to avoid joint action, are the key barriers preventing early diagnosis

⁶ See *Green Paper. Improving the mental health of the population: Towards a strategy on mental health for the European Union*, The Commission of the European Communities, Brussels 2005.

of mental disorders. The working method of including persons with mental health problems in educational efforts is based on the commonly accepted working principle of doing 'nothing about us without us'. There is ongoing research⁷ intended to confirm the effectiveness of social education through direct meetings between various social groups and people who are mentally ill and to preside over such meetings. The theoretical foundation was laid by the classic ideas of E. Goffman⁸ who described the destructive and dehumanising impact of stigmatisation, as a result of which people, often unconsciously and unintentionally, condemn 'others' to a life following a negative social scenario. Gradually, in the course of daily interaction, the stigma becomes internalised, driving out and replacing the previous self. Someone who is mentally ill must not just cope with the fact of his/her own illness, frequently dehumanised clinical practice and low social expectations but also with an internalised stigma as there is a serious risk that instead of a person, he/she may become the generalised and unfair image others have of his/her own illness. Such a state, in turn, leaves no part of the human personality healthy, parts which would have aided work towards recovery and the reconstruction of one's life according to one's dreams.

All teaching confined within university walls is not conducive to forming favourable attitudes towards people with mental illness to a degree comparable with teaching combined with the practical experience of meeting such people. Participants in such special

⁷ See Shor R. I. and Sykes J. (2002) *Introducing Structured Dialogue with People with Mental Illness into the Training of Social Work*, *Psychiatric Rehabilitation Journal*, 26 (1).

⁸ See Goffman E. (2005) *Piętno. Rozważania o zranionej tożsamości* (original title *Stigma. Notes on the Management of Spoiled Identity*), Gdańsk: Gdańskie Wydawnictwo Psychologiczne.

meetings often acknowledge that what they learn is that the difference between themselves and those with mental problems is not always that clear. The replacement of the stigmatising image with one reflected in a reality to which one may relate enables members of the groups so educated to realise that the illness could have befallen or may befall them as well. Listening to personal stories experienced by a psychiatrist lets them understand what a mentally ill person feels and what assistance he/she needs as well as facilitates better familiarisation with his/her needs and abilities⁹.

The role of the university in mental healthcare

The University has an important role to play supporting students with mental-health problems in developing their mental, social and intellectual potential. Pursuing university education in an environment both open towards differences and intellectually stimulating facilitates the building of individual self-confidence and a sense of being competent. Despite the illness, the continuation and completion of an activity once started may make the students feel responsible and reliable. Finally, the university fosters the building of bonds with other people and the establishment of a social support network, so much needed for people with profound emotional difficulties. University education itself, and an environment sensitive to the specific needs of mentally ill persons, makes them feel stronger and helps them believe

⁹ For a few years now, I have been involved in this special kind of social education at the Jagiellonian University Institute of Sociology in co-operation with members of the Open the Doors Association, see Liberadzka A. (2008) *Sprawozdanie z projektu „Przez edukację do akceptacji”* [A Report on the ‘Through Education to Acceptance’ Project] in Kaszyński H. (ed.) *Edukacja społeczna jako metoda przeciwdziałania stereotypizacji osób chorujących psychicznie na rynku pracy*, Kraków: Wydawnictwo TEXT.

that they may be successful in carrying out their own plans and lead happy lives. It must be emphasised yet again that university study which is adapted to the individual abilities of the student and to the fulfilling of the role of a student in a consistent manner are the key factors that inhibit the process of internalising stigma¹⁰.

The Jagiellonian University Disability Support Service reports that the possible consequences of mental illnesses for university study are as follows:

- the need to extend the settlement period (academic year or entire studies) due to a relapse into illness and the necessary psychiatric hospitalisation;
- increased absence from lectures/classes due to intensified symptoms of ill health;
- the need to extend examination times or change the form of examinations due to the student's difficulties in focusing attention;
- periodic difficulties in active participation in classes due to the side effects of medication, for instance sleepiness or slower reactivity;
- impeded relations with academic teachers and fellow students due to, for example: high anxiety levels in social contexts, tendency to social withdrawal and lowered self-esteem, and
- failing to meet the student's obligations due to his/her inadequate assessment of his/her own abilities and difficulties in organising work.

It must be emphasised that the answer to one question is of particular importance: In which way are university personnel able to

¹⁰ See Adamczyk M. and Kaszyński H. (2010) *Studenci z zaburzeniami psychicznymi w systemie edukacji. Próba konceptualizacji problemu* [Students with Mental Health Problems in the Educational System: A Conceptualisation], Kraków, submitted for publication.

support students to overcome difficulties related to their daily life at university which are the consequences of their mental disorder. The authors of the article entitled *Kryzys zdrowia psychicznego a studia* [*The Mental Health Crisis and Studying at University*]¹¹ claim that university staff may be helpful to students in maintaining a distance from their own illness and highly stressful situations, approaching other people effectively, solving formalistic university-related problems and, last but not least, not interpreting manifestations of the illness or effects of the treatment in terms of 'wrong' or 'funny' behaviour.

I wish to stress that in forming such supportive attitudes in university staff it is virtually mandatory to draw on social education referring to the philosophy of a meeting and reliable messages from the source. Such a conviction of mine is based on my reflections concerning the attitudes expressed by Poles towards mentally ill people. In recent years, the kindness declared towards them has been dramatically losing out to our indifference, a fact which has been emphasised by B. Wciórka and J. Wciórka in the report entitled *Osoby chore psychicznie w społeczeństwie* [*Mentally Ill Persons in Society*]¹² already cited. According to the results presented therein, 'kindness' is declared by a significant percentage of 72% only in the subgroup of those having personal contact with mentally ill persons, by 65% of all the subjects interviewed, and a mere 54% in the subgroup of those with no contact with such persons. One may assume that the emotional distance and negative ideas concerning mentally ill people as well as unfair stereotypes are going to be effectively modified thanks to educational efforts made at universities with the participation

¹¹ See Życzyńska-Ciołek D. and Boguszewska K. (2008) 'Kryzys zdrowia psychicznego a studia' [*The Mental Health Crisis and University Education*] in *Pełno(s)prawny student*, Kraków: Fundacja na Rzecz Rozwoju Regionalnego.

¹² See Wciórka B. and Wciórka J., *ibidem*.

of those who need such support most, students with mental-health problems.

In conclusion, I wish to emphasise that this publication is a contribution to making meetings possible between healthy people and those who are regaining from mental problems or have recovered their good mental health. The contributions herein, mostly by Jagiellonian University students, are to be applauded as they testify to a special way eliminating the social stigma accompanying vulnerable persons. It is about recognising and respecting insights and understanding stemming from their personal experiences since in this way they can be regarded as people having their own views and a voice, not just as a subject of knowledge had by others.

Urszula Szczocarz

Through the DSS Consultant's Eyes

Health and mental illness

I have been a staff member at the Disability Support Service for several years now and one of my tasks is to assist students with mental problems. 'Who are they? How do they behave? How come they study at university in the first place? How do they manage?' are some of the questions I sometimes hear concerning our clients. 'What are they like?' I smile before I answer. More often than not absolutely normal. They do not chase other members of the university community wielding an axe, they do not think they are Napoleon Bonaparte, they do not yell obscenities whilst travelling by tram... as these are only images from stereotypes, not actual people. University students with mental-health difficulties attend classes and lectures with their peers, take and pass tests, write MA dissertations, live in student homes and participate in student life. Very often no-one from their environment has a clue how hard the daily battle is they wage with the illness.

If so, what is the difference between the 'ill' and the 'healthy'? My view is that those two categories cannot be clearly delineated. Is an ill person someone who behaves abnormally? And maybe an ill person is

someone who presents a medical certificate stamped by a psychiatrist? Or maybe someone who, on a visit to the DSS, remains silent throughout the meeting, cries uncontrollably or talks visibly driven by aggression? Naturally, it does happen that students behave utterly inadequately, yet a large majority of our students look and behave observing broadly understood standards. Apart from their illness these people have a whole wide range of features adding shades to their personalities. For instance, some will show a good sense of humour straight away, some will be serious, some quick and hot-headed, some slow, some more hard-working, some lazy and so on. I try to never look at people through the prism of their illness, what befell them, but rather see people in their individuality. Also, a diagnosis of a mental illness itself does not seem to me a sufficient criterion to pigeonhole all the people so diagnosed as belonging to a single category of people having common features and problems.

On numerous occasions I have heard high praise of ‘us the healthy’ helping ‘them the ill’, poor, disabled. Personally, I would never dare use such a distinction, let alone believe in the actual existence of the ‘we the healthy/they the ill’ dichotomy. To me such an attitude is unfair both to the ‘ill’ and to the ‘healthy’, who carry the label of good health, and so it is unbecoming of them to occasionally behave strangely or depressively, experience a crisis or a period of heightened sensitivity. Following some reflections by Kępiński¹, one might ask which ‘soul’ is healthy and which one ill. Going more deeply into the matter, it is rather easy to conclude that this cannot be clearly defined. Each of us has better and worse days: people considered permanently ill experience

¹ See Kępiński A. (2005) *Jak leczyć i poznawać człowieka* [How to Treat and Become Familiar with the Human Being], Kraków: Wydawnictwo Literackie.

periods when they are feeling very good whilst even the healthiest people see themselves exhibiting some symptoms that might be called psychopathological. Virtually everybody has behaved 'abnormally' at one point in their lives or another and many university students reading psychiatry textbooks conclude they have most of the disorders described therein. All this suggests that whilst discussing good and ill health one assumes that we are somewhere on the *continuum* between absolutely perfect health (obviously non-existent in real life) and extreme illness (whose precise definition is not that easy, either). What is more, the position on that axis is never constant as we are unable to foresee whether our presently dominant 'health' or 'illness' will deteriorate or improve. Many a time even the hardest cases of psychosis pass and never return whilst the healthiest people see their lives dramatically changed in just a few days because of illness.

Support

Students approach the DSS with a wide variety of issues; sometimes with a brief question related to the regulations governing their studies, sometimes with a long and complicated story of alternate illness and education. Most interviews with them contain a more or less hidden (or sometimes even silent) request for support, some hope, a good word. Sometimes they come but are unable to clearly define the purpose of the meeting; then we jointly look at the situation, turn the face-down cards face up, look for what is difficult, important and needed in the context of university study. Listening to their stories and focusing on the students I follow Rogers² in trying to never impose my own

² See Rogers C. (2002) *Sposób bycia* (original title *A Way of Being*), Poznań: Dom Wydawniczy Rebis.

interpretation. My role is to emphatically sense how a given person feels, accompany them and collaborate with them in discovering the best academic solutions. The person himself/herself remains the best expert on their own life as he/she has direct access to the feelings coming from his/her inner self, which I will never reach equally deeply, no matter how rich my knowledge and experiences are. Yet I am always ready to provide information on rule book possibilities and procedures which govern the handling of various things at University, I come up with ideas on learning strategies, organisation of study time and stress management.

Empathy, understanding and acceptance turn out to be very important at meetings with students with mental-health problems. Yet it is also very important to set challenges for them, motivate them, make their plans and ambitions more realistic. It is very difficult as well as vitally important to select suitable strategies for action in the actual academic and health circumstances of a given person. No golden remedies can be offered in that regard and no solutions that are always correct can be used in most cases. Each student must be approached individually and two persons studying the same subject and having been diagnosed may require entirely different solutions. Even the very same student in different periods of his/her life may need extremely divergent adaptations. For example, taking a year off may be the best possible solution in some cases but in some others may turn out to be a complete disaster. As a consultant then I try to be very careful and think each decision over several times. In some periods the proposed solutions should, first and foremost, give the student the sense of security and stability of his/her academic situation where there is an intensification of the symptoms or a bout of illness. At other times, action is important which motivates the student to fulfil his/

her university obligations or gives them some space for activity and development.

Although the DSS does not offer psychotherapy as such, I always try to learn what is happening in a student's life in that regard: whether they are in close contact with a psychiatrist or a psychologist, are taking the prescribed medication or even whether they are satisfied with their own therapy and the direction it is taking. All this is very important since even the best educational support and maximum magnanimity of the academic environment will not be enough if a student with mental-health difficulties does not constantly receive professional support related to the entirety of his/her life and mental health.

Adaptations

To some, the word 'adaptation' sounds rather grand and is far from clear. The term actually refers to very simple technical things like, say, making it possible for a student with mental problems to record lectures with a dictaphone, take examinations in a changed format or spread the examination session over a period longer than the standard time. I always agree on adaptations together with the student, repeatedly holding discussions concerning the best solutions for a given situation. I always take into consideration a given person's specific needs as well as his/her problems with the studies experienced thus far. In this area, there are no unambiguously good solutions either, and it is often only after some time that the ideas prove right or wrong and actions effective or not. For instance, a student found it difficult to assimilate a lot of material at once and a good adaptation was to divide some bigger tests into 'halves'. The very same adaptation made some other student's hair stand on end although his/her learning difficulties were

similar. It turned out that he/she was so paralysed with stress before the test that making him/her take the same examination twice carried a serious risk of the student deciding not to take it at all.

Once adaptations which are best for a given person in a given situation have been defined and written down, they are transmitted – with the student’s consent, naturally – to the lecturers and academic teachers running the courses. The information concerning the reason why the student has been granted specific adaptations contains essential data only. The lecturer will learn then that one of their students has some health-related difficulties or a chronic illness resulting in some specific educational difficulties. They will also learn how he/she may alleviate some of those problems and support the student without compromising the academic requirements. When I transmit such ‘educational guidelines’ to the teachers conducting courses and lectures I am open to discussion since the very nature of some academic subjects will sometimes require adaptations other than those foreseen. The lecturer/teacher has also the right to hear my explanation as to why it is necessary to use particular educational strategies in the case of this or that student. However, I never give them information on the state of mental health of DSS clients. Likewise, all medical records are kept under lock and key and students often say that it is more beneficial and safer to bring a certificate signed by a psychiatrist to the DSS than straight to the hands of university administrative staff. It is up to the student, naturally, to decide how much of the sensitive data related to their person should be disclosed and to whom. Yet the DSS itself never transmits such data to other University units. I would also like to point out that even if a student does not receive the go-ahead for some adaptations, he/she may still complete the studies. Granted, that would be more difficult, yet still

possible. Nonetheless, all action aimed at improving the quality of the student's functioning in the academic context are worth considering. I experienced a difficult period at university myself, an examination session seemed an insurmountable wall back then. The University regulations allowed one to move examinations to September without providing justification. I made use of that opportunity thanks to which I did not receive any fail marks in June and my academic situation did not contribute to the crisis. In my view, each and every student – regardless of where they currently are on the health/illness *continuum* – should be given the right to be granted some adaptations, like some time off duty. The Jagiellonian University regulations envisage such – leave, extensions of examination sessions, individual tuition – they are all adaptations useful for all students, whether at any given time they are considered 'healthy', 'ill' or 'disabled'. On many occasions a single use of some form of change – be it even moving examinations to September – solves the problem (or at least does not aggravate it) and facilitates completion of the studies.

By way of summary I would like to underline that no adaptation ever entails lessening the requirements or lowering the educational bar. The schedule of academic progress laid down in the curriculum must be observed by all aspiring university graduates, also those with a history of mental problems. The criteria for receiving credits for individual courses and the level of knowledge required for such credits may on no account be changed. In academic terms then, things are no 'easier' at university for students with mental problems and the adaptations granted to them are only meant to ensure equal educational opportunities.

Barriers

With the support offered by the DSS and individually selected adaptations at university, as well as remaining in touch with a trusted psychotherapist, in principle one is fully equipped to complete university studies despite mental illness. What then is the reason for other problems which I call, for short, 'barriers', the word frequently used in the context of various disabilities? Students with mental problems must cope with a number of such barriers, from those existing in abundance in the environment and society, through those present at university, to barriers hidden within himself/herself which are sometimes the most difficult to overcome. I do not really want to dwell here on the stereotypes and prejudices as well as the fear of mentally ill people which is deeply rooted in society. Some students who have disclosed their mental problems talk of discrimination experienced from people they know, medical personnel and even their closest family members. They are fearful that their situation will be the same in the university context and sometimes – though not always – their fears are well founded. Even if people with mental problems do not meet any more people pointing their fingers in the open or hurling of insults, they still can become the subject of comments, curiosity and bias or simply an extreme lack of understanding. At university, such a barrier may be created, for example, by a lecturer who resolutely refuses to use specific adaptations or a roommate in a student house, who parties and disturbs the silence and quiet. Some impressive barriers may also be created by university administrative staff. One example may be a refusal to stamp a student card officially extending his/her student status as a staff member considers that the students will drop out soon anyway. Another example may be unwillingness shown

towards all requests made by a student stemming only from the fact that he/she has been a second-year student for three years. Before I call the university administration about a student with mental problems, as a disability consultant I brace up for a battle which indeed must sometimes be fought. However, when I meet with human kindness and openness my astonishment and joy are proportional to how little I expected it. My impression is that very little is needed to ensure that one doesn't make someone's academic situation even more difficult than it already is.

I try not to treat the barriers along the way as disasters but another challenge for the DSS. Indeed, in this regard a lot of work is still ahead of us as awareness changes are not made overnight. All the more, any visible progress and even minor successes are a source of satisfaction to me and let me hope that for students with mental problems our University is day by day becoming a friendlier place.

Hopes

In her book, Arnhild Lauveng³ describes how thinking about pursuing her dream university studies kept her alive in her most difficult mental crises. At certain times the dream was the most important thing in her life and the only one that mattered. At first, no-one treated her intention to obtain a higher education seriously, yet she managed to attain her goal: she studied psychology at university, won a degree and is a practicing psychologist now. In mental illness, a simple practical dream, a clearly defined goal, may be of key importance. It can

³ See Lauveng A. (2009) *Niepotrzebna jak róża* (original title *Unyttig som en rose*), Sopot: Smak Słowa.

motivate, give hope, define the way in which plans for the future are carried out; it points out a direction, however remote the objective may seem in difficult periods of illness. In numerous cases the perspective of university study or obtaining a diploma makes ill persons feel they have a goal in life and know they have a reason to fight the illness. To me, that is a huge potential for the future, which is why supporting the university education process is a worthy cause. It so happens that the environment and family treat the wish to pursue educational goals as a fancy dream, inaccessible to those with mental problems. 'I will have a university diploma' sounds like 'I will be a model' or 'I will be an astronaut' in declarations made by kindergarten-age children. If someone with symptoms of a mental illness does not give up his/her plans concerning university study despite unenthusiastic opinions from the environment, the person must be determined. In such cases, why doubt he/she will be successful? Some students are ashamed of their histories marked with studying alternating with illness or vice versa. My conclusion in such cases is that the diploma – whether won after five, seven or twelve years at university – remains the same diploma awarded to a Master of Law, Physics, English Philology. Nowhere does the document feature the note saying: 'Employers watch out! This university graduate studied twice as long as the rest!' Once the diploma has been awarded, such things cease to matter, just as it is unimportant how deep was the sea of tears wept over textbooks or how many laments he/she heard from their parents and the university administration. In my daily work I can see students showing emotional extremes – from passion and enthusiasm through modest hope, remains of faith in himself/herself to profound despair, breakdown and sense of defeat. Yet I never lose faith in people. It may seem strange, not least when at a given stage of one's life he/she is spending most

of the academic year in hospital rather than at university, is taking a year off for the third time or trying to complete a year of studies takes him/her several years. The students themselves very often experience moments of doubt, their hope dies out in the face of the difficulties piling up or an approaching examination. They sometimes tell me that I am the last person believing they may complete their studies successfully. It turns out that lecturers shake their heads in disbelief seeing them again sitting the same course, the parents keep repeating that they knew from the start that going to university was a bad idea and friends have even stopped asking them which year they are stuck at. In the circumstances, it is not difficult oneself to lose faith in being successful, hence the resignation expressed in the words: 'I will never finish my studies', 'All I do is bang my head against a brick wall', 'I am just running in circles.' I hear those words but I see a person who has come to see me as a representative of the University with the intention of undertaking something related to his/her education. Maybe that is why I believe, sometimes against hope, that a given student will be successful in completing his/her dream studies and reach the goal set for himself/herself. I know that for some students that is very important and thanks to that, the support that I offer as a consultant is complete. That is why I accept the role which is upon me and I shall not be discouraged.

Jolanta Bielicka

Faculty of Polish Studies, Jagiellonian University

Reflections of an Academic Teacher

It so happens that thus far I have never received any information concerning any of my students having mental-health difficulties and so even if I have been in direct contact with persons experiencing such problems I am not aware of it. I do recall several cases of students behaving in a way that I found strange, yet I am not competent to judge whether those were manifestations or evidence of mental difficulties or rather consequences of the stress related to life at university. Last academic year, a first-year student showed a very aggressive reaction to a fail mark in a test. Using vulgar language he communicated to his fellow students what he thought about the course which I happen to teach and myself as a teacher. The situation was obviously far from pleasant yet I turned it into a joke (rather forgiving than malicious), looking for a source of the student's behaviour in the inborn ambition shown by young Polish philologists and suspecting the young man's fervent outburst to be a sign of passion that should be put to some good use. He was pacified then but reacted to his later failures in a similar fashion. It was a consolation that the joke showing forgiveness turned out to be a long-lasting remedy. I remember that at least on two occasions I asked that student to stay behind after the classes and I talked to him about the situation. He always apologised politely. Does

he have mental-health difficulties? I do not know. He did behave in an unbalanced way, but maybe he is just quick-tempered. In my view, to suspect a mental condition in his case would be an overstatement.

I must confess that I have no idea where I would be supposed to go if I suspected a student has mental-health issues, nor from where I should get such information. Yet if I knew which of my students were ill, it could facilitate our co-operation. Such knowledge would doubtlessly make me somehow sensitive to the fact that in stressful situations persons with mental-health issues might react in ways different from their peers without such difficulties. I might then be successful in counteracting possible aggression or mitigating such behaviour. How? Let us say that a student with mental-health issues fails to pass a test. His/her condition will definitely not improve the well deserved mark but the knowledge of the problems that a given person has would allow me to prepare for his/her possible reaction or make an appropriate, encouraging, explanatory introduction before discussing the test results.

I am no supporter of clearing obstacles out of the way for people who experience problems. The very fact that they undertake university study shows they are ambitious and do not make the world revolve around their condition. As a lay person, I would most probably be unable to show an adequate reaction to every untypical situation. I would be guided by intuition, which in conjunction with a positive attitude to people and optimism helps one to obtain good results. If I knew that a student of mine has a problem, I would try to talk to him/her in private and learn how I could facilitate his/her participation in my course, without lowering the educational bar. I would definitely be ready to modify, for instance, the way I run the classes, as long as it does not make participation difficult for the other students. Should

a need arise, I would not find it hard to, say, replace an oral form of a test with a written one or the other way around. It would surely be invaluablely helpful to receive guidance from a relevant university unit on how to approach students with mental-health difficulties and how to make studying easier for them.

I have heard the opinion that people with mental-health issues should not be university students. I do not share this view which most probably is a result of stereotypical thinking about such persons as unpredictable madmen whose behaviour cannot be controlled. I am aware that there are different mental illnesses and that they have various symptoms; given that, it is hard to accept such a sweeping generalisation concerning higher education. In my view, the general public attitude to mental illness is very oppressive, too. Let us have a look at, say, the associations generated by the very place where mentally ill people are treated. Across Poland those behaving 'nonsensically' are sent (often jokingly) to the location of the nearest large hospital or facility for mental-health patients. In Kraków the place is called Kobierzyn, Tworki in Warsaw, Toszek in Silesia and Dębica around Rzeszów. The very reference to the name of a place (or a city district) is charged with a negative value judgement. In our culture a mental illness is a stigma, a brand, something shameful and as such belonging to the taboo zone. It must be difficult to be a student with mental-health difficulties.

