The Mental Hospital Survival Guide

How to Protect Yourself and Others from Abuse

4th Edition

Written by a person experienced with schizophrenia:
Jason Page

Foreword by W.C. Turck

~ 2025 ~

Written in dedication to those I have witnessed abused and to those who have gone abused unnoticed or unaware.

ISBN: 9798289441232

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Disclaimer

The content of this book is based solely on the personal experiences and observations of the author, Jason Page, who is not a medical professional or expert. The author lives with schizophrenia, and the insights, advice, and strategies presented here reflect his unique perspective and lived experiences within psychiatric hospitals and mental health systems. These experiences may not be representative of or applicable to every individual's situation, as mental health conditions, treatment environments, and personal circumstances vary widely.

This book is not intended to provide medical, legal, or professional advice. Readers are encouraged to consult qualified healthcare professionals, legal advisors, or other relevant experts for guidance specific to their needs. The author and publisher assume no responsibility for any actions taken based on the information provided in this book.

Use the information herein at your own discretion, and always prioritize your safety and well-being by seeking professional support when necessary.

Forward

> "The validation of my sanity may well be dependent on labeling the other insane."
> The Citizens Commission on Human Rights (CCHR)

If you do not understand much of what is written in Jason Page's Mental Hospital Survival Guide, it is likely not written for you. It is a different language for many of us, but it is only too familiar for someone you love, or someone close to you. This guide is written in the language of the schizophrenic, which is as unique as any other language on earth, complete with its own vocabulary, structure, culture and syntax. So much of it is lost in translation. Empathy fails In that regard, all too often becoming sympathy, which risks being rooted in ignorance. Support demands acumen with the language. Because language here is imperative, this may be the most important single piece of information they may ever receive. It may save their life. It will certainly impact the quality of their life. Over the years

Jason and I have had many conversations on the limits of language in describing what is commonly referred to as Mental Illness. Even as an author and playwright I grasp, I fear unsuccessfully, with the pale limits of language for a better descriptor that likewise does justice to the schizophrenic, as well as to the dignity of the individual. Mental illness seems to fall short. Mental Disorders almost seems to blame the individual for something entirely out of their control. Mental health seems to parcel people into separate pockets of the unhealthy and healthy. I have tried to use Perspectives, but even this falls short, as if there is agreement on mental issues. Even the word mental detaches mind from body. Mental Distress at least endeavors to indicate one of us is in need of help, support, access to medication, protection, love, care...

A 2010 World Health Organization's Mental Health Survey estimated that at any given moment there are 450 million mentally ill people in the world, or about 6% of the population. That number is almost certainly conservative. Whether lifelong or episodic, as with depression or despair at the loss of a loved one, or post partum depression, a myriad of distresses awaits all of us at some period in our lives. Being institutionalized, even over night, for severe mental distress, such as depression may happen without a person's consent if a health professional fears a person may do themselves or someone else harm. The shock and fear and disorientation in an unfamiliar, even seemingly hostile environment may cause a situation to spin out of control. Worse yet, if actions by individuals, the authorities or the institution itself turn abusive, resistance or "common-sense" reaction may lead to greater harm. Language also fails

us in our understanding by separating mind and body. We argue Nature vs. Nurture, as if either could exist independent of the other. More importantly, the question becomes, have we wrested ourselves from the horrific and inhumane 19th century Asylums. Inmates were routinely called Lunatics, Insane, Mad, Deranged and more, which keeps us mired in ignorance. That history is not so easily discarded, as the failure of language so clearly illustrates.

The first references to Schizophrenia appear from ancient Egypt, though likely it has been with us throughout most if not all of human history. The word itself was coined in 1911, a veritable blink of the eye in human history. The revolution in Magnetic Neuro-Imaging, only a couple decades old, reveals absolute physical differences in the brains of Schizophrenics in comparison to non-Schizophrenic brains. Schizophrenic males show differences from Schizophrenics of other genders.

Despite substantial breakthroughs in our understanding of Schizophrenia, we still live in a world in which demonic possession is popular in movies and fiction, in which every major religion advocates exorcism to deal with so-called demonic possession. While Schizophrenia is certainly not the fiction of demonic possession, far too many still believe they are connected. Heinous criminals are routinely called "demented," "lunatics" or "crazed." Here again we are allowing the failure of language and the burden of our history of ignorance to fail brothers and sisters who so desperately require our love and commitment, insight and support.

Perhaps the greatest failure is the state of institutions and hospitals. In 2014, the Citizens Commission on Human Rights, a global watchdog committed to investigating and exposing human rights violations in the field of mental health, exposed how, "our sane cures" and the "sanity" of psychiatric institutions often "abuse and punish the patients" under the guise of treatment or cure. The CCHR pointed to misdiagnosis, over-medication, disregard of restraint, violent restraint, punishment and isolation, abusive therapies and lack of training to name just a few.

Jason Page's Mental Hospital Survival Guide carries the CCHR assessment beyond the clinical to the experiential. The advice and perspective here is taken directly from his own experiences, detailing abuses and dangers from the perspective of the patient. Having known Jason for a number of years, watching him manage Schizophrenia with a rare and empowered agency, I can think of very few who possess the insight, experience and scars that this narrative is intended to help.

WC Turck

Preface

In my fifteen years since being diagnosed with paranoid schizophrenia, I have experienced more than twenty hospitalizations. During nearly all of those stays, I have witnessed numerous abuses, most of which—particularly the most severe —stem from a simple root: a lack of oversight in environments where confidence in the system persists, even as questions of abuse arise, often sparked by individuals exhibiting delusions and psychosis.

My observations have led me to reflect on the broader dynamics at play. In some cases, staff with backgrounds like ex-military service bring complexities—such as PTSD—that may amplify their responses, but the core issue lies elsewhere: unchecked authority in settings where empathy is too often absent. This mirrors a wider societal trend, a faint disregard for humanity that echoes through our culture. We see it in the desensitization bred by war, where enemies and innocents alike are reduced to abstractions, a pattern evident from Vietnam to today's conflicts. Those with a conscience must stay vigilant. We can sense the growing concern over a lack of empathy in the world, just as we can still admire the rare quality of humanity in those who possess it. Yet the mechanisms of dehumanization remain subtle and pervasive.

One example of this cultural conditioning—beyond the dominance of selfish materialism or the casual violence of entertainment—is the widespread, often unconscious belief that helping just one person isn't enough because the scale of need is too vast. As we pass by those we know are struggling, we diminish the value of a single act of kindness. But helping one person forges a real connection, setting an example that can ripple outward, inspiring others to act.

This book is not merely an observation of those in need, nor just a guide for the reader's benefit. It is an effort to equip readers to help others—even in small ways—especially those in vulnerable, unfamiliar situations. By seeing ourselves in others, we can cultivate empathy, sharing our knowledge and experience—whether by leading through example or stepping in as a personal advocate for someone caught in the grip of abuse and systemic manipulation.

Chapter 1
Why you are hospitalized

A. When you are hospitalized Against Your Will

When the state or someone close to you decides you're a danger—to yourself or others—or that your mental health has declined to a life-threatening point, you may find yourself admitted to a psychiatric facility against your wishes. Right now, you might disagree with this decision, convinced it's unnecessary or unjust. That's understandable. Hold on, though—this experience, however unsettling, is one you can navigate and emerge from intact.

You may already harbor doubts about the psychiatric system, and not without reason. Its history is shadowed by stark origins and well-documented abuses, from experimental treatments to outright neglect. Armed with this awareness, you carry a responsibility—not just for yourself, but for others—to ensure those wrongs don't persist or resurface. While you're here, consider yourself more than a patient. Be a quiet observer, a Good Samaritan poised to call out mistreatment when you see it. This isn't just about enduring hospitalization; it's a chance to act as an undercover advocate, watching for abuses that others might miss. My hope is that this book equips you with the insight and resilience to do so effectively, whether you're in a hospital ward or an institution.

That said, compliance doesn't mean surrender. Engage with your treatment, but stay sharp—never let it roll over you unquestioned. Strive to understand yourself and the therapies offered. If new medications come up, insist on a clear explanation beforehand. Don't agree to anything unless you grasp how it might help you, weighed against any side effects you're aware of. Knowledge is your shield; use it.

Hospitals, too, have a stake in this. Their reputation hinges on trust, and they know it. When evidence of a "bad apple" among their staff surfaces—someone crossing lines or neglecting care—they're incentivized to act, not just to protect patients but to safeguard their public image and operational integrity. Your observations can matter here. Speak up when it's warranted, not out of spite, but to hold the system to its own standards.

This moment, forced though it may be, isn't just a confinement—it's an opportunity. You're not powerless. Use it to learn, to protect, and to push back where it counts.

