VOICE, IDENTITY AND COERCION:

THE CONSUMER/SURVIVOR MOVEMENT

IN

ACUTE PUBLIC PSYCHIATRIC SERVICES

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Abstract

This thesis argues that current treatment in acute public mental health services is counterproductive for the wellbeing of those subject to such services. The consumer/survivor movement’s activism against the coercive nature of treatment is analysed according to new social movement theory. According to social theorists such as Alaine Touraine, new social movements are characterised by a struggle over identity. Consistent with this theme, what is identified in this thesis as central to the consumer/survivor movement’s objection to the nature of treatment in acute public mental health services is the failure of services to respect patient’s identity as persons. What might account for this failure is analysed in this thesis through an examination of the question of the conceptualisation of the subject in the theory and concepts of psychiatry, in the practice of psychiatry, in mental health law and in government policy.

As a counterposition to the above perspectives, the work of RD Laing, Charles Taylor and Paul Ricoeur are considered in an attempt to develop a conceptualisation of the subject grounded in a historical narrative. Further, Emmanuel Levinas’ and Axel Honneth’s work is drawn on to identify the practical implications of Honneth’s claim for a politics of recognition, which also supports the consumer/survivor movement’s demand for recognition as subjects in mental health services.
Stigma as opposition ................................................................. 85
Beyond Stigma: Voicing the Madness ........................................ 88

CHAPTER 2 .............................................................................. 93

PSYCHIATRY: A TOTALITY IN ACUTE PUBLIC MENTAL HEALTH
SERVICES.............................................................................. 93
Identity through Opposition: The Patient as an Object .......... 94
Creating the Object: Understanding and Explanation .......... 97
The Failure of Understanding Psychosis ............................... 102
Limitations of Methodology.................................................. 105
Psychopathology as Totality................................................. 107
Diagnostic system ............................................................... 112
Diagnosis ............................................................................. 114
Clinical Phenomenology and Mental Illness ...................... 118
Conflicts over ‘The Subject’................................................... 128

CHAPTER 3 ............................................................................ 134

INSTITUTIONAL PRACTICES OF MENTAL HEALTH SERVICES..... 134
1. Understanding as diagnosis .................................................. 135

Mental State Examination ......................................................... 138

2. Diagnosis as Surveillance: from Subject to Mental Patient .... 157

3. Acute Psychiatric Services: A Total Institution ....................... 165

Chapter 4 ........................................................................................ 181

INVOKING THE LAW: THE MENTAL HEALTH Law ..................... 181

The Admission Procedure ................................................................ 183

Legal Requirements for Involuntary Admission ......................... 184

Community Treatment Orders ..................................................... 190

Psychiatric Law and the Legitimisation of Coercion ................. 195

Consumer/Survivor Rights ........................................................... 200

Benchmarking Victoria by the United Nations Principles .......... 207

Some International Comparisons .............................................. 213

From Mental Health to Legal Control ........................................ 217

CHAPTER 5 ..................................................................................... 224

GOVERNMENTALITY, RISK AND THE LEGITIMISATION OF
PSYCHIATRY ................................................................................224

1. A Population at Risk.............................................................. 225

Systems for evaluating and regulating risk ......................... 227

2. Medical legitimacy ............................................................... 235

3. Problems with Governmentality: Risk and Medical Legitimacy 246

Contesting Governmentality: Risk and Psychiatric Legitimacy.... 256

Chapter 6 ........................................................................................ 262

RD LAING’S CONCEPTUALISATION OF THE PSYCHIATRIC SUBJECT
.................................................................................................... 262

1) Ontological Insecurity............................................................ 266

From the Case Study to the History of the Subject............... 288

2) The Intersubjective: The Primacy of the Interpersonal ......... 298

Conclusion................................................................................ 308

CHAPTER 7 ..................................................................................... 312

RECONSIDERING THE SUBJECT: THE NARRATIVE SUBJECT .... 312

Respect, autonomy and meaning............................................. 317
Recognising the Subject ............................................................ 380

Three Sites of Disrespect ........................................................... 383
  i) Physical abuse ................................................................. 383
  ii) Denial of Rights ............................................................... 388
  iii) Social Value ................................................................. 391

Practical implications ............................................................... 406

CONCLUSION.................................................................................. 412

An ‘Other’ Ethic............................................................................. 412

References....................................................................................... 422
INTRODUCTION

OUTLINE OF THE CURRENT PROBLEM

Nowadays the most horrible disease is not leprosy or tuberculosis: it is the feeling to be undesirable, rejected, uncared for and abandoned by all (This statement is on a wall in one of Mother Theresa’s mission houses).

In 1991, The United Nations Resolution on the Protection of Persons with a Mental Illness (United Nations General Assembly, 1991) stated that the rights of people accessing mental health services were the same as rights for all people. These rights included the right to participate in the treatment, planning, design, delivery and evaluation of services received. The Australian State ministers agreed to a Statement of Rights and Responsibilities for persons with mental illness, in response to this declaration (Commonwealth of Australia, 1995). This document introduced the philosophy of civil and human rights into the National Mental Health Policy. In April 1992 the national health ministers endorsed The First National Mental Health Plan, establishing a collaborative framework for the National Mental Health Strategy to proceed (Australian Health Ministers, 1995; Commonwealth of
Australia, 1992; Commonwealth of Australia, 1995).

The First National Mental Health Strategy was ‘designed to improve mental health outcomes for individuals and the community over the period 1992-98’ and was completed in 1998 (Commonwealth Department of Health and Aged Care, 1998: 2). These policy initiatives introduced many changes to psychiatric services (Commonwealth Department of Health and Aged Care, 1998; Commonwealth of Australia, 1995). They have resulted in the deinstitutionalisation and mainstreaming of public mental health services in general hospitals. Other services have been relocated to community support teams, such as community assessment teams (CATs) and mobile support teams (Victorian Government Department of Health and Community Services, 1995; Victoria’s Mental Health Department of Human Services, 1994; Victoria’s Mental Health Service, 1996b). This has meant that public mental health services are limited to people with a ‘serious mental illness’ (Victoria’s Mental Health Service, 1994). The 1994 policy document Victoria’s Framework for Service Delivery (Victoria’s Mental Health Service, 1994: 16) warned ‘a loss of this focus would quickly result in service capacity being swamped’ and ‘a consequential inability
to respond to those most in need’.

To accommodate terminology consistent with the mainstreaming of psychiatric service delivery, changes in mental health legislation were also initiated. This process of amendment was initiated across the nation in alignment with The United Nations Resolution (United Nations General Assembly, 1991: 5), though not without problems (Commonwealth Department of Health and Aged Care, 1996: 5; Delaney, 1992). The 1995 amendments to the Mental Health Act 1986 (Victoria, 1998) removed the voluntary admission category of admission and detention in an approved mental health service, in line with policy directives (Victorian Government Department of Health and Community Services, 1996; Victoria’s Mental Health Service, 1994).

Since that time, involuntary inpatient services have only been provided in accordance with the Mental Health Act 1986 (Victoria, 1998: 17) on the basis that: ‘The person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person’s freedom of decision and action’. This was an attempt to reduce the number of incidents of human rights abuses to which the United Nations declaration had responded (United Nations General Assembly, 1991).
However, the Burdekin report (Human Rights and Equal Opportunity Commission, 1993; Human Rights and Equal Opportunity Commission, 1995) identified that this aim was not in fact achieved and introduced its own problems.

The changes were implemented in a climate of economic rationalism. These economically driven policies have meant a change in policy over whose views define quality service. This shift, it is claimed, has the potential to locate those who receive services to be central to mental health services (Victoria’s Mental Health Service, 1996b). In the past service providers were the sole evaluators of quality, whereas now the views of recipients of mental health services, referred to in policy literature as ‘consumers’, are said to be accepted as: ‘an accurate reflection of the experience of receiving services’ (Victoria’s Mental Health Service, 1996a: 1). Though at present the mental health system is still purchaser/provider-driven, the intent was to shift from provider to ‘consumer’ orientated services (Victoria’s Mental Health Service, 1996b).

Professional stakeholders, however, have contested this move. Service providers claim to be fearful that policies that seem to be in the
interests of patients are actually working against them as funding is cut and even basic services reduced (Eisenberg, 1995). Even so, providers of mental health services find the use of the term ‘consumer’ for mental health patients inappropriate. Admission to an acute psychiatric facility and a diagnosis of ‘mental illness’, is associated with a question over the competency of the patient as a person and hence denial of legal, civil and ethical rights. This raises the question of who is the ‘consumer’. Ex-patient’s use of the term ‘survivor’ is also experienced as offensive by clinicians, not wanting to consider their services as having been ‘survived’. Nonetheless, an increasingly powerful new social movement in mental health, advocating for patient’s rights, is demanding patients gain recognition as legal, civil and ethical subjects. This movement will henceforth be referred to as the ‘consumer/survivor’ movement.

Consistent with the organisational style of economic rationalism, clinical autonomy in mental health services has been replaced with cost effectiveness (Sachdev, 1996) such that the role of the psychiatrist is reallocated to that of administrator and manager of risk (Rose, 1988). Subsequently, service providers are being held responsible for ‘risk
management’ of people with ‘mental illness’ while increasingly being divorced from ‘face to face’ contact with ‘consumers’ of acute public mental health services (Castel, 1991). Despite this shift, the Federal government cites Victoria as a successful example of the relocation of services (Commonwealth Department of Health and Aged Care, 1998).

In the National Mental Health Report (Commonwealth Department of Health and Aged Care, 1998: 56), Victoria was cited as providing twenty-nine percent less inpatient beds than the national average, and ranked the second lowest in the development of mechanisms for consumer and carer participation. Average length of stay was reduced to fourteen days for the 1996-97 financial year; at the same time fifty-two and a half percent of all public admissions were involuntary (Commonwealth Department of Health and Aged Care, 1998: 56-63).

These changes have been problematic for the users of public mental health services in a number of ways.

In Victoria, the changes have meant increased difficulty in accessing mental health services. Currently, admission to a mental health service is via assessment by a crisis assessment team, which assesses emergency situations. In 1996 and 1997, sixty-seven percent of
admissions to the northern, north east and inner south eastern regions were via crisis assessment teams (Victoria’s Mental Health Services, 1996; Victoria’s Mental Health Services, 1997). The recipients of these services question the effectiveness of these policies.

One of the measures of effectiveness of psychiatric treatment is relapse or readmission rates (World Health Organisation, 1991: 39). A United States study identified the worst ‘recidivists’ across one hundred and ninety-six state hospitals had an average of thirty-one readmissions in a year (Geller, 1992). However, the readmission rates in Victoria are only noted within twenty-eight days of discharge. This gives an inadequate indication of ‘effectiveness’. The People Living with Psychotic Illness: An Australian Study 1997-98 (Jablensky et al., 1999a; Jablensky et al., 1999b) recorded readmission rates over a year. Significantly, nearly one quarter (twenty-four percent) of those admitted in that study were readmissions in the same year. Yet this kind of information is not attended to. This failure perpetuates problems, as issues are not identified, much less addressed. These problems are also experienced elsewhere.

Chris Burford (2000), a psychiatrist in the United Kingdom, states ‘this
failure to properly monitor creates a perverse incentive to leave vulnerable people with inadequate support, and perpetuates the revolving door’. In Victoria, for instance, statistics have not been available since 1997 on the current public or community mental health services, the focus having changed to expenditure by the public sector. This is despite claims by the National Mental Health Strategy to greater accuracy in the reporting of mental health services (Commonwealth Department of Health and Aged Care, 1998: 6).

As stated, the current admission criterion focuses on the assessment of risk factors. This means that information available through the power of the Mental Health Act 1986 (Victoria, 1998) is not used to find out what goes wrong, but to continue to deprive people of liberties. In contrast, Chris Burford claims the British Mental Health Act and statutory bodies such as the Mental Health Review Board should be used to identify system failures and facilitate reviews of procedures under clinical governance. He states:

> Every readmission should be regarded as a treatment failure and the Mental Health Act Commission should be enquiring how the Trust ensures these are reviewed under clinical governance (Burford, 2000).

The two points in the Mental Health Act 1986 (Victoria, 1998) for which
the chief psychiatrist is responsible to intervene in service provision are:

a) that a person with a mental disorder is not being provided, or was not provided with proper medical care by the service; or
b) that the welfare of a person with a mental disorder is being, or has been endangered by the service (Victoria, 1998: 131).

These are the two claims that the new social movement in mental health, the consumer/survivor movement reports; yet they remain largely unacknowledged in mental health services.

Rather than attempt to address these problems in mental health services, an attempt to reduce the readmission rates has been made through the introduction of community treatment orders in Victoria, other Australian states and internationally. The British government has followed Australia’s example, despite resistance from consumers, survivors and clinicians alike (Mullen, 1996). However, the effectiveness of these orders is yet to be analysed (McDonnell & Bartholomew, 1997; Mclvor, 1998). The failure to comply with community treatment orders results in hospital readmission, resulting in scepticism over the
effectiveness of these orders to reduce readmission rates. Rather than respond to people’s needs, community treatment orders detain people as involuntary patients in the community and deny people’s liberties whilst maintaining them on drug regimes with little other support. 1

The problem with deinstitutionalisation Samson (1995: 67) argues, is that the relocation of involuntary patients to the community has ‘not

1 The Mental Health Review Board (1999) has identified a twenty-three (22.9) percent increase in the removal of liberties over the previous two years. Nearly all (98 percent) of the cases heard had clinical diagnoses of psychosis. Involuntary inpatients constituted twenty-eight and a half (28.5) percent of the cases heard and another twenty percent were (involuntary inpatients) on community treatment orders. Even though the number of inpatient hearings fell by five percent due to discharge before the hearing date, the number of community treatment orders hearings increased by twenty percent. Only six (6.4) percent of cases resulted in a discharge of persons from involuntary status.
been accompanied with shifts in thinking in psychiatry about mental illness from hereditarian to environmental terms but an expansion of mechanisms of social control into the social domain’. A further implication of this failure is the absence of much needed support services. The previously mentioned report, People Living with Psychotic Illness: An Australian Study 1997-98 (Jablensky et al., 1999a; Jablensky et al., 1999b) found mental health services were found to be limited to crisis and emergency mental health services with a lack of adequate community support services. The greatest perceived unmet need was for mental health services (25.6 percent), access to services and treatment (12.6 percent) and continuity of care (9.6 percent). The study found that Victoria had the highest rates of those with psychosis experiencing marginalisation and homelessness (1.3 per 1000 compared to 0.3 per 1000) across the nation. Despite government pledges of
improving conditions in the quality of mental health services, deinstitutionalisation has resulted in a crisis in mental health service delivery for governments’ worldwide. The resultant increased rates of homelessness, drug use and related problems in Australia and elsewhere (Jablensky et al., 1999a; Jablensky et al., 1999b), is then perceived as a threat to security. The State response notably in the United Kingdom and Australia is to re-emphasize institutional care and

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2 The World Health Organisation’s *World Development Report* (Murray & Lopez, 1996) predicts that in 2020 depression will be the leading cause of morbidity. *The Global Burden of Disease* (Department of Human Services, 1999) study has been adapted for use in Victoria and nationally. This study identified mental disorders as the leading cause of disability, and as accounting for twenty-six percent of morbidity, depression being the leading cause of the burden of disease in men and women. Depression is also the single largest cause of disability and mental illness accounts for eight of the top twenty leading causes of health problems in men and seven in women (Department of Human Services, 1999).
public safety (Morrall & Hazelton, 2000). The need to protect the public is achieved through forcibly removing ‘dangerous’ people from the community through acute psychiatric hospitalisation (Morrall & Hazelton, 2000).

Acute psychiatric hospitalisation has become what Hazelton (1999) calls ‘the new psychiatric institutionalism’, an indication of ‘the restoration of asylumdom in mental health care’ (Morrall & Hazelton, 2000: 89). The pressurised situation has heightened the crisis over conditions in the delivery of services. The reduction in bed numbers has raised the threshold for admission, and increased rates of compulsory admission, while high bed occupancy has compromised quality of care (Commonwealth Department of Health and Aged Care, 2000; Evaluation Steering Committee, 1997). The conditions have meant reduced staff time with patients and a non therapeutic environment with problems of violence, sexual harassment, and drug and alcohol use (Quirk & Lelliot, 2001).

In spite of the recent deinstitutionalisation and the development of a policy of ‘community care’, the hospital remains the site of mental health services (Morrall & Hazelton, 2000). The key to this analysis is
that the changes wrought by the First National Mental Health Strategy have not addressed the most important factor according to acute public mental health service users: dissatisfaction with the service itself. On the contrary, the recent policy changes has placed the quality of care in acute psychiatric services under further threat as demonstrated with increased compulsory admissions, admission rates, bed occupancy rates and a higher proportion of ‘difficult patients’.

There is growing evidence of dissatisfaction with service provision across the sector by providers and users alike, with poor staff morale and high staff turnover (McKay & Associates, 1996). Though professional relationships are considered an important aspect of care, due to reduced funds and nurse patient ratios, patient contact has declined. Patients are critical of conditions on the ward as boring and unsafe due to violence, sexual harassment and substance misuse (Graham, 1994; Quirk & Lelloit, 2001).

Barbara Tooth (Tooth, Kalyanansundaram & Glover, 1997: 49) at the Centre for Mental Health Nursing Research at the Queensland University of Technology found that sixty-one percent of patients found their interaction with health professionals damaging, which is: ‘not only
negative but detrimental to their recovery’. These kinds of claims, discussed further throughout the thesis, bring into question the Strategy’s aim to ensure the recognition of consumer evaluation of public mental health services as essential to ensure accountability and quality standards for delivery (Victoria’s Mental Health Service, 1994; 1996a: 1).

Further evidence of dissatisfaction is in satisfaction surveys. A recent survey, Consumer and Carer Satisfaction with Public Mental Health Services Summary Report (Quadrant Research Services, 1997) found that in the metropolitan areas of Victoria only fifty percent of inpatients were satisfied that their rights were being respected. In the metropolitan areas of Melbourne, only forty-two percent were satisfied with information received. The overall level of satisfaction in the 1998 results had only very slightly improved compared with the 1997 results (from 65.85 percent to 67.13 percent) (Nielsen, 1998). These poor levels of satisfaction were despite the methodological bias against hearing dissatisfaction in these surveys as Draper and Hill (1996) and others (Carr-Hill, 1992; Westbrook, 1993) have identified.

Further evidence of the consumer experience of damage from the service
is indicated in the levels of post-traumatic stress experienced as a result of treatment (McGorry et al., 1991). The Burdekin report (Human Rights and Equal Opportunity Commission, 1993; 1995) also identified ongoing and problematic issues in relation to recent changes in mental health. There is also growing evidence of an increase in suicide rates after contact with mental health services internationally (Appleby et al., 1999; Whiteford, 2000). The law literature (Hoge et al., 1997; 1998; Lidz et al., 1995) also makes it clear that the coercive methods used to fulfil the responsibility of a duty of care to patients generally works against the interests of those it claims to serve.

A recent study: Attitudes of Health Professionals Project: A Best Practice and Literature Review (Commonwealth Department of Health and Family Services, 1998), has also identified that consumers experience more discrimination and stigma from professionals than from anywhere else. This attitude then sets the tone for the rest of society. The recent Evaluation of the National Mental Health Strategy: Final Report (Evaluation Steering Committee, 1997: 12) has stated: ‘consumers reported that providers do not relate to them with an emphasis on dignity, respect and privacy’. And concluded that:

Mental health care in Australia is a considerable distance from
meeting the principles espoused in the Australian Ministers Mental Health Statement of Rights and Responsibilities (Evaluation Steering Committee, 1997: 13).

The two significant areas of concern to consumers in public mental health services were identified as access to treatment and stigma and discrimination experienced in mental health services. As a result of these ongoing problems, the difficulties facing mental health services were considered to be:

Considerable confusion about the values, attitudes and skills required to work in mental health, and the extent to which consumers can influence these (Evaluation Steering Committee, 1997: 27).