Anna Kapusta
Institute of Sociology, Jagiellonian University

Which Hour of Thoughts?

Once upon a time an obligatory-textbook-reading Romantic poet wrote a lyrical poem under the enigmatic title of *An Hour of Thoughts*¹. Predictably, the book included musings on now-forgotten melancholic concepts of the poet, poetry, time, memories and the creative process. Yet that is not what interests me most. What about the very idea of playing with time for thinking, the creative concept of ‘an hour of thoughts’? Were the thoughts originating the lyrical text woven within an hour? Did a specific biographical hour result in the text? What kind of hour? Which hour in the daily schedule? And why an hour in the first place? Such questions may be pondered by poets, poetry researchers and very romantic readers. And now for a story not so airy-fairy, contemporary and unromantic. Does it matter to you (or me) at all, at what time the washing machine you put your laundry into was invented? Are you at all curious to know the time when someone developed software for your PC? Does it matter to you at all which hour was struck by the clock on a wall in the study of your favourite writer, the author of the book which is most important to you? At

¹ See Słowacki J. (1952) *Godzina myśli [An Hour of Thoughts]* in idem *Dzieła*, vol. 2, *Poematy*, ed. Krzyżanowski J., Wrocław: Wydawnictwo Zakładu Narodowego im. Ossolińskich (editorial note).

what time the book was finished? This is a mundane story. And finally the most difficult story, and as simple as the mere perception of how someone else sees the clock face. Would you like your bus to be driven by a sleepy driver? Do you wish your language teacher to be tired? Would you like to work hours when your mind is unable to produce a single thought? If we had to follow one 'hour of thoughts', the same for all, would the washing machine, PC or *An Hour of Thoughts* have been created?

Possible thinking worlds

Having asked the preceding questions, one faces a surprisingly vital reflection on our daily lives, one that some of us have to face throughout life. It is a vital doubt concerning the constancy of norms, the appropriateness of the restrictions imposed on us by society or institutions, and so... the decisions of specific individuals. Why is it that some of us must think when their minds are asleep? Who or what is meant here? People around us whose educational difficulties go to sleep when we let them have a good sleep on an early winter morning. In the context of this story of 'an hour of thoughts' I remember a specific biographical 'hour for thoughts'.

Once, on a day like any other, fearing for my own eccentric carefree manner, I presented it to a student of mine. One single hour for her thoughts. At the beginning of the story the fearful girl told me that in actual fact she was unable to 'get' to my class scheduled to start at 9 a.m. She also asked whether the following year I would be running the course, too. I did not press her to know why 'she was that way'. At first, I thought it was all about her difficult travel arrangements from outside Kraków to the city's main market square. Yet I was surprised

by her interest in the following year's schedule. So I asked her about it. Then I learnt that 'after a year off granted by the University with the right to take examinations retained, the schedule of courses will be important to her, but for now she would like to try to complete the course'. Several weeks passed and – obviously – the girl failed to 'get there at nine'. The following month I received an email in which the student asked me whether I 'had already struck her off my list'. I replied that I had not and – jokingly – asked her whether she 'wanted to give up on me' as I kept no attendance list and in general never wasted my time on doing the maths concerning 'doing time' in the lecture room, and in fact I was most interested in whether she had already selected the subject of her paper allowing her to complete the course. I received another message, a 'technical' question that time, whether it was possible to 'receive a credit for the preceding month in the course during my office hours'. I wrote back that I considered that utterly pointless as the reading matter and discussion served the participants and I 'never questioned my students on footnotes'. A week later during my teacher's office hours the heroine appeared in person. It turned out that after these few sentences which I had written to her the girl had had the courage to ask face to face whether she 'could be allowed to complete the course extramurally' and come only to 'present and discuss the paper, as she was experiencing some personal problems'. I agreed encouraging her not to waste her time and go ahead with getting a credit for 'whatever she could already manage during her leave'. And so I got truly exceptional letters and reflections on her experience reaching me more and more frequently via email, a well thought-over and ambitiously drafted paper and at the end of the term a biographical story on the heroism of being a student during her episode of depression. She passed her exam successfully. The most

inspiring, however, was the final message offered by my interlocutor. I learnt from her that ‘if I had not offered her the 9:00 hour, she would have never completed the course.’ As it turned out, her world of possible thoughts started after 9:00 in the morning. Earlier, thinking was difficult for her. Even rising from her bed was impossible at 9:00.

(Un)Thinking moment

Such a seemingly simple story. To be able to think after 9:00. To be able to comb one’s hair after 9:00. To be able to raise one’s head from one’s pillow after 9:00. And such a tragically difficult story. To be considered a common sloth before 9:00. To be stigmatised for not participating in the debate before 9:00. To be regarded as untalented, unoriginal and semi-literate before 9:00. And if so..., if the author of *An Hour of Thoughts* had been given time to create from 8:00 to 9:00: then and only then. If the inventor of the washing machine had been ordered to innovate only between, say 9:00 and 10:30: then and only then. If we were obligatorily allowed to have access to technologies developed only at 8:30? Would our world look the same? Would that for sure be our world or our thoughts?

I have asked myself such questions thanks to the story of an hour of thoughts given to me by a person thinking at different hours than prescribed by the ‘hour for thoughts’ schedule that I had established. Was it in any way important to me at what time a brilliant paper was written? Could the time when an inspiring thought contained therein was created define the quality of such a thought as ‘past the deadline’ or ‘wrong’ because it ‘was not expressed between 9:00 and 10:30’? To me, an ‘hour of thoughts’ so understood would be a thoughtless moment. And I do hope that this is a world of impossible thoughts.

PART TWO

THE STUDENT'S PATH



Weronika Jung

My Journey

I am writing about my experiences with anorexia because I hope it may bring about something good – maybe somebody reading my story will find something valuable in it. The experiences I'm talking about in this story are very much 'mine' and difficult; I think it is important to say this, perhaps because I'm writing from a perspective of a person aware of her illness, yet not fully ready to bid final farewell to it. Perhaps I can pass on something vital, perhaps warn or encourage somebody to look for help – even though you can exist with anorexia, it is just a half-existence that makes you incapable of receiving anything from the world.

The anorexia that I know is a partner that is faithful and expects faithfulness; if you invite it into your life it may live with you for many years. We've gone the same way hand in hand, sometimes I'm ahead of it and sometimes, when I'm too tired, it is in front of me. Then I agree to follow it – sometimes because I trust it without any limits, some other time I'm simply too scared to make my own choices. When I look through anorexia's eyes, I see the world differently: I'm there alone, I don't fit in, I'm inadequate in a painful, depressing way. Too imperfect to exist, unable to meet the standards that I set myself. That

makes me anxious and full of obsessive thoughts that somebody as mediocre as me doesn't deserve to be happy.

Anorexia separates me from emotions that I don't want to feel. It makes me believe that the speaking of emotions is humiliating, that it is better to use intellect – it is less threatening, embarrassing, humiliating. It doesn't allow me to admit to weakness, lack of knowledge; it suggests that I should know everything, understand everything. It is difficult to muffle it, especially when I try to communicate with my own heart: with what I want, what I feel, what I miss. Then it tries to take me away from the world with double force and I yield, I leave this world on my own in order to avoid the pain of inadequacy.

Walking with anorexia hand in hand I reached the place where I stayed for longer. I'm surrounded with a wall there and I'm staying there – apparently safe. It's not comfortable – space is limited, air is limited; only myself and anorexia can fit in there. Too little space for people who would like to feed me with love, warmth, closeness. I huddle like a little child, close my eyes, close my heart, I hide my hands behind my back. I'm not allowed to ask for help, I can't do it, I'm too ashamed. It's easier to seal your eyes not to see the truth, to close your mouth not to admit that you are weak, to clench your fists not to accept help from anybody. I don't have to look for the right words to describe my suffering – when I can't do that, anorexia does it for me – it takes away a few kilos and sends a signal to the world that I belong to anorexia, that it is the only one that can alleviate my pain.

It takes care of me every moment, feeding me with its icy care. It doesn't allow me to eat anything else, even though it feasts itself, with no inhibitions, stuffing itself with my hunger. Thanks to this nutritious food it grows stronger to fight for greatness, for domination. It may grow only when I shrink, when I get thinner. So it looks at me,

watches me at meals, doesn't allow me to swallow too much, and if it is distracted for a moment and it overlooks a few smuggled bites of food, it punishes me for it. It puts sick thoughts into my head, it puts my own fingers into my throat. Thanks to that time is reversed and I go back to the ideal time – the time before a meal. It is with me when I fall asleep – then it lets me feel more. Loneliness, kept on a leash during the day, covered with a smile, is released with a stream of tears at night, when nobody watches, nobody sees my weakness, worthlessness, smallness. Then the words that were never uttered can be seen in puffed up eyes. I'm visited by sadness and unrest – I invite them when I think about my inadequacy and ask myself questions: whether I'll be fine, whether I'll be strong enough to destroy the wall around me, to move on. When I open my eyes in the morning, anorexia is already awake and serves me a plan of another day together. It is a very inventive companion – it presents a thick catalogue of games. Most often we play with death, ignoring our smallness in the face of death, forgetting how much we can pay for it. If we lose, not believing that we can lose, we play with life, we look for meaning in life, which we still cannot find.

Anorexia gives me many gifts: fear, chill, helplessness, but also a sense of security which results from the reassurance that nothing in the world needs to change, that I don't have to change, I don't have to take responsibility for what happens with my life. It has a monopoly for giving me gifts – it ties my hands so that I can't accept anything from others. So that I can't grow up and remain a child, quiet, self-contained, suffering – but a child. Hungry for love, craving for feelings, inhumanly ideal, angelically pure. I'm becoming its sculpture, a finely shaped structure of beautiful proportions. It wants to see me like that, to protect me from reality, to keep me for itself. That's not all. Anorexia gives me the form which I have to fill in with content on my own.

Of course, the content can't be any content, I can't pollute the ideal. I should take care of every element, so that it matches the rest perfectly, I should smooth any rough surface, every bump. When I create myself in this way, I more and more often escape from my own humanity, I freeze my feelings and neglect signals sent by my body – still alive and demanding. I don't know whether that is exactly what I want, but I know I should do it.

Since I can't talk aloud about feelings, I need a mask to hide my human face from others. Anorexia gives me that as well because it cares for my image in the eyes of others. Thanks to that I can deceive the world, which doesn't notice my sick thoughts, and I can deceive myself, forgetting for a while about the poison feeding me every day. A toxic dose goes to the corner of my head where it hides until I touch it, asking myself what I feel. My thoughts direct me to everyday life in which I can find a temporary antidote. Then I can have my little successes and enjoy reality – and still be sure that nobody guesses how I create my smile, how I take it every morning with pills that allow me to enjoy life.

I often can't understand what happens inside me, what requires my attention – I hear many sentences and it's difficult for me to recognise the voice of anorexia amongst them. Even though anorexia sends me many signals – sadness, discomfort, a feeling of being lost – it doesn't admit it generated them. It shows pain without revealing its cause. It prefers to remain in hiding, gaining the inviolability of the unidentified. It works quietly, peacefully, without hurrying, killing the soul and body of its host bit by bit, certain that it won't be disturbed. It looks coldly when I choke trying to swallow what it has prepared for me – it knows that I will not stop breathing, that I'm too entangled in this torture to run away just like that. When I befriended my illness, inviting it

to my life, I promised to be silent. Everything happening inside me since our first meeting was kept secret, I defended this secret with all my strength. I devoted several years of my life to creative pretending, denying, shushing thoughts that try to tell me something important – that I waste my time, I give it to anorexia because I delude myself that it will use this time better than I can. When I made this decision, I gave the whole of myself to anorexia – I belonged to it. It promised me happiness but it forced me to lie in return, it forced me to move away from the world. I couldn't live amongst people who were close to me, who wanted to understand me, building bridges over the precipice separating me from the reality. I had to choose – either anorexia, perfection and release from shame or the world and normality. I chose anorexia, without realising what exactly it was. It was my suicide.

At the beginning of our journey together I didn't realise that I wasn't alone, that it became my shadow. Quite the opposite: I was sure that I had discovered a part of my life that was only mine. First I didn't know that I was hurting myself, preparing a cage for myself in which I would imprison myself for several years. Then I already knew but I didn't want to be myself so desperately that I went on preparing the cage. This lonely preparation of the niche for my future life was very tiresome – then came the time when I was so weak that everything around me was grey and meaningless. Only anorexia meant something, it kept on drilling a hole in my head with its cold smile. Reality changed into a hazy dream, the world became a strange, ominous, distant place. I felt that my life was fading away and I didn't mind. I didn't want my life. Every day lasted so long, another person's smile aroused grief and anger. When I was no longer able to deal with anything and the only thing I felt was craving for non-existence and hatred to myself, a rescuer arrived – chemical resuscitation. For a while

it was beautiful, joyful, spring-like. Later on unsolved problems began to reappear. I was on the edge – I seemed to want to live but I didn't feel happiness. Once again it began to hurt.

After a long time of such half-existence there was a moment when there was too much pain even for me. What was left of me, this perfectly unhappy rest of me, could no longer bear myself. I no longer valued the seemingly wonderful moments when the world was colourful, when I seemed adjusted and quite happy. I no longer valued them because I realised that my joy is chemical and hope – built thanks to the remains of the energy produced by my brain – is fed by pills. Sadness grew to such dimensions that even anorexia seemed so small next to it. Then I was brave enough to oppose it and break my promise – I broke my silence. I admitted to myself and to others that I'm ill in some way, it helped a little bit but it didn't force anorexia to go. Amongst other reasons for this are because it is difficult for me to be humble – despite the whole suffering connected with my illness. Towards anorexia, towards the world, life, death. Anorexia shows me how to climb above humanity, sends me to places I would never visit of my own volition, because I wouldn't be brave enough, I wouldn't be ready to reject this more human, more imperfect part of myself. It tempts me with this vision of perfection. I still yield to it when it says that giving up on myself is a unique opportunity and I must take it, not to hate myself even more; after all, it knows better what is good for me. Perfectly good.

And where am I – this ordinary, physical, imperfect? I think that even quite recently there was no me – I definitely didn't feel my presence at all. It seemed to me that this former me disappeared somewhere, got lost, made too many mistakes, wasted too many chances, took wrong paths. I left h e r – m y s e l f – a bit surprised with the whole situation,

trying to protest, but hushed up by loud sentences about mediocrity – shouted out by the new version of me. I left h e r – m y s e l f – only because she didn't meet my expectations. I didn't need such a human being – after all, I had found a more perfect friend.

When I started to have regrets and miss myself, I went on a quest, however it's not very easy to find something that you wanted to lose so much. It's the most difficult thing to be mature enough to fight for yourself, to understand that there are no miracles, no magic wands, not on this path, not when we talk about a struggle with anorexia. It's all about hard work; you have to be ready for it. When you begin this struggle you can't have any doubts because any doubt works to the advantage of anorexia. I know it so my own attempts to break free are still quite timid – I'm not ready, too afraid that if anorexia leaves me, I'll be left totally alone. Sometimes I have moments of increased awareness when I know that in a way I stick to my illness and nobody can heal me without my participation, without my hands ready to work; when I know that I still have too little readiness and courage to suffer and at the same time to start my journey towards health. Then I become frightened. I need to run away from the place where I am even though I can't imagine how to leave it – how I could leave it, anorexia. This struggle with anorexia is a bit tragic, because I know that it is up to me to finish it, that I just have to choose one of the ways – but that whatever I choose, it will hurt. It requires perseverance and tremendous strength to face your own pain – because it is easier to give up.

Where to find strength, courage, willingness to get better? First of all I know now that I won't find it anywhere outside of me. No words of other people can heal me unless I believe in them – unless I accept them, tame them, utter them in my own way. I have rejected many

sentences, I didn't listen to their content only because I was afraid of confrontation with the truth; deep down I suspected that they were true. I also pushed away many hands that wanted to help me so I gave my life to anorexia of my own volition – I devoted a lot of time and energy to anorexia, giving her the most and taking the most from her. There is a very strong, unique bond between us, for a very long time I didn't reveal it to anybody; it's a very durable bond which can resist any interference from the outside. Today I'm trying to learn to accept help and tell the story of my life to people whom I trust, hoping that openness will bring me relief. And it brings me relief – it lets me for a while, during a conversation, combine both worlds in which I live, see my life from a distance. It helps me to accept and respect the illness without yielding to its every suggestion and its persuasions not to go anywhere, to continue to be ill, to stick to the uniqueness that anorexia gives me.

I think that one of the most important issues in struggling with the problem is depriving it – in my eyes – of the whole nimbus of mysticism, its *sacrum*, its almost magical uniqueness. I made it a kind of goddess and I gave it power – because of that I felt powerless in its presence but I also trusted it. I believed that determined pursuit of perfection may make my existence meaningful; thanks to that I may have people around me, I can be protected against solitude. After a very long time I've begun to understand that everything that anorexia tells me is a lie. High up the ladder to perfection there are no other people because no other person has any right or possibility to be there. The only thing you can find there is loneliness. If you choose anorexia as your companion you will meet there not only loneliness but also death. I'm beginning to see my smallness in face of life and death but it is not contemptible, it is very human and beautiful because it lets me plunge

into the greatness of life and give myself to the world to take care of me. A day will come when I'll part with my companion – anorexia, I'll shake its hand to say goodbye – without anger and regret, appreciating the years that we have spent together; thanks to them I could learn a lot. I will set off on a journey without it, humbly facing the truly great things – love, death, life.

Aleksandra Gracel

*Abre los ojos*¹

What makes a man hate himself?
Maybe cowardice.
Or inseparable fear of making mistakes,
Of doing wrong things, not the ones expected from him.

Paulo Coelho, *Veronika Decides to Die*

The beginning – because everything starts somewhere

Words have great power. They can comfort you, raise your spirits, make you laugh, but also hurt very badly. Unlike physical harm, the traces of which finally disappear, the harm caused by words reaches much deeper, touches your soul and heals for a very long time. Such scars make your soul more experienced and changed for ever. Maybe if people who had unconsciously hurt my soul knew about that, they would have thought twice before they said words that still reverberate in my head?

A day like any other day. I was going to school on a surprisingly empty bus. A new school – many changes, new friends, new teachers, new environment – everything was new! It was not easy for me to begin everything from scratch. I was fifteen and I had to leave my

¹ 'Open your eyes' in Spanish.

safe little world behind and enter a totally strange, untamed world! I was totally unaware and unprepared for what could happen there. I used to be a popular girl, a very good pupil, a promising volleyball player, the 'ubiquitous' and a bit hyperactive Ola; now I became an anonymous, meaningless grey mouse. It was too much for my sensitive heart, too much happened in a short time. I didn't understand what was happening and why it was happening.

9 December 2004, Thursday

I don't know what is happening to me. I feel somehow blocked inside. I can't open to knowledge, faith, people, to LIFE! I don't know why. Everything was fine until now. I've made a promise to myself that I will try to improve myself and I can't. What was I thinking?! Was I thinking that it'd be easier for me because my brother went to the same school?! NONSENSE! It's not easier. It's tragic!!! I'm curious for how long I'll have to suffer like that. It's not going in a good direction. Something is wrong! I'm living in the world of illusion. I believe I'm still the best, most special, most gifted. Now it's all gone! Hello! Girl! Welcome to the real life! Now it's different. I'm alone, I don't stand out against all the 900 people at school. In this school I'm nobody. I'm a totally insignificant nobody!! I'm afraid of my thoughts, my actions, of myself. Where is it going? I don't know...The end would be best for me. Isn't it going to be too painful? Not at all! I'm not important to anybody anyway. One Ola less or more, what's the difference! There is nothing inside me! Only emptiness, lack of joy! To want to live! What for? (an excerpt from my diary)

Nobody told me it would be difficult at the beginning, that I would have to 'knuckle down,' to work hard to earn my reputation. Up to now people always knew what I was like! The problem is that they were the

determinant of who I was. When they weren't there, I was left empty-handed. I didn't know who I was, what I wanted, what I dreamt of, what I liked. That's why I started to adjust to others. To some extent it helped me to be anchored somewhere. Never for long and never did I feel it was the right place for me. And that's how I started to lose myself. I forgot who I was. More and more often I stayed at home. I thought it would be better for my tormented soul. I lacked acceptance, warmth, normal selfless love. I missed my best friend. I clearly remember that day when I let her go and meet this boy. Maybe if I had told her what I really thought about him, she wouldn't have fallen into his possessive arms and she would be next to me? I don't know whether that is the case now, as I didn't know it six years ago. I was left alone at the time when every normal teenager has her best friend, they gossip about boys, go to parties, enter adulthood together. It was another reason to stay at home. The home full of my parents' love and full of peace. Every person who stays in one place long enough starts to discover its secrets. I discovered a secret that significantly, almost totally, changed my life! Now I can jokingly say – I discovered 'the power of the fridge.' Inside the fridge I found solace for my tormented soul. Food allowed me to forget for a while about other needs, it gave me joy, reassured me. At first I rarely took advantage of the comforts of food. Unfortunately, in time every problem, every test, quarrel with my mum or with my friends pushed me towards the fridge. It was a panacea for all evils. One bowl of porridge oats with milk was not enough. But five was OK! A normal person feels sick half-way through the second bowl. For me it became a norm. For dinner two courses – with a second helping... naturally! Then a bar of chocolate. The whole of it! How can you be satisfied with a piece of chocolate? This kind of behaviour didn't seem alarming to me. I thought it happens to everybody from time to time.

And I would go on thinking like that if it wasn't for the day of the ride on the bus. 'Look at her! She used to be so slim and now? In a while she won't push herself through the door.' I turned back to see who was so cruelly criticised. To my huge surprise there was nobody there but me...It was as if I emotionally covered my ears. I pushed it away. Yet I wasn't totally indifferent. Now there was a new dimension to my way of thinking about myself. Now a mirror was my oracle. Yes, my dear! It's all out in the open! I'm fat! Dreadfully fat! I can't look at myself! What is surprising is that you very soon come up with solutions for such a problem. A friend of mine, unaware of my emotions, told me that her dad was on a diet, that he had lost weight. Yeeees! – I thought – it's an ideal solution, I'll lose weight fast, I'll feel better, no asshole will tell me that I'm 'big', I'll surprise everybody! It'll be my new life! Slimmer – I'll be noticed, better perceived by people, maybe somebody will be interested in me – I was full of enthusiasm. It was irrelevant to me that my friend's dad felt weak, that he didn't go to work then, that he returned to his regular weight very soon. I'll be different – I thought – I'm sure he didn't follow all the instructions, I'll be more disciplined. I won't allow for any concessions! I will succeed!...

Holidays were the perfect time to do this. I started my adventure with losing weight... 172 centimetres in height and 60 kilos in weight... The diet was planned for thirteen days. Ready, steady, go! Every day kilos were going down. In the first week I lost 5 kilos! People! What a joy! Finally I could control something! Finally something depended on me alone! My ambition and perfectionism found vent in perfecting my own body. Clothes were getting too loose for me! It gave me a great power and motivation to go on. The next week was a bit difficult. I was weak because I ate even less of my already limited food rations. I collapsed in a shower, my muscles hurt from cramps!