You may have accepted the possibility that your schizophrenia is rather wireless harassment. In legitimate cases of mind control psy-ops and non-consensual experiments using wireless technology, even anti- psychotics are used as deterrents. So if you are worried about nano-bots, nano-fibers or some form of emotion control via wave impedance with implants or your nervous system, anti-psychotics are still considered the most effective in countering that sort of harassment. You are better off investigating this harassment when it can no longer gaslight you. Anti-psychotics work because they treat the symptoms and not the cause. That's why they work for all psychosis regardless of the source of the problem or harassment. Meanwhile it is important to monitor the effect of any new medications on your mood, self-will and cognition. If you start to feel or experience withdrawal, carelessness or lack of creativity and access to your mental faculties such as memory and comprehension then you need to report these in writing and have it placed in your chart for your doctor to see while hospitalized.

B. Voluntary Hospitalization

Sometimes the weight of the world becomes too much—crushing you with pain, suffering, or a sense that you can't manage on your own anymore. You've reached a point where you know you need help, and that's a brave realization. You don't have to face this alone; outside support is there for you to lean on.

If you're able to plan ahead, voluntary admission can give you some control. In many states, public insurance like Medicaid won't cover ambulance costs for non-emergencies, so driving yourself or arranging a ride to a hospital you trust can save you the expense. Sign yourself in and start the process on your terms. But if the situation feels urgent and you need an ambulance, don't hesitate—your safety matters more than the bill. Those costs, if unpaid, won't tank your credit. After a while, the reminders stop coming, and the city often absorbs the balance. Plus, if you rely on SSI or SSDI, that income is "judgment-proof"—legally protected from garnishment—so collectors can't touch it anyway. Focus on getting help, not the fine print.

When you arrive, come prepared. Bring a handwritten list of key contacts—phone numbers of family, friends, or advocates—tucked into your wallet or purse. Ideally, make this list ahead of time and keep it with you; emergencies don't wait for prep work. If you forgot and still have your phone, ask to jot down a few numbers before security confiscates it. You can do this in the ER or while they're locking up your belongings. Need your phone charged? Request it be held at the nurses' station on your unit—they're more likely to agree since you're there voluntarily. That choice to admit yourself puts you in the driver's seat, giving your requests more weight with staff. How you handle yourself—staying calm, respectful, and clear—will shape how they respond to your needs throughout your stay.

Voluntary doesn't mean easy, but it does mean you've got a say. Use it wisely to get the care you deserve.

C. Asylum Hospitalization for Social Reasons

In the United States, mental hospitals were historically envisioned not just to protect society from individuals deemed dangerous, but also to shield individuals from a society that might threaten them. This shift emerged around the early 20th century, when reformers began rethinking the moral framework of mental health care. No longer was the focus solely on isolating the "mad" to safeguard the public; instead, the idea took root that hospitals could serve as sanctuaries—places of asylum—for those overwhelmed or endangered by the world outside. While this ideal has evolved unevenly amid changing policies and practices, the notion persists that hospitalization can offer refuge in extreme circumstances.

If you feel targeted—whether by a conspiracy you're poised to expose, perceived gang-stalking, gaslighting, or other forces you believe imperil you or others—hospitalization can be a lifeline. If the danger feels immediate, call 911 and tell the dispatcher, "I believe what I'm experiencing puts me in immediate danger to myself." This phrasing aligns with crisis response protocols, signaling a need for urgent help. It doesn't matter in that moment whether these threats are objectively real or tied to psychosis—what counts is that they're real to you, driving your distress, and you need protection or support fast.

If law enforcement arrives and you're still on the line, stay calm and stay connected. Read the dispatcher the officers' badge numbers aloud to document the interaction. If an officer asks you to hang up, say clearly—while still on the phone—"I'm speaking with 911 dispatch right now." This keeps the call active and transparent. In many cases, police are trained to assist, not escalate, in mental health crises; they may even help coordinate your transport to a hospital via ambulance.

Once you're in the ambulance, you're on a path to care, not detention. Law enforcement or other authorities can't legally hold you for questioning until you're discharged-your status as a patient takes precedence. Upon arrival, request a social worker immediately. Explain your situation and ask them to document it thoroughly; they're there to advocate for you and navigate the system. Your medical records remain private under federal law (like HIPAA), accessible only to you, your authorized representatives, or, in rare cases, a court-appointed guardian or family member with legal standing. No one else gets in without your consent.

This isn't about proving your fears to the world—it's about securing safety when you need it most. The hospital can be a temporary shield, giving you space to breathe and sort through what's real, with help at your side.

Chapter 2
Why the immediate heavy sedation

A. Stable & Not Well

When you're admitted, the clock starts ticking—not just for you, but for the hospital. Insurance companies often cap how many days they'll cover, pushing doctors to stabilize you fast and get you back out the door. "Stable," though, doesn't always mean "well." It's not about restoring your quality of life or getting you to some ideal state of health. Instead, it's about hitting what they call your "baseline"—a minimum threshold where you're functional enough to leave, even if you're far from thriving.

Doctors also aim for what's called a "therapeutic level" of stability. That's jargon for finding a medication dose that keeps you from bouncing back to the hospital for the same crisis. To get there quickly, they often lean on sedation — sometimes heavy sedation. It's not unusual for the drugs to leave you foggy, muting your ability to express what you need or fully grasp what's happening around you. The priority is control, not conversation: quieting the symptoms enough to meet that insurance-driven timeline and reduce the risk of readmission. It's a blunt tool, and it can feel like your voice gets lost in the process.

B. Appealing for a Favorable Discharge Amid Concerns

If you're heavily sedated or feel sidelined in advocating for yourself or others, don't lose hope—you can still shape your path to a favorable discharge. A "favorable discharge" means leaving with a record that reflects stability and cooperation, which can ease your transition out and signal to staff that you're ready. Even if you're troubled by the care you're receiving, focusing on your own actions can build a case for release without confrontation. Here's how to approach it:

- **Start Small, Stay Consistent:** Make your bed each morning. It's a simple act, but it shows staff you're engaged and managing your space.
- **Be Present:** Show up for all meals. It signals you're maintaining a routine and taking care of your basic needs—key markers they look for.
- **Engage in Groups:** Attend most, if not all, group sessions. Participation demonstrates willingness to work within the program, even if you're skeptical of its value.
- **Keep Calm, Document Quietly:** Avoid outbursts, even if frustration builds. Instead, jot down concerns—date, time, and details of any incident—on paper if you can. This keeps you in control and creates a record you might use later, without escalating tensions now.

- **Navigate Medication Wisely:** Take prescribed meds unless they're causing clear physical harm—like rapid heartbeat, tremors, paralysis, seizures, or blackouts. If you notice serious side effects, calmly report them to a nurse or doctor and ask for a review. Compliance matters, but so does your safety.

By staying steady and visible in these ways, you're not just enduring—you're subtly proving you're ready to leave on good terms. If care quality worries you, these steps let you bide your time and build credibility while keeping your dignity intact.

C. Signing Out Against Medical Advice (AMA)

If you're sedated to the point of struggling to express your needs and you're still being held involuntarily, you have an option: signing an Against Medical Advice (AMA) form, sometimes called a "3-day notice" depending on your state's rules. This is your way to request discharge when you feel ready—or when the situation, like potential abuse, becomes unbearable. Use this sparingly—it's a serious step that can affect your care record—but it's there if you need it. If you suspect mistreatment, keep a detailed log: date, time, and a brief description of each incident. Make sure this log leaves with you—either carry it out or entrust it to someone you authorize. It's your evidence, and it matters.

Before you sign, ask a nurse or social worker to explain the AMA process clearly. Sedation might cloud your judgment, so confirm what you're agreeing to. Once you're out, the next steps are critical to keeping you on track.

D. Follow-Up After Discharge

After leaving—whether by AMA or standard discharge—see your doctor as soon as possible. Your medications might need tweaking, especially if sedation left you foggy or over-medicated. If you can't fully explain your experience, keep it simple: say, "I'm sedated to the point where I can't advocate for myself." That's enough to flag the issue. Your doctor's job is to assess whether that's true, but don't assume they'll dig deep—appointments are often brief. They'll watch your expressions, body language, and how clearly you speak, so you need to raise the concern yourself. If you don't, they're unlikely to push for your well-being beyond preventing another hospital stay.

Their main goal is keeping you stable, not necessarily thriving. Make your quality of life their priority by speaking up. If they brush you off or won't adjust your treatment to your satisfaction, consider switching doctors. Most insurance plans let you see your current provider while you search for a replacement—just check your policy or call the member services number on your insurance card.

If sedation or your condition makes self-advocacy impossible, designate someone you trust—a friend, partner, or relative—to speak for you. Sign a HIPAA release form to give them access to your records and a role in your treatment plan. You might also need a separate form for a DHS (Department of Human Services) representative if state assistance is involved—check with your caseworker. Every hospital or doctor's office has its own release forms, so contact their Medical Records department for the right one. A general release is included on the next page as a starting point, but it's legally binding only if it meets your state's standards. For each institution you've been treated at, file a specific HIPAA-compliant release. See Chapter 14 for more on legal advocacy options if you're incapacitated or unable to make decisions.