In response to consumer problems in the receipt of services the Report also recommended that:

The mental health industry needs to define the core competencies required, particularly staff values and attitudes and to develop these in collaboration with consumers and carers (Evaluation Steering Committee, 1997: 27).

The report identified that little training or planning had been invested in new models of care for the mental health workforce. It goes on to say that for core competencies to be developed in consumer/ survivor terms, a new direction is necessary: ‘The focus of the new strategy needs to move from the current emphasis on service inputs and structure to service standards, quality and outcomes’ (Evaluation
In response to these issues, the Second National Mental Health Plan (1998-2003) replaces the First National Mental Health Strategy with a focus on: promotion and prevention, improved responsiveness to the needs of ‘consumers’ and improved clinical outcomes, quality of life and consumer satisfaction. However, the consumer/survivor perspective, it will be argued here, offers its own definition of quality and service. The question then becomes whether these competencies will be implemented and evaluated in consumer/survivor defined terms.

The recent Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998-2003 (Department of Health and Aged Care, 1999) leaves out of the plan any reference to consumer knowledge in defining quality services. This leaves the definition of quality services in the hands of professionals, a contradiction of its own claims to partnerships with consumers in service provision in an attempt to improve the quality and effectiveness of mental health services.

The Second National Mental Health Strategy continues to rely exclusively on clinical concepts, even while claiming to introduce a new
direction. For instance, the introduction of ‘outcome measures’ was accompanied by the claim of a new direction in mental health for monitoring standards of care. But ‘consumer outcome measures’ are not subjective measures representing the interests of consumers but a clinical tool of interest to professionals (Andrews, Peters & Teeson, 1994; Stedman, Yellowlees, Mellsop, Clarke & Drake, 1997). And though the value of these instruments in predicting length of stay has been unsupported (Goldney, Fisher & Walmsley, 1998), they have still been instituted across the State of Victoria and elsewhere. Measures such as that recommended by the World Health Organisation (Szabo, 1996; The World Health Organisation, 1998) and of relevance to consumer/survivor issues, have not been implemented. Neither are the current measures of patient satisfaction adequate to represent the interests of consumer/survivors (Allen, Oberlin, Taylor & Zajdel, 1999; Draper & Hill, 1996).

Despite the claims in national policy to improve responsiveness to the needs of consumers and consumer satisfaction, this has not occurred. It is claimed here that improvement would require investigation into the conflict between consumers and professionals. Attempting this research without understanding the different perspectives and conflicting
interests involved would be naive. That is, it is not possible to address consumer interests from a professional point of view, as they are fundamentally different points of view. What is needed is an enquiry into what consumers find untenable in acute public mental health services and to inquire into what would be required to transform them. These questions have not been taken seriously in psychiatry because the consumer/survivor perspective has not been considered as legitimate. This thesis is an attempt to do so.

Aim of the Thesis

This thesis is an attempt to identify what concepts are needed to enable mental health services to better meet the needs of people in receipt of mental health services and to identify the practical, ethical and legal implications of any such conceptual shift. That is, what concepts would facilitate providing services that service users would experience as appropriate in psychiatric services? These questions are not to make light of the very great difficulties in the area of treatment of acute psychiatric patients but rather to recognise that even though biomedicine marginalises questions that raises moral, ethical or human
rights considerations, these important questions demand attention.

Quirk (2001) notes that:

Very little ethnographic research has been conducted on acute wards in the UK (and none since the 1970s) leaving us with a 'black box' view of inpatient care in this setting (Quirk & Lelliot, 2001: 1565).

Research amongst users is very difficult in the area of acute public mental health services because of the difficulties of eliciting true informed consent. So information will be drawn from other sources. Draper and Hill (1996) suggest the best way to get information is from research users themselves have conducted. So to consider the consumer/survivor experience of acute psychiatric services, a range of local and international consumer/survivor generated literature will be considered.

The consumer/survivor movement emerged as a new social movement internationally 30 years ago (Support Coalition International, 2000; US Department of Health and Human Services, 2001). The movement refers to a large and divergent group with a range of perspectives represented in the debates about the use of terms typical of new social movements explored in the first chapter. From the consumer/survivor perspective, continuing dissatisfaction with services is of great concern. Rogers and
Pilgrim’s (1991a) ‘Pulling Down Churches: Accounting for the British Mental Health Users’ Movement’ argue that because such patients use psychiatric services much more extensively than general health service users, psychiatric user’s views are more important than general health users.

The extensive use of psychiatric services, as consumer/survivors themselves highlight (Epstein & Shaw, 1997; Wadsworth & Epstein, 1996a), have long term implications, especially for patients in acute psychiatric wards, as they are already very vulnerable and at risk of further damage. ‘Consumers identified acute practices as where the most painful and deeply traumatic things can happen for them’ (Wadsworth & Epstein, 1996a: 10). So acute public psychiatric services are the focus of this analysis.

**Structure of Thesis**

This thesis considers the consumer/survivor movement as a new social movement. These movements are characterised by conflict over identity.
The consumer movement will be analysed in the first chapter as a new social movement according to the work of theorist Alaine Touraine. Touraine (1974; 1977; 1978) suggests analysis of new social movements require analysis of the central principal, context and conflict of a movement. He also suggests analysis proceed at two levels: the social events and the social relationships underlying these. The matrix of different aspects and levels of analysis will be addressed in the following chapters. The purpose of considering the consumer/survivor movement as a new social movement is to identify the issues new social movements recognise as central: the moral and ethical issues and their implications for practice. In the arena of psychiatry, this then offers new questions and new ways of understanding and addressing the problems of service delivery in public mental health facilities.

Even though consumer/survivors recognise that there is resistance to their opinions, what they desire most is a change in the culture of service delivery (Wadsworth & Epstein, 1996b). The issue identified as central to the conflict over service provision in the consumer movement literature is the way the patients are treated. This issue then begs the question of how the person in receipt of mental health services is
conceptualised. This is taken up as the central question of the thesis.

To address this question of the conceptualisation of the subject in mental health, each chapter explores a different perspective at work in mental health. These different perspectives are associated with and explain the use of different terms in each chapter to refer to the person (subject) in receipt of public mental health services. Chapters’ two to five raises the question of the conceptualisation of the person in receipt of acute public mental health services in terms of theory, practice, the law and policy in mental health respectively.

The question of the conceptualisation of the subject in mental health is not raised directly in psychiatry. Social theorists argue that it is theory that informs practice, so the theory that informs the current practice of psychiatry in acute public mental health services is considered in chapters two and three by reference to psychiatric texts and psychiatric journals (Fulford, 1994; Fulford, 1996; Ingleby, 1981; Radden, 1996; Rose, 1988; Sadler, Wiggins & Schwartz, 1994; Snaith, 1991). Chapter two identifies the reliance on biological concepts to explain the presentation of acute mental health problems such as psychosis. It then goes on to consider the work and influence of psychiatrist and
philosopher Jaspers (1963), who recognised methodology as centrally important to the development of knowledge. The implication of the reliance on biological is that providers of public mental health services tend to conceptualise acute psychiatric patients as 'mentally ill' or 'sick' and 'different from' or 'other than' professionals themselves. As a result, the status of the patient as a person is brought into question.

The second part of this analysis, in chapter three, examines the implications of the concepts utilised in psychiatry for the way a patient is treated in a dual sense. An analysis of the limitations of the rationality offered in the diagnostic categorisation highlights the limitations of the explanatory rationale. The implications of institutional treatment of mental health patients are examined in detail with sections on the work of Foucault and Goffman.

The juridification of the subject is considered in chapter four. The conception of the subject as 'mentally ill' is identified as the means whereby coercive practices are authorised in acute mental health services which are supported in mental health law. The Mental Health Act 1986 (Victoria, 1998) authorises the use of 'reasonable force' to admit patients against their will and thus protects those who deliver
coercive practices. This ‘treatment’ includes involuntary admission, detainment, isolation, physical restraint, drug and electroconvulsive treatment of patients. Psychiatrists are the personnel authorised to administer, diagnose, detain and treat people.

The result is that these coercive treatments contribute further damage to an already traumatised sense of self. It is argued in chapter five that the negative implications of these practices on the lives of those subjected to involuntary treatment are the responsibility of the authorising body: that is, the State. However, the information used to evaluate public mental health services is highly selective. For instance, indications of inpatient trauma are not recognised as such but considered further evidence of patient pathology. This chapter attempts to consider the broader issues of social, legal, medical, practical and institutional context of policy development in the light of the current construct of risk management and its implications for public mental health patients.

The next section of the thesis is an attempt to explore how to improve services in response to the issue consumer/survivors have raised. Chapter six enquires into how the philosophical debates within
psychiatry around the conception of the subject have been addressed in
the work of R.D. Laing (1965a; 1965b; 1966; 1971b; 1985). Laing
offered an alternative or counter paradigm for understanding
psychiatric problems, which also offers an understanding approach to
psychiatric patients. Chapter seven goes on to considers how Laing’s
understanding approach might be utilised in responding to people in
acute psychiatric services, in a way that accommodates the demands of
the consumer/survivor perspective.

For this to occur, what is required is considering patients as legitimate
subjects in a way that transforms the intersubjective practice of
psychiatry, so that the problems identified by consumer/survivors can
be addressed. Of particular relevance here is the conceptualisation of
the subject as an interpretative subject in the work of philosopher
Charles Taylor (1985b; 1985c; 1989). This conceptualisation is taken
further and operationalised into a simple though complex matrix and
workable approach of narrative in the work of Paul Ricoeur (1981a;
1981b; 1981c; 1992). What is identified is the important role of
narrative in the construction of identity. The basic requirement for this
ethical practice is listening in a face-to-face relationship, as expressed

Chapter eight is a discussion of the implications for practice of the claims of the consumer/survivor movement as a new social movement. The failure to involve consumers in the creation and design and evaluation of services leaves consumers as patients in a passive state. There is no recognition of the value of consumers’ contributions in their own right. The failure to listen to patients in acute psychiatric services is a failure to recognise people in receipt of acute psychiatric services as subjects. This failure is institutionalised through the failure to organise acute psychiatric services around interpersonal relationships between subjects based on dialogue and communication. Government and consumer/survivor incentives to reverse this failure and their limitations are considered.

The key premise of this chapter is that as established in chapter one, the barrier to participation for consumer/survivors is discrimination and stigma. Stigma denies the recognition of the value of the patient as a person and the value of consumer/survivor perspective and knowledge as legitimate. Overcoming stigma, it is claimed in chapter eight, is through recognition of the unique value and worth of each
patient as a person. The absolute basic necessity of recognition of the subject as an equal ethical, legal and social subject is considered through the work of Alex Honneth’s (1995) *The Struggle for Recognition: The Moral Grammar of Social Conflicts*. This concept calls into question the current ethos of acute psychiatric services. It highlights the ethical necessity of the need for the patient to be recognised as a subject.

In sum, the topic of the thesis can be put in a number of rhetorical questions. Does the concept of the patient as an ethical subject, embedded in a narrative, (as explored in chapter seven) provide an adequate methodology to meet the practical and ethical demands of the consumer/survivor movement? Does it address and articulate the interests and concerns of consumer/survivors? What else is needed? What community values and practices are needed to facilitate and support this ethic of practice? These questions necessarily raise questions of a broader social context. What community values are required to support and provide a framework whereby those who most rely on those services can be the designers of those services?

Consideration is given to consumer/survivor designed methodologies that utilise a consumer/survivor perspective ethic, and henceforth challenge and revolutionise the current paradigms of treatment. The
central question of the thesis is: what does it take to recognise the patient as a subject in acute public mental health services?
CHAPTER 1

THE CONSUMER/SURVIVOR MOVEMENT AS A NEW SOCIAL MOVEMENT

Assume a consumer understands their own experiences better than others do (Wadsworth & Epstein, 1996a: 76).

The purpose of this chapter is to understand the claims of the mental health consumer/survivor movement. The activism of this movement will be analysed in the first part of the chapter through new social movement theory. This provides some context and legitimacy for the demands being made. Recognition of the issues central to new social movements offers a framework to understand the kinds of demands being made by the consumer/survivor movement in mental health, which will be explored in the second half of the chapter. The intent being that understanding the perspective of the consumer/survivor movement, which is made up of patients and ex-patients of acute public mental health services, offers the possibility of new insights into conceptualising and responding to mental health problems in acute
public mental health services.

1. The Emergence of New Social Movements

In recent times, the political response to injustice, inequity, lack of rights and freedom has been the emergence of new social movements. The link between democracy, human rights and social movements is evident in the movements that have emerged to demand change in society. These include the women’s movement; the black rights movement, the gay and lesbian movement, the indigenous rights movement and more recently, the refugee movement. Burgmann (1993) describes new social movements as a result of the disillusionment with political structures that are unresponsive to the crises that arise. The battle, she claims, is over economic and political decision-making, which deeply effect people who are dependent on these structures. Touraine has written extensively on this topic and argues new social movements respond to such crises with an alternative form of political action which leads to the:

Deliberate reconstruction of a society based on the very principles of justice, liberty, and respect for human beings—the very principals on which democracy is based (Touraine, 1997: 58).
Other social theorists such as Giddens (1987a; 1987b; 1991), suggest, like Touraine (1974; 1997), that new social movements are political movements particular to post-industrial society. They consider new social movements to be part of a larger crisis over the legitimisation of traditional authority in the public sphere. Such movements, they claim, are a reaction against the systemic imposition of knowledge through instrumental measures of efficiency as a way of understanding human beings' relationships to the world, each other and to themselves. Notably, these relationships have resulted in the destruction of personal and cultural creativity and therefore identity. While it is structural factors within society which confer privilege upon those with power compared to those without, new social movements attempt to bring democracy and visibility to areas of discrimination, inequality and domination.

Typically, new social movements confront the traditions of authority in the public sphere and offer new sites of opportunity for the development of novel sites of social change or, in Gidden’s terms, ‘detraditionalisation’. New social movements represent the raising of qualitatively new issues about social life. They act as an agent of change in shifting the emphasis from economics, which has emotional costs,
to personal growth, which offers new possibilities. Thereby, they bring repressed areas of moral and existential issues into public discourse. These movements value personal identity as opposed to totalising ‘truth’. This however, increases political conflict over identity (Giddens, 1987a; 1987b; 1991; Touraine, 1974; 1997). Until now the role of identity has not been operationalised in the political conception of actors. However, the revolution of new social movements has been to focus on the everyday patterns of cultural life, which brings with it the realisation of the right of individuals to choose their own identity.

This shift to moral and existential issues is about strengthening autonomy in sensitive ways to promote personal wellbeing. This alternative approach, as Giddens (1991) identifies it, is tied to a life politics that extends the self-reflexive project beyond modernity’s self-referential systems. The impetus of social movements is to generate alternative kinds of practices in society that value human beings over products. Such social transformation is possible through innovative practices. New social movements recognise the role of narrative as central to innovative practices and the creation of a personal identity.

Cohen and Arato (1992: 492) affirm that new social movements make
the realisation of the positive potential of modern civil societies possible through a contestation of resource allocation and identity construction. For them, the salient features of new social movements are the involvement of:

Actors who have become aware of their capacity to create identities and of the power relationships involved in the social construction of those identities (Cohen & Arato, 1992: 511).

It is the realisation of the social construction of identity that initiates a social movement’s push for change. Social movements concern with participation leads to the identification of both the means and the ends as social products.

Cohen and Arato identify the success of these movements as to do with the democratisation of values and institutions in a political culture. The institutionalisation of rights is the catalyst for contemporary struggles and initiatives. The continuation of these initiatives requires the continuing reflexive democratisation of rights and communication. Cohen and Arato (1992: 517) recognise that the stakes of social conflict revolve around institutionalisation of the dominant cultural model, that is the: ‘elite controlled, technologically managed structures permeated by relationships of domination’.
In a similar way Nancy Fraser (1993) describes new social movements as involving two kinds of interrelated struggles: the struggle over institutional versus professional need interpretation. For example, the debate at the heart of the social movement in mental health is the contestation and opposition over the administrative and therapeutic interpretation of need by professionals. Those who oppose and contest the type of service delivered are at the same time also seeking State provision for their needs. The conflict in mental health services is over access to help for problems that those who require those services articulate and identify as what is needed for recovery.

The failure to provide basic respect to acute psychiatric patients according to Rogers and Pilgrim (1991a) is due to the dominance of the medical perspective in mental health. For example, Rogers and Pilgrim (1991a) identify that the dominance of professional discourses means that the British Mental Health Users’ Movements perspective and views are excluded. The failure to provide basic respect and or accommodate patient’s views in acute psychiatric services is the site of contention, which has generated the mental health movement both here in Australia (Epstein & Olsen, 1999) and elsewhere (Read & Reynolds,
1996) as will be demonstrated.

Language is central to this struggle over need interpretation, as how needs are defined in terms of the language used has implications for the identity of patients and professionals alike. In *The Self-Production of Society* (Touraine, 1977) describes new social movements as arising due to conflict over the definition of actors by the dominant culture. In the same way the mental health consumer/survivor movement contests the way patients are defined in acute public mental health services, as it has implications for identity. The challenge to established practices produces conflict both within and between stakeholders in the field of mental health services.
Analysing New Social Movements: Identity, Totality, Opposition

What distinguishes the consumer/survivor movement, as a new social movement will be discussed using Touraine's (1974; 1977; 1978; 1997) work. In *The Voice and the Eye: An Analysis of Social Movements* Touraine (1978) defines the sine qua non of new social movements as conflict over conventions in the relationships of identity. At the same time, these identities are totally interdependent. Thus new social movements always involve ‘a double relation, directed at an adversary and at what is at stake’ (Touraine, 1978: 80). Furthermore Touraine observes that what is culturally at stake is integral to the ideology of both the social movement and of the adversary (Touraine, 1978: 80).

The social movement, Touraine (1978: 80-94) explains, is a combination of three totally interdependent principles: identity, opposition, and totality. Touraine explains that ‘if one is to fight, however, should one not also know in whose name one is fighting, against whom and on what grounds’ (Touraine, 1978: 81)? Similarly, in the field of mental
health, the principle of identity is the site of conflict over which the consumer/survivor movement has emerged. Stigma, experienced by those who utilise acute psychiatric services, is the principal source of conflict. The opposition against whom the consumer/survivor movement fights is psychiatry itself. This is the group with whom consumer/survivors experience the most stigmatisation. The principle of totality is manifest as Goffman outlines later, in the domination of psychiatry in the field of acute public mental health services. What is at stake for consumer/survivors of acute psychiatric services is the stigma of a diagnostic-identity, the consequence of accepting a diagnosis of mental illness.

Touraine (1978: 81-94) identifies a model that represents the interdependence of identity, opposition and totality as particular to the field of relationships. The dimensions of a conflict in the relationships between a social movement and an adversary depend on whether the link between them is between the social movement and the stakes or between the stakes and the adversary. In the instance of the consumer/survivor movement, the stakes and the adversary reinforce each other as the adversary is totally in control of the relationships of identity. So the site of conflict for the consumer/survivor movement
involves opposition to both these dimensions. The three principles of social movements: identity, totality and opposition will be outlined further.

Identity, as stated, is central to the analysis of what is at stake for all the stakeholders in a system in conflict. Significantly, the identity of the participants emerges in the midst of the conflict. That is to say, the identity of the participants: ‘cannot be defined independently of the real conflict with the adversary and of recognition of the stake of the struggle’ (Touraine, 1977: 312). Notably, identity emerges through participants finding a voice to claim what is at stake, and it is this ‘self-expression that causes the principal of identity to appear’ (Touraine, 1977: 312).