I had to lie down but only when nobody could see me. 'If I fail right now, it'll mean everybody was right, if I give up only because it's tough, it'll mean I can't go through life independently. And then I'll be really worthless.'² So I was persistent. After two weeks my weight went down to 53 kilos. It was still too much for me so I continued my diet. For a long time I was afraid of eating anything, I was afraid of gaining weight. I was afraid to lose what I had achieved with such an effort! Now I don't remember clearly when I started to eat again. I remember I was getting fatter and fatter. Episodes of starvation were followed by episodes of overeating. I can't remember anything else from the time in the secondary school. I didn't go out too often because every time I would have to eat something. So I preferred to stay at home. I couldn't cope with what was happening to me at all. I imprisoned myself within my own body. I studied a lot. My ambition needed a new vent. I wanted to feel exceptionally good at something, I thought that education would be this 'something.' Since I'm not beautiful, I'm not funny, I can't be accused of being stupid as well. This conviction accompanied me right through the secondary school to another significant point – the third grade, just before my final exams. I was all nerves. New emotions appeared and I could cope with them only when I was overeating. Stress, no self-esteem, no idea what I want to study at university, no idea what to do with my life. It was too much for me. There was a key element added to overeating. I started to provoke vomits because I was so afraid to gain weight. An ideal combination! Food gave me emotional satisfaction, helped me make up for my defects, and vomiting prevented me from gaining weight. My whole world started

² Kowalska B. (2008) *Ludzie to wilcy* [*People Are Wolves*], Poznań: Wydawnictwo Zysk i S-ka.

to revolve around what I can eat, what I cannot eat, whether I can eat at all... I started to live in order to eat, not to eat in order to survive. Even now when I'm trying to recapture this period in my memories, it is so tiresome. It was the same back then. I didn't feel like doing anything. I could sit for hours, staring at the wall, doing nothing. I existed like that. I hated myself for it. I hated God for inflicting this on me. I didn't believe it would ever end. Nobody could help me. I couldn't help myself. With time it became quite comfortable. I liked to feel sorry for myself. For three years I didn't define what was happening to me, what my family witnessed. Nobody defined it because it was impossible for something so chaotic and imperfect as an illness to appear in this ordered, ideal world. Illness is a punishment and we didn't do anything wrong. A diagnosis appeared quite unexpectedly...

To face the truth...

...and admit to oneself – I HAVE A PROBLEM! It wasn't easy. My gynaecologist helped me. I went to see her in connection with something else. My periods had stopped. And it was she who started to ask insightful questions about my attempts to lose weight because another reason, pregnancy, was out of the question. And I snapped. With tears in my eyes I told her about the problems haunting me for the last three years. She clutched her head and without further delay gave me a phone number to a psychiatric clinic that specialised in eating disorders. For the first time somebody defined what I had been going through for years. It's bulimia. WHAT A SHOCK! What is this thing called bulimia? One word cannot suffice to describe what happened to me. My conclusion was that she was wrong. And I pushed this thought away because I could focus on one word and

one word alone: ‘psychiatric, psychiatric, psychiatric,’ it sounded like a verdict. Nice – I thought – you come for drugs to induce your period and you leave as a person who is mentally ill. No! No! No! I wasn’t fully convinced that the doctor was right. It was not about me. The fact that I was trying to lose weight didn’t mean that I was ill! The worst part was to break the news to my mum. I wasn’t sure if I should do it. I was scared that she wouldn’t believe me. After all, for many years she had seen what was happening to me. Maybe she will think that’s another whim of mine? What the hell! I talked to my mum. We talked for a long time and we both cried. I told her what the doctor had said, added a few words of my own, but I didn’t use this magical word. The word ‘bulimia’ couldn’t come out of my constricted throat. Not like that. We decided that I should go to the doctor’s the next day and ask for a referral to the psychiatric clinic. On my own! I wasn’t really sure I should. After all, I felt OK. There was nothing in my looks that would point to an illness. I was afraid that the doctor would think I was simulating it. Surprisingly, when you are healthy, asking for a referral is not a problem. It becomes a problem when you have to face a stranger and call your problem by its name, a mental health problem, and you have to ask for help. It’s like standing in the centre of the town, during the rush hour, and stripping yourself naked, hoping that nobody will notice. Impossible! Or possible, if you do it of your own free will and you are ready for a possible lack of understanding. I wasn’t. I went for the referral for the sake of peace and quiet. Two months later. After my secondary-school graduation exam and entrance exams to the university. In my case everything needed to develop. The referral as well. I stowed it away in my drawer, hoping that I wouldn’t have to use it. How naive of me! I was convinced that I would cope with everything on my own. After all, I hadn’t had severe fits of gluttony for the last few

months. I felt very well. This was caused by my intensive training for a fitness test. I ran and swam a lot. Too much. I was happy with it. I was losing weight at last! Some laxatives and a light diet added to that. Every moment had to be filled with an activity so that I didn't have time to eat, to think of eating. I had good cover – the fitness test. Nobody suspected that the aim of my exercises is totally different. At last I started to believe myself that my aim is to pass the university exams. I was so proud of myself. How clever I was!

I was admitted to university. Physiotherapy. Kraków. People told me it's a good choice, promising for the future. And I believed in that. I was even ready to be glad. Still I felt as if everything was happening alongside me. I had always dreamt of studying humanities or acting. I was more of an artist than of a physiotherapist, even though people say physiotherapy is also an art. My dreamy, artistic soul had to give way to common sense. I threw my dreams away and I finally accepted my university studies. The referral was still in my drawer. There were also other things that I had stowed away in my drawer, the things that could ruin my internal peace:

- dreams of a career as a volleyball player – because I was not that good at volleyball,
- dreams of studying psychology – because these studies are for people who don't have problems with themselves,
- dreams of love – because it was not the right time for such foolishness,
- thoughts of being special for someone,
- thoughts of suffering from an unknown illness that changed my life for ever.

I behaved passively. Since I couldn't lead the life I wanted, I would live a life others wanted me to live. What's the difference? Goodbye,

illusions! Welcome, mundane life! I guess it was meant to be like that. The holidays before my first year at the university passed very quickly. I worked a bit, I travelled a little. All was quiet on the bulimia front. I was sure that it was all in the past. That I had managed to close that phase of my life. But it was just the calm before the storm...

Myself as a student...

October 2007

I was full of hope when I left my hometown. I believed it was an opportunity to create a totally new, happy, healthy Ola in a new place. All the more so because Kraków is a place that gives great opportunities for development. I felt I had the strength to show myself to my best advantage. I wanted to prove to others that I have many good qualities. I had made two mistakes but I see that only now. First of all, it doesn't make much sense to change your place of residence if you don't bring order into your inner soul. You may change places, but you take yourself everywhere. And either you are reconciled with yourself or not. Secondly, I should prove things to myself, not to others, not to strangers. Without this knowledge I started to create my image, I started to pretend I'm a laid-back and go-getting student. It's surprising how easy it is for people to put on masks which hide their fears, anxieties and their real self. I became a group prefect because I wanted to be noticed, appreciated at any cost. I wanted people to need me and to like me. As a result people took advantage of that. Well, if that's the price of being somebody at the university, I may sacrifice myself. I was glad when people came to me and asked for help. Super! At last my dreams were coming true. I was more and more enthusiastic every day. For two months, because afterwards my emotions subsided. It was the time

when people didn't need anything. I dealt with the first formalities and everybody minded their own business. Nobody remembered about me. What did you expect? – I thought. – Nobody's going to be all over you. The whole world doesn't revolve around you. Welcome to the real world! Once again I had to start everything anew. In a strange city, without my parents, without my friends from secondary school, with broken spirit, without self-esteem. Alone. Totally alone.

Once again I started to think that if I lose weight, I'll be noticed. If I lose weight, everything will change. Yes! Wishful thinking. Justified by a special atmosphere at my university. A ubiquitous cult of the body. An ideal body made you somebody. Then I thought that nobody noticed my soul. What was important was the physical side and good fun. The need to belong to any group was stronger than the will to live according to my conscience. After all, why live according to the conscience of a person who doesn't like herself? Once again I stayed at home most of the time. I left to attend university classes only, nothing else. It was safe. I didn't feel like meeting people because then I would have to uncover myself. I didn't feel interesting and special enough to think that somebody will want to know me better. Since the very beginning I didn't give myself such a chance. Most of the time I studied, it was just before my first examination session. It was obvious I couldn't make excuses for my lack of knowledge by saying that I couldn't cope with my problems, that I felt lonely. It was not important to them what kind of person I was. Only my knowledge mattered. It was the determinant of who I was. It doesn't matter that you had a worse day, that you didn't sleep all night, that you couldn't learn, that you quarrelled with your parents, that you couldn't settle in at a new city, that... I could give so many examples here. Sometimes I think that lecturers forget that they used to be students themselves.

Back then I needed help so badly. I wanted somebody to give me some advice. Is it normal to be like that? Is it so difficult for every student at the beginning? Or is it only my problem? An omnipresent lack of information! I didn't know where to look for advice. Why isn't there a room with a sign: FOR LOST STUDENTS IN NEED: we can help you with talk, professional advice, understanding and good words. The situation was getting out of control... I couldn't cope with my own emotions. The fridge was smiling timidly at me in the kitchen. When I left in the morning, I had already started thinking what I would have to eat when I came back. It's only five more minutes. I'll catch a tram. Oh, it's coming! Faster, faster! How long can it take to go from one stop to another?! – I thought feverishly, and my irritation and anger were piling up in me – at last! My fridge, my fridge, my fridge! Dinner first, dumplings. I'll have ten... or twelve... yes! Twelve will be OK! – I analysed the situation. Then I had twenty. After that cereal with milk, because I could be hungry any time. A bar of chocolate, or rather two. A banana. And two ham sandwiches. Hang on... I had a Snickers somewhere... HERE IT IS! Five minutes later, with a sense of guilt, I kneeled in front of a toilet bowl. Such episodes were more and more frequent. On average three times a week. Then every day. I loved to stay in the flat alone during weekends. Then I could give vent to my gluttony. I didn't have to hide from my flat mate. In time I started to feel I was disgusting. I criticised myself for my lack of self-control. Other people can eat as much as they need and leave the table. So why can't I do that? Food can't be the centre of my life. Even though I provoked vomits and used laxatives, I kept on gaining weight. I didn't even notice the end of the session. Somehow I managed to pass the exams. At the first attempt. I was glad! But it was not a total happiness. It's no achievement – I thought – everybody passes. I was always very

critical of myself. I didn't give myself the right to make mistakes or to be weak. Everything had to be perfect. A perfectionist through and through...

I remember, it was January. I yielded to the pressure of the environment. I went to my first fitness class. Not for health, as other people do. I had one goal – it must help me to lose weight. It was true about every physical activity. That's why it was so difficult for me to motivate myself to exercise. The logic of a bulimic is very simple: exercises don't give immediate results, you need a lot of patience and effort, whereas fasting or vomiting give an almost immediate result. Why should I be bothered by running or fitness classes since it's easier not to eat? Exercises are helpful only if you want to fill up time in order not to think about not eating. At the first class I met a girl – as it turned out later, she was an anorexic after therapy. At the first class, one thing led to another and we told each other our stories. She instantly knew what was happening when she saw how determined I was. It wasn't normal determination. It was the determination of a bulimic. I was glad that I had met somebody who felt the same and who would help me to deal with it. Actually it was totally different. When I listened to her story, I realised that I didn't have any claims to call myself a bulimic. After all I wasn't even in hospital, I didn't lose so much weight. Maybe it was just my imagination? Maybe I wanted to attract the attention of others through pity and I had got this problem into my head?

I made a decision. If I dramatically lose weight, maybe somebody will finally help me?! I did what I had decided to do. I ate only natural yoghurt every day (obviously fat-free) and drank huge amounts of water. I started to run to accelerate the process of losing weight. Even though I ate so little, I felt very well. My clothes were falling off my back, my friends told me I looked good. I was powerful! The

biggest problem was to go home for weekends. How not to eat there?! My already vigilant mum would be suspicious. After three weeks of starving I went home. A bit weak. This trip put an end to my adventure of not eating. I forced myself to eat a little bit. A regular dinner. Gosh. What a shock to my constricted stomach. I had to vomit. My mum realised something was wrong. My worst fears came true. I had to talk to my mum and tell her everything. For the first time I admitted I HAD A PROBLEM! Then I looked for a psychologist, phone numbers, my referral. Then came the time of the referral ... six months after I had got it. It was six months of hoping that the problem would be solved on its own. I couldn't be more wrong! With the referral in my hand I went to Kraków. My first trip towards healing...

‘I went to see a psychiatrist’ – it’s so difficult to say that...

When you realise that you have a problem, you are halfway there. Then you have to find the will and strength to start treatment. And this is the more difficult half of your task because you have to go to a stranger and expose all your weaknesses to them. I was simply embarrassed. I was afraid that somebody would think I was a shallow teenager who thinks only about her looks, that they would think: she started to lose weight, caused her own problems and now she is hoping that somebody will understand her and help her. This was my vision of people suffering from eating disorders. Hence it was the image of myself as well. I didn't know that the problem was not inside my body, it was much deeper. It was my soul that was ill! I found a doctor for my soul. On my own! I made a phone call. On my own! I made an appointment and I went. On my own! The worst part was that I had nobody to support me then. I had support over the phone. But it's not the same. I sat in the

waiting room and I felt that everybody was only looking at me. Why are you staring at me, you are not so level-headed yourselves! – I was quite rebellious in my thoughts. I heard my surname. That's how it all started. I had to say what my problem was, when it began, how often it happened. Then a psychologist asked me questions. I only had to answer them. That's much easier. The psychologist made me aware that the therapy would last for about a year or longer. That we would often talk about painful issues. I agreed. If it was to help I should try. That's how I started to fight for myself.

Meetings took place twice a week. During the first five meetings we focused on the story of my childhood till the present moment. Then the therapy proper was to start, the therapy adjusted to my needs. At that time I also visited a psychiatrist who prescribed drugs for me. An indispensable element of therapy. They were to limit my appetite and prevent vomiting. During two meetings I cried. For the whole 45 minutes. The truth is painful sometimes. And the truth that surprises us is even more painful. Despite difficulties I continued the meetings. In time it was getting much better. I bloomed. I started to believe once again that I could change my life. That my situation is not totally hopeless. I started to meet my friends, I laughed more often. I was glad I was doing something with my life. I opened up a little bit to other people. The more so because I always liked to meet new people. It was too early to change my perception of myself. Since for four years I created a wrong image of myself, it wasn't realistic to expect that I would change it within four weeks. But I made my first attempts. When I went to meet people, I tried not to think what they would think of me, but how they would positively surprise me. I said to myself 'my biggest treasure is in my heart'. And what did I notice? The moment I started to have a better opinion of myself it turned out

that my contacts with others were no longer full of strain and stress. So that's the secret! – I thought. This magical sentence: 'you have to love and accept yourself' suddenly made sense to me. Before that it was too difficult to me. I hated it when my family repeated this sentence to me. If it was so simple – I thought – I wouldn't have the problem I have. I speak frankly! IT IS NOT EASY TO LIKE YOURSELF! When you don't know where to start, when you don't know what to like yourself for. It is a difficult challenge, just like to like your worst enemy. First you begin to accept his appearance which is not perfect and at first it repels you. Then you start to see his good qualities because everybody shows his good side at the beginning of an acquaintance. And eventually – his faults. That's a decisive moment that shows whether you can accept this human being as he is. With his weaknesses, weird behaviour. If you give yourself the right to make mistakes, you accept the idea that you don't have to be perfect – that's the best way to love yourself. I read somewhere that 'to love yourself – that's the beginning of a life-long romance'. And who isn't dreaming of such a romance? The first step of my therapy was to prepare an individual plan of meals and products that I could eat and have a healthy diet. First of all, put away sweets. Secondly, prepare my own diet with a calorie table in my hand (about 2000 calories a day), thirdly – buy only as many products as I need for one day, nothing more! For the first two weeks I even enjoyed it. I was finally doing something for myself. Plus drugs and a bit of exercise. Everything was going in the right direction. I was proud I was doing so fine. I was wondering why I had waited so long before I started my therapy since it helped me so much. These were the three months of my revival. Three months of life in every sense of the word. But bulimia is like a cat. It catches its prey and toys with it for some time. Then lets it go, catches again, lets go again. The cat rarely kills instantly, because

it derives pleasure from the game. When it decides it's enough, it leaves the prey and goes away. Not too far and only for some time. To attack again. Just a game...

The end of May. Another session was coming. An ideal moment to check my strength. Do I believe in myself strongly enough to pass all the exams and make my parents proud? I didn't want to let them down. I didn't even think of letting myself down. I always worried about others. The huge chunks of materials to learn were overwhelming. Don't they understand we are only humans, not robots programmed to memorise everything? – I was rebellious again. I couldn't allow for any weakness. Not at that time, not at that university. At first everything was fine. I passed all the exams but one. But I couldn't get over my failure. How come? I didn't listen to words of reassurance that I would pass it, that it was not the end of the world. Again I felt insecure. I was afraid to tell my parents that I had failed. They work so hard so that I can learn. I couldn't stand the pressure. The fridge smiled at me again. Welcome, honey! I knew you would be back. Only I know how to help you – it seemed to be saying. I ate everything in the fridge, including the frozen food! Then I returned to a well-known scheme. I took my drugs again and then, for the first time, I read the leaflet. I was especially interested in side effects: '(...) exceeding the recommended dose may induce nausea and vomiting.' BINGO! I thought that if I lost a little weight, my parents would regard me more favourably. Even though they told me nothing wrong had happened. I didn't listen to what others were saying if it was something good and non-judgmental. I had my plan and my way of thinking. Once again I started to starve myself and vomit. I stopped going to my therapy. I was ashamed to go back. I thought it was not the place for people like me. For the weak ones that gave up. I didn't want to talk to anybody. I sat in my empty flat. I didn't feel like

getting out of my bed. What for? I guess my life is supposed to be like that. The academic year finished. I came back home. I don't remember much of that period. Apart from one thing. Quite by chance I met my future boyfriend then. The time came to verify what glossy magazines for teenagers claim: 'it's enough if the man of your life accepts you as you are and all your problems will fade away.' I believed in it...

I love you vehemently...

We are not together any longer. After a year and a half in a relationship I daresay such a relationship doesn't solve any problems. It's not a panacea. Obviously, it gives you a temporary sense of acceptance and security. It helps to stop this cycle of starving and losing weight, it helps to improve your self-esteem. It takes up a lot of time, occupies your thoughts. You feel needed. A bulimic loves for two. She gives everything away not to stay alone. She doesn't think of herself. She doesn't know that when she gives herself away, she doesn't leave anything for herself. She builds her self-esteem on the basis of somebody else's opinion. And when a crisis comes, she loses ground, because she knows that when he leaves, she will lose herself. That's why loving yourself is so important! Respect! And conviction that it is up to your partner to do something to deserve to be with you! If you love yourself and you know how precious you are, you are not afraid to be on your own because you know you will cope anyway. Better or worse, but you will. I think that if a man feels good in his own company, he is ready to create a mature relationship. It's not easy. Especially for someone who desperately needs love. But it's viable. The break-up was a turning point for me after which I started to think differently of myself. The more so because I made the decision on my own. Without anybody's

opinion or impact. It's important because I felt that I was capable of deciding about my own life. And I have the right to do that. I felt that my life depends on me, on my decisions. Good or bad, doesn't matter. Each decision is a new experience, I was always afraid of that. For the first time in my life I was not afraid to take a risk. Yet I was afraid of the consequences. For the first time I didn't run away from a problem! I was trying to solve it. And that's a significant difference.

Healthy?

I discovered that solving problems is kind of cool. Each event, like an exam or a quarrel with my boyfriend or a disappointment, teaches me something new. A good or bad situation teaches me to have distance from myself and from people. It is connected with the possibility of making a mistake, of failing. After all, we are just humans. Everybody may fall down. Many times. But the most important part is to get up. Because 'power is manifested through weakness.' Today I'm twenty two years old. I've been a bulimic for seven years. I'm alive. I think that's the best proof that you can live with bulimia. For a long time I couldn't accept the fact that I can't live like other people. I didn't like the necessity to control myself whilst eating. I didn't like the fact that I have to struggle every time I do shopping and I see a bar of chocolate on the shelf. To eat or not to eat. Others don't have such a problem and if they feel like it, they buy a bar of chocolate and eat it. Today I think that my illness has formed my character. Every fall and rise from that fall made me stronger. More resilient. Apart from a healthy discipline I have tried to be more lenient with myself. I have learnt how to laugh at myself, at my imperfection. It was very difficult for me. But I'm happy I've learnt that. I've come to terms with the fact that bulimia

is part of my life. Once I thought it was my curse, it was unjust, now I believe that I'm special because of that. I believe that what happened to me has made sense. For instance I can share my experience with others who need support. Thanks to my illness I learnt to fight for myself. I became more aware of myself, of my needs. After seven years during which I didn't take care of my needs, I didn't treat myself as a person who is worthy of respect and has the right to lead a happy life, I want to say that it makes sense when you talk about your needs. It makes sense because otherwise we don't give ourselves a chance, we don't give others a chance to help us, to support us. I know it's difficult to talk aloud about such an embarrassing matter. We are afraid of lack of understanding, of mockery and rejection. You can't confide your secret to everybody. Yet there are people who know how to help you and are willing to do that. That's one of the reasons why you must start talking about your problems!

Am I healthy? Let me answer with another question: are there totally healthy people in this world? I've managed to subdue symptoms. I learnt how to react to problems in another way. For more than a year neither have I induced vomiting nor have I followed any strict diets. I have accepted my past and I'm hopeful about the future. I want to live! I want to continue my therapy because I want to know the causes of my illness. It doesn't matter if I fall down again. Even if I do, I know I have the strength and the people who will help me to rise up again. Everybody has! So 'don't be afraid of shadows. They prove that there is light somewhere!'

Miscellaneous remarks...

Incidentally, I find one thing interesting. Every day we meet people who are ill. We should learn to help them. Why can't we accept the idea that a student may be ill as well? Why should a student be afraid of approaching a lecturer and saying: 'I haven't managed to learn that, there was too much to learn, I had a headache.' Let's take a step further... Why during classes on psychology and psychiatry does nobody (with one exception) discuss such important issues as anorexia, bulimia, neurosis, schizophrenia, that most often pertain to people of our age? Knowledge about that is too limited, almost none. Mental health problems are not always conspicuous at first sight. It's interesting that people with similar problems can notice one another in a crowd. I've met as many as six of them in my life whereas people without such problems can't notice a single person like that. Some acquaintances of mine were shocked when they learnt about my bulimia. 'I would never guess you might have such a problem' – which shows the scale of ignorance. Nobody should be blamed for that. I wasn't really interested in it before I became ill. And information about it is scarce. It's hard to say where to look for it. An issue concerning any pathology is not usually discussed in open forum. Newspapers write that you have to be healthy, fit, sexy, trendy, and so on. Every deviation from the norm is inadvisable. Miracle diets, beauty treatments for your body, new clothes, make-up, retouched and pathologically thin models with an ideal complexion and body, career, money. And where is a place for human beings and their unique souls? What about the sensitive souls who are bombarded with the physical from all sides and start to lose their self-confidence? After all, beauty and physical appearance is just

temporary. Is it really necessary for young people to suffer so terribly to understand that?

There are more people like me. I'm not a rare case. They don't accept the world as it is, just like me. If they hurt themselves, they do it to attract attention to their problems! It is a desperate cry for help! But where can they get help since people around us have no idea why we behave like that? And is losing weight for them connected with weakness and vanity? Maybe instead of writing superficial, catchy articles, it would be better to write about the important things? To finish off with, let me say that there are people for whom the indisputable value is man's soul. We should look for them and we should live with them!