If you're unable to advocate for yourself, someone you trust—like a guardian, parent, partner, or friend—can step in to support you. They can call the hospital where you're staying and request that a consent form be signed to allow them access to your care details or to act on your behalf. Encourage them to ask for the hospital's specific authorization form, as each facility may have its own version, tailored to state laws and federal HIPAA regulations. To stay on track, they can call back an hour later to confirm whether the form has been signed and processed.

Don't have the right form handy? Your loved one can contact the hospital's Medical Records department or your state's health department website to get the exact paperwork required. Every state has its own rules, and providers often supply their own versions, so using the correct one ensures everything is legally binding and smooth.

Even if you don't sign a consent form, that person can still share useful information with your care team—typically your therapist, social worker, or doctor—to help guide your treatment. They just won't get updates back without your permission. If you're feeling paranoid or unsure about trusting those close to you, that's okay—it's common when your mind's under strain. Take a deep breath and stay steady; you've got this, and help is there when you're ready for it.

Chapter 3
Communicating with your overloaded doctor

Hospitals often run on lean budgets, meaning a handful of doctors juggle dozens of patients. You might only see your doctor once or twice during your stay, leaving little time to address every concern. Overloaded schedules can make communication tricky, but you've got options to manage your needs without waiting for a rare doctor visit.

For serious physical issues—like worsening pain or alarming symptoms—head to the nurses' station. Nurses can connect with your psychiatrist or a medical doctor faster than you can. Doctors must approve all medications and treatments due to legal and paperwork requirements, so even simple requests (like aspirin for a headache) can hit delays. To sidestep this, ask nurses for food-based or non-prescription solutions often available on the unit. These can tide you over while you wait—or spare you the wait entirely. Below are some common concerns and practical alternatives. Always check with staff to confirm what's on hand, as supplies vary.

- **Acid Relief:** Instead of waiting for antacids, ask for apple juice (ideally without added Vitamin C) or, better yet, a whole apple. Apples are naturally alkaline, neutralizing stomach acid quickly. There's truth to "an apple a day keeps the doctor away"—an alkaline diet can also bolster your resilience against viruses, which thrive in acidic conditions.

- **Headaches, Migraines, Constipation, or Colds:** Dehydration often triggers headaches or worsens migraines. Request warm water and a pinch of salt—stir it in and sip slowly, then rest. Salt helps your body hold onto the water. Save condiment packets from meal trays for this trick. If hydration's not the issue, try orange peels if available. Chewing them releases natural compounds that ease pain, boost immunity, and sharpen focus. Relief can kick in fast as the nutrients absorb through your mouth.

- **Blisters, Warts, or Painful Rashes:** Ask for a cup of water, baby powder, and turmeric powder (if they stock it). Mix into a thick paste with a spoon, apply it to the affected area, and let it sit for an hour. Reapply daily until it heals. This soothes irritation and speeds recovery—check with a nurse first to ensure it's okay for your skin.

- **Avoiding Fluoride Toothpaste:** Request baking soda and water for brushing—it's a gentle, effective cleaner. If that's unavailable, gargle with saltwater daily. For a deeper clean, ask for a capful of hydrogen peroxide once a week, diluted with twice as much water (2:1 ratio). Decaf coffee works too—its natural antibacterial properties freshen breath and fight bad bacteria, making it a solid mouthwash substitute. For example, chlorogenic acids, known for their antibacterial and antioxidant effects, are still present in decaf coffee. As for bad breath, the same logic applies as with regular coffee: decaf might have some mild antibacterial effects against oral bacteria like *Streptococcus mutans*, but it's not a direct solution for halitosis. However, brushing and staying hydrated are still your best bet.

- **Avoiding Harsh Soaps:** Water alone cleans nearly as well as soap for daily use. Adding soap helps with sweat buildup, but overuse—especially of "antibacterial" kinds—can dry out your skin, cause rashes, or weaken your immune system by limiting exposure to harmless bacteria it needs to adapt to. If you're admitted voluntarily, bring your own soap—African Black Soap with Shea Butter is a great, gentle option, or try palm oil soap if you don't need extra moisture. Hospitals usually allow new, unopened packages—call ahead to confirm.

When you do see your doctor, keep it concise: list your top concerns and any side effects from meds. They're swamped, so clear communication helps them prioritize. If you're stuck waiting, lean on these workarounds—they're your bridge to comfort until the system catches up.

A Note

If you have concerns about your treatment plan or considerations or exceptions you want to make a request as part of your treatment plan, you can write those concerns or requests down and ask that they be added to your charts for your doctor to see. Your doctor will consult your chart many times more than s/he will consult you personally.

Chapter 4
Understanding the problem with staffing

A. Navigating Hospital Staffing Challenges

Hospitals often hire staff with diverse backgrounds, including some who are ex-military. As noted in the preface, certain individuals may carry experiences—like PTSD—that can shape how they respond to stress. Quick movements or loud noises might startle them, potentially shifting their mindset into a defensive or controlling mode. This doesn't mean every staff member fits this mold, but some, especially those with a commanding build or demeanor, may be chosen for their ability to physically manage patients in crisis. Your safety matters, so it's wise to move calmly and speak steadily around staff to avoid unintentional escalation.

The bigger issue isn't just background—it's oversight. Some staff, regardless of their past, may struggle with empathy, whether from burnout, personal biases, or desensitization. In environments with lax supervision, this can spiral into abusive behavior: verbal threats, physical overreach, or, in rare cases, even sexual misconduct. Patients who seem vulnerable—those less able to speak up—can become targets. I've heard staff in Chicago hospitals casually mention their military ranks, suggesting this pattern might be more common in some areas, though it's hard to say how widespread it is beyond my own observations as of April 2025.

Abuse can take many forms. Verbal abuse might include direct or veiled threats—against you or your loved ones—or gaslighting that exploits your fears or delusions to shift blame onto you. When patients react emotionally, their credibility often gets dismissed in the chaos. Physical or sexual abuse, meanwhile, tends to happen out of sight—private rooms, away from cameras—where restraints might turn into kicks or worse without witnesses.

Here's how to protect yourself and others:

1. **Log Everything:** Write down every incident—date, time, and a clear description—as soon as you can. Keep this record safe; it's your proof.

2. **Report Strategically:** Wait until the involved staff are off-shift. Then, ask a nurse (not a tech) to use the phone to call the unit supervisor or director. Leave a calm message requesting a confidential meeting to share your documented concerns. If there's a "concern box" on your unit, slip a copy of your log there too.

3. **Find Allies:** Social workers, art therapists, or group counselors often visit the unit. They're typically more receptive—slide copies of your log under a social worker's door or hand them to a therapist during a session. In extreme cases, these folks can connect you to outside help. Keep originals of your logs; only share copies.

4. **Get Copies Safely:** Ask a nurse to photocopy your logs. If they refuse, request—politely but firmly—that it be noted in your chart that you want to see your social worker. Then explain everything to them or a trusted counselor.

Stay composed, even when it's hard. Your calm demeanor strengthens your case. Beyond self-protection, be a quiet support for others facing abuse. Sit with them, play a board game, watch a movie—simple presence can ease their isolation. Let them vent when they're ready; just listen. You're not just surviving—you're building a shield for yourself and those around you.

Hospitals rely on their reputation. They'll act on solid evidence of misconduct to protect it, so your logs and reports aren't just for you—they're a push for accountability. You've got more power here than you might think.

It is important to know that it is hospital policy that you cannot touch another patient with few exceptions such as bumping fists together. Once I kissed my hand and hovered that hand of mine over a patients forehead. He immediately gained trust in me and started to fall back where I had to catch him and guide his gradual descent to the floor. After that incident he started speaking English again and followed me everywhere for protection. He was being physically and perhaps sexually abused. Through my logging and reporting the entire staff on the unit changed and upon my discharge I remained in contact with the abused victim while he was still at the hospital. The abuse at that point according to him had ceased.

D. Know your Rights

Another type of abuse is taking advantage of a patients ignorance of their rights not to take medication. The patient I mentioned that was abused had also revealed to me that he had no choice but to take a medication that was causing him to drool and be sedated to sleep all day. He could not advocate for himself, and one day he crawled from out of his room begging a staff member, who turned to be his abuser, for help. The staffer turned around and started kicking him in the groin and continued to attack him in his room.

It is important to address a mental illness with proper treatment. If a patient cannot advocate for themselves, then gain their trust with your patience and ask them if they agree for you to be their advocate. Have them put that in writing with both your signatures and have that put in both your charts.

There were many times that this patient tried to curl up in the extra bed in my room, and each time the abuser dragged him out and proceeded to abuse him back in his own room.

I spoke to the abused victim one last time after his discharge and he was back with his family and on his way to recovery. He did not want to pursue charges because he feared persecution and retribution for being a minority.