The need ‘to claim a voice’ emerges in relation to the reliance on a system that has been experienced as inadequate. This contradictory set of relationships characterises new social movements. This concept of ‘voice’ or ‘self-articulation’ is the same notion consumer/survivors themselves have come to recognise as needed for their recovery. Touraine (1977) makes clear that a movement does not begin with a need for self-expression, but with an unmet need. Self-identity emerges
in the conflict with the adversary over the failure of the system to meet
the needs of those dependent on it. The importance of identity for
consumer/survivors will be explored further later in this chapter and in
chapter seven through the work of Charles Taylor and Paul Ricoeur.
Further, the importance of the recognition of one’s identity is considered
in chapter 8 through the work of Axel Honneth.

According to Touraine (1977), when a system is in conflict an adversary
appears. This is the second principal, the principal of opposition. The
conflict with the adversary subsequently shapes the consciousness of
the actors. Opposition to the adversary is from those who are defined
and receive identity from the system in conflict. This is characteristic of
the opposition in acute public mental health services.

Consumer/survivors receive diagnoses from professionals in the public
mental health system. This diagnosis carries a stigma for
consumer/survivors. Users of acute mental health services have been
marginalised in multiple ways through stigma, cultural, economic and
political exclusion, social isolation and disability. This stigma has
negative implications for the mental wellbeing of the actors, already
consumer/survivors of mental health services, and so is contested.
Another tension in social movements is the principal of totality. In Touraine’s (1977) work, totality refers to a dispute over the adversary’s domination of a system. The consumer/survivors’ claim is that the perspective of the medical profession in acute public mental health services dominates the system. The consumer/survivor movement is a reaction to the inequality of power in relationships in mental health services. Challenging the totalising power of the mental health professional in the field of acute public mental health services to define patients according to their diagnosis is the central intent of the consumer/survivor movement.

The second part of the chapter will consider the consumer/survivor movement perspective in the field of acute public mental health services around these three principals, whilst the position of psychiatry as adversary will be addressed in chapters two and three. The fourth and fifth chapters will analyse the totality of the ‘domination exercised by the adversary over the cultural stakes of the struggle’ (Touraine, 1978: 81) by examining the function of psychiatric concepts and practices in the Mental Health Act 1986 (Victoria, 1998) and in government.
2. The Consumer/Survivor Movement as a New Social Movement

A social movement is only defined as such, according to Touraine (1978: 85), if it matches up to four conditions. The first condition is that a committed population initiates the movement. The second is that it exists in terms of an integrated organisation. Thirdly, it must ‘fight against an adversary, which may be represented by a social group’ (Touraine, 1978: 85). Fourthly, the conflict with the adversary is a problem that concerns the broader society. Evidence that the consumer/survivor movement fulfils the first two conditions is demonstrated in the following section. Chapters two and three address the third condition, and the fourth condition is addressed in chapters four and five.

The context of recent policy changes has placed the quality of care in acute psychiatric services under further threat. The rising incidence of mental health problems (Australian Bureau of Statistics, 1998), and the crisis of the management of deinstitutionalisation, has precipitated a
crisis for governments internationally in the delivery of mental health services. Quirk (2001) has noted that the experience of users is ‘bleak’ with evidence of violence, sexual harassment and substance misuse. He notes that there has been very little research conducted on acute wards (Quirk & Lelliott, 2001: 1565).

The issue of eliciting true informed consent in this area makes researching in this area very difficult. Draper and Hill (1996) suggest the best way to get information is from research that users themselves have conducted. So, to consider the consumer/survivor experience of acute psychiatric services, a range of locally produced and international consumer generated literature will be considered. For example, groundbreaking research, which used ex-patients to research acute inpatient views was conducted in Melbourne and supported by the Victorian Mental Health Awareness Council.

This research began with *Understanding, Anytime: A Consumer Evaluation of an Acute Psychiatric Hospital* (McGuiness & Wadsworth, 1992) and developed into the *Understanding and Involvement Project* (Epstein & Wadsworth, 1994; McGuiness & Wadsworth, 1992; Wadsworth & Epstein, 1996b; Wadsworth & Epstein, 1996c). This led

The Mind charity in the United Kingdom also specialises in the research and publishing of consumer experiences (Pedler, 2001; Read & Reynolds, 1996; Read & Wallcraft, 1992). Examples include Experiencing Psychiatry: Users’ Views of Services (Rogers, Pilgrim & Lacy, 1993). These authors also produced other publications exploring the consumer perspective: Pulling Down Churches: Accounting for the British Mental Health Users’ Movement (Rogers & Pilgrim, 1991a); Experiencing Psychiatry: Users’ Views of Services (Rogers et al., 1993). Other research that explores the consumer/survivor perspective utilised here is: From the Mental Patient to the Person (Barham & Haywood, 1991). Research that consumer/survivors have produced in the United States will also be used.
The resources accessed to identify the problems users of acute psychiatric services experience are not limited to this published literature. It includes material the movement has generated internally. This internal literature is accessed via a network of collaborations established by the consumer/survivor movement across the globe. Consumer/survivors of mental health services locally, nationally and globally express their dissatisfaction with services in through a range of fora including conferences, emails, workshops, research literature and political fora. Active consumer groups include Survivors Speak Out (UK), The National Empowerment Centre (USA) and Support Coalition (USA) and The European Alliance. Email groups and Internet websites offer further opportunities for sharing information, research and active networking providing cross fertilisation of ideas.

Burgmann (1993) notes that movements are only able to function with the support of technology, providing contact and support for activists. The organisational methods of these movements are ends in themselves, as the ‘activists within these movements self-consciously practice, in the present, the future social changes they seek’ (Burgmann, 1993: 4). It is important to note that those consumer/survivors that become involved politically do not necessarily represent the views and
experiences of all consumer/survivors of mental health services

( Epstein & Olsen, 1999) as such activists are self-selected. Even so, the
growth of new social movements, Burgmann argues, requires
intellectual capital and the ability to understand theories of politics and
of change in theoretical ways. She (Burgmann, 1993: 13) claims: ‘new
social movement theorists aim on behalf of their class to claim the role
of privileged agent in social transformation’, though this would be
insufficient without recognition of the experience of oppression.

This formal and informal literature form the bulk of resources from
which I draw an understanding of what is referred to in this document
as the consumer/survivor movement perspective. This research and the
experiences noted by participants and researchers’ indicate that not
only are patients needs not met, but also that people are damaged by
the service. The findings from this research will be discussed in detail in
this second part of the chapter. This research provides details of
patients’ own experiences of acute public mental health services,
something that Quirk (2001), as stated earlier considers desperately
needed. An issue central to both the consumer/survivor movement and
other stakeholders is the issue of terminology.
Terminology Debates

The first and second principal that Touraine (1978: 85) identified as necessary to define a social movement is that it be initiated by a committed population and that it exists in terms of an integrated organisation. Demonstrated here is that the consumer/survivor movement fulfils these conditions. The consumer/survivor movement emerged internationally 30 years ago in response to the conflict over acute public mental health service provision (Support Coalition International, 2000). This world wide liberation movement is working towards setting up and running its own supportive services and advocacy groups (US Department of Health and Human Services, 2001). Australian activists use the term ‘consumer’, though there is lack of consensus over its use. In the United States and New Zealand the preference is for the term ‘survivors’, while in the United Kingdom the term is ‘users’. The term ‘consumer/survivor/ex-patient’ (C/S/X) is often used by activists themselves to encompass the varying positions represented in the debate and the complex relationships of identity around the experience of being a patient in an acute public mental health service. Each of the term’s consumer/survivor/user indicates in
one way or another, a person’s attempt to articulate their relation to mental health services. The different relationships to terms in the movement will be discussed further, while the term used here as identified, in the introduction, to refer to the complexity of personal perspectives represented in and by the movement will be ‘consumer/survivor’.

According to activists Epstein and Shaw (Epstein & Shaw, 1997) in Developing Effective Consumer Participation in Mental Health Services: The Report of the Lemon Tree Learning Project, the consumer/survivor perspective has grown out of belonging to a group that is discriminated against. The attempt to overcome this discrimination in Victoria has been through identifying with the term ‘consumer’, a term imposed in the context of economic rationalist driven policy. ‘Consumer’ is a term employed by users in an attempt to claim the provision and protection as ‘consumer’, even though patients of general health care have not found this expectation to be fulfilled (Wood, 1994).

The use of the term ‘consumer’ has been problematic from the point of view of service providers as well as consumer/survivors. For example, researchers from the Orientation and Job Manual: Staff Consumer
Consultants in Mental Health Services (Wadsworth & Epstein, 1996a), reported that the professional staff felt the term made them feel as though they were ‘being consumed’. Another limitation of the term is that it is perceived by consumer/survivors to reduce the person in receipt of services to an economic value. This reduces the position of the patient to that of a commodity, which misses the point of the consumer/survivor claims. It also bypasses the question of the right of the patient to participate in their treatment, which is what the movement is in reaction against (Epstein & Shaw, 1997). In addition the term ‘consumer’ locates and identifies patients as dependent on and in relationship to service providers. This positioning does not support the intention of the movement in the use of the term ‘consumer’ by these groups.

Neither is there agreement within the movement about the use of the term ‘consumer’. Judi Chamberlin (1978) in On Our Own: Patient Controlled Alternatives to Mental Health Services rejects the term ‘consumer’ for its depoliticising implications. It implies that there is freedom and choice in mental health services and creates a ‘bogus’ of ‘co-operation’. She rejects too the co-option of consumer organisations that claim to ‘work with’ and ‘improve’ the mental health system as
the Australian movement has done. Instead, the National Alliance of Mental Patients, of which she is a member and which formed in 1985, advocates for the abolition of involuntary psychiatric interventions and for the development of user run services as true alternatives to the mental health system (Chamberlin, 1978; US Department of Health and Human Services, 2001).

Even so, the term consumer has re-emerged in the American movement literature in combination with other terms. For instance, a recent issue of: The Key: National Mental Health Consumers’ Self-Help Clearinghouse Newsletter announces ‘Consumer/Survivors Need a Voice in Washington’ (Verna, 2000). A contributor to the Ozmad email list where these type of heated discussions take place, considers people who accept the term ‘consumers’ ‘dupes for believing that the mental health system has any value at all’ (Heyes, 2000). Amongst the movement, the term ‘survivor’ is often preferred. Another contributor to the Ozmad email list defines psychiatric survivor as:

indicating (a la cancer survivor) we have come through a serious of crises using our skills, guts, knowledge, wisdom, intuition, etc and a whole lot of other strengths and qualities we rarely get credit for. This is the term I like best. Many psychiatrists see it as meaning a survivor of psychiatry, which has the advantage of hopefully getting them to reflect on the quality of their care (Carne, 2000).
Likewise, Richard Gosden, a New South Wales survivor and activist, attests the term psychiatric survivor is used ‘to emphasize the ordeal they have claimed to endure’. Gosden (1999: 143) in ‘Coercive Psychiatry, Human Rights and Public Participation’ asserts there are two streams of belief regarding participation in mental health services, which are opposing. The dominant group is made up of a powerful coalition of professionals and support groups for carers of the mentally ill who seek to increase the legislative powers of involuntary treatment. The equation of this movement with the voluntary psychiatric consumers’ movement, Gosden considers, conceals the involuntary and coercive nature of public acute mental health services. He suggests that the tendency to identify all mental patients as ‘consumers’ implies consent and works against the interests of survivors who attempt to:

raise the public consciousness about the perceived fraudulent nature of psychiatric diagnosis, the injustice of involuntary incarceration and the dangers of psychiatric treatment (Gosden, 1999: 1).

Nonetheless, as will be demonstrated, the lines between voluntary and involuntary public mental health services are not clearly defined. What happens in practice is that users of services, whether involuntarily admitted or not, are considered to lack credibility, due to the diagnoses
they have been given. What has become clear in this discussion is that those who use mental health services are in conflict with providers over the definition of needs and methods of practice.

Hence, the consumer/survivor movement refers to a large and divergent movement with a range of perspectives represented in the debates about the use of terms typical of new social movements. The debate around these terms is characteristic of the debate over constructions of identity in new social movements as Touraine (1978) has pointed out. However, as Touraine’s framework of analysis of new social movements makes clear, the issue of terminology is linked with constructions of identity. The struggle over identity, represented in this debate over terms is in response to the failure to take consumer/survivor views seriously.

Though there is dissatisfaction with the use of terms amongst the Australian activists, it is also claimed that debates about terms are a
distraction from the more important issues of stigma. ³ Yet the issues are inextricably linked. The claim to the right to participation is tied up with identity, which has implications for stigma. The consumer/survivor movement is also in response to the exclusion of consumer/survivors from social membership and participation in the delivery of acute psychiatric services (Epstein & Wadsworth, 1994; Wadsworth & Epstein, 1996b; Wadsworth & Epstein, 1996c). ⁴

³Stigma and human rights were addressed at the Madpride events in Oregon, Toronto, London, Washington, California and the Congo. This was called an ‘internal celebration of psychiatric survivor human rights’. It was an attempt to destigmatise the concept of the ‘crazies’ similar to the Negro movement, and to invest such terms with strength and empowerment (Carne, 2000).

⁴Turner (1993: 14) suggests ‘citizenship as a model of social movements’, ‘be embraced and developed by such movements’. Turner defines citizenship as a practice of social membership, thereby overcoming the limitations of the concept. He defines citizenship
3. The Patient’s Experience of Acute Public Psychiatric Hospitalisation

As Touraine (1977: 12) attests, ‘democracy is the battle waged by subjects in the context of their culture and their liberty, against the domineering logic of systems’. Practices are the site where the attempt to democratise society occurs. The attempt to liberate the oppressed is through a contest over the politics of the construction of identity. Touraine claims social movements are created at sites where there is opposition between parties over practices. Opposition is typically from those who are defined and receive identity from the social system, which

as practices: ‘that define a person as a competent member of society’, and which ‘shape the flow of resources to persons and social groups’ (Turner, 1993: 14).
is the case for consumer/survivors of acute public mental health services.

The consumer/survivor movement opposes the treatment of those diagnosed as mentally ill in acute psychiatric services. This is because the stigma associated with being diagnosed as mentally ill, has implications for a person’s identity, and the way a person is treated. The diagnosis or \textit{diagnostic-identity} then has implications for interpersonal relationships and specifically with medical professionals in acute public psychiatric services. It is the associated stigma of being diagnosed as mentally ill, which affects the way consumer/survivors are treated.

The stigma attached to the identity of the ‘mental patient’ is what consumer/survivors are fighting against in the field of mental health. As this is central to the conflict, the dynamics of this stigmatisation will be examined, drawing on Touraine’s notion of totality, identity and opposition. The totality of identity with, and opposition to the experience of stigma by people utilising services will be explored here through examining the consumer/survivor movement literature already referred to. This analysis is an attempt to gain some insight into the problems as consumer/survivors themselves identify them, in order to
understand the perspective of consumer/survivors themselves.

**Stigma as Totality**

Admission to a mental health service is the last resort for acutely distressed persons. But psychiatric hospitalisation comes at a price according to those who have utilised these services. A person from The Melbourne Consumer Consultant’s Group claims:

> It costs a personal sense of self, of being prepared to submit to psychiatric constructs of serious mental illness, diagnoses of psychosis, and subjection to psychiatric treatment and practice and the stigma that entails (The Melbourne Consumer Consultant's Group, 1997: 4).

Ex-patients say the experience of psychiatric hospitalisation is like being: ‘in a rubbish bin sort of thing... the worst place to be...it makes you low just being in the place and knowing you’re in the place’ (Barham & Haywood, 1991: 38).

Research on coercion and the law has also found that threats of the loony bin start before admission, which also has a negative effect on recovery (Lidz et al., 1995). Scheff (1984) in *Being Mentally Ill: A Sociological Theory* argues that ‘mental illness’ acts as a conceptual dustbin or label for deviant behaviour. The negative implication of the
bin metaphor makes people feel ‘unwanted and neglected’ (Jewell & Posner, 1996: 7). For many ‘the psychiatric unit or psychiatric hospital will be the ultimate defining metaphor of rejection and abandonment’ (Jewell & Posner, 1996: 7).

A person’s experience of being devalued for receiving psychiatric services is referred to as stigma. Ex-patients claim stigma is acquired on admission to a psychiatric ward. For instance one person stated ‘Once you have been in there is a stigma’ (McGuiness & Wadsworth, 1992: 16). For Cath, the most damaging aspect of mental illness is stigma: ‘It is about labelling, and it’s about ownership and it’s about creating other’ (The Melbourne Consumer Consultant’s Group, 1997: 3).

To avoid stigma, what is really important according to Jon is: ‘To not accept the labels of the psychiatric medical model that they give you, because then you’re accepting the stigma that goes with it’ (The Melbourne Consumer Consultant’s Group, 1997: 4).

Consumer/survivors experience the psychiatric ward as the most stigmatising kind of environment. Cath says, ‘I think my experience of a psych hospital is somehow predicated on stigma itself’ (The Melbourne Consumer Consultant’s Group, 1997: 3-4). The introduction of The
National Mental Health Strategy has been reported by The Melbourne Consumer Consultants’ Group (1997) to be of some benefit in reducing stigma, though they also argue that it has only made stigma more covert. According to Jon the anti-stigma campaigns have not addressed the stigma inherent in professional services.

In spite of the latest $8 million government campaign for combating stigma, my own personal experience is that it is still rife everywhere - from the Federal Industrial Relationships Court all the way down to the staff in the psychiatric hospitals or in a hospital psych ward (The Melbourne Consumer Consultant’s Group, 1997: 1).

The biggest problem, consumer/survivors claim, is stigma from the medical profession. This claim was supported by the recent *Attitudes of Health Professionals Project* (Commonwealth Department of Health and Family Services, 1998) which demonstrated people experience more stigma and discrimination from professionals in mental health services than from anywhere else in society.

Jewell and Posner (1996: 7) identify the lack of understanding for the consumer/survivor perspective and the lack of recognition of the social context of ‘illness’ as the source of stigma. They say the negative judgement or stigma involved in the diagnosis of mental illness seems to justify treating someone as less than human. These serious negative
effects call for further investigation about the roots of stigma: what it is, its effects on a person experiencing mental illness, how it is to be managed and how it can be overcome. These questions will be discussed next.

Stigma is defined as a mark or brand of disgrace associated with a particular circumstance, quality or person (Pearsall, 1999: 1410). In Goffman's (1963) classic text *Stigma*, it is described as the disqualification of an individual from social acceptance. Furthermore he argues that stigma is a reference to a person’s negative moral status. He outlines how attributes that are different to the stereotype expected of an individual, mark, reduce, discount or stigmatise a person, rendering him/her less than human. This results in discriminatory treatment. Goffman (1963: 15) explains, stigma is: ‘an ideology to explain his inferiority and accounts for the danger he represents’.

Yet stigma is created in and varies with the social context. What is judged normal in one context may not be so in another depending on the social circumstances. For instance, depression is not considered depression in the context of bereavement. The International Pilot Study of Schizophrenia (World Health Organisation, 1973) showed that though
the incidence of schizophrenia was found to be similar across different cultures, developing countries had ‘significantly better clinical and social outcomes than patients in the developed world’ (Janca & Saxena, 2000: 2). The improved outcome for developing countries is considered to be due to a lack of stigma associated with mental health problems in these areas.

Warner (1996) demonstrates that those working in the third world found that mental disorder does not carry the same stigma as it does in Western societies. For instance, in Dakar, Senegal, those experiencing delusion and hallucination were not rejected or stigmatised as their experiences were considered culturally relevant, and this impacted on outcome: ninety percent of the psychosis did not last. Conversely, the stigma associated with psychosis in the west carries a significant emotional burden, which may account for the ongoing problems. In contrast, a supernatural explanation consistent with eastern views means that derogatory labels (crazy or insane) are not used. In some places psychosis may even improve status.