Piotr Berestecki

The Story of My Studies

The studies of my dreams

In 1994 I started to study law at the Jagiellonian University. I'd always dreamt of it. Previously I'd studied construction for two years, successfully, at the Technical University of Częstochowa. It was not my choice, I wasn't happy there because I dreamt of studying law all the time. But I couldn't hope for my parents' approval for my professional plans, I couldn't hope for their material support so I had to study in my hometown, Częstochowa. In December 1993 I was diagnosed with insulin-dependent diabetes. The illness changed my life, also in a positive sense. I decided to take the entrance exams to study law and I prepared for them during my sick leave from the Technical University. My parents, not without objections, eventually accepted my choice and offered material support. Law studies made it possible for me to have a job in line with my interests and one which might also make it possible for me to have an active professional life with diabetes. I passed the exams very successfully, I felt as if I was on cloud nine. My dreams came true – I felt that the Law Faculty was the right place for me. I didn't have any problems with my studies until May

1999 when I received a certificate of completion. I passed my exams without difficulty, I didn't have to repeat any year, I didn't take a year off. I managed to study despite financial problems as well as adaptation difficulties connected with living in a student hostel. In the course of my studies I didn't try to use an alternative mode of taking exams, actually none of other students knew I was ill. I was just a student, like everybody else.

Illness and problems with education

At the end of my fifth year (after I received my certificate of completion) I had some health problems but for a long time I thought they were caused by fatigue or they were the consequences of diabetes. I was so exhausted that I didn't manage to finish my Master's thesis on time. That is why I had to repeat the fifth year. For me it was a very negative experience because I wanted to graduate from the university without any problems, I wanted to write a good Master's thesis, I was very much interested in the thesis topic. I was writing a Master's thesis at a prestigious department of the Law Faculty. I was planning to take an exam to train as a solicitor. Repeating a year thwarted this professional plan and I had a breakdown... It's difficult to write about the period when I didn't know what was happening to me, I was mentally weak and incapable of any reasonable activity. For two years I couldn't formulate a proper sentence in legal language, I had to use a dictionary of the Polish language all the time whilst writing the thesis. I was achy all the time, I had terrible headaches, sometimes I couldn't get off the chair or out of bed in the morning. I repeated the fifth year twice because I didn't submit my Master's thesis. The time limit for repeating a year in full time studies had been reached. After one year,

in order to continue my education, I had to move to extramural studies. Nothing had changed in my mental condition. I was still afraid to go to the university admin; if I had to do so, I asked my friends for help. Of course, after the difficulties at the university started, other problems followed: personal, family, financial. My parents didn't understand the reasons for my problems with the Master's thesis, they felt disappointed by my behaviour, they thought they had been right to be against my law studies. Financial problems accumulated since repeating the year once again involved additional outlay and I couldn't afford it. For most of that time I didn't have a job. Nobody wanted to employ me – either they were afraid of a person with diabetes or they said I didn't have formal education. I was diagnosed with depression and I started treatment – a few months of pharmacological therapy and psychotherapy didn't give results... I couldn't continue the treatment for financial reasons.

In 2004 I had paralysis of the optic nerve. I was referred to do an MRI which showed demyelinating changes in my brain caused by multiple sclerosis or cerebral ischaemic strokes. Another examination a year later showed progression of these changes. At the moment the differential diagnosis is that it is relapsing multiple sclerosis or ischaemic strokes. With hindsight, it's difficult to say whether depression resulted from the multiple sclerosis, which may be the case, or whether it was produced by diabetes or social relations. It is possible that my depression was caused by numerous factors.

Why I couldn't write my Master's thesis

In the academic year 2008/2009 I decided to resume my studies once again. For all this time I couldn't sort out my personal and professional life. The decision to resume my university studies was associated with

a huge financial sacrifice. I could do it thanks to the help of my friends and parents. I had to make up for curriculum differences. During the winter session I passed three exams, I received good grades, I believed I could cope with my Master's thesis and graduate. I guess it is not a coincidence that when I could participate in classes and then had to take exams, I was successful. I was simply in touch with the university, with Kraków, I once again lived in a legal, university world and I dealt easily with education. Later on, when I no longer had these contacts and I went back to Częstochowa, it was very difficult for me to graduate. The deadline for submitting my Master's thesis was 15 December 2009. I applied to the Dean for prolongation of the deadline for another several months and my application was approved. The new deadline was 15 May 2010. Unfortunately, I couldn't write the thesis. I gathered a lot of literature on the topic, I wrote more than 200 pages of working materials, I didn't have problems with formulating my thoughts, constructing my argument, yet I didn't believe that I could complete my studies. After short periods of activity bad thoughts returned, lack of faith in my skills, in finding my place in life. There was a sense that maybe I don't deserve to graduate. This lack of faith in my success is caused by the lower mental resilience that accompanies diabetes or multiple sclerosis and by the lower physical immunity that makes it necessary to spread the work in time and at the same time makes it impossible to achieve the desired results.

Why have I not so far been able to finish my diploma thesis? I think it was very difficult for me to overcome my problems. Depression recurs, there are periods of apathy and fear of the future that last several months. The fact that I didn't graduate from the university totally upset my life. Depression, break-up with my girlfriend after a relationship lasting a few years, information about another illness, another failure

at the university... For a very long time I couldn't intellectually accept the words 'I want', 'I can.'

On 15 May I applied for prolongation of the deadline for submitting the Master's thesis by one month. I didn't even ask whether my application was approved. I thought it wasn't because when I opened my student's account there was information there that I don't have access to all the data and an explanation that a possible reason was losing the status of a student or failing to complete the studies on time. I stopped writing the thesis even though there were two weeks left to the deadline.... I'm aware that because of a change in the rules of the university that makes it possible to resume studies only once, it won't be possible for me to continue the studies in order to defend my Master's thesis. I will have to start the studies from scratch.

Current difficulties

I have great difficulties in finding a job. I've never worked on the basis of an employment contract, for many months I didn't even have health insurance. At the beginning of 2010 I submitted an application to be granted a disability certificate. I need it to apply for a subsidy to start my legal consultancy business activity or to look for a job for a disabled person. Quite recently I joined a discussion list of lawyers and I regained faith in my own abilities – I often take part in discussions there. I have been looking for a job unsuccessfully for the last few years. Twice I was invited for an interview in a law office – in one case I was not employed because of achromatosis on my face, in the other I was offered unpaid training – I had to give up because I couldn't afford to live in Warsaw. I'm going to another interview – everything will depend on my having the possibility of completing my studies.

The lack of permanent employment leads to financial problems. I live with my grandmother, I take care of her. A very important thing for me is to take care of fuel for the winter when the average temperature inside the house is twelve degrees Celsius at which time my hands go numb with cold on the computer keyboard. We take a loan for winter and pay it back during the rest of the year. Once, in wintertime, I had to sell scrap, after returning to the university we spent some of the coal money for my studies. I have a computer thanks to a friend of mine, who is an IT specialist (I bought computer parts and he put them together). I bought a lawyer's bag and I had the Internet installed four months ago...Despite these micro-successes I still can't cope with the main problem, namely completing the studies. I need much more time to write the thesis effectively (sometimes I write painstakingly) than if I wasn't chronically ill. I should avoid fatigue, otherwise I am liable to pass out, this can happen after incessant, intensive work. I should be careful because of a high risk of ischaemia of other parts of my brain, their effects may be dangerous to my health and life. As a result I can only spend a few hours a day writing, I have to reconcile writing with regular duties, like doing occasional assignments.

Plans for the future

To sum it up: I have received support from the Law Faculty, friendliness from my thesis supervisor and the Deans when they issued positive decisions in response to my applications. Maybe I lacked a normal conversation, nobody tried to send me for consultations with a university psychologist, maybe I should participate in a programme like the one that will be offered in the new academic year. I needed the boost that somebody could have offered me via a conversation,

I needed planned support or a cycle of meetings. A person who is depressed makes irrational decisions, doesn't notice opportunities and space for action, cannot ask for help and is ashamed to do so... I know how to get out of this difficult situation, how to change my life. My goal is to get education, take an exam to train as a solicitor, get a job in a law office or open my own company. I don't have enough strength and faith in myself. I got used to the thought that I may not complete my studies, I may not have a normal life, that I will have to start everything anew. On the other hand, I think that the summer holidays and early autumn now ahead of me may be a good time to write a diploma thesis. If I get a decision that will make it possible for me to complete my studies and take the diploma exam, I will use the support offered by the Disability Support Service. I think the DSS should help me stay in touch with the university. Apart from people from the DSS and my thesis supervisor at the Jagiellonian University I don't have anybody who could help me stay in the university world, believe in the success of my efforts, who could help me complete my education, finish this phase of my life and open a new one. I must stress that sometimes it is enough to go to university to have a positive effect and I'm really glad that the DSS gave me so much attention and help... In my unusual situation a consultant from the DSS symbolises that the whole university cares for the success of my education and believes in me.

Maybe my story will be the stimulus for creating a complex programme to monitor and inform the DSS about the mental health problems of students. Maybe it could happen at the level of the university administration. My example is quite extreme but nobody offered me effective help, instead I heard hurtful words (for instance that I'm a sponger) and it made me withdraw into myself. Maybe it is like that because I look like a 'healthy' man... Maybe people who are

supposed to provide services to students (the university admin) don't understand the health problems of students. It was only a few days ago that I looked at the university website and came across information about a project for students with mental health difficulties. Maybe my example will be a motivation to intensify their activities to support people who cannot overcome problems on their own.

Ewa Kowalska

My Studies, My Mental Health Problems

What it is like to have mental health problems

I've been ill since 2000. It all started with depression in secondary school but I didn't know it was depression then. When I was twenty-one I went to a psychiatrist and I started treatment. After a few years the depression subsided and paranoid schizophrenia appeared. That was when I started to have terrible thoughts, delusions, images... At the beginning it happened rarely, later on more and more frequently. My illness is linked with terrible thoughts. I feel that somebody orders me to do things that I would never do. For instance, I would never kill anyone and these thoughts are so terrible – they say I'll be fine if I kill eighty people. These are not 'my' thoughts. My thoughts are totally different. Yet both kinds of thoughts are inside me and they quarrel with one another. Then I feel internal tension which is indescribable, nobody can understand that. It's the feeling of being torn apart; due to the terrible thoughts I don't know what to do, how to behave. It's so awful and I so desperately do not want it. I don't want it to happen in my head, I want it to go away, because otherwise it is so difficult to live. Today I know that the only thing that can help me in such moments

is Valium. Sometimes I must take it to release tension, to feel relaxed. Valium is a drug to which one can easily get addicted, so I try to take it as rarely as possible, because addiction would be a nightmare to me. But when I feel bad, I start wondering why I should suffer so much and I call my mum or my sister and ask them whether I should take the medicine – to chase away the thoughts which are ‘not mine.’ When it happened for the first time, I didn’t know what it was, I didn’t even tell my psychiatrist who thought I was still depressed. When I was admitted to hospital, my schizophrenia was diagnosed. I was at a university in Kraków – not the current one. At the university I was on my own – like an orphan, no support, no understanding, I didn’t tell anyone about my mental health problems. I didn’t manage to graduate, I was there for only half a year. Today I don’t even like to think about it.

Reactions of others to my mental health problems

After my first episode of illness and my failure at university, I returned to my home town where I mostly stayed at home and visited different hospitals and psychiatrists. I had to suffer different insults especially from the nurses in the hospital and my distant relations. My environment is a small town. I don’t even know now how some people learnt about my problems, I suppose they heard about it from people working in the emergency service. When I had any problems, I ran fast to the emergency unit and went to the psychiatric hospital. I didn’t want my distant relations to know about my mental health problems. I don’t want anybody to know. I’m marked that it has come to light. Now I avoid people who know about my problems because they look differently at me: it looks like pity or approaching a child with special needs. I’ve never wanted my small town to learn about my mental

health problems but it's already happened so I don't want to go back there; now the most important thing is to study in Kraków. Staying at home and rotting there was awful. Here in Kraków life is different, I'm anonymous, I can go whenever I want to. In a small town you can't even go to the doctor's because, for instance, a nurse working in the room next to the psychiatrist's office is an acquaintance or a member of my family. That's why I can't go to a psychiatrist's there, I never would. Even when I wanted to buy the medicine, I went to another town so as not to buy psychotropic drugs in my own town, God forbid. I don't want to talk about my mental health difficulties at the university – people are different and they may perceive me as 'the crazy one', whether they have academic titles or not. Some will be favourably disposed towards me and others will think: 'what is she doing here?' I don't want that. I know I shouldn't be ashamed because it's an illness, it's not my choice. But in my opinion people treat those with mental health problems with a bit of contempt, differently from those with other health problems. I think it's not nice if a healthy person calls another healthy person 'you lunatic'. And what if you say that to a person who is ill? At the university nobody told me I was a lunatic but I suffered many insults from my family and medical staff, especially in my home town. That's why I don't want to go back.

Back at the university: studies and treatment

I went back to university after my schizophrenia was diagnosed. In Warsaw I had my psychiatrist. After I came to Kraków to study, I visited him less regularly and I found another one in Kraków, which was more convenient when I needed a prescription. Before my studies I stayed at home a lot, I had a different lifestyle. Here I was suddenly thrown

into a new environment and it was tough at the beginning. As a result of my mental health problems and drugs I couldn't really cope with learning. I took Clozapine which made me terribly numb. Clozapine is a neuroleptic which was to muffle 'not my' thoughts, but at the same time it made me numb. Now my new doctor prescribed me Abilify, also a neuroleptic, but this one, unlike Clozapine, stimulates me. There is a balance between them and thanks to that I feel fine. Abilify – I read about it – is a nice drug of a new generation, not addictive like Valium. I'm glad the doctor recommended it to me. When I took Clozapine only, it was difficult for me at lectures. It actually didn't matter whether I went to lectures or not. When I went to a lecture, I let my thoughts wander, I couldn't focus on the topic of the lecture. It was even difficult to get out of bed to go to classes in the morning. Now it is totally different – when I go to lectures, I'm interested in the topic, I want to listen, I want to learn. About a year ago I was in very poor condition mentally, I felt terrible, I had suicidal thoughts, I was totally pessimistic. I had problems with concentration. I remember that I read a textbook then and I had to comment on every sentence to myself because I couldn't understand its meaning. I couldn't focus, my thoughts were dispersed. It was so bad that I wasn't capable of passing exams during the summer session. Then I talked to a psychiatrist at the Disability Support Service (DSS) and she told me that in her opinion I couldn't pass exams because my health condition was too bad for that. It was true, I couldn't concentrate. Why read the same page over and over again if I don't understand a word of it? The psychiatrist said that when I go to hospital, I'll get drugs adjusted to my needs – then I'll be able to read a book in no time and I'll know what it is about. I felt very bad then, I was all messed up inside. I slept very long, I don't know why, I could fall asleep like a baby at 3 p.m. Because of suicidal

thoughts and all the rest I decided to go to hospital in May. I stayed there till mid-August. Now – with hindsight – I regret they didn't give me Abilify instantly (because the drug was already on the market), they gave me only the old drug Depakine. Once I felt in seventh heaven, then I was terribly low. The doctor told me that Depakine is a bipolar drug which balances the situation, you are neither very euphoric nor very depressed. It didn't help much – it neither improved my concentration nor my attitude to life. Only later, when I started treatment at an outpatients' clinic, did a doctor recommend Abilify to me. Then the situation began to change for the better. Not instantly, because you have to wait a while before psychotropic drugs start to work; now I see it's getting better.

The Disability Support Service, my salvation

I found the Disability Support Service during my second period of university studies. I received its address from my doctor. It was my salvation – something that changed my life. I would have been expelled from the university, just like before, and I would have visited different hospitals every six months, like before I studied. Now I'm more optimistic, I have more faith that I can graduate, I'm no longer afraid of that. If it wasn't for the DSS, I would have failed. The simplest example is dealing with errands in the secretariat – we all know that people who work there are not always very helpful... I didn't feel like going there at all. Some time ago I had to declare my participation in health and safety training. I went to the secretariat, I forced myself to do that, and the lady there told me it was not her duty. I was sure it was! I left the secretariat because I didn't know how to behave: quarrel with

her, tell her it was her duty? Only when I went to the DSS with that – the problem was solved.

My story with the DSS started when I had a problem with a social benefit. The moment I went on sick leave it turned out I was supposed to give the money back. I was scared because I didn't know what to do with that. Then the DSS helped me to clarify the matter, to solve the problem in such a way that I didn't have to give the money back. I was also afraid that due to the sick leave I would lose my place in a student hostel – this problem was also solved. Now, when I returned to university after sick leave, I prepared a list of several pieces of advice for me in collaboration with the DSS consultants. The point was that lecturers and teachers should understand what my situation is, they should understand that I want to have equal chances. I don't want them to facilitate anything for me, I want to learn normally and receive credits. I want to have a good knowledge of different subjects because it's interesting. On the other hand, like with my family, I don't want my lecturers to know about my mental-health problems at all, they just should know that I have some kind of ailment. My teachers received a message from the DSS concerning the kind of adaptation I need but without details about my mental health problems. One of the adaptations I was granted is an extended examination period and the possibility of taking some of the exams in September. Now I can take some of the exams before the holidays and the rest after the holidays. It's very important because at the moment I feel good, it's a period of remission. But sometimes it's worse – then I need more time than people who are healthy to prepare for exams. It would be difficult for me to pass all the exams now, in June. Another adaptation is recording on a Dictaphone – it's also very important. I can't take notes at lectures

very well, they are too chaotic, illegible. Recording is better because I can listen to that at home and write down the most important things.

To sum it up – I would like to say to other students with mental health problems that they should come to the DSS. Then they won't be alone with their problems. They will have a sense of safety, they will have the chance to tell the truth about their problems to a person they can trust, a person that can keep the secret and understands them. What is also important is awareness of your own disability, awareness that your mental health problems don't mean you are worse or you are bound to fail. It just means you need understanding, time and hope that everything will be fine. The DSS helps you to have this hope.

It's impossible to study without treatment

I want to emphasise another thing – I believe it is impossible to study without treatment. You need to take drugs, stay in touch with your doctor, your psychologist. I remember a guy I met in hospital. He tried to commit suicide, was admitted to hospital, then placed in different wards, one after another, altogether he spent more than a year in hospital. I don't know why, but he stopped taking his drugs when he left the hospital... Now he is in hospital again. I simply believe you have to take drugs. I know from my experience that it requires patience because it takes time before they are adjusted to your needs. I took all the drugs: Risperidone and Seroquel and Zolpidem – I just swallowed all of them. If you do that and nothing helps, doctors prescribe you Clozapine. So I take Clozapine which muffles thoughts which are 'not mine' and additionally I take Abilify not to be too numb.

Some drugs make you numb, you have very poor concentration after taking them. I used to feel like a thickhead (fortunately I can say

‘I used to feel,’ now it’s different), I used to feel lifeless. Then going to lectures didn’t make much sense.

I think it needs a good psychiatrist to look at you with his clever eyes and assess your condition. Some of the drugs I used to take only worsened my condition, every day I had these thoughts that told me to do stupid things. I read on the Internet that drugs have different effects on different people; that’s why you need time and the advice of a good specialist on mental health.

A few words about discrimination

Sometimes I come across an opinion that a person with mental health problems shouldn’t study at university. I disagree. Studies are about doing something with passion. If you like your field of study, reading things and listening to things connected with it are pleasant in themselves. You just need to give more time to students with mental health problems, you need to understand them. They are also people, they are not losers, they haven’t chosen these problems for themselves – it simply happened to them in their lives, full stop. It’s not their fault. Why should they be treated worse, for instance why should they only work in selected professions? Some people believe it would be best to put all the people with mental health problems in a special place like in a sewing room so that they sew or do other manual jobs. Discrimination is awful, it makes me so angry. I want equal chances, I want to achieve something in life. Besides if we discriminate against people with mental health problems, maybe we should discriminate against others as well? Like people with a throat infection? Maybe in some time mental illness will not be perceived as something you need to hide. Maybe society will understand what it’s like or there will be

more people with such problems, it's quite possible in this day and age. But I wouldn't wish anyone to have experiences like that. It's awful, in my opinion that's the worst form of life. With psychosis it's really difficult.

Finally, let me reiterate my message to lecturers – I didn't want to be ill. I wanted a normal life, I wanted to receive credits like healthy students. But now, when I can't do that, when I undergo a treatment, I still want very much to graduate from the university. I don't want pity, I don't want to be treated like a child with special needs. I didn't choose it but since I'm afflicted with this illness, I have to live with it. I hope I'll be cured one day, I hope that everything will be fine, that I won't need to take drugs, I will be able to live like other people, that I won't have these stupid thoughts. These are my two biggest dreams in life: to be healthy and to graduate from the university.

Kamila Sołowiej

Neurosis, an Opportunity to Notice Yourself

I would like to talk about my experience from the point of view of the lessons that I've learnt as a result of it. Today, a year and a half from the first panic attack, I think of neurosis as a phase of my development, development in cognitive and spiritual terms. I think that I have learnt a lot about myself, my strengths and weaknesses and about the human being as such. This experience is made up of different moments: physical experiences, meetings with other people, my own reflections... My neurosis has been present and still is present in everything. Yet I've decided to talk about the experience and describe the most important moments. For me they are symbolic situations, the meaning of which I understood only later. I'm sure I'll think of them in the future as well.

Once again I want to repeat the words 'my neurosis.' It is the neurosis which is mine, individual and the only one of its kind. It is an aspect of myself, my way of reacting to the world around me and to my place in this world. I needed a lot of time to accept neurosis as an integral part of me, of who I am. The part that I don't need to like but which I do appreciate. I had to get to know myself and to accept myself to achieve it.

Hi, nice to meet you

Let me begin from a symbolic situation which is the most distant in time. I am in the room of my close friend in a student hostel. I'm walking from one end of the room to the other, she is sitting on the bed and watching me. I'm walking because if I sit down, I'll start shaking and I don't want to shake any more. For the last three days I couldn't eat or sleep, I've had a barrage of negative thoughts in my head: I can't do it, I can't sleep, I won't go to classes tomorrow, I can't pass exams, I won't go to France to my boyfriend, I won't graduate. Now it seems absurd, then – it didn't. I feel I'm losing ground and I'm so scared. This fear pervades everything. Just like the air. It seems to me that me, my friend, a desk, the room, the student hostel, we are not surrounded by the air, we are surrounded by tension caused by fear... My friend says 'Listen, you must get a grip on yourself.'

This 'get a grip' is symbolic to me. You can't grip something that is absent. I must first define what I am, who I am in order to get a grip on myself. I had to understand myself, to understand what I was afraid of and why... And I was afraid of, to use the notions introduced by Erving Goffman¹, not fulfilling roles in the theatre of my own life. First of all I played the role of my parents' daughter. My parents' daughter is ideal. She is smiling, healthy, a good student at school first, at university now, everywhere. You can be proud of your daughter, praise her in front of your friends and neighbours because it is such a nice topic for conversation. Even if the world is lousy, the good daughter shows that you have achieved something in life. People who know something

¹ See Goffman E. (1922–1982) an American sociologist; his concept of social roles is described in *Człowiek w teatrze życia codziennego* (original title *The Presentation of Self in Everyday Life*) (2008), Warsaw: Wydawnictwo Naukowe PWN.

about psychology realise that it is close to the definition of a ‘family hero,’ one of the roles assumed by children in a family with addictions. A child can also be the scapegoat, the mascot, the lost child. I happened to be the hero. Suddenly I was no longer able to play this role and I didn’t know any other. At one point I badly wanted somebody to take care of me, to tell me what I should do and the real hero doesn’t have such needs. So fear appeared because it is caused by lack of knowledge and uncertainty.