Chapter 5
Plausible deniability of CIA involvement in staffing

Ignore but Document

While the MK ULTRA program such as Project Monarch by the CIA has ceased operations, officially anyways, there is still concern that some of the abuses that occur in the hospitals are by way of proxy or remains from it's proliferation of abuses, fronts to the CIA's defacto programs. It would not be likely, as was the case with MK ULTRA operations, that the hospital staff would have any legitimate knowledge of the experiments involved. Many of the experiments of MK ULTRA were less than scientific and crude, including but not limited to the proliferation of sexual abuse as to measure the effects of subduing an individual in order to take their will away (depersonalization) and make them docile and complicit to psychological manipulation and for gaslighting / triggering purposes. Through their depersonalization to measure the effectiveness to make that person an ideal assassin or patsy.

It is important to remain firm and calm, and not to touch any of the staff in anyway, as any touch, even a gesture towards a hug can be misconstrued as an attack on the staff. And do not allow them to trigger you. If what they say or do is triggering or agitating your symptoms just walk away, log it and save the log when you are ready to report. If you can recognize that they are triggering or gaslighting you, then just pretend to laugh with them and walk away. The moment they realize that they are not getting the desired reckless behavior from you they will stop and begin to fear you.

After bringing in a prominent journalist to visit and witness abuse, when that journalist steered him in the eye and caught in the act of dishonesty, the staff person admitted to me afterward that he really wanted to help himself be a better person. That same staffer earlier during my stay gave me an indirect threat that "I know people in high places and they will find you," after I warned of reporting him due to his indiscretions.

It will not be determined by any one patient that such abuses are an act of some organized entity such as the CIA, so a central depository of these reports is yet to be established. You can look forward to that reporting system to be linked from pagetelegram.com

I developed a platform for such reporting at **abusesystem.org**

Join the Telegram group listed on the last page of this book to become a part of that development and discussion.

Chapter 6
Hospital Zero-Day Technology

A. Hyper-Awareness and Perceived Targeting

When you're in a heightened state—like during psychosis—your senses can sharpen to an overwhelming degree. You might start noticing things others miss: flickers in the lights, odd hums from devices, or messages that seem aimed right at you. For some, this hyper-awareness sparks fears of gangstalking or exotic interference—maybe from shadowy government programs or even stranger forces. Whether it's real or a trick of the mind, the feeling of being watched or manipulated can be intense, especially if you suspect you're a target, a distraction, or a test subject. This chapter isn't about proving what's true—it's about managing what feels true to you, so you can stay steady.

B. Devices and Intrusions: What You Might Notice

Everyday electronics—TVs, fluorescent lights, microwaves—run on the power grid, and some believe these can double as listening tools. The theory goes that vibrations from your voice or movements ripple through a device's magnetic field, turning it into a makeshift bug. Smart TVs with cable boxes or digital receivers, each with a unique MAC address, could theoretically send or receive signals too. Hidden cameras in newer TVs, exposed years ago, were said by manufacturers to track viewer reactions to ads—not to spy—but the possibility lingers. In a hospital, where you're already on edge, these ideas can feel all too plausible. Staff

might not notice or care. If you mention CIA experiments or alien bases, they're likely to chalk it up to your condition or the TV blaring in the dayroom. Once, on my unit, a TV glitch spooked everyone—staff included—so they shut it off, sent us to our rooms, and switched to DVDs only. Shared unease can hint at something real, but it's just as possible the TV's "talking to you" is a hallucination. The line blurs when you're hyper-aware, and that's why people with psychosis might be singled out—their experiences are easy to dismiss as delusions, giving cover to anyone testing mind-bending tech.

C. Staying in Control

What matters most is how you handle it. If you suspect surveillance or influence—real or not—don't let it steer you. Here's how to keep your footing:

- **TV "Messages":** If the television feels like it's speaking to you, it could be a hallucination—or, as some speculate, a remnant of programs like MK-ULTRA probing for reactions. Either way, don't react. Ignore it completely. No response means no fuel for whatever's at play, and you stay clear-headed. Suggest watching DVDs instead—tell staff it's less stressful than live TV. They might agree for the group's sake.

- **Lights and Devices:** Fluorescent lights or humming appliances might feel intrusive, maybe even disruptive to your mood or energy. Ask staff politely to turn off overhead lights during the day, framing it as a relaxation request— daylight's better for your well-being anyway (it boosts serotonin). If others agree, it's more likely to happen. Unplugging isn't usually an option, so focus on what you can control.

- **Outside Threats:** Helicopters, drones, or odd shapes outside your window can spike your alarm. If you sense targeting—military-grade or otherwise—step into the bathroom for a breather. Hospital bathrooms often have thick walls or metallic paint that might block signals (like EMF, which some link to psych experiments). Wait there until the feeling passes, then peek out. If it's gone, relax; if not, retreat again. It's a simple shield, real or symbolic, to reclaim peace.

D. Why You Might Feel Targeted

Psychosis makes you vulnerable—not just to your own mind, but to exploitation. If exotic tech exists—like DARPA patents for nervous-system manipulation via low-frequency fields (e.g., Hendricus G. Loos's work)—your sensitivity could make you a perfect patsy. A hallucination's deniability masks any real interference, diverting you from meaningful action or resistance. In 2011, I left a message for a DARPA contact about a bizarre voicemail; soon after, a silent helicopter hovered near my window for five minutes. A nurse was there, but I sank into a three-month fog—too numb to speak up. In a hospital, I'd have ducked into the bathroom to dodge whatever hit me, real or imagined.

E. Practical Steps Forward

You don't need to solve the mystery—just manage it. Stay calm; fear only amplifies the chaos. Log anything concrete— dates, times, odd events—to ground yourself or share later with a trusted ally like a social worker. If tech feels oppressive, lean on low-tech comforts: daylight, quiet, a DVD over live TV. You're not powerless here—by choosing when and how to respond, you keep the reins, whether it's psychosis, gangstalking, or something deeper at play.

F. Why Psychotic Patients Might Feel Targeted for Exotic Intrusions

For those experiencing psychosis, the world can feel like it's closing in—not just through hallucinations, but through a nagging sense of being watched, manipulated, or even experimented on. Some believe that advanced technologies, operating beyond everyday awareness, could exploit this vulnerability. Low-frequency electromagnetic fields (EMFs), for instance, in the 0.5–2 Hz range, have been studied for their effects on the nervous system. Research—some linked to military projects like DARPA—suggests these frequencies might subtly influence mood, inducing docility, emotional swings, sleepiness, or even heightened arousal. Devices as common as televisions, fluorescent lights, or fans could, in theory, carry such signals if modified or misused.

Why target someone with psychosis? It's grim but logical: their experiences—already dismissed as delusions—offer perfect cover for covert experimentation. If you report a TV "speaking" to you or a buzzing light scrambling your thoughts, staff are likely to nod and adjust your meds, not investigate DARPA patents. This plausible deniability makes you an ideal subject for testing tech that, say, tweaks behavior or tracks reactions. Patents like those from Hendricus G. Loos, often tied to DARPA in public records, describe devices—think pulsed magnetic fields from a fan or TV screen—that could theoretically manipulate brain activity. One patent outlines using low-frequency EMFs to alter nervous system responses; another suggests a spinning device, like a fan, emitting signals to shift perception. These aren't sci-fi—they're documented, though their real-world use remains murky.

Take my 2011 encounter: after leaving a DARPA contact a voicemail about a strange, seemingly non-human message, a silent helicopter hovered near my window for five minutes. I sank into a three-month haze—docile, numb—unable to even mention it to the nurse beside me. Was it coincidence, or something more? Psychosis primes you to question, but also to be ignored, which is why these concerns feel so real and so isolating.

You can't control the tech, but you can control your response:

- **TV Signals:** If live TV feels like it's beaming messages or stirring your emotions, it might be a hallucination—or, as some patents hint, a stimulus test. Don't engage. Suggest watching DVDs instead—tell staff it's calmer for the group. It's a low-stakes way to sidestep the issue.
- **Lights or Fans:** Fluorescent hums or fan whirs can seem intrusive, especially if you're hyper-aware. Politely ask to turn off overhead lights during the day for "relaxation" (daylight boosts serotonin anyway). Fans are trickier—request a room change if one feels off, citing noise sensitivity.
- **Log Your Experience:** Jot down what you notice—time, device, sensation. It's not proof, but it's a record that keeps you grounded and could matter later.

These steps don't confirm a conspiracy—they just help you navigate the fear of one. Psychotic patients aren't just vulnerable; they're uniquely positioned to sense what others miss. Whether it's DARPA, private tech, or your own mind, staying calm and strategic strips away the power of any intrusion—real or perceived.

Chapter 7
Distinguishing Alien Abduction

A friend with schizophrenia—let's call him Tom—recently shared a haunting, recurring experience: a sudden energy shift around him, an instant plunge into sleep, then waking in what felt like a hollow shell of himself, assaulted by vivid sensations of anal rape. "They remotely raped me a few times," he said, describing an unseen force manipulating his body and mind. Sleep paralysis, kinetic disturbances, a lingering "dummy of myself" feeling—these echo countless alien abduction accounts. Are they delusions of psychosis, repressed traumas surfacing as extraterrestrial nightmares, or something genuinely otherworldly? The truth might blur, but to Tom—and maybe to you—these moments are real, and that's where we start.