Another contrasting view of stigma in the east is in Sri Lanka, where tuberculosis is more stigmatising than mental illness. The high level of
tolerance for the symptoms of mental disorder means that people so affected have an opportunity to readjust (World Health Organisation, 1978) without the added burden of social degradation. Warner also found that people who did not experience stigma did not experience ongoing problems. The point is that stigma actually influences the outcome and the course of mental illness and has important implications for prognosis.

The experience of stigma according to Fulford [1994; 1996] is a product of the judgement involved in a psychiatric diagnosis. The process of diagnosis, according to Victoria’s Chief Psychiatrist (2000: 5), ‘involves a judgement about what is normal’, though ‘it is subject to changing social norms’. And though the Chief Psychiatrist (2000: 5) argues ‘their illness is not them’, Fulford recognises the role of diagnoses as value judgement at two levels. At one level, the evaluation of symptoms according to the description of symptoms in the Diagnostic and Statistical Manual in the terms of a mental disorder, is a negative judgement of symptoms. That is, to judge a condition as a mental disorder is to import a negative value.

At another level, the descriptive criteria, established according to
convention by an ‘evaluating community’, carries the connotations of a negative judgement. Even though it is argued that the utilisation of the medical model in mental health has been an attempt to remove negative notions of badness and/or evil, this has not removed the connotations of a negative judgement. Negative connotations of descriptive terms emerge in a social context. Thus, Fulford considers diagnoses as negative value judgements with implications for the person being diagnosed. This challenges the notion of the supposedly descriptive, scientific approach of psychiatry as an objective medicine. Critics such as Szasz (2000) go so far as to argue that the evaluative nature of diagnostic criteria disqualifies mental disorders from the status of illness.

The effect of stigma was discussed by the Melbourne Consumer Consultants’ Group (1997: 2) in the first chapter *Do you mind?... The Ultimate Exit Survey: Survivors of Psychiatric Services Speak Out*. Joshua identified the negativity associated with stigma as preoccupying: ‘It sort of pre-empts whatever you do, even if there’s actually nobody else there, it’s something that’s in your mind all the time’ (The Melbourne Consumer Consultant’s Group, 1997: 2). Marina said the negative value
judgement of the diagnosis was internalised in her identity:

You end up thinking of yourself as a less worthwhile person simply because you've got a psychiatric disability. It just colours the whole way you go about your life because you're constantly thinking of yourself as a lesser person, and not a worthy person (The Melbourne Consumer Consultant’s Group, 1997: 2).

Trying to avoid admitting one’s history of admission to a psychiatric ward did not reduce the sense of stigma, and to deny one’s history also caused stress. For instance, Cath found herself thinking ‘ooh did I let something inadvertently slip which is going to identify me’ (The Melbourne Consumer Consultant’s Group, 1997: 11).

The Melbourne Consumer Consultant’s Group (1997) then went on to discuss how stigma added a further burden to the issues that had precipitated admission. The stigma involved in admission determined the type of treatment received and how it was delivered. That is, consumer/ survivors found that admission to an acute public psychiatric service involved being stigmatised. The consumer/survivor movement literature has highlighted the role of stigma in exacerbating the effects of ‘mental illness’. This theme was present in the consumer/survivor’s accounts recorded throughout Burdekin’s report.

The horrendous consequences of my illness have been a result of public attitudes of ignorance, fear, discrimination and professional indifference (Human Rights and Equal Opportunity Commission,
The consequence of stigma is that people receiving services do not experience being understood but judged. One person reported: 'you wouldn’t believe how many professional people don’t understand the illness' (Human Rights and Equal Opportunity Commission, 1993: 440). The failure to understand people with mental health problems results in stigmatising and avoiding people, which further compounds problems. As Burdekin’s report identified:

Lack of understanding of what is happening to a mentally ill person can make up for difficult situations. Many people prefer to avoid relationships with others whose behaviour is not seen as normal. This is not good for the mentally ill person. People need social interaction to improve health (Human Rights and Equal Opportunity Commission, 1993: 444).

A consequence of the stigmatised conception of mental illness is that under the Mental Health Act 1986 (Victoria, 1998) professionals are not required to get patients’ consent to participate in treatment once admitted to an acute psychiatric service. This is regardless of the added trauma the patients themselves experience by this failure. This is not to dismiss the complexity of the problems these people face, but an attempt to embrace them. This is discussed further in chapters four and eight. The failure to consider the patient’s symptoms as meaningful
or to involve the patient in their own care adds to the powerlessness of the patient. A person in Barham’s study says, ‘You do feel terrible because there’s nothing you can do …they make decisions and say, ‘Well, he’s out of his mind’ (Barham & Haywood, 1991: 17).

**Stigma as identity**

The totally stigmatising experience of acute psychiatric hospitalisation has implications for the consumer/survivor’s self-concept.

Consumer/survivors are very aware of the social stigma that is associated with their diagnosis. This negative evaluation of people with mental illness is a central concern in the consumer/survivor discourse, literature and other fora. The stigma of diagnosis has implications for identity in terms of a person’s self-conception of their status as a person.

Merinda Epstein’s (Epstein & Shaw, 1997: 38-39) account of her experience as a patient highlights the centrality of the issue of identity, and the potential for damage to self-identity in the patient’s experience of mental health services. Merinda (Epstein & Shaw, 1997: 38-39) stated: ‘I would not survive if I succumbed to naming myself as a
psychiatric patient’. She also said that ‘I made a very important decision when I decided that I couldn’t really afford to define myself as pathetic or as a victim, or as any other of the things that were so tempting at the time’. Merinda (Epstein & Shaw, 1997: 38-39) said that after hospital was the worst time ‘I felt unclean as though the words ‘been sectioned’ [that is involuntarily committed] were written across my brow for everyone to read’.

Sandy Jeffs (2000: 8) states ‘mental illness systemically strips you of your identity’. ‘To have no identity’ she states ‘is to move in the shadow of others and cast none of one’s own’. Conversely, mental health or wellness is ‘a state of being in which I can make connections’ (Jeffs, 2000: 8). Burdekin’s report also identified diagnosis as a process whereby the person’s identity, rights and status as an equal human being were removed. He noted that:

> Many witnesses recounted the loss of their identity once a diagnosis had been made. They felt that society only saw their label and with this they ceased to have the same needs, emotions and rights to make decisions about their lives (Human Rights and Equal Opportunity Commission, 1993: 445).

Thus, the stigma of mental illness was found to result in an ongoing denial of a person’s identity as a person, beyond that of the occurrence
of the problem itself. As one patient recounted:

It is important to note that my illness is episodic, but the label is continuous. So, the minute your mental illness is perceived you vanish. All they see is that (Human Rights and Equal Opportunity Commission, 1993: 444).

Further stigma means that complaints about mistreatment in mental health services are not taken seriously.

One of the worst things that can be done is to have a psychiatric label put on you... because it discredits you for the rest of your life. And people use that to discredit what you want to say, when you want to complain about abuses in psychiatric hospitals and the abuses in hospitals today (Human Rights and Equal Opportunity Commission, 1993: 444).

This theme was also apparent in Rogers and Pilgrims research (Rogers & Pilgrim, 1991a; Rogers & Pilgrim, 1991b; Rogers et al., 1993) and Barham and Hayward's (1991) research. Barham and Haywood (1991) interviewed 24 people who had schizophrenia and lived alone in Northtown, England. They explored the social side of what it is to live with schizophrenia. One of those interviewed identified the stigma of a psychiatric label as a problem as it meant that you were considered as being ‘useless’. As one consumer/survivor said ‘it’s that feeling of being useless that bugs me more than anything, I think people brand me as useless’ (Barham & Haywood, 1991: 40).
This sensitivity to how one is regarded is also revealed in Perceval’s 
*Perceval’s Narrative: A Patient’s Account of His Psychosis, 1830-1932* (Bateson, 1974). Perceval, in his account of his experience of ‘lunacy’ states:

> That many lunatics are extremely sensitive to ridicule, this sensitiveness is indeed one of the phenomena of an unsound mind and I know that many lunatics are very much pained and embarrassed by exposure of their misfortune (Bateson, 1974: 278-279).

Consumer/survivors report that what this means is that disclosure of a history of mental illness results in being made to feel ‘less of a person’ (Barham & Haywood, 1991: 16). Barham and Haywood (1991) found consumer/survivors experience the diagnosis of schizophrenia as an identity trap. It was not that the diagnosis was problematic, but the burden of a cultural devaluation that accompanied it, as the regard for a person as an individual was lost.

What has been indicated in this chapter, is that being diagnosed as mentally ill disrupts people’s self-definition and wellbeing in two ways. Firstly the experience that had precipitated the person’s distress is not considered meaningful, legitimate, or worth listening to. Secondly, a psychiatric diagnosis jeopardises a person’s civic standing, civil liberties and civil rights. Even if civil liberties and rights have not formally been
removed, the person experiences a failure to be respected as a person. Those who utilise services consider the failure of mental health providers to be aware of the negative impact of the way patients are treated, to indicate a serious lack of self-reflective practices (Wadsworth & Epstein, 1996b). Professionals, on the other hand, do not consider mental health patients capable of self-reflection.

Refusal to accept a diagnosis and treatment for mental illness is one of the criteria for involuntary admission in the Mental Health Act 1986 (Victoria, 1998). This failure to recognise the need for treatment is considered by mental health professionals as a lack of insight and one of the diagnostic criteria for psychosis. Paradoxically, what Barham’s (1991) study and other research such as the Understanding and Involvement Project identified, was that what undermined a person’s sense of wellbeing was the erosion of their identity as the status of being ‘mentally ill’ was accepted. This is because the acceptance of a diagnosis of ‘mental illness’ requires renegotiating one’s status as a devalued person with the world.

This conflict over need interpretation between patients and providers is central to the emergence of the consumer/survivor movement in acute
mental health services. The medical profession in acute public mental health services demand that patients accept their diagnosis, which as stated above, undermines a person’s sense of worth and value as a person. The power and dominance ascribed to medicine and consequently mental health services, results in the overriding of the patients’ need to resist the degrading and damaging effects of being diagnosed. The failure to accommodate the patient’s perspective in the professional’s response to a patient’s problem is paradoxically, a failure to support the patient as a person and therefore their sense of wellbeing.

The patient’s experience of the medical professional’s disregard of their needs, through failure to consider their perspective is demonstrated in two examples from Barham’s (1991: 102) study. Sidney went to hospital and ‘asked to be admitted because I was aware I was ill, I knew things weren’t right with my family’ [102]. He wasn’t admitted but was told he was merely fantasising. The result was, ‘the next day I had more or less a total breakdown’ [102]. Another example is from Ben. Ben ended up in hospital again after a spell of four years. He was having trouble sleeping, which had got him into trouble before but felt that the situation could have been managed differently. The sleep problems
come from the worry and the work ...In other words, it’s not just in my chemistry, it’s to do with the life that I lead’ [128].

Even though Ben did not think it necessary to seek mental health treatment, as all he felt he needed was a good night’s sleep, he was denied being able to make a decision about his own well being. He found this created a lot more problems in getting on with people as they were ‘thinking that you’re mad because you’ve been in a mental hospital’ [130]. The depression he experienced facing these kinds of difficulties was then considered further evidence of his ‘illness’, rather than of internalising the effects of stigma, and he was put back on sick leave. This kind of vicious cycle is intractable.

For people experiencing ‘mental health problems’, the identity incurred through the stigma of diagnosis with a mental illness becomes a greater problem than the original problem. People with a history of mental illness reported experiencing stigma in every aspect of their lives. For people subject to acute public mental health services, being labelled as mentally ill was reported as involving being exposed to many abuses in mental health services. These problems were then re-interpreted as illness. For example Epstein (1997: 18) says she was described in her
case notes as ‘manipulative’ for saying what treatment she preferred.

This overview of consumer/survivor perspectives in research indicates that the stigma associated with admission and diagnosis in acute mental health services devalues the patient as a person. The imposed diagnosis undermines a person’s own narrative based identity and results in a diminished sense of value and worth. A personal sense of value and worth depends to some degree on social recognition. This is discussed further in chapter eight through reference to Honneth’s work. Denial of this recognition has implications for social membership, which means for consumer/survivors, social marginalisation and diminished access to resources. The marginalisation and diminished access to resources is induced by stigma requires management.

Managing Stigma

Managing the burden of social stigma is a skill in itself. People with a diagnosis of schizophrenia feel that their credibility is constantly in question. The dilemma over how to manage a contradiction in their sense of self is discussed by The Melbourne Consumer Consultant’s Group [1997]. They reported their credibility as being constantly on
probation, and that there was a need to constantly demonstrate normality while being denied their capabilities. Even those ex-patients who are well, experience others as wary of them, because once diagnosed, credibility as a person is jeopardised. This discussion of Goffman’s (1963) *Stigma* identified this as a fundamental self-contradiction. He states that the stigmatised person considers him/herself as ‘no different from any other human being, while at the same time he and those around him define him as someone set apart’ [132].

Goffman (1963) recognised the code to coping as a process of revealing the stigma to some and concealing it from others. Complete concealment is not acceptable; neither is accepting the negative attitudes of others. Goffman (1963) explained that the skill involved in what is expected of people with ‘mental illness’ is an example of a contradiction of the reputation associated with people considered to be sufferers. These codes are very important, as they provide ‘recipes for an appropriate attitude regarding the self’ (Goffman, 1963: 135).

To fail to adhere to the code is to be a self deluded, misguided person; to succeed is to be both real and worthy, two spiritual qualities that combine to produce what is called authenticity (Goffman, 1963: 135).
Negotiating the complexities of when to and when not to reveal such stigma is taxing.

Goffman (1963) indicated that those who are stigmatised become ‘situation conscious’. That is, become conscious of a whole array of contingencies of acceptance and disclosure. In other words, the stigmatised are aware of and conscious of the codes that those not stigmatised are unaware of. Interaction then is a very different experience for the consumer/ survivor and the professional. Both are alert to and conscious of very different social codes and cues. Goffman (1963) identified how the awareness of these social codes by the stigmatised may result in them becoming social critics of these scenes of human relationships. This has been formalised in recent times with the introduction of consumer consultants: ex-patients employed in acute public hospital wards on a part-time basis to provide a systemic evaluation of the service from the consumer/survivor perspective (Epstein & Olsen, 1999).

Goffman (1963) pointed out the stigmatised position of a person diagnosed with a mental illness constitutes the discrediting of an entire category of persons. It is the social positioning of the individual within a
stigmatised group that continues to deny this group a legitimate voice as their contribution is devalued, rejected and discredited. It is not that this group do not have a valid contribution to make, but that the perspective from which they speak is denied validity. These processes as described by Goffman and consumer/survivors themselves have been identified in the consumer/survivor movement literature. However, as Goffman (1963) and others such as Scull (1983:118-119) have discerned, the attempt to draw attention to the stigma involved, enigmatically confirms the problem, with the advocate considered an adversary to both the movement and the adversary.  

5Scull (1983: 119) likens the territory to that of a combat zone between husband and wife, where those intervening receiving ‘an assault from both forces simultaneously.’ He states ‘the best I can hope to look forward to is matching lumps on each side of my head’ (Scull, 1983: 119).
Humanity is denied those labelled ‘mentally ill’. Goffman (1963) noted that it is up to those most stigmatised to provide evidence of their humanness. This requires providing evidence of the possession of their subjective self to others, even while this is what is constantly being denied. This paradox is continually renegotiated. Yet, the stigmatised individual needs to accept him/herself as normal to be well adjusted, while acknowledging others may not consider him/her so. The onus is put on the stigmatised person to not present to others what would invoke their intolerance for the stigmatised. The ability to maintain this level of containment is the mark of adjustment. The irony as Goffman (1963: 148) identified it is that the demands made of the stigmatised person are not offered to back to them in return.

Thus, Goffman (1963) concluded that the stigmatised and the normal are not different persons but different perspectives, played by the same people at different times. This is highlighted by the changing capacity of an attribute to be stigmatising. That is, stigmatisation is historically located and socially changeable.

The painfulness then of sudden stigmatisation can come not from the individual’s confusion about his identity, but from his knowing too well what he has become (Goffman, 1963: 158).
To interrupt the process of stigmatisation, Goffman (1963) suggests separation from the stigmatising community. That is because a break in exposure to the normative expectations of social life facilitates disregarding the stigmatising norms of identity. Alternatively, he suggests training in maintaining impression management to strategically control the image presented. Instruction in the roles of the ‘normal-deviant drama’ highlights how individuals can participate in both roles at different times.

**Stigma as opposition**

Service providers and recipients conceptualise problems in fundamentally different ways, which explains the failure of service providers to meet needs as defined by those who use services. The consumers/survivor movement as a new social movement challenges the total domination of the medical profession in the determination of needs. This is ultimately a contest over the power to define needs, which has implications for the identity of the stakeholders. The opposition by the consumer/survivor movement to the total domination of need interpretation by medical professions is a struggle internal to
the system itself.

The consumer/survivor movement research literature makes clear that established acute public mental health services do not respond to patient’s accounts of problems as ‘not coping with living’. Paradoxically, professional ‘treatments’ are reported as precipitating further problems. What the consumer/survivor research has identified is that the conceptualisation of problems in terms of ‘mental illness’ carries a stigma that precipitates inhumane treatment by staff: ‘the heavies came and dragged me off’ (McGuiness & Wadsworth, 1992: 13-14). This was found to create further problems for person’s sense of self.

The stigma associated with mental health problems has created a culture of professionals avoiding interpersonal relationships with patients. For instance, patients said: ‘There was not enough contact with staff—they just didn’t talk to you’ (McGuiness & Wadsworth, 1992: 13); ‘There is no feedback from doctors and there is no human level of relationship’ (McGuiness & Wadsworth, 1992: 16). Central to the consumer/survivors’ accounts of professionals’ style of relationship was that respect for patients’ personhood was missing: ‘I was not treated like a sick person but as a criminal’ (McGuiness & Wadsworth, 1992: 16).
23). The way that people are treated in mental health services indicates that patients are not treated with respect as persons. As is evident from the consumer/survivor movement literature considered here, failure to acknowledge consumer/survivor views works against a person’s sense of wellbeing.

The problem that stigma has created for patients’ identity is a negative feedback system about their identity as a person. One consumer/survivor said: ‘It is very difficult when people don’t acknowledge you’ (McGuiness & Wadsworth, 1992: 39). Researchers in the Understanding and Involvement Project (Epstein & Wadsworth, 1994; Wadsworth & Epstein, 1996b; Wadsworth & Epstein, 1996c) and in the precursor study (McGuiness & Wadsworth, 1992) said that they were consistently told by consumer/survivors that they wished to be treated as individuals: ‘I wish to be talked to as a person’ (McGuiness & Wadsworth, 1992: 23); ‘The main problem seems to be that... you’re not treated as a person, you’re treated as part of a group or you’re treated as a disease’ (McGuiness & Wadsworth, 1992: 54). Patients also said they didn’t like being treated as a group in psychiatric hospitals and felt stripped of their identity, which was reported as taking a long
time to recover (McGuiness & Wadsworth, 1992: 54).

The question is: can this fundamental difference in conceptualisation of the problem and treatment be addressed? Even though the National Mental Health Strategy has initiated changes, clearly these changes have not gone far enough. The recent consumer/survivor movement literature indicates the consumer/survivor perspective is still not heard or responded to.

**Beyond Stigma: Voicing the Madness**

New social movement theory offers a framework for understanding the conflict in mental health services. Touraine (1974) states it is the absence of correspondence between the different stakeholders located in the historical field of action that generates the force for social transformation. A social movement is an attempt to intervene in the replication of a future that reflects a past of professional domination. Contestation is over the battle to create a new future: a new identity. This is only possible where many factors have intersected to recognise the constructed and political nature of identity.