I’m not trying to say: I’m an ACoA (ACoA = Adult Children of Alcoholics or ACA = Adult Children Anonymous)² so I have neurosis. It would be an oversimplification, especially since I don’t see myself as a child of alcoholics, I see myself as a daughter of great people who have had smaller or larger problems with alcohol. I’m talking about it only because I believe it is absolutely necessary to look closely at my life and search for possible reasons for my reaction. In my case one of the reasons for my problems is my aspiration to be an ideal daughter; this role was chosen due to the situation in my family home. All the time I see symptoms of my role as hero – I feel responsible for everything, I hide negative emotions not to burden anybody, I justify every mistake of other people. Yet I’ve been working on changing that; I need to come to the conclusion that I can’t always be the hero. And what is more important: I don’t have to. All the other roles that I assume in my life refer back to this role from my childhood – I save boyfriends, cook for friends, prepare presentations on my own at the university and when I start my work I’ll probably be paid for extra hours. But now, after so many panic attacks, I know how harmful is my aspiration to be an

² More on the idea of ACoA/ACA can be found at www.psychologia.net.pl and www.dda.pl.

ideal daughter, girlfriend, friend, student. In my case it's not a problem of reconciling different roles, I have more than enough energy for that. My problem is that I want to make the most of each role. I don't even remember anybody demanding the strength, resourcefulness and joy from me ... I think I chose this role for myself and I created norms and requirements connected with it. It can be proved during the periods of my crises – even though I didn't fulfil this role, the world didn't collapse and nothing changed in my relations with others.

My return to university after the first crisis and two-week stay at home is a good example. I knew I didn't have to tell anything to some of my lecturers, but I had to explain my absence to others. On the one hand, I was ashamed to approach them and hand in a doctor's certificate where it was written in black and white that I had an anxiety-depressive disorder. On the other hand, I wanted to justify my absence so badly because I wanted to fulfil the role of an ideal student. I took two options into account: undermining the validity of the certificate or accepting it without any problems. Only the other option proved right.

Apart from that I was quite surprised by one reaction because one of the lecturers read the doctor's certificate thoroughly and asked whether I was better. I was a bit embarrassed but I said I was fine. Then, instead of folding the piece of paper and saying 'I see, ok, thank you, good-bye' he gave me a short, nice booklet to read and then discuss: *One Small Step. Moving Beyond Trauma and Therapy to a Life of Joy* by Yvonne Dolan³. It was to be my additional assignment to make up for the classes I missed. I felt noticed, it boosted my self-confidence. The lecturer was interested in my problem, how I was, whether I was all

³ See Dolan Y. (2004) *Jeden mały krok do szczęśliwego życia: jak odnaleźć swoje prawdziwe ja* (original title *One Small Step. Moving Beyond Trauma and Therapy to a Life of Joy*), Warsaw: Wydawnictwo Jacek Santorski & Co.

right. Yet he didn't give up on me but gave me a task that was adequate to my abilities then and which was to help me recover. It's true that the lecturer specialises in psychotherapy and sociotherapy, still I didn't expect that and I don't think his field of specialisation was the main reason for this reaction. I think the main reason was his attitude towards a student and a human being. It was all about devoting time to noticing the strengths and weaknesses of another human being and taking them into account in your relationship.

Between a pill and lemon balm

The next symbolic situation: me in a psychiatrist's office. A very important thing is that for me he was not only a psychiatrist, he was 'Mr Psychiatrist'. I came to him so that he could explain to me professionally why I was shaking, why my stomach was constricted and why suddenly the world seemed unreal. As if previously, apart from the mysterious gravity that kept us close to ground and everything in its place, there was a mental gravity that kept the world on a leash. And now the mental gravity disappeared all of a sudden... So I'm sitting in front of the psychiatrist, I'm crying and saying that actually I don't have any problems and I do realise that. I know that returning from France after a one-year stay, my slipped disc, moving to a new flat, my break-up with a boyfriend, being far away from my family home, getting closer to graduation are no problems at all. I know that people have more serious problems, wars, floods, famine... So I want him to tell me why I'm shaking, what kind of illness is that and what to do next. So far I was taught that if there is some problem with our health and there are physical symptoms, you go to a doctor, he gives you a diagnosis, and prescribes drugs. The psychiatrist told me something along the

line 'you have a nervous breakdown', and I replied 'but give me my diagnosis, please!' In this situation I believed the most important thing is a professional diagnosis. I went to the psychiatrist many times thinking that I needed a scientific diagnosis, it would be best to have it in writing to have a document certifying my weakness. I was pleased when another psychiatrist gave me such a diagnosis when she wrote a doctor's certificate to explain my absence at the university. At last I had confirmation that I had the right not to be fully effective, to be lazy. Later on I realised that this document changed nothing, that I needed it because, just like the whole contemporary world, I look for an expert to solve every problem. Ulrich Beck⁴ wrote about the dictatorship of experts: in the information society there is such a huge amount of information that we rely on experts in almost every field. I was the person who believed in the power of experts. I was convinced that I needed an expert in mental health to tell me what was happening inside my own head and why.

Obviously, the specialist information that I found reassured me; the information that my illness is called anxiety neurosis, that such symptoms are frequent, that it is fully curable, that about twenty per cent of people around me have this problem and amongst students it may be as many as thirty per cent. I found it because I needed an explanation that I could understand. I'm not trying to say that you don't need any help from specialists, quite the opposite. You just need to remember that they don't play the most important role in defining what is happening to you. You can't transfer all the responsibility to

⁴ Beck U. (b. 1944), a German sociologist; his concepts of the risk society and the dictatorship of experts can be found in *Spoleczeństwo ryzyka. W drodze do innej nowoczesności* (original title *Risk Society: Towards a New Modernity*) (2002, 2004), Warsaw: Wydawnictwo Scholar.

them, you can't transfer the power over your world to them because it makes you incapacitated of your own volition – then you renounce your own strength and your potential to cope with the situation. In time, when I felt better, some doubts appeared and my trust in the psychiatrist disappeared. Beck⁵ explains this phenomenon as well: distrust is a typical reaction of representatives of the risk society who, because they have difficulties with processing information, live in constant fear of the unknown. So I decided I would not listen to psychiatrists manipulated by pharmaceutical companies. As early as after three months I stopped taking drugs that I should have taken for from six up to nine months. Everything was fine as long as my life was calm and ordered, without stressful experiences. But when the situation got more difficult, I needed all my strength, I slept six hours a night and I had to be active all day, my mind and body gave up. The world became stormy again and I was like Pascal's fragile cane... a cane that was thinking too negatively.

Firstly I believed too strongly in science and medicine and then I totally lost faith in them. It seems like a cliché recurring in almost every reasonable philosophy – extremes won't take us anywhere, only the middle way will help you to find yourself and the meaning in life. And yet it turned out that I had to mature even to understand the cliché about the golden mean. I had to learn to find the balance between drugs and understanding myself and therapy.

⁵ Ibidem.

I would like to talk to someone...

The last situation that I would like to describe was just a split second: before I opened the door to a taxi on an early summer morning, after a sleepless night, full of fear. I decided that in order to fall asleep and escape from my thoughts and shaking body I needed 'something stronger.' I went to a clinic because I believed only there could I get help. Because I was there several hours ago and I got a tranquiliser, I demanded 'something more.' I was truly surprised when they refused to give me a drug that would knock me off my feet. They told me that I should try to calm down and go to sleep or 'you may take a referral to a psychiatric hospital.' It was a dilemma: do I feel bad enough to go to a psychiatrist or will I cope with it on my own? I felt a great need to be professionally taken care of, I didn't believe I could cope on my own. What is more, I didn't want to cope with anything on my own. Secondly, I thought that if I went to a psychiatric hospital, such a serious health care institution, it would be a sign that I was not just making a fuss, that I had the right to feel bad. I asked for the referral.

And I was to go there. I went towards a taxi. I was about to open the door to the taxi and I imagined the next minute: at 4 a.m. I would open the door, look at the taxi driver and say: 'To the psychiatric hospital, please.' I'm not a lunatic! What would the taxi driver think? I imagined that he would see a young, well-dressed, quite well-groomed girl and maybe he wouldn't think I was a lunatic... maybe he would think I wanted to visit somebody? Up to now I didn't know that such terrible stereotypes about people with mental health problems were so deeply rooted in my head. I didn't know that I had no idea about who these people were, what happened to them that they had to go to a psychiatric hospital. On my way to the hospital, I had an

image of people in straitjackets jumping in cold, grey rooms but I was also hoping that I would meet a specialist there who would tell me what I should do with myself. Of course, none of the images proved accurate... I woke up the whole hospital, they were furious with me and a lady at the reception desk asked me what I really wanted from them. It was quite thought-provoking for me... So far I didn't know what I was actually looking for. Finally I said that I just wanted to talk to somebody. I had to visit a clinic twice and a psychiatric hospital once to understand that I needed to talk to somebody. I'm not saying that I didn't have anybody to talk to. I went there with a friend of mine. She was holding my hand, supported me and I told her how I felt. But it was not a real conversation. Because a conversation, a meeting or a dialogue is opening to another person and showing your real face. The philosophy of dialogue says that it is about removing all your masks and facing another human being as you are. I didn't do that because I didn't want to blurt out the whole story of my life. We are living in the world of individualism and competition. First of all, everything is individual: time, dreams, experiences, problems. Secondly, I didn't want to appear as the worse, the weaker one. It's easier if you go to a specialist – you pay for that so the relationship is more balanced. Another reason for my acute need of conversation was an urge to hear somebody say: 'You are not going to freak out completely.' I didn't ask anybody about that but I needed to hear that so badly; I needed to know that I wouldn't stare in one point for the rest of my life – as in the worst film scenarios. And here comes the destructive force of a stereotype. Maybe if I had known that there are so many mental health problems and even the most severe form of this illness is curable, I wouldn't have had such absurd visions and I wouldn't be so scared. Maybe if I had seen one of the actions of the Open the Doors Association earlier or at least

had read an article about a person with severe mental health problems, I would have had a totally different approach to my experiences...

I sleep, I swim, I talk to myself, I value my rhythm

Finally I would like to say how I got to this point when I'm sitting calmly in front of a computer, drinking tea, and I almost boast of my neurosis as the experience that made me stronger and taught me many lessons. First of all, I learnt to take care of my sleep and peace. I know that young and active people in particular may think it's banal and meaningless. Yet if you are somehow more sensitive than others, when you experience things a bit deeper and stronger, you need to rest from that. The best method is sleep. Of course as much as an individual needs. Secondly, I look at myself carefully and I talk to myself. When I feel internal unrest, I try to sit down and think carefully what worries me and what's the reason for that. When I know, more or less, what the problem is, I either try to avoid it (for example I cancel a meeting that may evoke many negative emotions) or to change it (for example I ask for more time to prepare for an exam). Sometimes I use the catastrophe method: I'm trying to imagine the worst possible scenario of this event and as a rule I come to the conclusion that it is impossible for something so bad to happen. It turns out that there is time for everything, almost everything can be corrected and there is always a light at the end of the tunnel. Obviously I can't forget about drugs. For the last year I took anti-depressants which were to help my brain to regenerate its ability to react to stress. I've just stopped taking them but this time it was different, I didn't do it overnight, but gradually. I think that the drugs really helped me to some extent. It is difficult to analyse yourself objectively but I seem to be more balanced in my reactions and

I think it is also due to the drugs. I'm also trying to assess my abilities in a more realistic way and adjust tasks to my abilities, not the other way round. It is not about lower ambitions or giving up on your goals. Just the opposite – I'm doing a lot, I'm setting myself high standards but I'm trying to spread my tasks in time and not to overburden myself. These are simple things. Yes, I almost always have tranquilisers in my drawer. Yet I'm trying to avoid them, I know when I can take them and I know I have to do everything not to reach the point when I need them. And I exercise! The night when I woke up the psychiatric hospital, the psychiatrist who admitted me there asked me whether I practised any sport. I admitted I didn't – you know, I have to learn, I read newspapers, go for coffee with friends, I have to do things in my flat... and I don't have time for sport. And I was reprimanded! How come, he said, a girl with neurosis, problems with sleep, problems with her spine and she doesn't practise any sport?! After that conversation I think till the end of my life I will try to do something for my physical condition at least once a week. Trivial again, isn't it? For me a motto 'a healthy mind in a healthy body' always evoked unpleasant images of sweaty gym shoes and shouting PE teachers. It turns out it makes sense.

I hope that these several moments of my life will help you believe a little bit that you don't need to be afraid of your own weaknesses. It is better to have a closer look at them, learn how to overcome them and use them to your benefit. Weaknesses are an indispensable part of our personality just as our talents and abilities. We just cannot ignore them or yield to them. We must notice them, we must accept ourselves as we are and then we can use our weaknesses to become better people.

Anna Liberadzka

One in a Million

Hope is paradoxical. It is neither passive waiting
nor is it unrealistic forcing of circumstances
that cannot occur.
It is like the crouched tiger who will jump only when
the moment for jumping has come.

E. Fromm

When I think about a mental illness I see a flashback in my head, an image, a memory of holidays, back in the secondary school: mountains, sun, taste of summer, *The Bell Jar* by Sylvia Plath¹ and my theoretical thoughts: what does it mean to be mentally ill, what is it like? I remember my thought that perhaps it is better that I don't know. I didn't realise then that I would learn what it means and I would know all too well what it is to have mental health problems.

I'm one of a million people in Poland who have experienced psychosis. I've come across negative stereotypes, prejudice and I've experienced discrimination connected with my illness. I don't want to write about it today. I don't want to accuse anyone. I don't want to arouse a sense of guilt. I want to give hope. I've written this article because

¹ See Plath S. (1995) *Szklany kosz* (original title *The Bell Jar*), Poznań: Wydawnictwo Zysk i S-ka.

I thought about the remaining 999 999 people who have experienced psychosis, their families, friends; I thought about everybody who is interested in their fate and who can create moments of 'crouched hope.' Today I'm writing about an experience of a mental illness from the point of view of a person who overcame a crisis. My university studies formed an extremely important moment in my story because these were the peak of my struggle for health. My graduation was a double victory for me and today I'm glad that I'm a graduate of the Jagiellonian University. There is a common belief that people who want to study psychology have problems with themselves. Maybe there is a grain of truth in that. Yet I decided to study psychology because I was deeply convinced that a human being is a mystery, a puzzle. I believed that studying psychology would help me get closer to that mystery.

Studying was fascinating, I was very enthusiastic about everything, I read the required and recommended books with bated breath, I soaked them up like great novels. I had a lot of zeal, energy and openness. I liked the fact that lecturers discussed things with us, asked us about our opinions, that we could formulate our thoughts freely, share our reflections and observations. I saw a big qualitative difference between learning at school and studying at university. What I liked even more was that these discussions sometimes didn't end the moment classes ended. Several enthusiastic people, including me, continued discussions in a café; we talked not only about psychology, but also about philosophy, religion, ethics, politics. Meeting people with such different personalities, different life stories, experiences, views and beliefs was an amazing experience for me. What we had in common was our willingness to search for the truth, to learn. We spent a lot of time together, not only talking but also having fun, going away; we tasted life and crossed limits, we were not always responsible. Then

I thought that the world is full of opportunities, that it invites me to enjoy life, to take advantage of it. I saw everything in bright colours. I thought I was on a threshold of adulthood and I liked the adulthood very much.

After the first year, during the holidays, I went to work in the UK. There I experienced something that was decisive for my future life. This experience struck me, broke me down, deprived me of my protective shell, I became vulnerable. I returned as a different person, with an opened wound, full of a sense of guilt, shame and hurt. I decided not to talk about it with anybody. Theoretically nothing changed after I came back to Kraków after the holidays. I prepared for classes, participated in them, I met my friends, went to parties. Yet slowly I began to withdraw. On the outside I was talkative, joyful and smiling as always but inside I was focused on my wound. My pain grew, I tried to muffle it with more and more alcohol.

I can't define specifically when first symptoms of the illness appeared. It crept imperceptibly. It all started when I began to think that I was not that welcome in the group of my friends with whom I had felt so close in the past. Today I'm not sure whether it was the fact or only my impressions. At the same time my thoughts went back to the London events, it bothered me, it hurt me, I couldn't sleep. I decided to confide in Miłosz, a friend of mine in whom I had great trust. We went out for a drink and I told him the whole story and cried on his shoulder. I felt a big relief, it helped me for some time. Then there was a moment when I started to think (now I know it was due to my illness) that everybody had learnt about my story, that they condemned me, withdrew from my life. I started to notice weird smiles, full of pity, disgust and revulsion. Later on I began to interpret the conversations that I overheard as directed against me. I lacked self-confidence, I had

a sense of threat and fear. My interpretation of the surrounding world got more and more bizarre every day. All my senses were very acute, I was alert and convinced that my alertness may protect me against the more and more ominous world. I was physically looking for some place where I could hide but I didn't feel safe anywhere because a sense of fear, uncertainty and fragility was inside me, regardless of the surrounding world. I had racing thoughts, sequences of associations that I couldn't get rid of. Firstly I tried to talk about it to my family and friends but they were so weird that people reacted with surprise, disbelief, sometimes mild ridicule. And then I knew that everybody was against me, there was a conspiracy against me, I couldn't trust anyone, I couldn't open to anyone because then I would be more vulnerable. I tried to make sense of it all and I came to a conclusion that it was quite obvious – I must be part of a psychological experiment, I must be its main subject. That is why people stop talking when I enter the room. That is why they look at me in a strange way – they must observe and take notes. That is why they put me to different tests. Step by step I began to notice that it was an experiment on a big scale. Every person I met on the street was part of it and had his or her role in it. Every fragment of every conversation was meaningful and included references to my life, my family, my past and my future. I felt that I had lost my privacy, that my life was deconstructed into small components and analysed by a team of experts. I tried to defend my own self by burning photos and letters to close access to at least a part of my past. Today I have no idea how I managed to pass all the exams of the winter session. At the beginning of the new semester, after several sleepless nights, when my behaviour got more and more bizarre, my flat mates called an ambulance and I was admitted to hospital. Obviously I was sure that was another part of the experiment, all the people, including

the medical staff and patients, just played their roles. I spent several months in hospital and I was subject to intensive pharmacotherapy. The most frustrating thing was the locked door with a handle on one side only and the fact that I lost my freedom and the right to decide about my own fate. In my opinion it was a serious violation of my rights, I was rebellious, I didn't want to participate in that, I believed it was a huge mistake and nightmare. Sometimes I looked at my situation in categories of guilt and punishment. I was very worried that I missed so many classes at the university, that I wasted my time on some experiments and elsewhere so many interesting things took place. My closest university friends visited me sometimes but it was very difficult for us to talk. Nonetheless I liked their visits, they were a diversion in the monotonous rhythm of the hospital. I was craving for news from the university and I hoped that I would manage to come back, to catch up with the curriculum. I thought that I could learn in hospital but it wasn't possible. I managed to laboriously read three books over several months. I still remember that these were: *Psychology of Crowds*², *The Magician of Lublin*³ and the script for *Lulu on the Bridge*⁴. I read a few pages a day and it was a big effort for me. I was terribly upset since nobody could tell me when I would be discharged; they were always very vague about it. Yet when some symptoms gradually subsided thanks to drugs, they decided to discharge me from hospital.

With hindsight I may say that a mental illness is a surreal experience, so surreal that you cannot believe in what has happened

² See Le Bon G. (1986) *Psychologia tłumy* (original title *La psychologie des foules*), Warsaw: Wydawnictwo Marek Derewiecki.

³ See Singer I.B. (1983) *Sztukmistrz z Lublina* (original title *The Magician of Lublin*), Warsaw: Państwowy Instytut Wydawniczy.

⁴ See Auster P. (1998) *Lulu na moście* (original title *Lulu on the Bridge*), Warsaw.

yourself. But whilst it lasts, the illness is so obvious; then it's difficult to notice that certain things are not real and obvious to people around you. The world created by the illness, the illusory world, seems to be the only one that exists, common to all the people, to the whole universe. People don't understand the person who is ill, and he or she doesn't understand other people; sometimes she doesn't even notice that there is any misunderstanding. People around you become an element of the sick world and their behaviour, words, gestures make up a certain whole, become a separate reality. This separate reality becomes the only world when you are not aware that there is an alternative world, the real one, common for all people. It's also difficult to explain to others that you are entering a different world for several reasons. First of all, as I've said, you can't explain symptoms to the sick person because you can't explain obvious things (the sick person thinks these things are obvious to everybody), just as you don't explain why the earth is round. The experiences of the sick person seem so real that it's difficult to question them. Another reason is the blurry state of the borders between the healthy and the sick worlds. Illness creeps in, sneaks into our life treacherously, not asking for permission. Especially the first time, it's difficult to notice the first symptoms of the illness, to address them, to foresee where they may take us. The third reason is fear and a sense of threat connected with the surrounding world. You don't know whom you can trust, whether you can trust anyone. The world is hostile and inaccessible. Words uttered by family and friends are interpreted as ambiguous, it's difficult to guess what their intention is even if these people thought the message was clear and obvious. A tone of voice, facial expression, direction of somebody's gaze acquire additional meaning, in line with your delusions. A sense of threat is intensified by these signals which are actually not sent at

all or are supposed to mean something else. Because of all that, you feel very lonely and help comes too late. It is difficult to help a person who doesn't know that she needs help. Only when people around you notice your weird behaviour do they realise that something is wrong. The illness may develop for a very long time, creep, take hold of your soul and mind. Throughout this time you suffer and even though it is impossible to ask for help, you need help very much. I think that at this phase of the illness the most important thing is people around you. The sick person's fate depends on their reaction, on whether they'll notice subtle differences in her behaviour (which is not so easy), on how they will interpret these changes, on what they will do. I believe that if they step in faster, your stay in hospital may be shorter, you may suffer for a shorter time. What is also important is your attitude towards others. You may ignore problems, you may neglect them, you may deny them or you may at least try to help, try to make contact, diminish the distance between both worlds. The key thing is to find professional care as soon as possible, to go to a psychologist or a psychiatrist. Yet the stigma of a mental illness is so deeply rooted in our society that going to a psychiatrist is considered shameful; it is even embarrassing to suggest to somebody that she may need such help. We are afraid that somebody may feel offended, we are afraid that we may lose this close relationship, that we may lose face, that we may be misunderstood. These fears are often justified because a popular sentence 'go and get yourself some treatment' is a manifestation of contempt towards another human being and it is no longer connected with real care and responsibility. In my opinion people with mental health problems don't do anything not because they don't know what to do, but because they don't know how to do it. There is no ideal solution to this problem. There are so many ways directing one to different people. So there is no

single solution, no single scenario; that would contradict the richness of individual experiences, fates, personalities. There is nothing like a manual for a person with mental health problems even though some rules may be common.

In my opinion one of the rules is honesty towards the person who needs help. Perhaps it is possible to encourage somebody to start therapy using tricks or deceit but it is so much better to talk about it openly. The person with mental health problems will have to face the facts anyway – it is impossible to hide the fact of being mentally ill, there is no need to do that. You don't help the person when you lie about her health condition, you don't protect her that way. We may think that we protect ourselves but it is very short-sighted. It is more difficult to recover when you need to separate the real from the imaginary as well as the truth from the lies. It is more difficult to accept that you have mental health problems if your family and friends deny it. And yet it is of key importance to have an insight into your illness during therapy, it is an indispensable factor in recovery. You cannot get better if you are not aware of your illness. Therefore I believe that honesty is especially important when you deal with such a person.

Another rule, or perhaps a counsel, is that if you want to help a person with mental health problems, you should use rational arguments in conversation. There are too many things happening in the sphere of emotions; additional emotional pressure is not recommended. You never know how much this person can bear. Using rational arguments shows that you treat this person seriously; the strength of these arguments is not necessarily connected with how precise or how sophisticated they are. I would rather say that a simple message is better understood and more easily accepted. The world of illness is so complicated, includes so many relationships, meanings,

that it is so much better to have clear, consistent messages rather than complex arguments.