A. Patterns and Possibilities

Tom's story isn't unique. The sudden sleep, paralysis, and eerie detachment align with abduction narratives collected by researchers like Eric Donnelly, a Chicago-based UFOlogist I've spoken with. He argues that people with psychosis might be prime targets—not just because their claims are easily dismissed, but because their hyper-awareness makes them sensitive to subtle intrusions, real or perceived. Whether it's aliens, covert experiments, or the mind folding in on itself, the distinction matters less than the impact. Donnelly suggests hypnosis as a tool to unearth repressed memories, potentially revealing whether these are hallucin- ations, masked sexual abuse from human hands, or something stranger. Tom agreed—he wanted answers, not just relief.

That "dummy" sensation Tom described—a temporary hollowness—crops up often in abduction tales. It's akin to depersonalization, though not a chronic disorder here; it's tied to the event itself. Some link it to trauma's aftermath, others to alien "erasure" of conscious memory. Then there's the anal rape detail. Unlike probes reported in abduction lore—leaving physical soreness or odd marks — Tom's experience felt intensely sexual, possibly a psychotic twist on fear or violation. Delusion could amplify a vague sensation into something specific; still, the consistency across accounts keeps the question open.

B. My Own Brush

I've felt it too, once. Waking paralyzed, eyes darting, I heard a low hum above my house. Panic hit, but I thought firmly, *I do not consent.* The paralysis broke, the hum faded, and I was free. Alien or not, that mental push worked. Donnelly and others claim abductors—logical but empathy-blind—might respect a clear, stern refusal if they're real and experimenting, perhaps to fix their own genetic flaws with our DNA. True or not, it's a tactic worth trying.

C. Treating the Experience—Real or Not

Here's the crux: you don't need to prove aliens to heal from this. If you suspect abduction—cosmic or otherwise—try these steps:

1. **Assert Control:** Silently or aloud, think, *I do not consent to this.* It's a shield, whether against entities or your own mind. If paralysis hits, focus on that thought—it might snap you out.

2. **Log It:** Write down every detail—time, sensations, aftermath. It's not about convincing skeptics; it's about tracking patterns for yourself or a trusted confidant.

3. **Seek Hypnosis:** If it haunts you, find a therapist or hypnotist (check with your doctor or social worker for referrals). It could uncover trauma—alien, human, or imagined—buried deep.

4. **Ground Yourself:** After, lean on daylight, quiet, or a friend's voice. Psychosis thrives in isolation—connection pulls you back.

D. Beyond the Rabbit Hole

Eric's theories—and Tom's pain—hint at a bigger picture: aliens consulting intelligence agencies, a slave race fleeing cosmic tyrants. Maybe it's "as above, so below," a mirror of earthly struggles. But chasing that can spiral you into futility, especially with psychosis amplifying doubt. I've seen it drag people into depression, fixating on unprovable vastness while losing sight of what's real: your mother's laugh, a friend's hand, this Earth under your feet.

You don't need the cosmic playbook to spot good or evil—it's in your gut, your heart, the flicker of clarity between thoughts. React with that, but always weigh the chance it's a trick of the mind. Alien or not, your life's value isn't in decoding the heavens—it's in lifting those around you. Improve their days, and yours will follow. Let the abductors—real, imagined, or human—deal with their own mess.

Chapter 8
When physical harm is done

Use the Law:

Addressing Physical Harm

Physical harm in a hospital—whether from staff, neglect, or any other cause—isn't just wrong; it could be malpractice, a legal breach of the care you're owed. You don't have to prove why it happened—only that it did. If you've been injured during your stay, you have the right to pursue a lawsuit, not just for justice, but to stop it from happening again—to you or anyone else.

Here's how to take action:

- **Get Your Records:** Request copies of your full hospital chart from the medical records department. Most hospitals provide these at no cost, though you'll need to sign a release form. You can do this in person, or, if it's urgent, ask if they'll accept a faxed signature (policies vary—call ahead to confirm). Charts document everything—treatments, staff notes, incidents—and they're your foundation.

- **Consult a Lawyer:** Find an attorney to review your chart with you. Many take cases pro bono (free upfront), banking on a cut of any settlement if you win—it's an investment for them, so they'll only sign on if your case looks strong. Look for lawyers specializing in medical malpractice; local legal aid or bar associations can point you to options.

- **Build Your Case:** Your lawyer will spot discrepancies or evidence in the records—like unreported injuries or ignored complaints. Pair this with your own log of events (date, time, details) if you kept one. Together, it's a solid start to proving harm.

Malpractice doesn't need intent—just results. A bruise from a rough restraint, a fall from neglect, or worse—all count if they shouldn't have happened under proper care. Filing isn't easy, but it's your leverage to hold the hospital accountable. Start with the records; they're your voice when you need it most.

Chapter 9
When and why to file a lawsuit

If you've been harmed in a hospital—physically, emotionally, or both—you might wonder whether a lawsuit is worth it. The answer hinges on the impact: is the damage lasting, chronic, or something you'll carry for life? Filing isn't just about compensation—it's about covering the costs of your recovery and setting a precedent to protect others from the same fate. Here's how different circumstances might shape your choice.

A. When Harm Lingers

- **Physical Damage:** Say you were over-restrained, leaving a fractured wrist that never fully heals, or neglected until a bedsore turns into a chronic infection. These aren't fleeting injuries—they alter how you move, work, or live. A lawsuit could fund ongoing medical care, therapy, or equipment (like a brace or wheelchair) while holding the hospital accountable for sloppy oversight.

- **Emotional Scars:** Maybe verbal abuse or a traumatic incident—like being forcibly sedated against your will — triggers persistent anxiety, nightmares, or PTSD-like symptoms. Emotional harm can be as crippling as a broken bone, especially if it deepens existing conditions like psychosis or depression. Legal action might pay for counseling and push for better staff training.

- **Mixed Fallout:** Often, it's both—physical harm (a bruising tackle) amplifies emotional distress (fear of authority), creating a feedback loop. If the effects linger—say, chronic pain plus distrust that isolates you—a suit could address the full scope, from meds to mental health support.

B. Why File?

- **Covering Costs:** Treatment isn't cheap. A settlement can offset bills for doctors, therapists, or meds tied to the harm— think surgery for a botched restraint injury or antipsychotics for new paranoia sparked by gaslighting. Without it, you're stuck footing the bill for someone else's mistake.
- **Setting a Precedent:** Your case could force change: stricter rules, better hiring, more cameras. If a staff member's unchecked aggression hurt you, a lawsuit might ensure they're retrained or removed, sparing the next patient.
- **Closure:** Facing the harm head-on can heal, too. Winning (or even just filing) validates your experience, countering the dismissal you might've faced in the moment.

C. When to Pause

Not every harm warrants a suit. A one-off shove with no lasting mark? Tough to win, and the effort might drain you more than it's worth. Emotional upset that fades after discharge? Harder to prove without a paper trail. Lawsuits take time—years, sometimes—and energy, so weigh if the damage justifies the fight. Minor incidents might be better handled with a complaint to the hospital's director or a state health board.

D. How to Start

If you're leaning toward filing:

- **Gather Evidence:** Request your hospital chart (see the previous section) and log your own account—dates, injuries, symptoms. Photos of bruises or a witness's statement (like a roommate) bolster your case.
- **Find a Lawyer:** Seek a malpractice attorney, ideally pro bono if money's tight. They'll assess if your harm— say, a lifelong limp or therapy-worthy trauma— has grounds in court.
- **Know the Stakes:** You're not just suing for you. A win could ripple, making hospitals rethink how they treat vulnerable patients like you.

E. Circumstances in Context

- **Neglect:** Left unfed or unmonitored, leading to malnutrition or a fall? Chronic weakness or a permanent limp could justify action.
- **Abuse:** A staff member's kick leaves a scar, or their threats haunt your sleep? That's grounds if it sticks with you.
- **Medical Error:** Over-sedation causes a seizure, damag- ing your memory? Lifelong cognitive fog screams lawsuit.
- **Systemic Failures:** No oversight lets a predator roam, and you're assaulted? The hospital's negligence could fund your healing and force reform.

Filing's a big step, but it's your right when harm doesn't fade. It's not about revenge—it's about reclaiming your life and ensuring the system doesn't shrug at the next person in your shoes. Decide what you can carry, and what you can't.

Chapter 10
Putting lawsuit reward into a trust

Plan Ahead for Your Future Well-Being

If you receive SSDI benefits, a financial award from a lawsuit— such as a personal injury settlement—could put those benefits at risk if not handled properly. To protect both your settlement and your eligibility for SSDI, consider the following options:

- **Establish a Special Needs Trust (SNT):** This type of trust can hold settlement funds without affecting your benefits. The trust is managed by a trusted family member—such as a parent, sibling, or even a legal guardian or representative from the state—who ensures the money is used only for your benefit while maintaining your eligibility.
- **Open an ABLE Account:** If you're eligible, an ABLE (Achieving a Better Life Experience) account allows you to save money (including legal settlements) without affecting SSDI or Medicaid benefits. Funds in an ABLE account can be used for qualified disability expenses like housing, education, transportation, and healthcare.