Rogers and Pilgrim (1991a) question whether British mental health
users would be able to establish their own discourse in the light of the interdependence of user and provider identity. Lyotard (1994) suggests the failure of a profession to address the needs of those dependants on it, reduces that perspective to one of no superior knowledge of theory or praxis over other discourses. What may overcome these limitations Lyotard (1994) suggests, are the linguistic practices, discourses, communication and critiques of survivors. As Gray & Alcoff [1993] highlight, survivor discourses are in violent confrontation with dominant conceptions. This is especially the case in the field of mental health problems (Johnstone, 1996; Johnstone, 1998).

Though the consumer/survivor movement is making a claim for the recognition of the voice and identity of patients in acute public psychiatric services, this is not what is happening in acute psychiatric services. The experience of consumer/survivors in acute psychiatric services is that personal identity is unrecognised. This denial of a patient’s account or voice or story, is a denial of the legitimacy of the patient as a human being. This legitimacy is unmade through the medical practice of imposing a diagnostic-identity. This medicalisation also lends authority to coercive practices. This is a function of the
stigma associated with diagnosis.

Thus: the consumer/survivor movement is a response to the way consumer/survivors are treated in institutionalised mental health services. Patients expect to be treated with respect as persons and not as they report being treated, impersonally, and coercively as objects. Mental health patients, who have been denied respect, are making a claim for such. The conflict is over access for people to define their own experience and to access respectful help for problems that they themselves define.

The consumer/survivor movement demands that patients be allowed to participate in defining mental health services. By claiming a voice, recipients of psychiatric services are contesting their exclusion from access to social membership and thereby cultural resources. The conflict in mental health services is over the right for social participation. Hence, the central question that emerges in this analysis
of the claims consumer/survivor movement literature is to do with the status of the mental health patient as a subject. 6

What consumer/survivor’s argued they want is to be treated with respect as a person: ‘I want to be treated with respect as a human being, not like how the elephant man was treated’ (McGuiness & Wadsworth, 1992: 19)! And though professionals in acute psychiatric services claim this is the case, this is not what consumer/survivors experience. One consumer/survivor’s experience of mental health professionals was:

6 The term ‘subject’ is used in a political sense, to refer to a democratic actor, attempting to make meaning out of his/her own lived experience by transforming ‘events and experience into a life-project,’ in Touraine’s (1997: 12) terms. This is in line with new social movements’ attempts to improve their participation in their own lives. It is about letting people produce their own history, reconciling the universalism and particularism of their own identity (Touraine, 1997).
They say: ‘We treat people as individuals’ I’d like to know what kind of individuals they mean cause they don’t treat people here like human beings (McGuiness & Wadsworth, 1992: 39).

Patients in the consumer/survivor research said that it is in the time spent listening that enables recovery of sanity. But what is reported as happening is that ‘they ignore you and that’s very frightening’ (McGuiness & Wadsworth, 1992: 55).

What patients claimed they want is to be treated as whole persons, as self aware, thinking, feeling and needing subjects (Wadsworth & Epstein, 1996b). What might have prevented this from happening will be analysed in the next four chapters, before going on to explore what other attempts have been made to address this problem in chapter six. The last two chapters go on to explore alternatives possibilities.
In our era, the experience of madness remains silent in the composure of a knowledge which, knowing too much about madness, forgets it (Foucault, 1967: xiv).

The third condition that Touraine (1978: 85) identified as necessary to distinguish a social movement is that it must have an adversary. For the consumer/survivor movement in mental health, the adversary is psychiatry itself. The previous chapter established the central principal of the consumer/survivor movement’s conflict with the adversary to be the way patients receiving acute psychiatric services are treated. Touraine’s model of new social movements suggests that the conflict that gives rise to a new social movement is embedded in the concepts or ideology of the adversary. Therefore, this analysis of the consumer/survivor movement as a new social movement calls for an investigation into the theory, and concepts of the adversary.

Chapter two explores the way in which the subject is conceptualised in psychiatric theory. This involves an analysis of the theory, concepts and
methods that psychiatry utilises to conceptualise psychiatric problems, which has the consequence of objectifying the patient. It is argued here that what is at stake for psychiatry is the recognition of a legitimate object for medicalisation. The second part of this analysis, in chapter three, considers the implications of these concepts for the treatment of patients in the institutional setting of acute public mental health services.

Identity through Opposition: The Patient as an Object

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (American Psychiatric Association, 1994) claims that psychiatry utilises a phenomenological approach. The psychiatric profession claims that psychiatry utilises a multifactorial approach (Wilson, 1998). Conversely, accounts of those that utilise acute public psychiatric services indicate otherwise. Consumer/survivors claim, as alluded to in chapter one and which will be explored further in the next two chapters, that mental health professionals are dependent on the conceptual framework of diagnosis to ‘understand’ recipients of acute psychiatric services. A
consequence of this methodological reliance on diagnosis in acute public mental health services is that patient’s themselves are objectified as pathological.

In other words, the reliance on the scientific approach of diagnostic categorisation to ‘explain’ acute psychiatric patient’s symptoms, without also employing a methodology of understanding, results in a ‘methodological confusion’ as Plastow (1997) calls it, which means psychiatry mistakes the subject for an object. That is, the dependence on an objective legitimate scientific approach in psychiatry results in the patient being pathologised ‘as’ a mental disorder. As will be demonstrated in the next two chapters, the total reliance in acute psychiatric services on the ‘scientific methodology’ of diagnostic categorisation results in the person being objectified. The consumer/survivor movement opposes the totality of this methodology in acute public psychiatric services, because there is no acknowledgement of the patient as a person.

The diagnostic process relies on the psychiatrist’s judgement to assess a subject’s mental status. The psychiatrist’s failure to relate to the psychiatric patient’s experience results in reliance on scientific
explanatory terms to account for mental health problems, which means that the patient as a person has not been acknowledged, considered or addressed. This lack of understanding results in failure to engage with the psychiatric patient as a person. This pathologising has been referred to as a defence mechanism to justify avoidance of the psychiatric patient (Main, 1977).

As Kahr (1994: 76) says ‘when we ourselves cannot think symbolically about the bizarre, we tend to distance ourselves from it through diagnosis and pathologisation’. This scientific conceptualisation of the patient as ‘other’ or ‘different’, labelled and diagnosed as a mental disorder protects the professional from subjective involvement with the patient. In the process, dehumanising practices are justified and the identification of the needs of the patient as a subject is evaded.

The failure to recognise the patient as a subject occurs twice. First as the person’s problems and concerns as they themselves see them are not recognised or engaged with, and secondly through the medicalisation and classification of problems in terms of mental disorder. In the process, the person classified as disordered is erased and overwritten as a ‘mental disorder’ and as such, is eliminated as a
legitimate human being. The importance of the link between being a legitimate human being and the denial of this status through diagnosis with a serious mental disorder is the focus of the consumer/survivor movement.

This is because this is the site where the person is lost. It seems that according to the medical approach, the person IS the diagnosis in the eyes of the clinician, mental health services, the public, and themselves. However:

Segregating a person into who she is versus the disease that afflicts her makes some sense when the affliction is not a disease of an organ central to being the human one is. Calling mental illness a brain disease does not fit that description. Calling mental illness a brain disease—and a chronic, constitutional brain disease that—actually confirms every patient’s worst fear: This problem bears witness to something fundamentally wrong with the person I am (Fancher, 1995: 285).

Creating the Object: Understanding and Explanation

To identify the process whereby the objectification of the subject in acute psychiatric services occurs, psychiatric theory and concepts will be explored for their implicit conceptualisation of the subject. To do
this, a range of recently published and readily available texts will be explored *Oxford Textbook of Psychiatry* (Gelder, Gath & Mayou, 1996); *Textbook of Psychiatry* (Beumont & Hampshire, 1990); *Student Psychiatry Today: A Comprehensive Textbook* (Cohen & Hart, 1995); *Psychiatry* (Tasman, Kay & Lieberman, 1997); and a locally Melbourne edited collection, *Foundations of Clinical Psychiatry* (Bloch & Singh, 1994); and others. The influence of psychiatrist and philosopher Karl Jaspers’ (1963) important text, *General Psychopathology* will also be considered.

Psychiatry acknowledges two ways of knowing or conceptualising patients’ problems: ‘understanding’ and ‘explanation’. These terms originated with Windelband and Dilthey. Karl Jaspers’ (1963) first introduced the terms to psychiatry in his 1913 edition of *General Psychopathology*. ‘Understanding’ (*Verstehen*) refers to subjective appreciation. ‘Explanation’ (*Erklaerung*) refers to objective causal connections. Notably, he describes these different conceptions as polar opposite sources of knowledge. The Oxford Textbook of Psychiatry (Gelder et al., 1996), typical of other texts, identifies the oppositional nature of these two terms as the paradox at the heart of psychiatry.
distinct capacities. One is the capacity to collect clinical data objectively and accurately by history taking and examination of mental state and to organise the data in a systemic and balanced way. The other is the capacity for intuitive understanding of each patient as an individual (Gelder et al., 1996: 1).

Theoretically, these two forms of reasoning work together.

Understanding in current texts is described as the intuitive response that psychiatrists as human beings bring with them into psychiatry:

> Based on our ability to empathise with the experiences of another, we are able to put ourselves in their shoes and to imagine how it must be to feel as they do (Szmukler, 1994: 11).

This perspective considers the ‘other’ person as a subject based on the meaningful connections the person has made between his/her experiences and the events experienced. This approach considers the mental (or phenomenal) world of others: ‘their thoughts, motives, intentions, feelings and their status as an experiencing self or agent’ (Szmukler, 1994: 11).

Explanation is defined as the objective study of mental phenomena as scientific forms, in terms of causal and predictive relationships using knowledge of biochemistry of the brain. The person is not seen ‘as a subject but as an object or organism’ (Szmukler, 1994: 13), where recurring ‘forms’ of mental experiences, regularities or patterns are
Jaspers identified the subjectivity of the practitioner as central to diagnosis. He characterised the diagnostic process as involving the meeting of one psyche with another. Further, he claimed that the success of such a meeting depended on the willingness of the psychiatrist to be involved in the psychic life of his patient. The power of the psychiatrist depends upon empathetic listening and his/her ability to 'see and experience', and more specifically on the 'receptivity and complexity of such power' (Jaspers, 1963: 21). Jaspers (1963: 22) also stated that such experiencing needed to be codified, whilst, acknowledging that 'dispassionate observation misses the essence of things'. This is an argument for both detachment and empathy.

The intersubjective and interpersonal nature of psychological problems, diagnosis and treatment is highlighted in Jasper’s text. He recognised the impact of the practitioner’s own state of mind on his/her perception and the importance of the awareness of this perception. To achieve this awareness he suggested psychiatrists ask themselves about their own process of reasoning by asking: ‘what construction am I putting on them’, and ‘how do they affect my own conscious reality?’ (Jaspers,
1963: 22). He avowed that: ‘In order to appreciate facts properly we must always work on ourselves as well as on our material’ (Jaspers, 1963: 22). Such wise advice is needful in contemporary practice.

Although understanding, or empathy, is considered by Jaspers to be essential in dealing with patients, it is considered inadequate to ‘explain’ mental disorders. To ‘explain’ clinical phenomena, psychiatry, refers to an array of factors that are claimed to play a role in the aetiology of psychiatric problems. Aetiological perspectives are important because the way a problem is conceptualised determines how it is treated. Psychological texts (Nevid, Rathus & Greene, 1994) rehearse these aetiological perspectives. These include the biological, behavioural, cognitive, family and socio-cultural perspectives. Psychodynamic and various psychotherapeutic schools of thought extend the list from existentialist to self-psychology to object relationships theory to neo-Freudian and to eclectic.

Moreover, psychiatry as a discipline claims to utilise a multifactorial causal model which acknowledges biological factors, psychological factors, and social factors in a ‘biopsychosocial model’ (Wilson, 1998) developed by George Engel and Adolf Meyer. Even so, what will be the
focus of attention here is the condition whose presentation is most frequent and troublesome in acute psychiatric service: that is psychosis.

The Failure of Understanding Psychosis

In contrast to most other mental disorders, psychotic disorders are considered to be not understandable. Nevertheless, psychosis, which includes schizophrenia and other major affective disorders together, constitute the leading cause of acute psychiatric admissions in State managed acute psychiatric inpatient programs (Victorian Psychiatric Services Division: Health and Community Services, 1995: 15). The other groups besides schizophrenia which come under the category of psychosis are major affective disorders, which include depressive (unipolar) and manic (bipolar) mood disturbance. Other psychotic disorders include delusional and acute transient psychoses, as well as tentative categories that do not satisfy the research criteria for inclusion as a diagnosis so appear as diagnostic categories in the Diagnostic and Statistical Manual of Mental Disorders’ (American Psychiatric Association, 1994) appendix. The inpatient group also includes people
on community treatment orders.

Jaspers considers psychotic phenomena as ‘not understandable’ in a meaningful way at all in either ‘normal’ or ‘abnormal’ people. For this reason, he argues:

> We can only resort to ‘causal explanation’ as with phenomena in the natural sciences which, as distinct from psychological phenomena, ‘are never seen ‘from within’ but ‘from the outside’ only (Jaspers, 1963: 28).

Jaspers determined the experience of psychosis to be due to ‘genetic and constitutional’ factors. This instituted the current biological axiom in psychiatry to explain psychosis. Thus, his focus on the role of biology has informed the current conceptualisations of psychiatry.

Jaspers argued that there was no greater difference in the psychic life of human beings than that between the normal person and the psychotic. This difference he referred to as an ‘abyss of difference’. Laing’s alternative conceptualisation will be considered in chapter six. Though Jaspers differentiated the psychotic from what became known as the functional disorders, it is apparent from the recent literature that these differences are in name only.

A consequence of the failure to understand psychosis, there is an
endorsement of the reliance on explanatory models. McGorry (1994: 222) recognises that this approach, particularly with people experiencing acute psychosis, means the loss of the capacity for empathy by professionals and that ‘the objective approach will dominate over the subjective’. That is to say, from the psychiatrist’s point of view, acutely psychotic psychiatric patients are not considered understandable (Jaspers, 1963) but rather as ‘mad’ or ‘irrational’. In the words of a psychiatric registrar:

My experience so far... (is that) it is extremely difficult when someone is floridly psychotic initially and has extremely poor insight; it is actually hard to have to-and-fro communication (Wadsworth & Epstein, 1996c: 161).

McGorry (1994) defines psychosis as a group of disorders that assumes a misinterpretation of reality. The symptoms include hallucinations, delusions, thought disorder, disorganised speech, and altered affect. These symptoms are then interpreted to mean that the person is incompetent, and therefore his/her status as a person is under question. McGorry (1994: 221) highlights the paradox that though no cerebral dysfunction is diagnosable in psychoses, ‘most psychiatrists believe that these syndromes are associated with disturbed brain function’.
The current reliance on a biological ‘disturbed brain function’ model to explain psychosis is marked by a deficiency in understanding. The central nervous system vulnerability model that psychiatry claims to utilise is an attempt to integrate stress and personality. The greater the vulnerability the less the stress required to precipitate the disorder. Psychiatry acknowledges a number of sources of vulnerability for psychosis such as genetic, neurodevelopmental, birth injury, viral, neurochemical, gender, drugs, stress, and sociocultural factors (Beumont & Hampshire, 1990; Bloch & Singh, 1994; Cohen & Hart, 1995; Cooper, 1986; Dakis & Singh, 1994; Gelder et al., 1996; Lidz et al., 1995; McGorry, 1994; Sims, 1995; Snaith, 1991).

However, as alluded to in the introduction, there are a number of philosophical problems with this approach, which are not directly addressed in contemporary psychiatry. The problems with the current reliance on the scientific explanatory approaches implied in psychopathology will be explored further.

**Limitations of Methodology**

Even though understanding is acknowledged as essential in the
introductory chapters of psychiatric texts, the theoretical discussions about understanding, explanation, formulations and aetiology fill only the first chapter or two of the theory books. The rest of the chapters are devoted to diagnosis, and the diagnostic categorisation of ‘psychopathology’. The distinction between theory and practice is used to explain the reliance on the methods of natural sciences. But the distinction between ‘explanation’ and ‘understanding’ is not only a theoretical distinction but also a distinction of method.

When the psychiatrist exercises the first capacity, he draws on his clinical skills and knowledge of clinical phenomena: when he exercises the second capacity, he draws on his general understanding of human nature to gain insights into the feelings and behaviour of each individual patient, and into ways in which life experiences have affected that person’s development (Gelder et al., 1996: 1).

Psychiatry’s practical reliance on explanatory methods has resulted in a focus on diagnostic categories in psychiatric texts, at the expense of models of understanding. The failure to conceptualise and theorise understanding is justified by a claim that understanding is a skill learnt from practice rather than textbooks.

From a textbook, however, it is inevitable that the reader can learn more about clinical skills than about intuitive understanding... This emphasis on clinical skills in no way implies that intuitive understanding is regarded as unimportant but simply that it cannot be learnt from reading a textbook (Gelder et al., 1996: 1).
The separation of intuitive understanding and clinical skills demonstrates the failure to grasp the centrality of ‘methodology’ as the means to understanding, as Jasper has outlined in his philosophy of psychiatry. He suggests that methodology is central to and determines what knowledge can be gained. He identifies research methodology to be central to the production of the object of study. The object is not a reality in itself but only a perspective.

The object is therefore never reality as a whole but always something in particular, an aspect or a perspective, never the happening in its totality (Jaspers, 1963: 23).

Jaspers’ critique highlights the limitations of an interpretation implicit in a methodology, central to identifying objects. In recognition of the importance of methodology in the identification of an object, the task at hand is to examine the methodologies utilised in current acute psychiatric practice and consider their conceptual limitations.

**Psychopathology as Totality**

Mental disorders are considered to be due to pathology. The *Concise Oxford Dictionary* (Pearsall, 1999: 1045) defines pathology as a branch of medicine concerned with the cause, effect and nature of disease.
According to *Taber’s Cyclopedic Medical Dictionary* (Thomas, 1979), pathology refers to the study of a condition produced by a disease. Disease is defined as a pathological condition with abnormal and peculiar symptoms. Illness also has connotations of disease and presumes pathology.

An influential psychiatrist, Lewis (1963), defined the psychopathology of mental illness as evidence of the disturbance of ‘part functions’ as well as general efficiency. Gelder (1996: 77) attempted a more specific use of the terms. ‘Part functions’ he defined as a reference to ‘perception, memory, learning, emotion and other psychological functions’. Disease he referred to as ‘objective physical pathology’ and illness as ‘subjective awareness of distress or limitation of function’ (Gelder, 1996: 77). Gelder goes on to question the use of pedantic terms in mental health because by his definition they are not due to pathology but illness.

This distinction has little bearing on psychiatric disorders since most of them have not demonstrable physical pathology. Most psychiatric disorders are best regarded as illnesses (Gelder et al., 1996: 76).

In spite of the reliance on the notion of pathology in texts of mental illness, there is limited evidence upon which to base the conception of mental health problems as biological. Goldstein (1997) asserts, after a
thorough review of the current literature on biological research, that:

The aetiology of most, if not all, of the mental disorders will be at the systemic level, and will require new conceptual models as neural networks for further theoretical development. It seems now that the definitive biological factors may be at the level of dendritic coding or architecture, cell membrane metabolism, or complex genetic variations that are not of the single gene type. Indeed, intensive genetic investigation indicates that there is no gene for schizophrenia (Goldstein, 1997: 320).

In other words, the common yet problematic claim in psychiatry is that mental disorders are biologically derived at the level of the biological functioning, which includes biochemistry. However, there is only limited evidence to substantiate this claim. The interpretation of postmortem studies does not provide support because changes could have occurred after death, or have been due to drug treatment. For instance, the increased number of dopamine receptors found in those with schizophrenia could be due to drugs, which block dopamine receptors, or receptors may be a compensatory mechanism acting in response to another neurotransmitter. The dopamine hypothesis has been questioned with the introduction of new generation drugs, as they work very differently. The use of magnetic resonance imaging for biochemical studies is also a limited form of evidence, as evidence from these studies may show a process but not necessarily a cause.
The utilisation of a medical metaphor has been promoted in an attempt to destigmatised, though for the patient, the implication of a polluted gene pool has had the opposite effect. The implications of biological reductionism are depressing.