And the last rule that I can think of, perhaps the most important one, is the attitude towards the person with mental health problems. I think you cannot be afraid of a person whom you want to help. You have to see the person who needs care and not the person who is potentially dangerous and threatening. Unfortunately, there are negative stereotypes that have an impact on our perception of people with mental health problems which often lead to prejudice, negative emotions, fear. It is important to see the difference between fear for somebody and being afraid of somebody. If you are afraid of somebody you may be paralysed, passive, you may be tempted to withdraw, to run away. If you fear for somebody, it may be the driving force that will make you help this person. These are my reflections when I think about the first phase of my illness and the experiences of others with such problems; I also look at it from the angle of the knowledge that I acquired later on. Yet the fact that my delusions subsided, totally or partially, was not tantamount to full recovery. It is just part of the way; the return to normal life is longer, more difficult, sometimes impossible. An experience of mental illness is like a crack, fissure, that divides your life into two parts: before and after. You idealise things that happened before the illness, it's connected with your longing for something you have lost. The changes that take place in you due to illness are then translated into changes of the attitudes of people around you, which in turn may influence the quality of many aspects of life (usually they change for the worse). You need to have a great willpower to overcome the consequences of the illness and sometimes it is really tough to have this willpower.

When I was discharged from hospital, I had documents with a note that further treatment was recommended. I came back home and tried to return to normal life. It was difficult because after several months spent mostly in a hospital bed I was strangely apathetic and every activity was tiresome. I couldn't see any sense in making any effort. I wanted to return to university to have the life I had liked before. It seemed impossible then because I couldn't even read the whole of a newspaper. Yet my parents and siblings never doubted that I would return to the university and graduate. They infected me with this faith in myself. My sister found a day ward in Kraków and convinced me that it was the best solution at the time. I very much wanted to return to Kraków and yet I was terribly afraid. And then a friend of mine, Ania, with whom I stayed in touch over the phone, suggested that she would come and take me to Kraków. She told me that she would like to visit me at my parents' and then we would go together to Kraków. I would never forget that gesture. I had almost resigned, I wanted to withdraw. Ania convinced me by saying that she had already arranged a meeting with our friends in a pub, that everybody was waiting for me, that I couldn't let them down. And we really met them. During that meeting I said not more than five sentences but my friends weren't bothered by that or they pretended they weren't but I was grateful for that. For the first time in several months I felt normal.

In Kraków once again I moved in with my friends from the university who were then preparing for the summer session. My parents did something very important: when I was in hospital, they paid for my room in Kraków so that I could return there. I started to go to the day ward, I participated in different sessions and psychotherapy there. I learnt how to talk about my problems, how to tell the difference between illness and the reality. The illness deprived me of half of the

academic year and I had to reconcile myself to the fact that I would study with younger students. I decided to return to the university during the second semester yet I wanted to get used to the system of education sooner. That was why I applied for permission to attend an English class even though I was still on leave. In this way I went to the day ward for half a day every day and I went to the university once a week. I prepared for the English classes the whole week but I was still afraid; I was especially afraid of meeting my colleagues. I was afraid of their questions, I was terrified that there was no topic that I could discuss with them when I met them. I thought that a good excuse was that I was in a hurry and I couldn't talk to them and I used that excuse many times even though there was nothing or nobody to rush to. Every time I said that I hoped that the person who talked to me would stop me, would convince me that we should go for a coffee or go for a walk. After some time I managed to arrange some meetings but only with individual people, people whom I trusted enough to tell them about my stay in hospital because I couldn't come up with any other topic for conversation. I think that the stay at the day ward and sessions there weakened the shock of my return to the university. It was like training, a warming-up session.

The return was difficult because I studied with younger students and it was a bit difficult for me to find a place in the new group. I missed the studies that I remembered from before my illness, I missed the enthusiasm, discussions, social life. Studies after the illness were different, it was more difficult for me to learn, I didn't enjoy it that much. I needed a great deal of energy to hide my illness, to make up more or less convincing stories about that. The new group of students was not very favourably inclined towards me, I was a stranger amongst them; a long time passed before I identified some people with whom

I established closer contacts. Even more time passed before I started to enjoy learning again. I got interested in specific areas of psychology: psycholinguistics and psychosomatics. My studies became more about individual work, had a different quality and it was quite attractive.

During the fourth year I fell ill once again. This time it was depression, a different kind of experience. There is a difference between experiencing psychosis and depression. In depression you have an insight into your illness and in psychosis you don't. In depression reality is the real one, yet perceived in a difficult, brutal, painful and scary way. Minor problems seem abysmal, the simplest tasks seem impossible to do. A person feels powerless, paralysed and finds it difficult to do even the simplest things. Life seems meaningless because every new day brings more sense of hopelessness and despair. In my opinion depression is not only about emotions, it is also a condition of mind and spirit, yet when you describe it, it is easier to use words that describe emotions. Even now I don't know what was the reason for my depression, I can only guess but I'm not really sure. Perhaps it was the delayed post-psychotic depression described in textbooks. It is also possible that it was a delayed reaction to what had happened in London, as if I gave vent to sadness and grief only now. This episode of illness could be also interpreted as an escape from adulthood, from an inability to cope with new challenges because it happened when we were supposed to choose topics for our Master's theses and thesis supervisors. I remember I was afraid of that. It seemed to me too difficult to decide, now I have no idea whether it was a cause or a symptom of the illness. Actually since I was a child I tended to magnify difficulties, I perceived them as piling up in front of me, impossible to deal with; during my illness this feature was intensified, sharpened. In psychosis there are moments when you believe you can

do everything, in depression you believe you can't do anything. When you can't do anything, every day is equally dull, you can't hope for any change, you start wondering if it makes any sense to go on living. It is just tiresome. I also felt tension that I couldn't reduce. The tension that prevented me from doing almost every activity, I felt instantly on alert and every stronger stimulus caused pain. The person's psyche can't bear it, the whole body can't bear it. It leads to exhaustion which is so acute that suicide doesn't seem an escape but an act of self-defence, the most reasonable solution, the only solution. After my first unsuccessful suicide attempt, after I was rescued at the toxicology ward, I was taken to hospital and was diagnosed with depression. I made another attempt to kill myself one week after I had been discharged from hospital. Once again I was taken to the toxicology ward and to the same psychiatric hospital. When I was discharged the second time a nurse who filled in documents said jokingly: 'no more returns here, Ania.' Then I decided that I'd do anything not to return to this hospital, not to return to the 24-hour a day treatment at all.

Then I went back to the day ward that once again played a very important role in my rehabilitation. And once again I tried to return to life, to university life as well. I remember that I was very much motivated by the thought that I should complete my studies. The university admin didn't really believe it was possible, anyway I was granted additional leave, due to 'special circumstances.' Today I appreciate that opportunity very much. I chose psycholinguistics, found a good thesis supervisor who liked his job and was full of academic zeal, which was quite contagious. There were moments of doubts and difficulties whilst I was writing the thesis but I managed to complete it and defend it.

My studies taught me that sometimes you need to fight, even though your goal seems distant and difficult to attain. The fact that I've

managed to attain this goal very strongly influenced my self-esteem, my faith in my skills. I learnt that I shouldn't give up. I'm strongly convinced that the illness cannot determine my life. Thanks to that I believe that I can have a satisfying life, I can develop, work, create. It's up to me to decide about my life, I stand at the helm of my life.

What is of paramount importance is what kind of people you meet on your way. I try to remember those who were helpful, it doesn't mean however that I didn't meet others. Nonetheless, I think that showing good examples is more beneficial than criticising the bad ones. I've always believed that the negative attitudes that I saw resulted from lack of knowledge and fear, not ill will. What was very helpful to me was that I didn't get any special treatment from my lecturers. I think that apart from the person responsible for students' affairs no other member of the teaching staff knew about my mental health problems. At least I had such an impression and I felt safer thanks to that. It was better for me because I didn't feel I was there on special conditions, I didn't feel I was treated differently or assessed in a more lenient way or had special privileges. After both the first and the second leave of absence I had much worse grades than before my illness but the awareness that I was assessed as other students was more important to me than good grades. I had to accept the fact that I no longer was a good student, I had become an average student. Yet the awareness that no double standards were applied to me made up for the sense of being average. I'm not sure whether it is a good solution for every person with such problems and whether it should be treated as a kind of model. For me it was good.

In my opinion an example of a good solution might be the introduction of an individual syllabus for students with mental health difficulties. As I've mentioned, the fact that I was allowed to

go to English classes even though I was officially on leave was an opportunity for me, allowed me to maintain a certain continuity. It has to be decided how to do it in a discreet way, not to reveal the reason for introducing extraordinary solutions. In my opinion it is up to the student to decide who knows about their mental health problems and how much the people know. Another solution that could be introduced by the university, or to be more specific by the Jagiellonian University Disability Support Service, is to organise a support group for students who have undergone a mental health crisis. I remember that the most painful thing was that I no longer had any social life; I guess it was the most difficult thing to reconcile myself to emotionally. The sense of being excluded was a bigger loss for me than worse grades at university. My social 'me' suffered most. Learning how to establish social contacts anew was very time-consuming, a breakthrough took place thanks to participation in a therapeutic group. The fact that I managed to establish relations with people in this group meant that I could do that anywhere; that's how I started to re-create this social 'me.' I think that such support groups for recovering students would be a great help for them, even though it may be difficult to verify the benefits ensuing from them. And another task, of great importance, is undertaking activities against stigmatising students with mental health problems, changing stereotypes, making people more sensitive to such problems and giving them solid knowledge. Perhaps this book will be the first step in this direction.

Karolina Wianecka

Striving for Perfection

– Name?

– Karolina.

– Karolina, stand on the scales.

(...)

– I do not have to tell you how much you weigh,
I may just put it in your file. Do you want to know?

I said yes. I wanted to hear for the last time what the scales showed, just before hospital food changed this state of affairs. But the question put to me and the choice I was allowed was probably the one last such right that I would have to decide about something that was strictly related to my illness after having been admitted to the psychiatric ward. Later, standing on the hospital scales became almost a ritual, a regular duty always accompanied by great fear. And today? I don't know my weight. I have liberated myself from the need to check the scales, which was to be part of the therapy. Now, I know that the number of kilograms cannot be the criterion for my happiness. But for a long time I was unable to believe it.

Zero – the desired goal

It is not easy to indicate the onset of the illness. Usually, it starts with a simple diet which is often neither a healthy lifestyle nor a way to lose excessive kilograms monitored by the doctor. Anorexia is about the gradual refusal to eat until the moment when a leaf of lettuce or a piece of crisp bread becomes too calorific as a meal. Eating it every time means thinking: Can I afford that? Won't I gain weight? An immediate response of the sick person's mind is: You are not allowed! For a young girl focused on her looks, the way from a regular and relatively healthy diet to anorexia is very simple, but the moment of moving from one state to the other goes almost unnoticed. All this is caused by a negative image of oneself, problems with discovering one's identity, no acceptance of the changing body, which may be rooted in family relations or difficult experiences. Negative feelings towards one's body are sometimes so strong that an ill person is not able to look at herself in the mirror without aversion and hatred.

All the meals of an anorexic are well considered and planned. She must maintain regular meal hours because otherwise even a several minute delay may be a pretext for not eating. She must consume a carefully calculated number of calories, stick to the list of meals and stock the fridge up every time one product is missing, so that there is no need to change the diet she set for herself. Next to rigorous rations of food and putting down each calorie consumed in a special diary, a particularly important element of the anorexic's everyday life is physical exercise. She may always prefer a brisk walk to a bus, which gives her a chance to burn some more of her already meagre-sized meal. Moreover, she exercises in her own room, which becomes a little fortress during her illness. Leaving it is often a difficult barrier

to overcome, both for the anorexic and her family who feel helpless in the face of the hostility demonstrated by the girl when they pass yet again by a closed door. An anorexic person is very harsh on and critical of herself. She may punish herself with an additional one hundred sit-ups if the scales go up by as little as 100 grams. The total number of exercise repetitions in a day may go up to one thousand, or even more. Usually, she is a frequent visitor to a gym, where she may often spend a few hours. No one is ever surprised when, fighting her own tiredness, sweating on her face, she keeps running on the treadmill increasing the necessary parameters. After all, this is what you do at a fitness club and checking whether the club is attended by healthy individuals who may spend all their energy on exercising is the responsibility of nobody. An anorexic may, late at night, spend what is left of her energy on several dozen unplanned repetitions of sit-ups because having added up all the meals consumed on this day she remembered the apple that, in her view, she should not have eaten. She ignores the fact that it was her only meal, possibly even divided into different size bits for different times of the day. In this way each of her days starts and finishes with exercise, which also fills all her free moments. There is no place for inactivity.

The anorexic's regular companion is her mirror. But in fact, from her perspective, it is a companion to be damned - not a fairy-tale mirror but a distorting one which always shows a deformed view of her body when she looks at it. She may avoid eye contact with the girl in the mirror, but sometimes she deliberately seeks the confirmation of her sick thoughts in the glass reflection. She carefully observes her face and hip bones. Always worried that they may not protrude as much as they used to several minutes ago when she last checked on them. Just by looking, she may assess whether the meal consumed

caused any weight gain, even as little as 100 grams, and should this method of determining the perimeter of her body parts be insufficient, she uses a simple tape-measure to take precise measurements of her dimensions. Only after having confirmed that she has not grown in size can she afford eating. Even if she has lost a lot of weight, she still thinks she is the same girl from before the twenty or thirty kilograms. She feels fat and strives to lose more weight.

Each meal is a struggle. First of all, it is a battle with her sick thoughts telling her that with the next bite she will lose control over herself as the huge number of calories it provides will be automatically absorbed by her body. All the time she is accompanied by remorse transposed from eating habits onto other spheres of life. Each meal is also a fight with her family who, if they are aware of the problem, are trying to carefully watch the amount of food consumed by her. As a result, they have never-ending conversations on how much the girls should eat. This is often accompanied by anger if lunch is late by as little as quarter of an hour and the anorexic cannot have it at a fixed time. When the meal is already on the table, just one glance is enough to launch a calorie calculator in the sick girl's head. All calculations employ nutritious values printed on product packages, which the anorexic knows by heart. Whilst eating she picks the best products, meaning the least calorific. She takes a sandwich apart and first eats the tomato, lettuce and ham whilst leaving the bread out. When her mother asks her: 'What have you eaten?', the anorexic will successfully convince her of the entire list of products that have apparently found their way to her stomach on this very day. Why should anyone distrust her? She speaks with such confidence.

The feeling of hunger, which all the time accompanies the girl, is a symptom telling her that everything is all right. It brings her peace

and gives her the impression of control over her body as she is the one to decide what and how much she eats. She knows how to deafen this terrible feeling of hunger by, for example, drinking several litres of water per day or chewing hundreds of gums. In order to satisfy her 'mental' desire to eat, it is enough to spend a moment looking at a ready-made meal, foodstuff packaging at a shop or a cooking recipe with colourful pictures that stimulate the imagination. She fills her stomach whilst looking at and smelling food, this is why cooking for the family is such a pleasure for her. Feeding them gives her this comforting feeling that it will be them who put on weight – not her.

An obsession of (not) eating

Her thoughts keep revolving around food. This is an obsession which does not abandon her at school or university, does not disappear at night when she is asleep or during the day when she is most occupied. What happens in her head seems incomprehensible for those persons who have never experienced or encountered such a problem. Each negative comment on the looks of an anorexic girl may be the greatest misery for her. She will remember it for weeks, especially when facing another meal. Then, without any consideration, she will put a full plate away. Her thoughts will bring up the reminiscence of ice-cream she ate several months ago or a rather impolite comment made by a friend saying that 'you must have put on a bit of weight recently'. This is a simple way to not eating because if others notice something like that, then it must be true. The anorexic will punish herself when she learns that someone has noticed the weight she has gained and will do everything to lose it as fast as she can. Moreover, she is looking forward to comments about her excessive slimness, which are an

additional motivation for her. She feels happy when someone notices how fast her kilograms disappear because it is a sign that the effort invested into losing weight has not been wasted. If possible, she eats alone. Best, when closed in her room where no one can see if she really eats the meals she has prepared. It is more difficult if the family insists on having a meal together, but even then there are ways of not finishing the meal or hiding food and then throwing away what she considered too calorie rich. Eating in company is a punishment for her. Others can see how consecutive bites reach her mouth as if they were looking at something that is forbidden. And then doubts arrive again as to whether she should have eaten at all, maybe others are right, maybe she is not allowed. It is not easy to go back to having meals with other people, so she will always come up with the right excuse for avoiding it. Sometimes it is impossible not to eat. Her body screams with hunger, her family is screaming horrified with the entire situation, the sick girl is screaming because she is afraid that eating something may cause an irreversible loss of control and increase in her weight. Eating small meals may be accompanied by bulimic episodes. An anorexic, as much as it is hard for her and fills her with disgust towards herself and her body, tries to remove all the calories consumed from her body. Unconsciously, she ruins her health. She provokes vomiting and often uses all kinds of purgative or slimming products which, as advertised, promise to help her acquire the desired figure without any miraculous diet. And she cannot recognise any utopia in these promises. They must be real because if a woman in the advert can do it, she should be able, too. This type of commercial message can be found in the streets, newspapers and on TV in ample amounts, it cannot be ignored. Dietary products are available everywhere without a receipt, there is common consent as to their use without limitations.

Thus, unaware of consequences, the anorexic pops more slimming pills and appetite suppressants than allowed or drinks yet another cup of metabolism-boosting tea. Sometimes they work as a simple meal, albeit an exceptional one because it is consumed without limitations.

Not only does looking at the pictures of dishes make her happy. Looking at the photographs of slim models and very thin girls plays a similar motivating role. These, in a way inspirational, pictures are supposed to show the sick girl what she may achieve if she sticks by her dietary rules. Although in many cases she herself already weighs much less than the girl in the picture, she wants to achieve an ideal size (in her opinion) forgetting, at the same time, about the image-editing software which can magically take excessive kilograms away, with just a few mouse clicks, and remove any defects in the looks of the models featuring in the advertisements.

Anorexia – my best friend

The Internet diaries of other sick girls are another type of inspiration for an anorexic person. Probably not all anorexic girls read them but there are hundreds of such blogs in virtual space and their authors are often 12- or 13-year old girls. The owners of such diaries exchange experiences on non-eating, share ideas on how to accelerate weight loss, support each other when their kilograms on the scales go down. The slogans, repeated like mantras, which inspire them to lose weight seem shocking. They share the so-called ‘Anorexic Decalogue’ which provides clear rules on eating and imposes the perception of your own body as ideal only when you are striving to achieve the ill-understood perfection. Pro-ana blogs, as they are called by their authors, also include recommendations on how to follow this lifestyle, which is

what they consider anorexia to be describing it as their 'best friend'. In fact, this is the aim they keep pursuing. They often call themselves butterflies and the graphic signs on blogs remind them about their resolve to be thin. Butterflies are also used by anorexics who belong to pro-ana groups as symbols next to their profile names on social networking portals. In this way they build networks of friends who are easy to recognise. Pro-ana is a way of life, a desire to control your body and manage it in such a way as to achieve a critically low body weight. Membership in this type of group must give a sense of understanding – so valuable when it seems that my condition is my problem and no one is able to help me. Ill girls seek support, help and advice on what to do to lose weight in such a way that the family members do not realise that something is wrong. Hence there are messages telling the girls to keep their activity in pro-ana secret and although these groups are active in virtual space – blogs, social networking portals, internet forums – their members recognise each other in real life using a defined sign. This symbol of membership is a red wristband, which also plays a special role as a reminder of their difficult path to perfection, i.e. life with anorexia. Anorexic Internet users undoubtedly have a common goal, which, albeit achieved individually, is usually easier to attain if it is shared with others. Sick girls can also easily recognise other persons with a similar problem, even without the red bracelets symbolising membership in pro-ana. It is difficult to explain where this skill comes from and whether it is always accurate. Not every thin woman achieved slimness by means of anorexia, but persons with such experiences pay attention to the details of the body, notice characteristic protruding cheek or hip bones. Without any special identification sign two sick girls may look at each other with understanding and empathy, or sometimes jealousy wanting to achieve a similarly low weight.

Just as the exact point of onset of the illness is difficult to determine, in the same way it is not easy to sketch a picture of the typical environment where the girl's problem of anorexia may be especially prone to becoming serious. It seems that eating disorders often appear in an environment where problems overwhelm the patient, a patient who is often young, entangled in contentious family issues, sensitive to every comment concerning her and who always takes them personally. The personality factor – unique sensitivity – is also an important element of anorexia but family conflicts, problems with communication amongst family members and other problematic situations may become the cause. Simple misunderstanding, the parents' divorce, a difficult adolescence accompanied by problems at school, excessive sensitivity make it very easy to slip into the illness. Difficulties of everyday life may overwhelm us and everyone reacts personally to them. Anorexia is exactly this response to the surrounding reality perceived as incomprehensible, problematic and difficult to follow. The patient always takes family problems personally, feels remorse and guilt for every misunderstanding, even in the case of completely absurd situations. She believes that it is her fault that family life does not take the course everyone would expect, keeps blaming herself, which makes her become even sicker. She can maintain the appearances of a healthy, innocent diet and then the family may not realise how serious the problem is. In such circumstances it is even more difficult to obtain specialist advice because everyone is oblivious of her eating problems. The patient insists that she is fine and does not want to notice that something is going wrong, which is why the issue usually dies down. However, something must happen before the girl finally visits a specialist. Sometimes it happens by accident or she chooses to go there by herself feeling down because of her condition

and asking for help. Once this visit to a psychologist does occur, then the therapist can hardly work alone. Consulting the psychiatrist – along with the psychologist – is an extremely embarrassing problem, which is difficult to overcome for the entire family. We think of psychologists and psychiatrists as the specialists whom we would never like to ask for help. Whether it is because we fear the reaction of people in our environment who will abandon us upon learning about our mental health problems or because we are unaware of the necessity of treatment, psychological help is treated as the last resort. At this stage, an anorexic woman is usually also unaware that she should start cooperating with doctors, either. She may rebel, reject every helping hand extended to her. But in fact, she really desires this help, she is tired with her struggle with herself every day. These are extremely ambivalent feelings which change from day to day, hour to hour. One time she may openly admit that she needs support because she cannot cope with her eating problems and is no longer able to tire herself out with the entire complex situation of her illness. But a moment later she rejects the thought that she needs treatment and convinces everyone including herself that eating is not a problem for her. This is nothing other but the fear of losing the ability to decide about herself, especially as regards eating issues as well as a great fear of gaining weight, which is to be expected after she starts consuming the meals recommended by doctors. Contact with a psychologist is a very valuable relationship which may only have positive effects when the anorexic is open to help and wants to accept it. It is important that the two find understanding. On the one hand, she needs understanding in the eyes of the therapist and on the other, firmness and determination in being guided towards health, qualities that may be lacking in her relationship with those close to her. Saving her life is combined with depriving her of her

pathological freedom with regard to her eating, her control over the amounts of food she consumes, which is her great concern. Someone must decide for her about the meals she must eat, control whether they are really swallowed and not hidden to be thrown away later. The time after the meal is important, too, when her obsessive thoughts do not allow her to wait patiently until her body absorbs the calories and she tries to do everything to minimise the number so absorbed within the same nutritional value. This is why she performs all kinds of exercise, intensively or furtively, that may help her achieve this goal or just jumps up and down thinking that this might enable her to burn at least a few more calories before her body absorbs them. The entire process of getting healthy again is extremely difficult at home. The patient's parents cannot or have no opportunity to constantly monitor each mouthful of food. An additional difficulty is the rebellion that appears when the anorexic must lose the control she previously had over the rations consumed. This is accompanied by an ambivalent attitude to health and her asking herself the question whether she really wants to give up control over her entire life. Her mother does not want to see her child dying but it is hard for her to see how difficult it is for the patient to eat and at the moment of rebellion allows her not to finish the meal this last time. The anorexic does not believe that what someone puts on her plate will not cause weight gain. On the contrary, she thinks that everyone wants to 'fatten her up', not to help her. Her reaction is often very emotional, which destroys good relations or makes it impossible to create positive ones, which may never have been there in the family in any case. In such circumstances hospitalisation is necessary. It makes a good start in the struggle with the illness and the doctors' knowledge and experience may be helpful in guiding the way the anorexic's family looks at her problem. They also need assistance in deciding what

approach they should take towards the condition of a family member. It seems that anorexia appears in environments that are out of balance. This is why psychological assistance is essential, not only for the ill person but also for her family members. Everyone thinks, however, that sending their child into a psychiatric ward is something that could not happen to them. What is going to happen if their neighbours and friends find out? What will others think about us? Why does the entire family need treatment if only one member has a problem? Because sometimes it is the only way if your child wants to have a chance to live a normal life. This is the way to save the patient who cannot eat, think, look at herself and live in a healthy way anymore.