Planning ahead can help you make the most of your legal reward while preserving the support you depend on. Consult with a financial advisor or attorney experienced in disability benefits to explore the best option for your situation.

Chapter 11
The falsification of your chart

During my admission process to the psychiatric hospital, I was in the emergency room when a nurse presented me with a liability contract. I was expected to sign it immediately, without reading it in full. However, upon reviewing it, I noticed clauses that posed potential harm to me if left unchallenged particularly if oversight was lacking. I made edits and initialed my changes before signing and returning the document.

Shortly afterward, the nurse returned with a newly revised version of the same contract. Once again, I reviewed it, made the necessary changes to address my concerns, signed it, and handed it back. At this point, I noticed a shift in the demeanor of the staff—they appeared visibly irritated. When the staff briefly stepped away, two guards—one stationed by the door and another standing next to me— suddenly snatched the clipboard from my hands. One guard then threw it to the other. Later, it was falsely recorded in my chart that I had thrown the clipboard at a staff member, despite witnesses and my own recollection proving otherwise. This marked a turning point in my

understanding of how easily the truth can be altered within psychiatric institutions. From that moment forward, I realized that any action, word, or behavior—whether mine or the staff's—could be manipulated in documentation. I began to suspect that staff and doctors might engage in:

- Protecting the hospital's reputation by downplaying incidents.
- Shielding individual staff members from accountability.
- Extending a patient's stay unnecessarily to continue exploitative or abusive practices.
- Prematurely discharging a "problem" patient to avoid liability, regardless of their actual mental state.

Another disturbing incident confirmed these fears. A nurse administered a PRN injection, intentionally targeting a site near my sciatic nerve. Within moments, I lost the ability to move the lower half of my body. I was left incapacitated, forced to defecate in my bed. Eventually, the staff brought a wheelchair to my room. However, when I later requested a copy of my medical chart, the documentation falsely stated that I had fabricated the need for a wheelchair. There was no mention of the paralysis or the incident surrounding the injection.

It's important to note that most patients never review their charts. Heavy sedation, disempowerment, and fear of retaliation—especially among patients who are economically disadvantaged, minorities, or socially marginalized—often prevent them from questioning their treatment or seeking justice. The system, by design or neglect, discourages transparency.

I am reminded of one patient from a different facility—one that was ultimately shut down by the state following an investigation into systemic abuse. Their experience mirrors the patterns I witnessed: falsified records, retaliatory treatment, and a general culture of silencing.

Chapter 12
Psychosis introspection & selfchecks

Schizophrenia is a complex condition, often misunderstood not only by society but sometimes even by those who live with it. Numerous studies have shown that many individuals diagnosed with schizophrenia exhibit enlarged ventricles— fluid-filled cavities in the brain. These changes are believed to impact the development of the frontal lobe, which is responsible for executive functions like decision-making, impulse control, and emotional regulation. Since the frontal lobe continues to develop into early adulthood, a disruption during this critical phase may contribute to the onset of symptoms typically seen in late adolescence or early adulthood.

The symptoms of schizophrenia— disorganized thinking, altered perceptions, and emotional fluctuations— can be profoundly disorienting. Yet, within this disorganization, there can exist a heightened sensitivity to the world. For some, the blending of thoughts and senses may lead to a deeper emotional awareness, a kind of clarity that transcends the superficial and gravitates toward what is real, raw, and often ignored by society.

One common symptom is emotional blunting or a diminished ability to express feelings. This is frequently mistaken for apathy, but it's important to make a distinction. Not feeling outwardly does not mean you don't care. In fact, many people with schizophrenia possess deep wells of empathy— sometimes more so than those who wear their emotions on their sleeves. Emotional intelligence isn't always visible; it's often felt in how one responds to the suffering of others, how one holds space for pain without turning away. I've observed that many so-called "normal"

people can laugh, cry, and express joy over fleeting, trivial moments—like a shopping spree or a movie scene—yet walk past a suffering person on the street without a second thought. Meanwhile, those with mental illness may feel the weight of that suffering profoundly, even if they can't express it conventionally. There is a kind of empathy that lives in the bones, in the silence, in the heaviness of uncried tears.

So if you find that you struggle to feel or express your emotions, know that you are not broken. You are not cold, and you are certainly not without a conscience. Depression can sometimes arise not from within, but from the overwhelming sadness we sense in the world around us. This is empathy too—just turned inward, where it has no outlet.

It took me years to stop feeling ashamed that I couldn't cry. I used to think it made me heartless. But I've come to understand: the inability to express doesn't mean the absence of feeling. Often, the emotions are simply trapped—held outside the self by trauma, stigma, or the emotional overload of a world that feels too much and does too little.

A. Peering Through the Fog: Identifying Psychosis Through the Lens of Tangible Reality

Psychosis is not always a crash, a spectacular break from the world. Sometimes, it creeps in like fog— gradual, quiet, and disorienting. Gaining insight into psychosis means learning how to distinguish between the realities we build in our minds and the shared world that exists outside them. It's about asking the right questions, even when the answers are distorted by fear, confusion, or doubt.

When functioning at baseline—calm, grounded, and oriented —everyday tasks are mundane and manageable. Returning a phone call, responding to a message, making an appointment. These things might feel like small pebbles in a day. But in psychosis, those same pebbles become boulders, looming large with imagined threats or hidden meanings.

I. Phone Calls and the Anxiety Loop

Take the act of answering the phone. At baseline, it might be mildly annoying or momentarily inconvenient, but it's doable. Under psychosis, however, the phone becomes something else entirely. The ring itself might be perceived as a threat. A harbinger of bad news. A government agent. A trap.

You might start imagining who is on the other end. A former friend turned enemy. Someone who "knows too much." The mind spins webs so intricate that even lifting the phone becomes impossible. You may believe your calls are being monitored, that your words are being recorded and twisted. So you don't call back. You don't answer. And then you isolate.

At baseline, this avoidance might be recognized as procrast - ination. In psychosis, it becomes self - preservation — based on delusion, not logic.

II. Disorganized Thinking and the Struggle to Complete Tasks

Another signpost is the unraveling of thought. What begins as a simple intention—say, making breakfast—can spiral. You start looking for a pan and find yourself halfway through reorganizing your spice rack. Then suddenly, you're crying because the cumin reminded you of someone who might be watching you. The thought sequence lacks cohesion. Time slips, actions fragment.

At baseline, you might get distracted but you redirect. In psychosis, distractions morph into tangents, detours into paranoia or hallucination. The internal narrative no longer follows a straight line—it loops, breaks, doubles back, and dissolves.

III. Self-Check Questions That Often Go Unasked

When insight begins to return, these self-checks can help bridge the gap between psychotic distortion and grounded reality. But they are often ignored or unseen in the moment. Delusions feel real. Paranoia feels protective. Still, certain questions can offer a map:

- "Would other people agree with this interpretation?"
- "Is there a simpler explanation for what I'm experiencing?"
- "Have I eaten, slept, and hydrated recently?"
- "Do I feel overwhelmed by things I used to find easy?"
- "Am I hearing/seeing/thinking things that others aren't responding to?"

These seem basic, but when the mind is under siege, basics become foreign. Even understanding that your thoughts might be disorganized takes a certain meta—awareness that psychosis often erodes.

B. Patterns That Signal Trouble

Some warning patterns:

- Repeatedly checking windows for "watchers."
- Believing strangers are speaking in code about you.
- Assigning intense meaning to random objects or events.
- Feeling convinced that you're being "punished" or "tested."
- Writing obsessively to track connections that don't exist.

All of these signs have tangible reference points in baseline reality: yes, people do talk; yes, government surveillance exists; yes, coincidences happen. But in psychosis, the meaning assigned becomes outsized, internally justified, and deeply rooted in fear.

C. Closing Thoughts

The ability to distinguish psychosis from reality often comes in glimpses. A sudden moment of clarity. A soft doubt about a hard belief. Insight is rarely a switch—it's a slow returning. If you can recognize that something feels off, if you can ask yourself why making a sandwich feels like solving a riddle, or why a phone call feels like a threat—you may already be halfway back.

Identifying psychosis isn't about condemning yourself. It's about compassionately observing the shifts—how fear rewrites simplicity, how meaning becomes a trap, how silence can feel safer than connection.

Recovery starts not just with medication or therapy, but with one radical act: believing your mind might be lying to you, and having the courage to question it anyway.

And finally, remember this: you have schizophrenia. You are not a schizophrenic. Your diagnosis is not your identity. Schizophrenia is part of your experience—it does not define your humanity, your intelligence, your empathy, or your worth.

Chapter 13
The case for medically induced psychosis

A. Medically Induced Psychosis in Older Adults: Understanding, Preventing and Resolving

I. Introduction

Psychosis can emerge unexpectedly in individuals with no prior history of psychiatric illness, particularly among middle-aged or older adults. A notable, under-discussed cause of new-onset psychosis in this group is medication-induced psychosis—a temporary or prolonged state brought on by adverse reactions to certain pharmaceutical drugs.