To say that a person is constitutionally, genetically, chronically impaired biologically is to say that the person is chronically, genetically impaired as a person. How is that supposed to help increase tolerance of the mentally ill? (Fancher, 1995: 284).

The medical training of psychiatrists maintains the medical understanding or axiom of psychiatry. The problem with this perspective is that it is presented as fact, as already substantiated by research, to patients, practitioners and the public. As Fancher (1995) has stated:

So long as the devotees of biological psychiatry acknowledge the difference between their hypotheses and the results of their work, we can only wish them well (or ill, as may be our wont). What is objectionable is the attempt to persuade patients, the public, and clinicians (especially psychiatrists) outside the research community that the scientific work has already shown the [psychiatry's] culture's agenda to be correct, capable of fulfilment, and significantly fulfilled (Fancher, 1995: 255-256).

Fancher (1995) also points out the logic of biological psychiatry is contradictory as monism is argued for on the one hand and dualism on the other. Material reduction is argued for in that it is argued that biology alone accounts for aetiology, but this also invokes a dualism
as the affect of other factors such as the social, developmental on biology are discounted. 7

7 Current research and philosophy recognise that many factors affect biology: that is, biology is seen as an effect, rather than the cause of a broader problem (Mishara & Schwartz, 1997). But clearly: 'This philosophical line necessarily implies the need for a change in the attitude of the psychiatrist himself' (Naudin et al., 1997: 393).
Furthermore, Pilgrim and Rogers (1993) list five reasons for reliance upon medical treatments for psychiatric problems.

Firstly, the treatment of madness has long involved doctors with biological treatments. Alternatively, if this is not the case, mental illness is a social problem, and providers of talking treatments would not be required to be physicians. Secondly, the shift to rejoin psychiatry with mainstream medicine in the general hospital by the process of deinstitutionalisation has tended to compensate for psychiatrists’ previously low status, and made physical treatments for psychiatric disorders more credible, by being consistent with other types of medical procedures. Thirdly, drug treatments are legitimised and encouraged by the profit motive. In 1992 in Britain, twenty four percent of all scripts were psychotropic drugs. Fourthly, cost control treatments. Drugs are cheaper than labour intensive psychotherapy. Medical visits are viewed as
Diagnostic system

A central aspect of psychiatric objectification is the diagnostic system. The diagnostic system itself relies on a medical conceptualisation of psychiatric disorders. The system utilises an explanatory model, where symptoms are conceptualised as forms and studied as mental phenomena, the premise being that the cause is biological. The DSM IV (American Psychiatric Association, 1994) is an attempt to contain the complexity and standardise diagnostic practice. The DSM IV presents symptoms, grouped together into a syndrome and thus used as criteria to diagnose mental disorder. The DSM IV claims to be ‘atheoretical’,

commodities on a production line (Hart, 1992). Efficiency is gauged by the number of patients processed per unit of time, however destructive that is to the relationship between the doctor and the patient (Eisenberg, 1995; Graham, 1994). Fifthly, physical treatments such as drug treatment and electroconvulsive therapy, even straitjackets and confinement, can be imposed without cooperation or consent, while psychotherapy cannot.
‘objective’ and ‘neutral’ and to utilise a phenomenological approach.

Thus it defines a mental disorder as:

A clinically significant behaviour or psychological syndrome or pattern that occurs in a person and that is associated with present distress (painful symptom) or disability (impairment of one or more important areas of functioning) or with a significantly increased risk of suffering or death, pain, disability, or an important loss of freedom (APA, 1994: xxi).

The DSM IV’s claim to being atheoretical is naïve because any classificatory system requires a conceptual framework. The first two editions of DSM were based on psychoanalytical concepts of neurosis and psychosis, which are still informally used today. The division refers to a qualitative difference in symptoms. A defining feature of psychosis is lack of insight, the failure of the person to recognise that they are ill and need treatment. The marked difference between psychosis and neurosis according to Gelder (1996: 61) is ‘the patient’s ability to distinguish between subjective experience and reality, as evidenced by hallucinations and delusions’.

Gelder acknowledges that the use of psychosis as a term is difficult to apply, because of the difficulty of the definition, and because it refers to a broad group of disorders. Psychosis and neurosis are currently used in order to determine what drugs will be used to control them. This is
especially the case when a provisional diagnosis is made, such as when 
the choice is between schizophrenia and mania, or ‘psychotic disorders 
not otherwise specified’. Psychosis and neurosis have been abandoned 
in the DSM III, III-R and IV in preference for the defining of specific 
disorders (Gelder et al., 1996).

The analytic approach fell into disfavor in the United States, in the face 
of the difficulty of diagnosing mental disorders consistently as 
evidenced by the International Pilot Study on Schizophrenia (World 
Health Organisation, 1973). Since then, Jasperian notions of a 
phenomenological approach in relation to mental disorder have been 
utilised, where understanding people’s subjective experience is claimed 
to be considered as central. The claims of the DSM III, III-R and IV to 
attempt to utilise a phenomenological approach explain the inclusion of 
the terms behavioural and psychological in the DSM IV’s definition of 
mental illness.

Diagnosis

Each mental disorder in the DSM IV is a group of symptoms arbitrarily 
grouped together and called a mental disorder. Diagnoses are basically
hypotheses based on groups of symptoms called syndromes. There is nothing that defines these symptoms as a group. The diagnostic categories are not discrete groups. There is nothing external that verifies, identifies or defines them. They are only hypotheses that guide research. This means that the validity of the disorder is questionable, and yet it is not treated as such.

Whole industries of research effort are devoted to classifying and reclassifying categories of psychiatric disorders and revisions of systems are published. The disorders appear in neat lines on the printed page and this procedure provides a general sense of professional security, a structuring of uncertainty and chaos. This comfort lasts only until it is realised that all these categories may coexist, that in fact they are not separate from each other—a phenomenon for which the jargon, ‘comorbidity’ has been introduced (Snaith, 1991: 129).

Yet, diagnosis is what psychiatrists are trained to do. And it is the diagnosis that determines treatment and outcome. Therefore, a person’s symptoms are reinterpreted as evidence to support a diagnosis. This reading of symptoms invalidates a person’s personal account. The availability of categories of diagnostic systems does not provide understanding for the person, but does explain the way that providers of acute mental health services listen to their patients. What are listened for are symptoms that will fit specific diagnostic criteria. These criteria are essentially arbitrary, but have extreme consequences for the
person receiving the diagnosis, because professionals inadvertently conflate the person with the diagnosis.

Even if a psychiatrist in the public mental health service does not personally adhere to the biological model, the mental health service system requires that the patient be diagnosed for treatment in the mental health system, which means the outcome is the same for the patient: objectification. This will be examined further in chapter three.

Healy (1990) claims that psychopathology has been abandoned in preference for psychiatry as a practice based on DSM IV criteria. This claim is made in the face of the acknowledgement amongst psychiatrists that ‘diagnosis alludes to aetiological factors’ (Dakis & Singh, 1994: 9). The DSM IV’s claim that the categories are ‘descriptive’, and that symptoms fall into ‘natural’ categories is an attempt to bypass the problems of aetiology altogether. Yet the DSM is considered necessary to generate theoretical concepts for causes of mental disorders, which can then be described, researched, evaluated, communicated, and used to predict outcomes (American Psychiatric Association, 1994: xv-xvi). The strict criteria and simple format of the DSM were intended to redeem psychiatry by making diagnosis a science, which has largely been
However, it seems that the manufactured construction of the diagnostic system is not apparent to many of those who use it. While psychiatrists may well acknowledge these problems and limitations, the mental health service system itself does not accommodate the limitations of the approach by providing resources to overcome the limitations of the present diagnostic system. This would mean providing services that utilise different conceptual tools and models. Currently, through the total reliance on the approach of psychiatry in acute public mental health services, the message to the patient and the public is that the current approach is adequate in its totality. The limitations and compensations for these limitations are not acknowledged, much less addressed.

Even so, the categorical organisation of symptoms is perpetually under dispute. An example is the dispute about the different categories of psychosis, such as psychotic depression and schizophrenia, which are often difficult to differentiate. The two are often also mixed in a person’s family history. This fundamental uncertainty is problematic considering the assumed legitimacy of diagnostic categories, and how central these
classification systems are to mental health services and the impact that such labels have on patients’ identities.

Moreover, psychiatric philosopher Jennifer Radden (1996) argues aetiological assumptions work to limit approaches to research.

Questions about aetiology implicate philosophical and theoretical assumptions reinforcing diagnostic classification involved. In an important review of the findings... distinct syndromes may prevent a discovery of the causal correlations involved (Radden, 1996: 366).

Radden (1994) goes on to argue elsewhere along with other philosophers of psychiatry (Caws, 1994 and Fulford, 1994) that the current DSM IV is far from satisfactory. The assumptions it relies on are obscure and undefined. For instance, what exactly constitutes a mental disorder is difficult if not impossible to define. The problem is that the area of interest of psychiatry, that of the mental or the mind, cannot be seen or observed directly. What ‘the mind’ is or how it functions is not known. What constitutes the mind is presumed to happen in the brain.

**Clinical Phenomenology and Mental Illness**

Despite the DSM IV’s claim to a phenomenological approach, the phenomenology of the DSM IV is not what Jaspers referred to. As the above outline indicates, the subjective phenomenology of Jaspers
has been reconfigured as ‘objective’ evidence. This is evident in the criticism of the DSM IV today ‘modern classifications give too little attention to the deep meaning of subjective experiences as well as to the patient’s life history’ (Naudin et al., 1997: 391). Sims (1995) Symptoms in the Mind: An introduction to Descriptive Psychopathology highlights that even though the Diagnostic and Statistical Manual of Mental Disorders (DSM) claims to be based on phenomenology, it is a reversal of Jaspers definition of phenomenology.

Jaspers differentiated subjective phenomenology from objective phenomena. Objective data can be observed and tested. For evidence called objective in mental health, this is not the case. Subjective phenomenology, such as that which is experienced by the patient can only be reported on by the patient and therefore observed indirectly. The subjective experience of hallucinations and delusions are misconstructed in the DSM IV as objective criteria. Subjective phenomenology are unobservable, untestable, and inexplicable, and relies on the subjective judgement of someone else to validate the experience. Significantly, Jaspers also maintains that revelation of such subjective experiences requires empathy.
Moreover, clinical phenomenology in psychiatry has been assumed to be representative of underlying neurobiology, but this claim is unsubstantiated. In three independent empirical studies of neuropsychology and diagnosis, no relationship has been found. That is, neuropsychological tests do not necessarily support diagnostic categorical claims (Goldstein, 1997). Cohen argues that psychiatrists recognise that:

Clear diagnostic entities exist only in textbooks and that in clinical practice, few patients fit neatly into one category or another. Consequently, this leads to unreliability in psychiatric diagnosis, and to unrealistic assumptions being made about disease categories. Furthermore, making a diagnosis of depressive disorder or schizophrenia conveys nothing about the uniqueness of the individual, nor how interpersonal problems, personality factors, childhood experiences and life events may have contributed to his current state (Cohen & Hart, 1995: 11).

Jaspers’ (1963: 55) phenomenology is ‘the study which describes patient’s subjective experiences and everything else that exists or comes to be’. And despite the claim that phenomena is always individual, and cannot be directly observed, Jaspers sets out to:

Give a concrete description of the psychic states which patients actually experience and present them for observation. It [phenomenology] reviews the inter-relationships of these and delineates them as sharply as possible, differentiates them and creates a suitable terminology (Jaspers, 1963: 55).

The goal of phenomenology is according to Jaspers (1963: 56) to find
out ‘what is really happening in our patients, what they are actually going through, how it strikes them, and how they feel’. The basis of this phenomenology is self-description which relies on the ‘psychological judgement of the patient himself’ (Jaspers, 1963: 56).

This would seem to be an ideal approach. Yet, this next statement by Jaspers pinpoints the site of the fundamental weakness in the current approach of psychiatry.

> We are not concerned at this stage with connections nor with the patients’ experience as a whole and certainly not with any subsidiary speculations, fundamental theory or basic postulates. We confine description solely to the things that are present to the patients’ consciousness (Jaspers, 1963: 56).

In this statement, Jaspers has differentiated the social context of peoples’ experience from psychiatry’s role in the diagnosis of the problem. This distinction has resulted in a failure in psychiatry to recognise the role of context in precipitating peoples’ problems. This also accounts for the dominant role of diagnosis in psychiatry. The decontextualisation of symptoms in psychiatry is a false one, as Laing in chapter six demonstrates, and explains the lack of understanding in psychiatry.

The distinction between experience as a whole and subjective
experience in particular also explains the failure to discuss the
ambiguities of the symptoms of delusions and hallucinations in the
major texts (Sass, 1994). These ‘symptoms’ are instead treated as
disconnected categories that are definable in a context independent
manner (Parnas & Bovet, 1995). The implicit questions regarding the
theory of mind are not accommodated in the ‘scientific’ approach and
are therefore not discussed. Today’s psychiatry is based on a common
clinical usage of the term ‘phenomenology’ to refer to ‘objective’ signs
and symptoms, as in phenomenological psychopathology. Current texts
do not discuss the historical roots of the terms such as ‘phenomenology’
or ‘descriptive psychopathology’ or the categories of the mental state
examination. There is no discussion of how, where or when they
originated or if they are appropriate or useful.

Mulder (1993: 559) argues psychiatrists need to be aware of the
historical, cultural, legal, religious, medical and educational
knowledge’s and disciplines to make sense of psychiatry, otherwise
there is a ‘danger’ that trainees will learn a simplistic application of
diagnostic criteria and management techniques, and ‘how to mesh them
together’. Mulder (1993: 559) complains: ‘there is an even greater
danger that they will believe them [diagnostic category] absolutely’.
Naudin (1997: 391) suggests: diagnostic classifications give insufficient attention to the subjective meaning of symptoms and life histories.

If the philosophical discussions of psychiatry are anything to go by, it seems that phenomenology is making a comeback (Mishara & Schwartz, 1997; Naudin et al., 1997). There is an acknowledgement that philosophically at least, a phenomenological approach is potentially productive (Sims, 1995). Current philosophy indicates the move to recognise the role of multifactorial factors affecting biology, such that biology is seen as an effect, rather than the cause of a broader problem (Mishara & Schwartz, 1997). However, ‘this philosophical line necessarily implies the need for a change in the attitude of the psychiatrist himself’ (Naudin et al., 1997: 393). Furthermore, whether ‘behaviour’ is interpreted as a symptom is dependent on social mores.

The criteria that define symptoms as disorders has changed over time, depending on the theoretical model in vogue by those responsible for decision making.

For example, homosexuality was and now is no longer a ‘mental disorder’. Attention deficit disorder was not and now is a ‘mental disorder’. The ever increasing list of ‘mental disorders’ constitutes a
growing list of behaviours as symptoms that are subject to diagnosis or labelling as ‘mental disorder’. The logic is cyclic; diagnosis depends on labelling of symptoms considered a ‘mental disorder’. The symptoms that occur outside one syndrome are either disregarded, or are considered to indicate comorbidity. For example, hallucinations and delusions, two defining features of schizophrenia also occur in depression, post traumatic stress disorder, and other disorders. What is considered diagnostic criteria is not necessarily valid, but arbitrary. Jaspers’ analysis is critical of the tendency in psychiatry to confuse knowledge and belief as what is observed is informed by value judgements. For instance, the desire to understand leads to the search for a rational explanation while the reliance on causal explanation means that the human experience itself is ignored. This approach, Jaspers suggests, fails to acknowledge that we cannot see psychic life. Psychic life is an experience. In discussing it we need to rely on layers of imagery, metaphor and simile. It seems that what has happened in contemporary psychiatric practice and research is that these similes have been taken for granted as fact. The breaking down of the psyche into mechanistic, biological, biochemical, electrical, genetic and
hormonal factors, have come to be seen as a certainty, rather than possible influences on psychic life.

Psychiatric categories work, according to Jaspers, to prejudicially influence how we think about psychiatric problems. He goes on to say that prejudice relating to quantitative assessment, objectivity and diagnostics derives from the natural sciences where: ‘qualitative changes are regarded as arbitrary, subjective and not scientific’. Even though Jaspers’ first edition of this General Psychopathology was in 1913, and the last revision in 1963, these comments are true of today’s practice.

Jaspers also warned of confusing individual cases with probabilities, an injunction, which is formally transgressed in the diagnostic process. This process involves a professional consensus about what symptoms should be grouped into what category. These are then formulated into diagnostic criteria of mental disorders which are presumed to be representative of the individual’s experience. The criteria are assumed to represent the disorder, yet without a ‘gold standard test’ (Office of the Chief Psychiatrist, Mental Health Branch, Department of Human Services, Victoria, 2000). Categorising is a way of representing what is
not understood. The statistical evidence about how these symptoms may coincide in people does not predict what treatment is appropriate for individual persons.

The phenomenology of the DSM IV practiced within acute psychiatry today makes the experience of the psychiatrist, rather than that of the patient, central. Diagnosis is based on the doctor’s subjective experience, which is the only instrument a psychiatrist has to diagnose problems. The reliance upon the professional’s subjective ‘intuitive’ sense to diagnose the patient as psychotic is counter-productive, because it is devoid of a method of understanding. The patient’s reported symptoms are interpreted bereft of empathy, within the frame of the scientific methodology required for diagnostic categorisation. The absence of a methodology of understanding decontextualises and pathologises the experience of the patient.

This conceptual framework betrays the ‘great personal significance’ (Watkins, 1998) patients place upon their experience. This betrayal works against the establishment of rapport so essential for a therapeutic relationship. A therapeutic relationship is not what psychiatry offers for the public patient in acute mental health services,
where public mental health services funding, practice and teaching limit
treatment to the mainstream medical practice of psychiatrists:
diagnosis and drugs. It seems that for acutely distressed people
experiencing psychosis, expecting to be understood is out of the
question as there is not a model of understanding in place for practice.
The perception of the patient as suffering an objective problem of
mental disorder means that the meaning or subjective content is not
considered relevant. It seems that psychiatric training and concepts,
‘cultures out’ understanding in favour of the more ‘sophisticated’
explanatory approach to psychiatry. Perceiving the person’s feeling,
state and behaviour as objects to be studied means that the subjective
experiences of the person concerned is considered irrelevant to acute
psychiatric hospital practice. Such is the violence of the label ‘mental
illness’: once diagnosed, the person as a person ceases to exist. The
person becomes the diagnosis. What has been demonstrated here is
that the current conceptual model is inadequate to understand, much
less accommodate, patients’ needs, and makes clear the methodology
whereby the experience of the patient is considered not relevant.
Conflicts over ‘The Subject’

Nonetheless, professionals consider the conceptual framework utilised in psychiatry legitimate. The use of diagnostic classification in regard to the person subject to diagnosis is defended on a number of grounds. Classification is justified as a scientific activity, worthy of merit. And while there are those who find comfort in having a label for their disorder and experience, the practice of diagnosis itself is reductive, as the diagnosis becomes the explanation and short circuits the attempt to understand the person and their specific needs and experiences.

The professional diagnosis of ‘psychosis’ also justifies or rationalises the evasion of the psychiatric patient by the professional, by providing a rational explanation for what is otherwise considered ‘not understandable’. Main (1977) points out, diagnosis is an intellectualisation, a defence against the psychiatrist’s own subjective involvement with the ‘mad’. The problem is the failure to acknowledge the limitations of psychiatric concepts, and the inadequacies of the approach for conceptualising what patients are experiencing. The limitations of psychiatric concepts reduce its generality and applicability; however, society continues to look to medicine for
totalising frameworks which result in further negative implications. This is not to say that psychiatry and psychiatric diagnosis and treatment do not have a place, but a call to recognise and address the limitations of this conceptual framework.