Weight – a reflection of your successes and failures

The stay at the hospital ward providing treatment for eating disorders is not an easy experience for the person affected by the problem or for her family. It involves loneliness, fear of an unknown situation, meetings with many new people. This is why the first day at hospital, according to the anorexia treatment programme, is devoted to adjustment, getting to know and fitting into the entire system slowly. For anorexics these are also the last moments when they themselves may decide how much they will eat during individual meals and usually doing so they put the plate away. Submission to the hospital rules and, additionally, signing the so-called contract, i.e. the programme of treating eating disorders, deprives them of control over everything that concerns eating. The entire cycle of treatment includes three phases whose border points are the levels of body mass index (BMI) to be achieved, which are determined in advance. From then on someone else puts food on your plate, serves the table, tells you how much weight you have to gain to

move to the second and third stage of the programme. This is related to additional privileges, like going out in a group or going home on leave. Taking the right to decide about food away from the anorexic is essential to be able to teach her from the start how and how much to eat because all her destructive behaviour so far has made it difficult for her to determine what the right portion of food is. Each mouthful seems too big, not even to mention a full dinner whose sight fills her with fear and concern about weight gain. Additional pressure as well as control of the anorexics' behaviour at the table in hospital is exerted by nurses who observe them very carefully. The control does not cease until one hour after the meal, which is devoted to calorie absorption, and any attempts to shorten it or use it for physical exercise become ineffective because they are forbidden by nurses in the ward. In some situations even this strict control is not perfect and some anorexics transfer their habits from home to the hospital canteen and putting their own health at risk, they disobey the rules and smuggle out some uneaten leftovers hidden under their clothes. Food is put into pockets, underneath the clothes, in underwear. Sometimes other patients who notice the full situation inform nurses or doctors about it at joint meetings. It is difficult to say why they do so. They explain it by citing the good of their friend, the rules that everyone must observe and not break, and – as they are in hospital – the struggle to become healthy. In fact, there must be an element of jealousy in it too, the feeling that if I have to finish the meal and absorb these calories, she has to do it as well.

The difficulty of hospitalisation also includes the need to stay in a general psychiatric ward where there are patients with a variety of mental problems. You find out about so many different conditions, so many different cases whilst staying at hospital. Being open to

these circumstances and accepting the stay at the ward as the right of everyone who needs it reduces to a minimum the frustration brought about by another sleepless night caused by the symptoms of another patient's illness. Naturally, it is difficult to be separated from your family who often live too far away to be able to visit the patient in hospital. Undoubtedly, the greatest obstacle to overcome for an anorexic in the entire treatment process includes eating issues and the next body weight limits, which, initially against her own self, she is supposed to achieve. Sometimes it is forgotten that patients with eating disorders not only must achieve and maintain a healthy weight, but also change their way of thinking, which is the most important objective in my opinion. Eliminating symptoms does not eradicate the source of the illness, which, once dormant, may come to life some time later. It is impossible to recover physically without achieving a psychological balance, which cannot be attained without accepting the need to gain weight and without living in harmony with oneself. The way the anorexic sees her body is similar, to some extent, to alienation. My body is not my body and although I live in it, I do not accept it. It is especially evident during the hospital process of bringing girls with eating disorders back to a healthy state. The girls eat and gain additional kilograms that should save their lives. At the beginning they cannot accept it and they are not able to accept their new, healthy body. Then there comes a breakthrough moment when the girl notices that she may live in harmony with herself and also eat normal portions or even wait for a meal feeling hungry. The moment when it happens is different for each individual. An extremely important thing in the entire treatment process is to get the girl to love her body with which she now lives in harmony. She has to accept the weight that is healthy for her and enables her to lead a normal life without the so

familiar symptoms of vertigo and tiredness and, above all, with natural menstruation, which, once restored during treatment, is an important sign of achieving the correct body mass.

After the therapy it is to be expected that the distorting mirror that reflected the patient's deformed body image is turned away. Psychotherapy is obligatory for persons with anorexia, even if they do not want to take an active part in it. Finally they realise that group therapy or a psycho-drawing is not just a way of killing the excess free time in hospital but above all provides assistance in understanding their own problems, especially if they can count on feedback from other patients. There are also classes devoted to working with your body. The moments spent on understanding yourself, striving to accept yourself and your body are very valuable as this is when the girl may notice that she and her body are one and living by this motto is living in harmony with yourself. It is not enough to tell an anorexic: 'Eat!', or even more explicitly: 'If you don't eat, you will die' as these are just words to her. It may even be more frustrating rather than bringing a positive effect. It is difficult for her to force herself to take something to eat by herself, even if hunger becomes really oppressive. On the other hand, placing a meal in front of her at home and making sure that she eats it up is a losing battle which only causes more rebellion and fear in the ill girl. It is the anorexic who needs to understand that her life need not look the way it does when accompanied by obsessive, sick thoughts and the constant fear of gaining weight. Someone needs to show her that, in fact, eating may be a pleasure, not just a punishment or a problem. She should become convinced that healthy portions, which initially will be prepared for her, provide the normal amount that she should eat. For an anorexic it is difficult to say what portion of food is the right one, even when she is already trying to get back to normality and eat

in a healthy way. The limited portions knocked her perception of food as something normal so far out of balance that her ill habits, which are not easy to eliminate, may often remain for a long time following the treatment. Such habits include, for example, dividing the food on the plate into small pieces or eating light products. Maybe one day this will change and having tea with sugar instead of a sweetener will no longer be a problem for her. All this may be learned from experienced doctors, psychologists or other patients during therapeutic group sessions. Depending on the patient's family situation or her environment, however, such assistance may be provided at outpatients' clinics but sometimes hospitalisation is necessary.

The condition itself is not perceived as suffering by the patient. Often the anorexic sees her problem as something uniting her family, something that makes her parents, who have not spoken to each other recently, meet at family therapy sessions and try to overcome their child's illness together. Anorexia is sometimes a way of life, so insistently pursued by increasingly younger persons meeting in virtual space and supporting each other in these aspirations that it becomes more difficult to say goodbye to your friend – Ana – who has been with you all the time until now. It is not easy to leave someone who, for a long time, was your entire life, overshadowed your real world and allowed you to see it as you wanted it to be. The hospital is often treated as an asylum where the patient has been released from the burden of making decisions about problematic issues, a place where she could find warmth which she might not have had at home, meet people who had similar problems and stop feeling alone anymore. It is difficult to go back to real life. Three months is an absolute minimum participation in the programme and after this time the expected results of treatment can be observed thanks to relatively systematic work.

Often, hospitalisation because of anorexia does not end with one successful stay in the ward. This enemy is so difficult that the struggle may last for years and mean going back to hospital many times in a much worse condition of health. What is more, a relatively successful period of hospitalisation is not the end to fighting the illness. It may even be claimed that it is the beginning because the real effort to go back to normal life will begin after leaving the hospital walls. A person who has lived with anorexia for a long time is now pushed back into the framework of the world where her problems began. Temporarily separated from her, the stimuli that caused the symptoms of the condition before hospitalisation appear again. Each, even the least problematic, situation for a healthy person may remind the girl of her pathological reactions and habits, especially immediately after her return to the real world. Hence cooperation with a psychologist and psychotherapist is absolutely essential and required. It may seem that a discharge from hospital is synonymous with recovery, whilst it is just a beginning of the process of bringing full strength back to the patient with anorexia. The ability to stand on your own, stable in the normal environment and cope with eating issues is the stage when one day the patient may deal with her doubts on her own and on another occasion she may need specialist assistance or at least have people around her who can show her the right way to health. The anorexic may now feel she is not an ill person but she still remains affected by the disease and may experience ups and downs for a long time.

In search of your identity

Writing this I keep using the female pronoun when describing patients with anorexia. It might be caused by my limited experience with

anorexics but it should be remembered that this condition affects not only women. It seems that they are the ones who pay special attention to their appearance and figure but anorexia is something deeper than just care about the body. It is a problem with finding your own identity, which may also concern anyone, regardless of gender.

It has been over three years and six months since I was discharged from the Institute of Psychiatry and Neurology in Warsaw. It was my second attempt to recover at hospital, finally concluded with the following statement: 'General condition: good. The patient was willing to take part in psychotherapy and activities offered at the ward'. I know that had it not been for those closest to me who were always with me throughout this time, difficult for all of us, and for my internal motivation to recover, my hospitalisation would not have stopped after the second time. In those circumstances I knew that it was my adult life that I had to take into my own hands. I slowly became convinced that it was up to me what my everyday life would be like further on and I did not want to fill it with anorexia anymore. My family members, although until now probably not fully aware of what this condition really is, found out how to help me with my struggle with anorexia. Initially, it was a new and alien problem for all of us and the efforts of people around me who wanted to encourage me to eat were a complete failure. Now I am grateful to them for the control they maintained over me, although it often led to arguments and lots of tears. I could not understand that those nearest to me see anorexia as slow death, what is more, death at one's own hand. I wanted to make my own decisions and reading pro-ana blogs confirmed my conviction that it was better to die slim than to live fat. Looking back on it, it all seems absurd and unbelievable, but when I lived with anorexia I was not aware of such pathological associations in my thinking. The

least critical comment made by a healthy person about me was an accusation that I immediately wanted to change regardless of whether it concerned my looks, behaviour or achievement at school. Perfection obsessively forced its way into all areas of my life, getting me to worry pathologically about the objectives I set for myself. The bar was moving up, whilst I had increasingly less strength. Above all, I lacked mental stamina, which took the smile away from my face and made me clam up in loneliness, isolate myself from friends and family. But I had less and less physical power, too, despite the exercises which were the first thing I did in the morning and the last activity before going to bed. With each kilogram my life was seeping away from me. One gram less on the scales meant one smile less on my face, although in the anorexic perception it was yet another step towards perfection, so much sought-after. What a pathological, idealised perception of beauty.

The experience of the illness, treatment at the clinic, hospitalisation and then visits to local doctors again and contacts with other patients have taught me a lot about eating and looking at myself. I remember very well the moment when I entered the hospital ward. A doorbell and large, heavy door, always locked, leading to a slightly more friendly hall just behind it. Armchairs standing next to the heaters, boards with timetables, doctor's duty hours, patients' rights and obligations. But above all I remembered emaciated girls sneaking past and looking at me as if they wanted to assess the type of condition I had and my BMI value. Everything at the ward was organised with the objective of teaching patients a sense of responsibility and compliance with some framework, necessary to function well through a regular plan of the week. The first thing in the morning was the weighing of patients with eating disorders. We would meet in the hall and wait for our turn to find out our parameters. Then we would go back to

our rooms to accept, think it over and survive the difficult moment when the scales went up. Sometimes a girl who felt weight loss and was aware of the consequences, which included the withdrawal of some privileges, would, for example, furtively overindulge in water so that this difference of several hundred grams did not result in sending her back to the earlier stage of the programme. It was possible to not know how much you weighed and sometimes it was easier. Then you could earlier free yourself from this pathological thinking that your weight is the criterion of your happiness and that your mood over the next few days depended on it. When the meal trolley arrived in the ward, the first to receive meals were the patients with eating disorders who were truly frustrated with a slight change of the time of lunch or breakfast. Anorexics usually wanted to find out the menu for the entire day at breakfast time. On the one hand, they wanted to satisfy their curiosity and know what they would have to eat and on the other, prior knowledge of what would be served allowed them to prepare and accept that they would have to consume things they did not necessarily like. School classes were an important highlight of the day as they often diverted our thoughts away from our miserable situation, the stay at the ward and the treatment. Lessons gave us a chance to delve into the world of mathematics or history and at the same time get a good grade, which usually brought a smile to the faces of pathological perfectionists. Sometimes we went out for walks with our counsellors and although these were not especially interesting outings because they always followed the same route, they gave us a little freedom, something we missed very much during our stay at hospital, behind the big door. There were some very interesting trips when we could go to the cinema or theatre, which was a valuable experience for many girls from small towns and villages, far away from Warsaw. These are

good memories which cast a positive light on the long period of several weeks spent in hospital, despite the great difficulty and problems I had in overcoming the pathological thoughts that had been the routine of my everyday life so far.

And what is the situation now? In moments of crisis I try to refrain from pathological practice and thoughts knowing that I do it not only for myself but also for my nearest and dearest. Once I heard from someone close to me that in order to love someone truly and genuinely, I needed to love myself first. At that time I thought it was an exaggeration and did not consider it true. But today I know that it was to a large extent correct and although it is a long way before I put this maxim into practice, I believe that living in harmony with myself, understanding my body and soul, my needs and thoughts will eventually bring me to my destination – a happy life. After leaving the Warsaw hospital I dreamt that one day I would like to turn my own experience of the illness into something positive and be able to demonstrate that it was possible to feel happy with life despite a less happy past and difficult experiences. During one class in my programme at university, directly linked with mental health, I thought I had enough strength to talk about it and to start to carry out my plans. In the past I got my chance and now I have another one. I would like my story to be told to people who have not yet become familiar with the problem of anorexia but also read by those for whom anorexia was or still is a great problem. You may win over it, but you need a lot of perseverance, internal strength and confidence that it is not the best way of life. It will be easier if you choose the healthy approach in which eating is a source of joy and pleasure and not, as is the case with anorexia, a source of anguish, constant fear about losing your figure, worry and lots of tears, both those of your own and those of your loved ones. It is the family

that plays a crucial role here. Without loving people who will look at the ensuing problem in a clear-headed manner and take the necessary steps to send the sick person to specialists, an anorexic cannot possibly win this difficult battle alone.

Where to find the strength to fight?

I often ask myself the question what can be done to prevent anorexia. All campaigns, including billboards, seem deceptive because they feature skinny girls showing protruding bones which are not beautiful at all, but they are a dream come true for a person with an eating disorder and present the looks she has always truly wanted. Similar-looking girls walk the catwalks during fashion shows or pose for photographs. It seems that if they achieved such success, not insignificant, why shouldn't they become an inspiration to young people who would like to gain recognition and become known in the wider world? Taking action against extremely emaciated models, as was done in the past, and admitting to the catwalk only the models whose BMI is above a certain limit proved unsuccessful and was not maintained in the long term. The same was the case with the billboards which featured an extremely skeletal anorexic to demonstrate opposition to the illness, but, in my opinion, had an opposite result. Girls with this disorder are not frightened by the sight of bodies which are sometimes brought to extreme exhaustion. They think they know when to stop and do not notice that the thresholds of increasingly lower body weight, which would make them feel comfortable, keep going down. For them, looking at thin bodies is motivation to action. They, too, want to have a perfect body, just like the model in the photograph. This is like a positive group of reference to which many would like

to aspire. The media and the beauty canons promoted by them have made a significant contribution to the growing numbers of anorexic women. The world of fashion rewards and promotes a skinny canon of beauty. Seldom does it appreciate a fuller figure or openly admit its attractiveness as the trend is to promote increasingly smaller sizes. Maybe showing an image of a woman who is happy about her body and does not wear an XS size would help us realise that our weight does not have to determine the relation with and acceptance of ourselves, or decide about how others assess us. There are women whose bodies, regardless of their slim or full figure, look healthy and beautiful and would not attract the attention of girls with eating disorders if they were shown in advertisements. It is hard to believe that slimness is not in demand when in every shop window there are mannequins of an inhumanly cut shape dressed in clothes of the smallest size. And although a healthy person knows that it is just a plastic doll, someone with an eating disorder will start to think again: I want to look like that, too! In a similar way, it is difficult for her to be indifferent to the posters advertising more slimming products and not to stop to put down the name of the next product whilst passing it. Who knows, maybe this one is worth trying.

Along with the media it is the family that, on the one hand, may influence the incidence of the illness, and, on the other, has an obligation to do something when they notice dangerous changes in the behaviour or looks of their daughter, sister, brother or other close friend. Parents often fail to notice the symptoms of the illness because an anorexic can conceal them very well. But there is behaviour that should arouse those who observe the patient's daily life and make them aware that something is going wrong. It includes aversion to food, going to the gym or other establishments that promote intensive physical exercise,

isolation, which I have already mentioned. They are not healthy symptoms of growing up and although it is difficult to respond to such behaviour without causing a scene or rebellion from the sick girl, quick reaction to such situations gives you a chance to deal with the problem in an effective way. Improving the situation means helping not just the adolescent girl but her entire family. Over time anorexia may bring more and more conflicts, invade more and more relationships and destroy previously good or already poor relations at home.

If the family cannot see the ensuing pathology, the school should take action. The sick girl might still be doing equally well at school because she strives for perfection in every area, but changes in her looks cannot be missed. The illness takes most of her time or at least accompanies most of the activities she performs every day. Her thoughts all the time revolve around eating and then it is difficult to focus on classes and what she should be doing in class at any given moment. Moreover, there are regular check-ups at the school nurse's office who can see the loss of weight as compared with the previous examination. Her complete lack of reaction to such a drastic change is not a fully professional attitude. From my own experience I remember situations when I received support from the school counsellor, nurse or just teachers who could see my problem. By asking a question about my health in private they let me feel that I was not unimportant to them. And although in some situations I considered it interference in the issues that should not concern teachers, today I think that this care about students and their health is a natural and even commendable reaction of the school, not just as an educational environment but also as a community bringing us up. Similar interventions are difficult in the case of a university student because she is an adult and invading her privacy might be especially badly received. This is why there should be

places where such a person may turn for help – psychological centres at university or just groups of people providing provisional assistance and sending us to specialist centres. These establishments should provide more than just provisional help. Their tasks should include prevention and dissemination of knowledge about mental health problems. At the same time I cannot imagine a situation when an anorexic is denied dean's leave (for example for hospitalisation) or her recovery process is hindered in any similar way. The role of university and school authorities is to make this already sufficiently difficult stage of treatment easier for patients and also to inform them about the centres providing assistance in case of any serious crisis. The crisis may be a silent moment, but in fact it is an extremely desperate cry for help.

Friends and the persons she knows have a great influence on the sick person, too. They may be the first ones to notice the problem at the moment when their social contacts become rarer due to her isolation. Even before the illness manifests itself, a lot depends on the circle of friends and the way they perceive a given person. It may seem that close friendship is selfless and people like us regardless of how much we weigh. This is usually the case but honest conversations in such a group or sometimes even a subtle remark suggesting someone's excessive weight may turn on the red light in the head of someone who tends to look critically at herself and trigger the desire to lose some misjudged extra kilograms. The point is not to avoid people or lie that our friend's weight is ideal when you really think otherwise. But it is important to suggest healthy options for losing weight to her – maybe sports, maybe a visit to a dietician who, by controlling the entire dieting process, will help her achieve a healthy body mass. Or maybe she is naturally prone to a full figure and torturing her with a strict diet would only be an ineffective struggle, an alternating process of

losing and gaining weight. An anorexic is very sensitive to comments concerning her looks, even those expressed in good faith. Usually her friends may not know her problem and notice one day that she has gained a kilo or two. They may put it in a positive light emphasising that they like it, but the girl's perception is completely different.

I know very well how long these words may sound in her head and come again to her at every meal which, as a result, she will not finish. Just like the unplanned meal which she has to eat with her family. Even several weeks later she may remember these calories and that she did not include them in the menu which had been carefully prepared earlier, but had to consume because she was under the special control of her family. Many a time she will put a plate away compensating for the unplanned extra meal. I have told my story to many people but no one could fully understand my problem because they had not encountered it or had not had similar experiences. Then they asked me whether, if I could turn the clock back and avoid anorexia, I would use this opportunity and do everything to steer clear of it. I have thought about it a number of times. I think that these few difficult years were an excellent lesson for me and changed me forever. Although I am not a person who always wears a smile on her face (a few years of the illness, depression and isolation have taken their toll), I can enjoy life. I want to tell this story to others, so that instead of repeating my mistakes and going through a painful lesson, they may learn from my experience and try to seek their identity in another way, not along the winding path to anorexia. Today I know it was not easy to regain the confidence of my family, lost in such a trivial way by lying about eating. It is equally difficult to reverse the physical changes in the body caused by starvation, 'miraculously' slimming products and exhausting exercises. For a long time I believed that my body and what I did with

it was my problem. But I never wanted to land on the border between life and death.

Thanks to the people close to my heart who keep helping me discover beauty in myself I am on a good avenue, after having accepted my body, to starting to love myself. The way I am. Not an ideal that I once wanted to be.

Jakub Krakowski

Saving Yourself

Before I realised I was ill

When I started studying in 2001, which is almost ten years ago, I did not realise that I had mental-health problems. Many a time did I change my subject of study. I thought that a given specialisation was not for me because I was unable to 'get the knowledge to work in practice' to obtain good grades or to find myself within a group of students. Finally, I enrolled in the programme that I really wanted to pursue. Nevertheless, I am repeating the first year. Initially, I was convinced that all my problems at university were related to a physical illness. For a long time, somehow subconsciously, my mental illness disguised itself as other symptoms including inflammation of the upper respiratory tract and stays in hospital. I thought these were the main reasons why I could not continue my studies. But the truth turned out to be different as it was the psychological reasons that hampered my education process. I did not quite realise what was happening to me. Mental symptoms kept increasing but I could not see them and even when I began to notice them, I was too afraid to talk about them. Only now can I slowly start to do something about it and get treatment as

I am aware of my illness: I am addicted to alcohol and drugs, I also suffer from obsessive-compulsive neurosis. I have been in treatment for two years, although effective treatment has only taken place throughout this last year.

The first symptoms of my illness primarily included self-containment, lack of concentration, memory loss and fear of approaching my teachers to tell them about my problems. My illness – when untreated – is characterised by an unstable image of oneself – I consider myself a fine person only when others see me as valuable and have a good assessment of me. I have noticed that during studies the symptoms of my illness have been increasing: I saw myself as someone inferior, lacking knowledge, ineffectual, with the wrong approach to studies. From the moment I realised that these were the exact symptoms of my illness, I have felt better. I know that my problems with studying are not my fault but they are caused by my condition, which is something one cannot choose.

When the illness wins

The symptoms of my illness include problems with concentration and memory accompanied by a high level of stress, which periodically prevents me from studying. I need more time to understand the material, learn it or write an essay. Many times, intentionally, I would not take the exam on the first date assigned, aware that a later date would give me more time to prepare. On the other hand, spending more time on studying I was able to prepare the material in great detail – this is such a positive message. My knowledge was more extensive than that of other students who took and passed the exam on the first date – they knew the necessary minimum, which, in many cases, was

simply generally available information. I, myself, on the other hand, having slogged away at books and reading on a given subject, felt well-prepared but at the cost of postponing the exam. Then I experienced irritation, frustration and at some point I would give up as I felt overwhelmed. Before I started treatment I used to have such fits of anger that, for example, I destroyed my notes and threw books around. The reason for such behaviour was my limited resistance to stress and an inability to deal with it as well as the pressure imposed by my situation. My motivation was slowly fading and the illness would defeat me again. The stress used to be so great that I often went to classes afraid and apprehensive because I knew that I was very well prepared on this day. I knew that I would want to say something and I would be nervous. Even when I felt that my answers to the teachers' questions were correct, that I took an active part in class and the conversation was indeed based on facts, the stress would not lessen. It was even greater because this was when my problems with self-esteem became evident – I felt that the people in the room were looking at me and assessing me and I was afraid of what they would think about me.