Understanding this phenomenon is crucial. It not only challenges our assumptions about mental illness but reveals the profound influence of biochemical factors on perception, cognition, and behavior.

II. Medications Commonly Linked to Induced Psychosis

Several drug classes have been identified as capable of inducing psychotic symptoms, especially in older populations:

1. **Corticosteroids (eg Prednisone, Dexamethasone)**
    - *Common Use:* Inflammatory diseases, asthma, autoimmune conditions.
    - *Mechanism:* High doses can disrupt dopamine and serotonin pathways.
    - *Symptoms:* Paranoia, auditory hallucinations, mania, disorganized thinking.
    - *Study Example:* A 2006 review in CNS Drugs found that up to 6% of patients on corticosteroids develop psychotic symptoms, with higher rates in elderly patients.
2. **Dopaminergic Medications (eg Levodopa for Parkinson's)**
    - *Common Use:* Parkinson's disease.
    - *Mechanism:* Excess dopamine can overstimulate mesolimbic pathways.
    - *Symptoms:* Delusions, hallucinations, impulse control disorders.
    - *Prevalence:* About 20%–30% of patients with Parkinson's experience medication- related psychosis.

3. **Anticholinergics (eg Benztropine, Diphenhydramine)**
    - *Common Use:* Parkinson's symptoms, allergies, sleep aids.
    - *Effect:* Can impair memory and cause confusion, especially in the elderly.
    - *Symptoms:* Confusion, paranoia, visual hallucinations, delirium.
    - *Vulnerability:* Older adults are especially sensitive due to age-related decreases in cholinergic reserve.
4. **Benzodiazepines and Sedative-Hypnotics**
    - *Common Use:* Anxiety, insomnia.
    - *Symptoms:* Paradoxical agitation, confusion, depersonalization.
    - *Risk Factor:* Tolerance, withdrawal, or drug interactions in polypharmacy scenarios.
5. **Opioids and Polypharmacy Interactions**
    - Particularly when mixed with SSRIs, anticholinergics, or alcohol, opioids can produce psychosis-like states in older patients due to impaired metabolism and CNS sensitivity.

III. Identifying and Preventing Medication Induced Psychosis

Prevention Strategies:

- Comprehensive Medication Reviews, especially in geriatric care.
- Start Low, Go Slow: Adjust doses cautiously, monitor behavior.
- Deprescribing Culture: Encouraging reduction where possible.
- Interdisciplinary Oversight: Geriatricians, pharmacists, and neurologists working together to detect early warning signs.
- Regular Cognitive and Mental State Assessments during treatment with high-risk medications.

IV. Resolution and Treatment

In many cases, medication-induced psychosis is reversible:

1. Immediate discontinuation or reduction of the offending medication.
2. Supportive care, including reorientation strategies, hydration, and safe environments.
3. Short-term use of antipsychotics may be necessary—but only cautiously, especially due to black-box warnings in elderly dementia patients.
4. Nutritional and sleep stabilization can hasten recovery.
5. Close monitoring during withdrawal, as rebound symptoms can appear.

B. CCHR International: Role / Controversies

What Is CCHR?

The Citizens Commission on Human Rights (CCHR) is a watchdog organization that focuses on alleged abuses in the mental health field. They highlight stories of harm caused by psychiatric medications, forced treatments, and institutional abuses.

- *Founded:* In 1969 by the Church of Scientology and psychiatrist Thomas Szasz.
- *Stance:* Highly critical of psychiatry as a whole, often framing it as a pseudoscience or a profit-driven industry.
- *Focus Areas:* Psychotropic drug risks, involuntary commitment laws, electroconvulsive therapy, and psychiatric labeling.

Scientology Connection

- The organization is closely tied to the Church of Scientology, which fundamentally rejects psychiatry and psychiatric medications.
- This affiliation has led to widespread skepticism of CCHR's motivations and scientific neutrality.
- Claims through CCHR are often viewed through this lens—sometimes discrediting otherwise legitimate concerns about medication side effects.

C. Processing Claims and Reporting Adverse Reactions

If you or a loved one has experienced medication-induced psychosis:

Reporting Routes:

1. **FDA's MedWatch Program (U.S.):**
   `https://www.fda.gov/safety/medwatch` Allows consumers and healthcare providers to report adverse drug reactions.

2. **State Medical Boards:**
   For cases involving prescriber negligence or over-prescribing.

3. **Legal Action:**
   Possible if harm resulted from off-label prescribing without informed consent or known contraindications were ignored.

4. **Patient Advocacy Groups:**
   Such as NAMI (National Alliance on Mental Illness) or Public Citizen for guidance.

5. **CCHR:**
   CCHR offers legal referrals and document archives. However, any engagement with CCHR should be approached with caution, especially for those seeking unbiased, medically grounded guidance. Their resources can sometimes be useful, but their messaging & recommend –ations are ideologically driven and may reject legitimate psychiatric interventions altogether.

D. Barriers to Resolution and Recognition

- **Stigma:** Patients and families may be hesitant to report psychotic episodes, especially when induced by trusted medications.
- **Medical Denial:** Providers may downplay medication links, instead assigning new psychiatric labels.
- **Complexity of Proof:** Establishing causality between a specific drug and psychosis is difficult, particularly in polypharmacy cases.
- **Legal Complexity:** Filing malpractice claims can be long, expensive, and emotionally taxing—especially when the condition resolves quickly and evidence fades.

Chapter 14
Be an Advocate: Help Those Get Through the Struggles You Have Been Through

You are a Teacher

Your lived experiences—no matter how painful, chaotic, or misunderstood—hold immense value. They are not stains on your existence, nor are they signs of failure. They are lessons. Each struggle, each breakdown, each time you felt lost or silenced or dismissed—those moments taught you something no textbook ever could. And because you've walked that path, you carry within you a unique kind of wisdom: one born from survival, growth, and resilience.

As a peer advocate, you are not just someone who "got through it." You are a guide, a living example that healing— however slow, however non-linear—is possible. Your story can be a lifeline for someone else who thinks they're alone. You don't have to have it all figured out to be helpful. Sometimes the most powerful thing you can offer is simply saying, "I've been there, too."

Remember this: you are not defined by what happened to you—you are defined by how you carry it forward. When you choose to share your journey with honesty and compassion, you are doing something revolutionary. You are transforming your pain into purpose. You are teaching others how to believe in themselves, how to find strength in vulnerability, and how to rebuild trust in a world that may have let them down.

Your presence alone can challenge stigma. Your voice can open doors. Your empathy can break cycles. And your courage can light a path for those still finding their way.

So no—your experiences are not shameful. They are sacred. They are the very tools you use to help someone else keep going. And in doing so, you continue to heal, too.

Because if life were easy, there would be little to learn, and little to give. But life isn't easy—and that's what makes your journey meaningful, and your voice necessary.

Chapter 15
Making Your Wishes Legally Binding & Known

This chapter is dedicated to my dear friend, Andrey—a creative, courageous, and brilliant soul whose life was filled with both beauty and unimaginable struggle. His journey was marked by resilience, artistic expression, and a constant search for truth. And yet, his life also reveals the cracks in our mental health system—the places where support, intervention, and autonomy can tragically fall out of reach.

Andrey lived with a mental health condition that required consistent care and medication, but he grew increasingly uncertain about the treatment he was receiving. He stopped taking his medication without informing his doctor or me. By the time I found his apartment abandoned and his life's work—his art, writings, and memories—discarded in a dumpster, it was already too late to intervene in a meaningful way.

I filed a missing person report. When the police finally located him, wandering the streets of Chicago, they found no grounds to detain or hospitalize him. Though clearly disoriented and unhoused, he was deemed legally competent. It was a technicality that stripped him of the help he needed most.

After a brief hospitalization and a long-acting injection, Andrey began to regain clarity. He reconnected with his sister and other family members, and he allowed me to work with his treatment team. For a moment, it seemed like things might turn around. But when the medication wore off, the fog returned. Andrey withdrew again—canceling releases, removing himself from disability services, and shutting down all support. Weeks later, I received a

call from a Tennessee police officer. Andrey had been found walking along a highway with only a few cigarettes and loose change, claiming he was walking to Area 51 in Nevada. Again, authorities said he did not meet criteria for hospitalization.

I tried everything—contacted law enforcement across state lines, pleaded with Nevada authorities to watch for him, even tried to meet up with him when he shared his location online. Eventually, he made it to California, attempting to vanish into Mexico. After crossing the border, he was deported back to the U.S. He claimed Mexican authorities confiscated his state ID; border officials denied he had any identification on him.

Shortly after, Andrey welcomed a visit from me and our mutual friend, Mike Kalas, and his father helped fund our trip. I didn't know then that Andrey still held deep reservations toward his family and remained in a fragile state of mind. He was slipping further into his own world—removing all ties, emotionally and physically, to anyone who loved him.