The present classificatory system also limits research as the implicit philosophical and theoretical assumptions restrict further research to those areas which substantiate (or as is in the case—fail to substantiate) the current theoretical and conceptual approach. This reliance on current conceptual models, Jennifer Radden (1996: 366) argues, ‘may prevent a discovery of the causal correlations involved’.

The failure to explore the disjuncture between theory and practice has negative implications for patients. There is a failure to acknowledge what psychiatrists themselves know to be ‘true’: that first and foremost there is a person to engage with and respond to and not a diagnosis. But this is not the experience of patients on acute psychiatric wards of public hospitals. It is inappropriate and unrealistic to expect psychiatrists to learn that the patient is most important if there is no model of understanding conceptualised, taught or practiced in acute psychiatric wards of public hospitals, the training ground of
psychiatrists.

The failure to identify the context, the connections and meanings the patients themselves have identified, is to miss a great deal, as philosophers before and since Jaspers have identified. Jaspers (1963: 58) himself identified ‘immediate experience is always within a total relational context’ which he suggests, needs to be dissected to describe phenomena. Nonetheless, this ‘relational context is founded on the way we experience space and time in the mode of body-awareness and the awareness of reality’ (Jaspers, 1963: 58).

Jaspers noted:

Human beings are creatures of culture, they develop beliefs and moral standards and constantly transcend their own empirical human self which is the only self that scientific research can recognise and grasp (Jaspers, 1963: 8).

Jaspers appreciated the defining characteristics of a person to be a product of biology and environment. He says that the self arises when confronted with *frontier-situations*:

the final frontiers of existence—death, chance, suffering, guilt. These may awake in him something we have called Existence itself—a reality of selfhood (Jaspers, 1963: 12).

The consumer/survivor literature indicates that admission to an acute
psychiatric service would be considered such a critical moment. And, in the context of Jaspers’ philosophy, this provides an important opportunity for the consumer/survivor to deal with their sense of self. Though this is not what happens in the services supposedly designed for such problems, the concepts required to do so will be discussed in chapter six through the work of Charles Taylor and Paul Ricoeur. Nonetheless, Jaspers acknowledges the role of the mind and the spirit involved in psychic illnesses. He argues humanness alone to be vulnerable because of the freedom and possibilities associated with the subjective experience of consciousness and self-reflection. Such that ‘man is not merely pattern, he patterns himself’ (Jaspers, 1963: 8).

There is a conflict of interest in psychiatry. An acutely distressed person wants to be heard, and listened to, so that his/her utterances may not be taken as a form or a symptom to be diagnosed, but as an account of a person. Laing argues that the problem for a person with schizophrenia is that they have never felt loved, and so experience desperation and aloneness.

The schizophrenic is desperate, is simply without hope. I have never known a schizophrenic who could say he was loved...We have to recognise all the time his... separateness and loneliness and despair [Laing, 1965: 38].
One of Laing’s patients said:

> It feels so much better to be able to share the problem with someone, to have him understand how badly you feel. If you’re not alone, you don’t feel hopeless any more. Somehow it gives you life and a willingness to fight again (Laing, 1965a: 165).

There is acknowledgement within psychiatry of the therapeutic benefit of being listened to. As Mohl (1997) states:

> There is nothing more healing than the experience of being found by another… Psychiatric patients, deep inside, have lost or never had that experience. However obnoxious, destructive or desperate the overt behaviour, it is the psychiatrist’s job to seek and find the patient. That is the purpose of listening (Mohl & McLaughlin, 1997: 11-12).

Laing (1965a: 32) argues that it is the psychiatrist’s responsibility to see the world from the patient’s point of view, as ‘expressive of his mode of being-in-the-world, which requires us to relate his actions to his way of experiencing the situation’.

However for patients to be apprehended as persons, a re-conceptualisation of the patient as a subject is required as one who is
not merely ill, an ‘object’ or as mentally disordered. Consumer/survivors themselves are providing a space for patients’ concerns to be listened to and accepted as legitimate, which opens up new possibilities. Consumer/survivors themselves are mobilising for change by taking up their perspective in a political movement in an attempt to have their voices heard and understood.

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Yet, for those requiring access to resources such as income, support services, housing etc., much depends on fitting into a suitable diagnostic category. This puts the person in a double bind: if the diagnosis is not accepted the resources are not made available, if it is accepted the resulting stigma is debilitating (Even so, access to resources are not guaranteed as the people living with psychosis study indicates (Jablensky et al., 1999a; 1999b).
CHAPTER 3

INSTITUTIONAL PRACTICES OF MENTAL HEALTH SERVICES

A powerful identity will strive to constitute a range of differences as intrinsically evil, irrational, abnormal, mad, sick, primitive, monstrous, dangerous, or anarchical—as other. It does so in order to secure itself as intrinsically good, coherent, complete or rational and in order to protect itself from the other that would unravel its self-certainty and capacity for collective mobilisation if it established its legitimacy. This constellation of constructed others now becomes both essential to the truth of powerful identity and a threat to it. The threat is not posed merely by actions the other might take to injure or defeat the true identity but by the very visibility of its mode of being as other (Connolly, 1991 in Smith, 1998).

The previous chapter identified the reliance in psychiatry on ‘mental illness’ to explain symptoms. As we saw, this approach brought into question the competence of the patient as a person. As shall be discussed in the next chapter, chapter four, mental health law authorises mental health service providers to admit someone involuntarily on the grounds of ‘mental illness’. This includes authority to use ‘such force as may reasonably be necessary’ to: restrain, administer, sedate, transport, detain and isolate a person. The purpose of this chapter is to consider the practical implications of this legally
authorised treatment of a patient as mentally ill and therefore ‘incompetent’. Though the consumer/survivor movement is a reaction against the coercive nature of these ‘services’, psychiatry maintains its conceptual integrity, in the manner quoted above, by the way patients are treated.

1. Understanding as diagnosis

The importance of psychiatry’s theoretical and conceptual practices (outlined in the previous chapter) are delineated by Laclau (1979), who argues like Jaspers, that theory produces objects for knowledge. Though constructed and limited, theoretical concepts and their consequent methods have real effects. A theoretical approach introduces a paradigm or a way of seeing reality. A paradigm, in turn constructs a perception of reality, which is incommensurate with other paradigms. This is because a paradigm is a particular way of seeing: a perspective through which the world is viewed and through which it becomes a reality.

The test of the value of the theoretical, Laclau suggests, is the empirical. But the self-referential nature of knowledge means that the methods are
necessarily self-verifying. That is, a point of view external to a paradigm, such as the consumer/survivor perspective of acute psychiatric services, are excluded. To identify theoretical problems, Laclau suggests like Touraine, the need to identify where the theory falls down in practice. That is, the internal contradictions of a theoretical approach are demonstrated in its practical limitations. For example, though Smukler (1994) argues that the clinician appreciates the person as a subject, not an object, this does not concord with the experience of patients.

What patients find, according to consumer/survivor research, as was discussed in chapters one and two, is that the reliance upon diagnostic categories to ‘explain’ behaviour has negative implications for patients in acute public mental health services. The practical implications of reliance on the medical paradigm in psychiatry to respond to people in acute distress will be discussed further.

The problem is that the explanatory rationale utilised in psychiatry as identified in the previous chapter draws not just from established knowledge, but from a particular style of reasoning. That is to say, what is considered true or false emerges from a style of reasoning about
things, not from the things themselves. Ways of reasoning, similar to paradigms, present different ways of investigating the world. An established rationality is not open to external evaluation ‘because the very sense of what can be established by that style depends on the style itself’ according to Hindess (1988: 79).

Hindess (1988) goes on to state, that an analysis of behaviour or practice requires identification of the style of rationality, rather than a judgement made from within the style itself. That is to say, the limitations of the usefulness of a style of reasoning utilised by a professional body, needs to be recognised and compensated for in practice. For instance, Hindess (1988) points out that the limited cognitive capacities of human beings means that the processing of gathering information is structured to simplify decision making by the use of techniques. Techniques are developed to limit searching for information from situations that yield results. Hindess’ (1988) concept of the ‘boundedness of rationality’ applies to the limitations of the cognitive functions of professionals. Professionals do the best they can according to agreed on ‘standards of satisfactory performance’.

As explored in the previous chapter, in the field of mental health,
psychiatrists are trained to identify and categorise behaviour as symptoms of mental disorders as set out in DSM IV (American Psychiatric Association, 1994). These categories simplify and define the practitioner’s task as one of perceiving only information relevant to the diagnostic task. The diagnostic task thus becomes one of gathering information relevant to diagnose a disorder, whilst excluding other information that may aid in understanding. The usefulness of the theory and techniques practiced by medical professionals in mental health services in diagnosing mental illness will be considered henceforth in the light of the consumer/survivors who have experienced them.

**Mental State Examination**

Psychiatric disorders are considered to be primarily disorders of the mental state (Spitzer, 1994). The mental state examination is intended to elicit objective evidence of an underlying disorder, and is assumed to be equivalent to the physical examination in medicine. It is described in psychiatric texts in terms of an objective, empirical observation. But as Keks (1994: 68, 69) points out, the mental state examination is based on symptoms, not signs. That is, the description of the mental state
is based upon the patient’s account of their feelings, experiences, fears, and worries: that is, the patient’s subjective experience. These reported ‘symptoms’ are not ‘objective’ signs but internal, personal experiences. Yet, psychiatrists are required to use explanatory rationality to ‘objectively’ describe the patient’s experience (Dakis & Singh, 1994), which is a practical conundrum.

Additionally, this objective, scientific assessment presumes a biological causation, which informs the perspective on how symptoms are interpreted.

The style and the content of a psychiatric interview are necessarily shaped by the interviewer’s theory of psychopathology. Thus a biological theory of illness leads to an emphasis on signs, symptoms, and course of illness (Silberman & Corta, 1997: 19).

So although psychiatrists also look for disturbance in behaviour, which is also assumed to be related to biology, what is diagnosed is a disturbance in the patient’s mental state: in mood, perception, thought, cognition, experience of the self and world, through indirect observation. This requires the psychiatrist to assess another person’s mental state accurately (Kaplan, Sadock & Grebb, 1994). However, this requirement, carried out in the mental state examination, exposes the limits of the empiricist scientific perspective to know another’s mind.
This type of assessment keeps concealed the question of how another’s mind can be known. The reliance on an empirical scientific categorical methodology presumes direct and concrete knowledge, while the complexity of the philosophical question of mental state is rarely engaged with in psychiatric theory or practice. The lack of engagement with these problems is a failure to acknowledge the limitations of science, resulting in ‘a tension between the need to define specific phenomena and the desire to do justice to the complexities of actual experience’ (Mullen, 1984: 15).

Clayton (1998) while a psychiatric registrar, grappled with the limits of a scientific approach to deal with the experience of the patient and clinician. The presumption of the scientific model in psychiatry, Clayton points out, is that the technical and procedural difficulties of the clinician can be overcome with experience. This means, she argues, that procedures themselves are not seen as intrinsically problematic for the clinician, but that the problems that arise from them are indicative of the limitations in the technician or patient. This leaves the methodology unquestioned and the problematics of the theory of the mental state
examination invisible (Halasz, 1994). This is consistent with the empiricist theoretical view of the observation of phenomena.

Even though there is some recognition of the role of understanding or intuition of the psychiatrist in the mental state examination, the subsequent diagnosis is considered ‘scientific’ and ‘objective’.

Subsequently, the professional’s account of the symptoms, though not the patient’s, are considered to be reliable and ‘true’. The frame or philosophy that is utilised to interpret symptoms or behaviour as objective evidence is not discussed. Diagnoses then are based upon subjective symptoms as reported by the patient and on patient’s behaviour as observed and interpreted from the clinician’s point of view.

Yet the problem of reliance on the subjective experience reported by the patient, and the subjective nature of the assessment and diagnosis and treatment made by the professional (often with the added burden of pressure from the patient’s family to do so), is not addressed. The central role of the subjectivity of the patient and the examiner in the diagnosis as highlighted by Jaspers in the previous chapter are not adequately discussed in current theory and practice. Keks (1994: 67) claims that what is required to overcome the practical limitations is that
practitioners become aware of their emotional biases, liabilities and blind spots, so that their own subjective and hence observational biases may be minimised.  

9 The Understanding and Involvement study (Epstein & Wadsworth, 1994; Wadsworth & Epstein, 1996b; Wadsworth & Epstein, 1996c) found that there needed to be ongoing research or evaluation to provide an opportunity for some form of self reflection, as otherwise professional staff maintained a distance from patients. The project recognised that such change required incremental changes over time. But even so, this would require a fundamental shift in the way patients are conceptualised, which is what consumer/survivor activists are arguing for: ‘fundamental changes in the way service providers see and are able to be with consumers’ (Epstein & Shaw, 1997: 87).

Consumer/survivor activists (Wadsworth & Epstein, 1996b) argue that this can come through a ‘comprehensive and systemic system of change’, and a process of ‘new forms of reflective practice’. Inquiries into the consumer/survivor perspective have been facilitated through the introduction of Staff-Consumer Consultants carrying the perspective of the consumer/survivor into the hospital culture (Epstein & Shaw,
1997). Rather than to blame or excuse, the Understanding and Involvement project suggests change through respect and not control, addressing the fears that result in dehumanising practices. It also involves strengthening positive practices through dialogue and communication. This means ‘doing something about ensuring that fear and control responses are contained and do not get out of hand’ (Wadsworth & Epstein, 1996b: 165).

The Understanding and Involvement Project is concerned with how to change current practices so that the services are more respectful. They found that central to a change in Mental Health Services was to address: ‘How could staff get the chance to surface their own repressed undiscussables’ (Wadsworth & Epstein, 1996b: 167)? The Understanding and Involvement Project argued that without emotional support, staff could not ‘carry out their work with maximum compassion and humanity’ (Wadsworth & Epstein, 1996b: 167). They asked, how could:

Staff work to identify and support consumers' energies and happiness if their own loss of energies and unhappiness were unacknowledged and unsupported (Wadsworth & Epstein, 1996b: 167)?
Wadsworth and Epstein (1996b) found that without there being a willingness for practitioners to acknowledge and deal with their own emotions, there was no preparedness or resources to be able to be with anyone else’s. Wadsworth and Epstein (1996b: 168) thought that the expectations of staff as ‘all competent, all coping, all rational, tough and all-knowing’ was unrealistic as was the expectation that consumer/survivors were ‘all-incompetent, all-failing, all-irrational, weak and ignorant’. The Understanding and Involvement Project found for staff to be able to respect and listen to patients, and not reject or repress their expression, then staff also needed to support and resource each other, and to maintain a nurturing environment. Wadsworth and Epstein called this the missing site in mental health services. Only if the organisation supports the staff, can they in turn support the patients. Only then, they say, can the system work toward healing and recovery (Wadsworth & Epstein, 1996b).

The *Understanding Anytime* (McGuiness & Wadsworth, 1992) project found a need for staff to get beyond their current practices and think about why they objected to patients’ comments. It queried what stopped them from engaging with patients, which required ongoing discussion and an opportunity for self-reflection. The opportunity for self-reflection was considered vital for change as: ‘All new practice involves a pause
The reliance on the subjective view of the medical professional as the tool of diagnosis is based on a rationale that assumes credibility. The legitimacy of this endowment is established through the legal authority of the *Mental Health Act 1986* (Victoria, 1998). Even so, the implications of this legally sanctioned mental health practice are extreme. What this rationality means for mental health service providers in practice according to Kahr (1994: 76), is that the ‘bizarre behaviour’ of the and conceptual shifting and distancing from old practice’ (Epstein & Shaw, 1997: 15). The Understanding and Involvement Project found that for this ‘reflecting on practices and making changes’ to occur, there needed to be the presence of some form of research or evaluation to provide the opportunity, as otherwise staff maintained a distance from patients. This meant that they were not aware of the patient perspective, so that inappropriate and insensitive approaches were also used when surveys were done. The current role of consumer consultants fulfils this function of having someone who has been there and knows what it is like and has come through it and survived. This offers a positive role model and hope for the patient that there are prospects for the future.
‘mentally ill’, elicits ‘powerful effects of revulsion’. That is to say that psychiatrists respond to a patients ‘bizarre behaviour’ with the authority invested in them through the Mental Health Act 1986 (Victoria, 1998) in the words of a Melbourne consumer/survivor activist Jon Kroshel (1997) ‘to order the patient to be jumped, stripped, injected and secluded’.

The threat and/or use of violence are not limited to involuntary patients, but accompanies even voluntary public mental health patients experiences of ‘treatment’. One of the entrenched problems of mental health services in public hospitals is that this impoverished style of practice is the site of training for psychiatric registrars. This effectively means that the least trained staff are responsible for the most distressed patients. The training is ‘on the job’, so the failure to develop skills for understanding is missing from the trainee’s clinical experience which is primarily in the acute care settings of public hospitals.

The impact of these legally protected coercive ‘psychiatric’ services is that people subjected to them feel traumatised and dehumanised: ‘You’re not a person any more, no matter what you were before’ (Epstein & Wadsworth, 1994: 62). Patients do not experience being treated with
respect, though this is what is desired:

I would have liked to be treated as a person. You are treated as if you are an idiot, as if you can’t understand English. I am at least as intelligent as the staff. I was not treated as a person with a problem; I was treated as if I was the problem... I was degraded when they stripped me. Someone came in and said ‘take everything off’ (McGuiness & Wadsworth, 1992: 14).

So even though a mental state examination, like a physical examination, is meant to be independent of the case history and prior to making a diagnosis, ‘in practice an immediate intuitive diagnosis; often made in the first few minutes (a good clinical nose) plays an inordinate role’ (Scharfetter, 1980: 25).

Finlay-Jones (1990: 5) says an adequate examination would take 100 hours, but as indicated, diagnosis is usually made within the first one to two minutes of an interview (Cooper, 1986; Finlay-Jones, 1990; Tasman et al., 1997). What concerns the psychiatrist for the rest of the 10-20 minutes is finding evidence to confirm the diagnosis. Expected symptoms are more diligently sort in the interviewing technique so as to confirm diagnosis. It seems that cognitively, the psychiatrist:

First of all makes a decision that the person is good or bad in general; he then makes more specific trait ratings so as to fit in with the overall goodness or badness to a much greater extent than is justified by the detailed evidence available about the specific traits (Cooper, 1986: 240).
The diagnosis is later written up in the case report. Dakis and Singh (1994) in ‘Making Sense of the Psychiatric Patient’ discuss the case report as a ‘comprehensive account of the patient’s illness’ which is:

A valuable reference point for the clinician and acts as a vital communication tool in clinical settings and between the numerous professional groups (Dakis & Singh, 1994: 79).

In A Psychiatric Catechism, McGuffin and Greer (1987) discuss how psychiatrists customarily write up each ‘case’. The case history includes the history of the presenting symptoms, their effects and treatment and any other past, family or personal history along with the mental state examination, written up in a formulation.

The formulation involves guessing at the aetiology by considering the role of the predisposing, precipitating and perpetuating factors. A formulation is ‘a conceptualisation of the ‘case’ which involves, ‘postulating connections’ between ‘aetiological determinants’ and will often be ‘hypothetical’ (Dakis & Singh, 1994: 93). The formulation also includes a list of the evidence upon which the diagnostic inference is based. Cohen (1995) argues that the diagnostic formulation is an attempt to incorporate all factors in ‘a unique profile’. The major ‘findings reported in the psychiatric case history are on mental state’
Dakis and Singh (1994) argue the case report appreciates the life-story of the person as a major part of a psychiatric history. However, the psychiatric admission, interview and case report does not involve listening to a patient’s problems. Rather, it involves finding evidence to fulfil the criteria required to establish a diagnosis so that treatment can commence. Psychiatry’s reliance on diagnosis is because diagnosis is central to treatment and it is what psychiatrists are trained to do: ‘In company with all medically trained physicians, psychiatrists abhor the absence of a diagnosis’ (Snaith, 1991: 129).