I was so stressed out that one day before my presentation in class I ran out of the room. I ran out and never came back again thinking with bitterness that I would never see these students again. I would stop studying suddenly, many a time I would disappear and hole up. I was so paralyzed with fear that I was even unable to approach the administration office to tell them that I did not want to study again and collect my documents. My preparations for the exam session were also accompanied by great stress and I either wanted to do everything chaotically at once or I focused on one thing, but in great detail and at a slow pace. Studying includes gaining knowledge and passing exams within set deadlines. But I kept making one mistake: when I was

preparing for an exam, I collected extensive information related to a given subject whilst other students were learning from one book or even a collection of notes prepared by someone else. I would read two or three books, my notes and also look for additional information in the Internet. It was a huge amount of work and this is why I was not able to do it on time. For example, I learned half of the material and I was afraid to take the exam – there was always a chance that if I was asked questions from the other part, all my work would be wasted. Then I would lose motivation to such an extent that I did not feel like doing anything more. Many a time, however, I knew that I was very well prepared for the exam but at the last moment I would give up. For example, I would leave home and escape instead of going to the exam. Then I would quickly give up – if I failed I had no motivation to ask the teacher for another date and explain my problems.

When I was repeating the first year again, I forced myself to do even more work. I decided that I had to get excellent grades in the exams because I knew the material to a certain extent from the previous years. Moreover, I should have finished university already as I was much older than the other students and in the future I might have problems with employment. Considering all this, I decided that I must show myself to my best advantage and get the best grades in the exams demonstrating my knowledge. My ambition was not just to pass but to be the best. Throughout the year I was actually one of the most active students, unfortunately this came at a cost as I experienced severe recurrences of my illness. I had severe symptoms but ignored them thinking that I could manage. The pressure that I imposed upon myself was enormous and I could not bear its mental impact. Eventually, when the exams began, I failed them and my illness won this battle. What I did was to approach the teacher and ask whether

I could take the exam in a different form – not in writing but orally, so that I could show off the best of my abilities. I knew the material very well, I even had additional information. However, finally, I did not go to the exam because of stress and right up until today I still have not earned any credits for this subject. Other students passed it a long time ago, although in some extreme cases they only knew the name of the subject and not much else.

Once again in the first year

Sometimes I feel sorry when I meet some people and see how they continue university study – they are in the second or third year and I am still a first year student. I can see how other students continue education and finish university although they do not study the material in so much detail as myself. I do not remember how many times I have been a first year student – definitely four or five. I do not know whether this is in line with any of the university rules and regulations. I submitted formal requests to the department administration office and after their kind approval I could continue education but it was just prevarication throughout all these years. Once I made it into the second year but it cost me great stress, too. The problems related to clamming up and assuming no responsibility for my actions always resulted at some point in me giving up university, thinking that next year I would start afresh. When I repeated the year and other students knew it, I would become the person they asked about individual subjects, teachers' requirements or the atmosphere at university. Initially, I felt good about it, I was open in relations with others, confident and calm. But after some time I had concerns as to how the group of students would see me, whether they would perceive me as a loser who was in

the first year for yet another time, for an unknown reason. I was not able to admit that I had a mental illness and I was addicted in front of the group – I would never dare do that. I could encounter insults, lack of understanding or unjustified opinions concerning myself: that I was dumb, that university was not the place for me, that I was growing older and still unable to deal with the material in the first year. Luckily, I noticed a positive aspect of repeating a year – I got used to the teachers and the environment, which made me feel more confident. I did experience fear, anxiety, concerns over, for example, active participation in classes, but I was still active. Before I had not been able to express my opinion in public when I attended a lecture for the first time and had never before met the teacher. Back then this stress was so paralysing that I was not able to open my mouth. Then again, I felt resentment and regret about why I never spoke although I was well prepared.

Concealed problems

The atmosphere at the department where I am studying is conducive to gaining knowledge. The teachers are accessible to students and, above all, understanding. Despite these favourable circumstances I do not want to tell anyone about my illness and I simply do not do it. Still, I think that I could report these problems to, for example, some teachers or even the Head of the institute. I think I would not face rejection, nevertheless I feel that I could be seen as someone worse who should fully recover first of all before resuming my studies. I concealed my illness simply because I was ashamed of it (and still am). On the one hand, I realised that I was at university and I would not experience any unpleasant situations, for example the suggestion that I should give

up studying. On the other, I had psychological barriers as I was afraid to reveal my illness because I thought it would be reported to other teachers who would treat me worse. Personally, I never encountered a situation when any of my teachers would indicate that I was worse, different or that I should have passed a given subject a long time ago. Only once, at the beginning of the lecture, did the teacher indicate that I was the person who was repeating the year. Maybe it was a warning to other students: 'study my subject because there is someone here who has not been able to pass it over several years' (laughter here). It was unpleasant for me, even if I had wanted to admit it in front of the group of students myself, I could not have done it as I was forestalled. No other lecturer – even when they saw me in their class yet again – informed the group about it.

Only recently have I told the Director in charge of education that I have serious psychological problems and I receive treatment. But I did not tell him what the illness was because I was ashamed and feared his reaction. There is a very strong social stigma associated with my illness; it is not accepted, especially in Poland. I knew that the doctor I visited was a very open, friendly person and indeed approached my illness with the necessary understanding. What also mattered was that I had already had the support of the Disability Support Office and this was my additional argument in conversations with him.

How I found the Disability Support Service

I found out about the Disability Support Service (DSS) about two years ago from a student who also received support from them. Before, I had had no idea whatsoever that an office of this kind existed and I did not realise that it could help people with conditions similar to mine. For

me, finding the DSS was a good and positive boost, it gave me hope that I might still do something about my studies. My situation at that time was critical, I was aware that I would not request the department administration office yet again to allow me to take exams and study in the first year. Even prior to that I had already been surprised with the positive response to my case from the administration office. At that time I did not know what to do. Back then I was ill, I went to hospital – these were the reasons why I could not continue education. Finally, I recovered but there was still something wrong... On what grounds was I to request them to allow me to continue my studies? I was not aware of what was happening with me. Finding out about the DSS and the realisation of my illness was more or less parallel. I had serious concerns as to whether the university administration office would see me as a great prevaricator who wanted to get into the first year and then had no clue where and what kind of help to seek, thus ending up turning to the DSS. Then I realised that I could use their support, that this was recommended and that it would be helpful to me. First of all, I would be able to continue university provided that, of course, the department administration office agreed. The DSS has helped me with this, it has given me a chance and hope. A breakthrough moment for me was also the realisation that I was ill and that the DSS might support me in all of this. The first kind of assistance I was given concerned submitting an application to the University administration. Secondly, and this was the most important, they found a way to enable me to continue studying. I would not have been able to discover myself that, for example, I may apply for an official leave backdated because of ill health, I never even realised that such leave exists. What is more, my application was supported by the DSS, that is additionally approved. The opinion of the DSS strengthened my position before the university

administration office, lent credence to my aspirations proving that I really was trying hard and to the fact that I had failed not by lack of knowledge, negligence or inappropriate attitude to studying, but by the symptoms of my illness. If I had submitted my application without the DSS's assistance I would certainly have had to enclose a medical certificate including the information, albeit probably general, about my illness. At present, precisely due to the support of the DSS, the university administration office and teachers have received a signal that I want to study and can study.

My hopes for the future

As I will be going back to university after convalescent leave, my greatest hope is, first of all, to be treated as an equal with other students, neither worse nor better. I would not like to feel that I am someone who is somehow isolated or stigmatised. I think that Polish universities need special centres providing psychological support for students which could operate within universities but not as part of student clinics. Personally, when I receive support from the DSS, this is the kind of help I need because when talking about my problems I discuss the emotions that have accompanied me over the course of my studies and the ones I feel when I prepare for the final exams. Sometimes, even the fact that I am able to open up and talk about it is important. I have heard that in other countries there are centres for students providing psychological assistance. They are especially active before the exam session and their role is to help students who have mental health difficulties or who are sensitive. The point is not to 'push' someone through university, encourage or console them but to talk, to meet a specialist who is able to listen and provide some kind of help. Practical assistance is vital,

too, like advising what can be done in a given situation. Even if there is already psychological assistance at any of the Polish universities, I think that many students have no access to it, which means there is no awareness or information that such an option is available.

Finally, I would like to tell other students who have any difficulties, for example just like mine, that the most important thing is to realise that you have a mental illness. I am not a specialist in this field but from what I know these illnesses are very hard for the patients to diagnose by themselves. If a person with mental health difficulties comes to a specialist, the diagnosis is something obvious to an expert. But to make the patient realise that he or she has a mental illness requires time. This is why the most important thing is going to a specialist and overcoming this internal barrier. If someone goes to a psychologist or a psychiatrist, it does not mean that they are mad or someone worse, they simply need help because of an illness, just like in the case of cancer. There are people who have mental health problems but are not aware of them or do not want to be aware and think that they do not concern them or there is nothing that can be done about them. The effects are long-term – untreated mental illnesses may even lead to death. The human psyche is so strongly linked to the body that it may even have an impact on its health in a physical sense. If a mental illness is not treated, the body may manifest some symptoms, then the person is not able to function, not to mention studying.

The mental illness that I have been grappling with is characterised by a loss of touch with oneself, one's own emotions, deceiving oneself. It is important to find sufficient motivation to begin treatment, and start rescuing your personal development and studies. Motivation is based upon the realisation of what the consequences of non-treatment are. Speaking of my case, I cannot imagine that I could study without

receiving treatment. After all, this has been confirmed by my experience related to studies – all the time in the first year. I think that effective studying and lack of treatment cannot be combined. I would also like to say that it is essential to understand that when you notice something worrying about yourself, do not ignore the first symptoms, such as great stress, feeling that something strange is happening to you. It is important to look for help then. What is embarrassing about saving yourself?

Marta Rynda

Reflections on the ‘Let’s Talk about Mental Illness’ Meetings

The series of meetings called ‘Let’s Talk about Mental Illness’ held in the summer term of the 2009/2010 academic year at the Institute of Psychology was organised by the Clinical Section of the Scientific Club of the Jagiellonian University Psychology Students in co-operation with the Open the Doors Association and the Jagiellonian University Disability Support Service. Each of the four meetings could accommodate thirty participants. They were mostly psychology students, but also students in the fields of sociology, public health, medicine, journalism and law. The role of volunteer lecturers was played by representatives of the Open the Doors Association and Dr Hubert Kaszyński acted as moderator of the debate. So much for the facts. The question arises: what was the goal of these meetings?

Their principal task was to educate students in the field of mental illness as improving their knowledge of the subject was meant to be a form of changing their negative attitudes towards those affected. In the case of psychology students extending their knowledge was supposed to prepare them for possible work in the field of psychiatry. An additional goal was to reach students with mental-health difficulties themselves, reaching them with a tale of illness and recovery which would give

them hope in their fight with mental problems. It was obvious at the beginning that such goals were to be attained through conversation. It was only during project implementation that the question arose of how to talk so that the desired result could be reached. The participants, mainly with a keen interest in clinical psychology, expected contact with people fighting with a mental crisis. They wanted to become familiar with the perspective of someone who is ill, their history, hopes and fears. That interest in particular individuals and their view of the world turned out to be closely linked to the need to compare such 'live' information with the knowledge obtained at university. It was about learning what did not feature in textbooks. It was about being able to better understand the contents of the textbooks thanks to listening attentively to the tales of illness and recovery.

Psychology students, whose education provides only very limited opportunities to acquaint themselves with clinical practice, crave for specific knowledge, meeting with patients differing from those imagined on the basis of lectures and textbooks. The meetings held at university with representatives of the Association, that is people who have experienced illness and are able to relate to their experiences in a reflective manner, could be a way for students to come into contact with psychosis, which if under control is not so menacing; it could be a way to come to terms with and lessen their fear through better knowledge. For students of psychology it is of particular importance to learn about the perspective of those affected. Knowledge of the illness and understanding those suffering from it should be a tool to be used later at work. It is probably the reason why questions were asked during the meetings concerning the elements of the patient/psychologist or patient/doctor relationship which were useful in the treatment. The answers – respect, patience, conversation – something

that seems intuitive when said by patients and illustrated with their own stories, suddenly becomes concrete and full of personal meaning. And suddenly the lack of respect shown by medical staff becomes related to the shame and humiliation felt by a person used to personal contact. Somehow it is harder then to forget it.

The participants were appreciative of the knowledge acquired from representatives of the Open the Doors Association. They emphasised the fact that no textbook would convey the message that could be expressed by someone who has been or is still ill. They also said they needed such information to be able to help others in the future. Some even claimed that such classes should be compulsory, not just for students of psychology, but also for students of medicine, sociology and social work. They also expressed their lack of interest in discussing common definitions of illness and recovery without relating them to the educators' own experiences. Such reluctance may be understood in a variety of ways. One might think that the participants needed an empirical justification for the claims made; they needed information which would legitimise the definitions given. The students may have also been hungry for something 'sensational' and that could be the second explanation. Yet both those explanations are negative, i.e. they are based on the students seen as people who attack the intimacy and undermine the reality of someone else's experiences. There is another, simpler and positive explanation: they are fed up and bored with theory. Many participants claimed that in the course of their psychology studies they had already covered courses on mental problems. Were they to listen to the same again, they would not find that attractive. Students expected the meeting to offer some novelty, help update the textbook-based knowledge that they already had. It is not about being sensational or proving anything; it is simply about being curious about

another human being and the need to have a better understanding of mental illness. The model of meetings preferred by psychology students where actual experiences are discussed seems suitable also for students of other subjects, unrelated to psychiatry or clinical psychology¹. Education is extremely important as the term 'psychosis' still evokes fear and public attitudes to people with mental-health problems are harmful and limit opportunities for a dignified life for those on the road to recovery. The meetings where students could meet directly with people recovering from mental illness would make them more sensitive to mental illness and improve their understanding in that regard, thus in one manner combating stigmatisation.

The negative public attitudes may discourage people with mental problems (also university students) from coming forward as such and getting support. As the university should be a structure offering its students assistance, discussing issues related to mental illness during meetings held at university could be a way of disseminating information that the university wants to be a supportive institution; that the Jagiellonian University Disability Support Service provides assistance to students affected by mental problems. Moreover, such meetings would be some form of prevention for people who are new students and because of taking on new roles and challenges are at risk of experiencing adaptation problems. The meetings held so far have been attended by students who have experienced mental health crises.

¹ The experience of the Open the Doors Association thus far has confirmed that the participants of educational meetings attach most value to what educators say about their experiences and problems derived from their own lives (see Liberadzka A., Białek I. and Kaszyński H. (2009) 'Metody profilaktyki w zakresie ochrony zdrowia psychicznego w grupach studenckich' [Preventive Methods in Mental Healthcare in Student Groups]. A paper delivered at the conference entitled 'Disability Awareness and New Challenges for Education', Kraków, 22-23 October, 2009).

They claim that their participation was an important event for them. The awareness that such people are (or may be) in the room lets us organisers understand some questions that come up in a different way. As an illustration: reflecting on the initial meeting, one participant stated that she had very much wanted to learn what motivated people with mental health problems to work so hard towards recovery. She then explained that – as she was fighting a mental condition herself – she was often left without strength and so was interested what was the source of hope and motivation for other people with mental problems. And so a question asked from the floor may be a way of looking for solutions to one's own problems, looking for answers to people who are coping with similar issues.

In brief: meetings are needed at university that offer an opportunity to talk about mental illness. They are not just an exercise in knowledge enhancement and change of public attitudes to people with mental-health difficulties, but also a form of prevention and help. The incidence of mental-health issues in the university student population is considerable and this publication is a proof of the gravity of the problem. The university should be an institution which instead of eliminating people with problems should support them in attaining the important goal of acquiring an education, thus giving them a chance to function with dignity in society at a later stage. As a student of psychology, I also think that meetings with those who have gone through mental health crises would significantly complement the educational value offered by psychology studies. Other participants share this view. Our plan is to be involved in clinical work and so we want to talk about psychosis; we want to understand it and make it more familiar. We do not want to attack, we want to listen. We feel uncertainty and are concerned about those who wish to share their experiences of illness and recovery. We

are grateful for such tales. At the same time, I know that holding such meetings requires readiness on the part of the educators themselves, firstly to remain in direct contact with the difficult area of one's own experiences and secondly to share one's own intimate experiences with strangers. As an organiser I believe, however, that for the educators themselves dialogue with students may be helpful whilst emotional contact with one's own experience of psychosis makes it easier to control it again, permitting its reinterpretation and therefore assisting recovery.

Since the university should be a forum for open debate on mental illness and since such a conversation may be of benefit to both students and educators, and since a participant entered the following in the evaluation form: 'you have done something truly valuable, keep up the good work', we should clearly continue with the project and we are already now extending our invitation to more meetings to be held in the next academic year in the series of 'Let's Talk about Mental Illness'. See you there!

The Journey Is Not Yet Over

‘But lunatics at University?’ asked a journalist who interviewed me about Constellation Leo. His was a harsh way of touching upon the common stereotype concerning mental illness which is one of the most difficult stereotypes to combat: that people with mental-health difficulties are a threat to those around them. Another such a stereotype is a belief that mental illness equals intellectual disability. It is my hope that after this journey the reader is left questioning the truth of both these stereotypes.

We at the Disability Support Service are visited by highly intelligent and sensitive people every day. Some of them have agreed to have their histories published here and definitely no-one in their environment would think they may have mental-health difficulties. People’s assumption is that this one person out of a million with such conditions is somewhere far away, safely isolated from us, because if he/she were close, they would no doubt be a menace to us in one way or another. We do not think that the one-in-a-million may be our good fellow student or a colleague working in the same room. Aren’t we ourselves really not that infrequently in a state which is commonly known as depressive or don’t we ever feel the blues? We cannot always influence the way such ordinary ‘depression’ may morph into actual

depression and a state where our daily problems overwhelm us so much that we are unable to cope with them ourselves. It may be only then that some understanding for the fellow student or colleague will turn out to be of the utmost importance. We must, anyway, be able to count on just that. As long as we conceal such problems for fear of open or hidden discrimination, we are not yet a socially responsible University. Yet if we create a climate of understanding and support for those who at a given moment happen to have suffered failure as their problems were too much for them, yet are highly educated and may soon create a modern university for the generations to come with us, we may be on the right track towards becoming such a University and the journey will then end. Or maybe it is a never-ending journey, maybe it is a constant meeting with fellow human beings, the way they are, with all their virtues and vices, the diversity of their world views and attitudes, with or without disability and with all the richness of being human. This is also good for the University and the values it carries. So there will be no moral to *My Journey*. I would like each reader to reflect in his/her own way on the issues discussed in this collection and to look for answers or ask further questions. The reader may like to share them with us using the Constellation Leo forum. Feel free to do so as in this way we will continue the dialogue within the academic community launched with the publication of this book.

Ireneusz Białek
Chief Coordinator,
Jagiellonian University Disability Support Service
www.KonstelacjaLwa.pl

Glossary

(JU) DSS – For more than ten years now, the Jagiellonian University Disability Support Service has been a centre of educational support whose mission is to provide students with disabilities with equal access to the University’s educational programme. This requires the application of various adaptations thanks to which students are able to attain the academic standards envisaged in the curriculum. The Service has a team of qualified consultants as well as Poland’s most advanced specialist technological tools focusing on the individual needs of persons with disabilities. The Service welcomes current and future University students holding valid certificates confirming their disability or other health problems which will have an impact on the university study process. An initial interview with the student, however, is not conditional upon presentation of specialist documentation. Any information provided by the student is treated as confidential, so ensuring that persons with mental difficulties are at ease with the process. The Service’s consultants co-operate with University lecturers in order to develop individual educational strategies which make the opportunities for such students to gain access to education as equal as possible. Such collaboration facilitates the provision of adaptations

which take into consideration the specific features of a given course and its key requirements.

Mental illness – The very term mental illness sounds like a sentence dooming one to rejection, loneliness and suffering. This is often indeed the case. However, combating the condition and its consequences also brings us strength and positive changes in our self-esteem. When affected, we can set off on an individual path towards truth, freedom and acceptance of oneself as a human being.

European experience – Our programme is based on the knowledge compiled throughout the decade of operation of the Jagiellonian University Disability Support Service and a variety of experiences gained at various European academic centres. We would like that capital of knowledge and experience to serve to build a climate of openness and tolerance towards, as well as an understanding of, problems faced by persons with disabilities, in particular those with mental-health difficulties.

Hidden discrimination – Covert discrimination takes place when we sense it as inappropriate to publicly reveal our views which are generally considered discriminatory, yet in practice we follow them. In Poland, there is very often hidden discrimination associated with disability, although in the case of mental health difficulties discrimination is very often open. That is why there is still so much to do in this area.

Leo – As a brave animal, the lion has become the symbol of our programme. In Poland, one must be very courageous to talk openly about mental illness. Even more courage is needed to talk to others about one's own condition. Yet courage helps.

Programme of support – The ‘Educational Support Programme for Jagiellonian University Students with Mental-health Difficulties’ is a novelty for Polish schools of higher education. The programme seeks to develop an effective support system for that target group. On the one hand, the programme seeks to support specific students, and on the other to dispel the taboo surrounding mental-health conditions in the academic community.

University students – Being a university student means tasting life, maturing, but also learning to be responsible for oneself and others. A lot of maturity and responsibility is indeed needed to respect each budding individual identity, attend to it with care when it is in pain, and extend a helping hand. Such situations are true tests of maturity, and at times the life of a fellow man depends on maturity.

Disability awareness – In our daily actions and decisions taken as part of our duties, one may or may not pay attention to the needs of people with disabilities. Each single one of us carries their own element of responsibility for improving their living, working or education-related conditions. Likewise, persons with disabilities themselves also carry their own element of that responsibility. The level of development in societies may be measured by the level of awareness of specific needs stemming from disability.

The responsible university – Such a university is trying to reach out and make a connection with the various experiences and needs of its students, including those undergoing or following on from mental health crises. There is a special bond between such a university and its graduates, regardless of where they work at a later stage in their career or what kind of life they choose for themselves.

Educational support – This covers services involving adaptations of teaching materials, counselling and adjusting the way that classes are organised to the students' individual needs. This is intended to ensure that persons with disabilities enjoy equal access to the standard educational programme of the Jagiellonian University.

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Lucyna Małgorzata Szok-Ciechacka

The drawings presented in *My Journey* are by Lucyna Małgorzata Szok-Ciechacka, an artist, graphic designer, journalist and researcher of Deaf Culture. She maintains an art blog focusing on the Deaf and hard of hearing community as well as Polish Sign Language. The blog is designed to combat stereotypes concerning disability with good humour and the featured cartoons are a tongue-in-cheek lesson in not fearing otherness.

Visit her blog at: <http://szok-art.blogspot.com/>

The artist about herself: I was born hearing but for reasons unknown to doctors I lost the sense of hearing as a one-year-old baby. Hearing people, who are not very familiar with the Silent World consider such hearing loss a tragedy but I see it as something only positive as I do not think I have lost something – quite the opposite: I regard my Deafness to be a fantastic gift from fate. If I could hear, I do not think my life would be equally colourful, beautiful and full of emotions. I have been drawing cartoons virtually ‘since always’, but it was only at university that I had the idea of creating cartoons featuring Deaf characters and making their main theme the joys and sorrows daily experienced by

Deaf people as they interact with hearing persons. I work as a computer graphic designer, satirist and graphic artist; the job is my true passion, inherited from me, as I can see, by my daughter Basia. I spend my free time with her and travelling by motorbike with my husband Jakub or on my own. I love motorbikes and find that solitary rides in the wilderness let me find inner peace.



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