In the summer of 2024, Andrey passed away while living on the streets of California. He had been trying to self-medicate his condition, still cut off from reality and from everyone who once knew him. His death was a quiet tragedy, but its impact echoes deeply. His family continues to mourn him. So do I. His life was a testament to the urgent need for better tools, better laws, and an aim for compassion. Despite the suffering, his life was also an inspiration—to pursue truth, to defend creative freedom and to honor our right to exist authentically.

What Is a Mental Health Advance Directive?

A Mental Health Advance Directive (MHAD) is a legally binding document that allows a person to express their wishes about mental health treatment in the event they become unable to make decisions during a psychiatric crisis. Just as a medical advance directive communicates your end-of-life preferences, an MHAD provides guidance for your mental health care when you're in an altered or vulnerable state.

What Can It Include?

- Your preferences regarding medications, including which ones you do or do not want to take.
- Preferred hospitals or treatment centers.
- Consent or refusal for specific treatments (eg electroconvulsive therapy).
- Appointing a trusted person (a health care proxy) to make decisions on your behalf.
- Instructions for what to do if you're unable to communicate clearly—such as how to maintain housing, care for pets, or manage finances.

Why Is It Important?

If Andrey had created a Mental Health Advance Directive when he was stable and capable, his treatment preferences could have been legally honored even when he wasn't in a state to advocate for himself. It could have:

- Prevented early release without follow-up care.
- Helped the treatment team stay aligned with his actual wishes.
- Given those close to him, like me, the legal standing to help manage his care.

Most states in the U.S. recognize Mental Health Advance Directives, but the details vary. In general, it's recommended to establish one:

- After a hospitalization or period of stability.
- When you have a trusted support system.
- Before major changes in treatment plans or legal status (such as changes in disability or conservatorship).

How to Create One

- Consult your provider or legal advocate. Mental health professionals can walk you through your options.
- Check your state's laws. Some states require notarization, specific forms, or witnesses.
- Involve people you trust. Identify who will speak on your behalf if needed.
- Share copies. Give your directive to your doctor, hospital, legal advocate, and trusted friends or family.

Closing Thoughts

Andrey deserved better—not just from the system, but from a society that too often responds with fear or indifference to mental illness. A Mental Health Advance Directive is not a magic solution, but it is a powerful step toward self-protection, dignity, and agency. It's a way to ensure your voice continues to be heard, even in the silence of crisis.

If you live with mental illness, or love someone who does, I urge you: make the plan now, while things are calm. Because the storm doesn't wait. And neither should we.

Andrey's story is not just a cautionary tale—it is a call to action.

Each state has their own forms for all these situations.

Chapter 16
Nowhere to Go on Discharge?

Discharge from a psychiatric hospital is not the end of your journey—it's a transition. One that, if handled with care and awareness, can help you move toward greater independence, dignity, and healing. Knowing your options and understanding the system is key.

Discharge Planning: Nursing Homes and Step-Down Care

Before you're discharged, the hospital's treatment team—often including a case manager or social worker—will begin planning your next level of care. If you're not yet ready to return to independent living, you may be referred to a nursing home or a residential treatment facility that offers a more structured environment. This step-down care is intended to provide continued support as you stabilize.

You'll likely be asked to sign a release form so prospective facilities can review your medical records and determine whether you're a fit for their program and available roommates. While you can have a say in this process, it's common for facilities to be selected based on what's available locally at the time of discharge.

What to Expect in a Nursing Home Setting

Nursing homes that admit individuals with mental health needs will have some rules in place for your safety and well-being:

- Restrictions on outside access may be in place initially. These often ease over time based on your progress and your treatment plan.
- Passes to leave the facility, such as day visits or overnights, may be granted depending on your situation and whether your designated contacts (like family) are supportive of your recovery goals.
- You have the right to participate in your treatment planning, including expressing your desire to move to more independent housing when ready.

If you're not able to live with family or friends, or if returning to your previous living situation isn't safe or realistic, you might be referred to a halfway house or group home. These homes are designed for people recovering from mental illness and are usually separate from those designed for individuals recovering from substance use—unless you have a dual diagnosis, in which case a facility experienced in both areas may be appropriate.

Halfway Houses and Community-Based Options
Social workers often choose these placements based on availability and perceived fit. But you have agency. If you're not comfortable with the initial suggestion, you can ask to wait for a better option—though this may require patience.

While living in a nursing home or transitional facility, you can also take initiative:

- Visit the local library or use the internet to research other housing options, roommate listings, or advocacy groups.
- Join peer-led groups or community mental health programs that may connect you with additional social workers and housing leads.
- Ask about mental health drop-in centers or clubhouses— these are often hubs of information and support.

Safety, Dignity, and Abuse Awareness
While many nursing homes operate ethically, abuse and neglect unfortunately still happen. This can range from neglect—such as ignoring medical needs or poor hygiene care—to more severe violations, including verbal harassment or, in rare cases, physical or sexual abuse.

Be aware of your rights:

- You are entitled to reasonable privacy, except during scheduled care, safety checks, or housekeeping.
- If you feel unsafe or mistreated, speak to a patient advocate, ombudsperson, or external agency like Adult Protective Services or your state's long-term care ombudsman program.

- Keep a journal of concerning incidents with dates and details. If you're unable to document, ask a trusted advocate to help you.

It's worth noting that while hospitals may be more likely to employ ex-military or law enforcement as staff, nursing homes often attract underpaid or undertrained workers, including some with troubled backgrounds. While this isn't always a problem, it means vigilance and advocacy are especially important in these settings.

Final Thoughts

Discharge doesn't mean you're being abandoned or written off—it's a shift. Whether you're moving to a nursing home, halfway house, or back home, this is a new chapter in your healing. You don't have to do it alone. Lean on your support system, ask questions, and speak up for what you need.

Most importantly, remember this: you have the right to be safe, supported, and treated with dignity—no matter where you are in your recovery journey.

Afterword: A Dedication to My Mother, and to Those Who Pulled Me Back from the Edge

I may not be here today, writing these words, had it not been for my mother—who, in an act of love and urgency, rescued me while I was lost in a deep psychosis, drifting through the streets in early 2004.

At the time, I had just returned from a transformative trip to India. I had poured my reflections into a long article for the student newspaper, released a music album titled *Theme is Trapezoid*, and unknowingly stepped onto the precipice of a psychological unraveling.

My delusions took hold quickly. I believed I was encountering secret agents on the street. Driven by this surreal and consuming wonderment, I walked for two days without sleep—from Mundelein to Winnetka. At one point, I tossed my driver's license at a satellite dish in someone's yard, thinking it was a statement of rebellion against a surveillance state. I crawled into a car parked at a post office, believing it held clues to a larger mission. I gave away one of my shoes at a donation box, convinced that walking with just one would confuse the secret society tracking me.

The world around me blurred. Newspapers seemed encoded with messages. I remember reading an article about Alan Greenspan's retirement as if it were a divine revelation. Reality and delusion were no longer separate.

Eventually, a police officer—working with my mother—found me. I was wary at first, even fearful of her. But the officer gently persuaded me to go home, and promised that I could explain everything I was experiencing to my doctor the next day. I agreed. That visit led to my hospitalization at Read Mental Health Center, where I remained for over six months.

That experience, as painful and disorienting as it was, ultimately saved my life.

In the years that followed, I worked to gain a better understanding of my psychosis and reclaim agency over my mental health. Along the way, I found myself under the care of Dr. Michael Reinstein—a psychiatrist who would later be convicted of medical fraud and receiving kickbacks for overprescribing powerful antipsychotics.

I witnessed firsthand the harm done under his care. Reinstein prescribed the same sedative medication to almost every patient, regardless of their unique needs. Many of us were silenced not just by illness, but by the sheer chemical weight of these prescriptions. His patients were often warehoused in nursing homes, effectively removed from the world.

He was eventually exposed, charged with Medicaid fraud, and served prison time. But the damage to so many lives lingers on.

This book is, in part, a tribute to those lives. And it is a love letter to those who pulled me from the brink—especially my mother, whose unwavering love and intuition gave me a second chance.

Andrey, whose story appears earlier in this book, was not so lucky. His journey, filled with artistic brilliance and heartbreaking isolation, ended on the streets of California in the summer of 2024, as he tried to self-medicate and survive. He died disconnected from family, from friends, from the reality he once cherished. His family mourns him to this day.

His life was not in vain. It was a testament to how much more we need to do. And an inspiration—to speak the truth, to ensure dignity, and to protect the freedom to express, create, and feel fully human.

Be good to yourself

You can join the author's new group "Schizophrenia Support Group" on Telegram Messenger available on iPhone, Android devices, and all major computer operating systems including Linux by using this QR Code or link:

Use this group to connect with the author with any questions and to set a platform for another way to connect for peer support using an end-to-end encrypted platform.

Ask the author about at-cost purchase of this book in bulk for your efforts in getting this book in the hands of those in need.

Contact the author by email using pagetelegram@proton.me