The Mental Health System depends on diagnosis to determine treatment and prognosis.

Psychiatrists are encouraged to believe that once the diagnosis is made, the correct treatment will follow. Unfortunately treatment is prescribed by diagnostic category rather than by the needs of the patient (Snaith, 1991: 140).

Diagnoses are dependent on clinical descriptions. What symptoms are looked for is dependent on diagnostic categories. A mental illness, which is considered to have an established course and treatment, is derived from a body of general empirical knowledge, which is not unique to the individual.
Patients’ on the other hand, resent their feelings being responded to as symptoms: ‘Emotions are seen as mental illnesses’ (The Melbourne Consumer Consultant’s Group, 1997: 2). Ex-patients report the experience of feelings being pathologised as invalidating and humiliating.

It’s all right if you’re not mentally ill and you’re angry and express anger. But if you’ve had a psych disability or whatever, if you become angry and express it, then that’s seen in a totally different context (The Melbourne Consumer Consultant’s Group, 1997: 2).

Once diagnosed, patients report: ‘The diagnosis becomes the master status which (then) determines everything else’ (Epstein & Wadsworth, 1994: 56). Despite the arbitrariness of the categories, they are used as if they are substantiated. The diagnosis is primarily the meaning the psychiatrist makes of the patient’s behaviour.

Cooper (1986), argues the diagnostic approach necessitates a confirmation bias. Cooper’s analysis of diagnostic decision-making found that psychiatrists were unaware of what factors were important in this decision making process. Even though a search for disconfirming evidence would be more scientific, this evidence is not noticed. The reverse occurs. Diagnostic categories shape what symptoms are
looked for to confirm diagnosis. Cooper argues that clinical experience interferes with the ability to make nonprejudicial ratings. The length of the clinician’s experience in this process is important. The clinician’s judgement about the patient is subject to the same errors any judgements are. Consequently, the reality perceived is the product of a process whereby what is observed is selected according to a limited frame of reference. This involves:

a process of omitting some features, supplying others, highlighting one or a few and subordinating the rest in the interests of making sense of the environment (Newcomb, 1950, in Cooper, 1986: 203).

This demonstrates that those things not considered relevant are not perceived.

Another ‘logical error’ is that those considered ‘mentally ill’ are rated similarly on traits without the necessary evidence to support the view held in the mind of the observer. Cooper points out that:

The perceptual processors and personalities of those making the judgements can have a considerable influence upon supposedly rational ratings of normal individuals (Cooper, 1986: 204).

Kleinman (1988: 78-91) also found in observations of clinicians at work, that data collected was constrained by both the patients’ and clinicians’
personal experiences. Though there will always be bias in judgement, being aware of it can minimise it. Cooper argues that:

some knowledge of one’s own decision processes and prejudices should form part of clinical training and continued education, for without it there is presumably an inevitable tendency to develop idiosyncratic and inexplicable clinical habits (Cooper, 1986: 205).

Even though ‘the expectations of the observer influence the conclusions he arrives at from a given set of information’ (Cooper, 1986: 239), these factors that influence the judgement are not recognised or discussed in psychiatric training.

Diagnostic reliability is also a problematic feature of a Psychiatrist’s decision making. Though diagnostic accuracy is meant to depend on the consistency of what the patient says and how the patient behaves, diagnostic reliability based on an unstructured interview is low. Cohen (1995) makes the case that diagnostic accuracy relies on the way the questions are put to the person, the interpretation of the answers by the interviewer, the symptoms that the patient reports and how important the interviewer considers the answers given. The consistent differences in psychiatrists’ diagnostic ratings are well established (Round, Bray, Polak & Graham, 1995; Sheldon, 1994). Cooper discusses this as a result of psychiatrists’ tendency to judge according to stereotypical
categorical thinking, which disregards disconfirming evidence. Even so, diagnostic inter-rater reliability does not establish the reliability of the categories themselves.

The virtues of the operational criteria for comparative research must not be allowed to elevate them beyond their arbitrary and completely practical nature (Cooper, 1986: 208).

The admission interview is the only occasion when the doctor spends one-on-one time with the patient. Once diagnosed, patients are supposedly reviewed regularly and evaluated by the resident on the ward. What happens in practice though is that the reassessment is made by the resident passing through the ward on his rounds in consultation with the nursing staff who report ‘disturbed behaviour’. The resident is required by the demands of the system to respond with adjustments to treatments, including increased prescription of drugs, the options being psychotropic, neuroleptic, antidepressant and anti manic medication. Other options include seclusion, electroconvulsive therapy and/or restraint.

From the point of view of the patient, this is not considered adequate: ‘They reckon they review us, yeah! But they don’t involve us or listen to
us’ (The Melbourne Consumer Consultant’s Group, 1997: 10); ‘They make arbitrary decisions around here, they never consult us, we’re just the bastards that come here for help’ (Consumer Consultation Report, 1993: 16). Patients feel that their distress is not taken seriously:

I was having a terrible time and needed to talk to someone, the doctor was busy and my case manager could not see me, and when I finally got to see somebody it was only for 5 minutes, My God I needed to see somebody for a F------ hour (The Melbourne Consumer Consultant’s Group, 1997: 7).

Ex-patients consider these practices as excluding, inappropriate and inadequate. Patients say they do not feel respected, validated, listened to:

[Psychiatrists] want to lock you up to shut you up, but see, locking you up only makes it worse because you’ve got more to—you want to communicate past that room at the people—someone there that should be listening to you (Epstein & Wadsworth, 1994: 57).

Consumer/survivors consider this type of ‘treatment’ to be in the interests of ‘the system’ or institution: ‘They always listen to their reality, never my reality’ (The Melbourne Consumer Consultant’s Group, 1997: 11).

Professionals defend diagnostic practices, on the grounds that it is necessary for the purposes of drug treatment. However, recipients of
drug treatments claim that drugs do not address the underlying problem:

The medications only mask it and when I come off them I am still left with exactly the same problems. While I'm on the medication they aren't a problem to me, so I don't bother addressing them. All of these core things that I've carried for a long time—they need to be worked through (The Melbourne Consumer Consultant's Group, 1997: 126).

The reliance on drug treatment has also been contested by consumer/survivor advocate organisations.

*Sane Australia* has highlighted that *The National Survey of People Living with Psychotic Illness: An Australian Study 1997-98* (Jablensky et al., 1999b) identified difficulties with daily living experienced by people with mental illness were the side effects of prescribed drugs. Reports of distorted thinking, perceptions and cognition are attributed to the disorder by professionals without recognition of the impairments induced by the drugs themselves. Eighty-six percent of those surveyed were taking prescribed medication and eighty-four percent said that the side effects impaired their daily activities. These people also had high rates of smoking, alcohol and drug abuse, physical abuse and violence, suicide, self-harm, criminality and homelessness. Highlighting a consumer/survivor's claim:
Clinicians also rely on their subjective clinical judgement to monitor and evaluate the outcome of their treatments. However, this judgement is subject to cognitive bias called ‘The Clinician’s Illusion’ (Cohen & Cohen, 1984). This is where constant exposure to people experiencing chronic and difficult problems means that the psychiatrist has an impression that the outcome for this type of patient is always poor, while if the entire cohort is followed, a good prognosis is evident. In other words, exposure only to those whose problems are unrelenting in acute psychiatric services, means the impression is held that such problems are persistent. This means that treatment is affected by a distorted representation of outcomes.

These tendencies have coincided with a number of other reports and findings (Andrews et al., 1994) that have resulted in an initiative generated by the National Mental Health Strategy to measure ‘consumer outcomes’. Consumer outcome measures are an attempt to overcome the limitations of clinicians’ bias, and to measure the effectiveness of treatments (Andrews et al., 1994). But as Tanenbaum (1994) has
explained, this is a different type of assessment and therefore does not address the limitations in the practitioner's knowledge base or style of reasoning and assessment.

2. Diagnosis as Surveillance: from Subject to Mental Patient

The medical profession discards patients’ complaints, as outlined in the last chapter and in the first section of this chapter, as symptoms of ‘mental illness’. In contrast, Foucault offers another explanation for the way psychotic behaviour is examined by mental health professionals. Foucault (1991a: 185) asks questions, not as medicine does, of the history of the presentation of mental illness, but of the process of the examination. Foucault’s analysis will be utilised to reframe symptoms, conceptualised in diagnostic practices as evidence of pathology.

The process of examination is important, according to Foucault (1991a) as outlined in the ‘The Means of Correct Training’ in Discipline and Punish, as such practices constitute subjectivity. He defines disciplinary measures as the specific techniques that create individuals’ as objects.
The tools of discipline he identifies as observation, judgement and examination. Observation is considered a subtle coercive mechanism of subjection and exploitation. The structural organisation of psychiatric units recently mainstreamed into general hospitals, are characterised by the ability to maintain visibility of patients, which facilitates control, training and recording. Thus, present day patients are disciplined and altered through the mechanisms Foucault described.

This organisation of surveillance Foucault (Foucault, 1991a: 170-194) suggests, derives effects for supervisors and the supervised alike. The effects are automatic, discreet, permanent, everywhere, silent and unseen (Foucault, 1991a: 187). Constant visibility, he suggests, produces fixed and docile individuals. Domination is achieved through observation, surveillance and judgement, which links individual patients together in a disciplinary space. The structure of the hospital can be seen as unimportant if these objectifying effects are not appreciated. It is the constant surveillance of behaviour that is the key to disciplinary technology. Disciplinary technology Foucault (1991a: 170-192) argues, produces individuals as objectified, analysed, fixed. Foucault (1991a: 189-192) also identifies the individual as a case, made
concrete in writing or records. The documentary apparatus is an important component of the growth of the power of health services. The accumulation of documentation establishes characteristics and distributions of a population. The chief disciplinary technique is the examination. The examination is the technique by which, individuals are subject to power:

Its rituals, its methods, its characters and their roles, its play of questions and answers, its systems of marking and classification. For in this slender technique are to be found a whole domain of knowledge, a whole type of power (Foucault, 1991a: 185).

In this space of domination, surveillance and judgement patients are reduced to objects through a ‘ceremony of objectification’ (Foucault, 1991a: 187). This ritual involves the use of power and knowledge to subject ‘those who are perceived as objects and the objectification of those who are subjected’ (Foucault, 1991a: 185). The claim to truth, though constructed, is rationalised and ritualised through examination and diagnosis, with real effects (Foucault, 1991a: 192).

Foucault (1991a: 192) identified the clinical examination and the imposing of the diagnosis as the moment of crossing over of knowledge and power between the professional and the patient. Dreyfus (1982a) writing on Foucault states:
The individual is the effect and object of a certain crossing of power and knowledge. Here is the product of complex strategic developments in the field of power (Dreyfus & Rabinow, 1982a: 160).

The experience of the clinical examination for the patient is one of crossing over of power, because this is the moment when a person is stripped of their right to define their own identity, through the imposing of a diagnosis: the *diagnostic-identity*. This process of diagnosis was also identified in chapter one by users of mental health services, as the point where people experienced their sense of wellbeing was being undermined.

The initiation into the acute psychiatric public hospital ward via the clinical mental state examination and diagnosis raises existential questions for the patient: ‘Am I what you say I am?’ (Kroschel, 2000). The diagnosis of a person by an authoritative medical professional with control over the patient’s social, legal and health status, denies the patient the power to answer for themselves the question: ‘Who am I?’ (Ferreiro, 2000). This denies the patient the power to define their identity for themselves. Patients report that they feel that they have become a product of a coercive clinical, disciplinary and objectifying practice and conclude: ‘I am a schizophrenic’ (Kroschel, 2000). These
diagnostic objectifying practices are at the expense of understanding the person’s lived experience which leaves him/her feeling distressed, isolated, not understood and less than human (Watkins, 1998).

Foucault (1982; 1990) points out how modern science has created a science out of confession. An authoritative scientific interpretation of what the subject says results also in subjectification. The confession, in a clinical setting, interpreted through the methodology of the examination, results in both the production of a subject and object for itself. These objectifying and subjectifying modes of interpretation have allowed medical sciences the privilege of interpreting hidden meanings to which the persons themselves are not considered to have access.

Constructing problems in this way has meant an expert, the psychiatrist for example, is considered needed to decipher the language, behaviour and experience of the person who is deemed ‘mentally ill’, where: ‘Individuality, discourse, truth and coercion were thereby given a common localisation’ (Dreyfus & Rabinow, 1982b: 180). The continuing reliance on an expert as the source of truth, through privileged access to interpretation, maintains relational power structures. The continued reliance on diagnosis in acute psychiatric services preserves the
diagnostic method unproblematically as a suitable way of addressing human distress. But this approach denies the reality of the person on the other side of ‘the diagnostic encounter’.

The structuring of this ‘science’ around a profession has resulted in the denial of the power of the patient to interpret his/her own discourse and establishes the need for an expert to interpret ‘truth’. The authority of the medical profession of psychiatry demands that the client speak, while claiming that only professionals can interpret ‘the truth’ of what is said. The continuing reliance on a truth other than the patients’ own maintains the dynamics of power that reduces the patient to an object. The professional’s claim to the authority to interpret ‘the truth’ of a person’s speech establishes the authority to prescribe enforcement treatment. This is reported by the consumer/survivor movement, as has been demonstrated already in this thesis, as an experience of the denial of a patient’s legitimacy.

The refusal to allow the patient to arbitrate his/her own truth is, according to the consumer/survivor movement, an experience of violence. The violence of this approach is particularly evident in public mental health services where reports of abuse and trauma are
considered symptoms of pathology (Graham, 1994). The consequential interventions on these objectified bodies are therefore-punitive. This is despite growing evidence that abuse explains even the most unresponsive psychosis (Hawthorne, McKenzie & Dawson, 1996; Herman, 1992; Read, 1997; Read, 1998). What alternative interventions or responses might be attempted will be discussed in chapters seven and eight.

The medical examination according to Foucault (Foucault, 1990) ‘functions as a mechanism with a double impetus: pleasure and power’ (Dreyfus & Rabinow, 1982a: 173). Dreyfus and Rabinow (1982a: 173) articulate the seductive power of the encounter explicitly: ‘the medical power of penetration and the patient’s pleasures of evasion seduce both parties’. The evasion of medical power is evident in the consumer/survivor movement’s failure to reveal relevant details of their experience in order to maintain some power and control over their lives.

This process was articulated explicitly as ‘secret nutcase business’ at the launch of The Melbourne Consumer Consultants’ Group self written text, *Do You Mind?... The Ultimate Exit Survey: Survivors of Psychiatric Services Speak Out* (Group, 1997). The Melbourne Consumer
Consultants’ Group bemoaned the fact that this necessity was learnt the hard way: through suffering the consequences of being pathologised: that is, treated ‘badly’, for revealing personal information. In clinical services however, the meaning of symptoms for patients is considered outside the domain of concern, which also ignores the implications of the experience of services for recipients. Meanwhile, reliance on diagnosis alone in acute public psychiatric services as a means of responding to a person’s distress is a failure to respond to consumer/survivors’ reports of their experiences and therefore the expectation of an appropriate and ethical response to their needs.

Dreyfus and Rabinow identify the continuing claim that knowledge is independent of power as the problem. They maintain that ‘biopower rests on this assumption of externality and difference’ (Dreyfus & Rabinow, 1982b: 182).

While insisting that the truth they uncover lies outside the sphere of power, these sciences seem fated to contribute to the strategies of power. They claim a privileged externality, but they actually are part of the deployment of power (Dreyfus & Rabinow, 1982b: 180-181).

This maintains the objectifying practices that consequently dehumanise people’s suffering and pain.
These difficulties plague public mental health services and result in a range of anomalies. One such anomaly that Dreyfus and Rabinow identify, is that for practices already found to be ineffective, rather than reduce funding, funding is increased in an attempt to verify results.

The promise that these anomalies will eventually yield to their procedures justified the grant proposals, enlarged research facilities, and government agencies... the failure to fulfil their promises does not discredit them, in fact, the failure itself provides the argument that they use for further expansion (Dreyfus & Rabinow, 1982b: 182).

Dreyfus and Rabinow concluded that both objectification and subjectification are problematic. The resolution they suggest is in an alternative approach as advocated by Foucault: relocating power back with patients as the authority on their needs.

3. Acute Psychiatric Services: A Total Institution

The common site where objectification and subjectification come together is in the psychiatric institution. This coalescence of the two (objectification and subjectification) can be considered as a total institution. Drawing further from Goffman’s (1961) work *Asylums* provides an analysis of acute public psychiatric services as a total institution and supplements Foucault’s analysis. Goffman conducted
ethnographic fieldwork in a mental hospital in an attempt to understand the patient’s point of view in acute psychiatric services.

However, critics of Goffman’s (1961) *Asylums* claim it is ‘more a delineation of the mental hospital from the researcher’s point of view than from the patient’s’ (Weinstein, 1994: 358). Even though its approach is different to what is attempted by the British mental health user movement, whose focus is on the experience of consumer/survivors more generally (Rogers & Pilgrim, 1991a: 130), similar themes and issues reoccur as will be seen. Goffman’s observations have been re-affirmed by contemporary consumer/survivor claims as outlined in chapter one and elsewhere (Rogers & Pilgrim, 1991b; Rogers et al., 1993) and in recent literature (Wright, Gronfein & Owens, 2000). Consumer/survivor claims have in turn been supported by Goffman’s research and analysis.

Despite the changes in acute psychiatric services since Goffman wrote his text—such as length of stay, mainstreaming, and funding structures—the dynamics that define psychiatric services as total institutions, which he named, remain (Quirk & Lelliot, 2001; Weinstein, 1994). Weinstein however, discounts Goffman’s reliance on the notion of
a totalitarianism to define the mental institution. He argues that ‘the total institution model is not representative at all of the system of hospitalised care’ (Weinstein, 1994: 351). Nonetheless he still considers Goffman’s analysis as applicable, as the public hospital not only continues to be the major source of care in the mental health system, the demand on the hospital system has increased since deinstitutionalisation.  

10 Though Goffman’s analysis is forty years old, it is still quoted as the classic study regarding treatment in acute psychiatric services, as little other ethnographic research has been conducted on the wards since the 1970s (Quirk & Lelliot, 2001). ‘The second chapter of the book, ‘The Moral Career of the Patient’ originally published in 1959, has been reprinted 33 times, more than any other article in the journal history’ (Weinstein, 1994: 349). Weinstein’s (1994) recent review of Asylums notes that it is quoted 90-160 times a year and as such, its influence as a remarkable text endures.
Goffman immersed himself in the life of the patients on the ward in an attempt to understand them. In 1955-56 Goffman spent a year's fieldwork at St. Elizabeth Hospital Washington D.C., an institution of over 7000 ‘inmates’. In the guise of assistant to the athletic director, he set out to study ‘the social world of the hospital inmate, as this world is subjectively experienced by him’ (Goffman, 1961: 7). He found patients:

- Develop a life of their own that becomes meaningful, reasonable, and normal once you get close to it, and that a good way to learn about any of these worlds is to submit oneself in the company of the members to the daily round of petty contingencies they are subject to (Goffman, 1961: 7).

On the basis of his experiences, Goffman (1961) went on to write Asylums and to make a number of important observations.

Goffman (1961) identified the power of the psychiatrist over the life and circumstances of the patient as surpassing that of any other profession in society. This power, professionals claim, is necessary to ‘treat the whole person’. But Goffman (1961: 358) notes this has negative consequences for patients, reluctant to reveal their problems for fear they will be considered and treated as if to be ‘imagining things’, which has also been reported by consumer/survivors (The Melbourne Consumer Consultant’s Group, 1997). Meanwhile, Goffman notes, the
meaning the person him/herself gives to their experience is considered irrelevant: the psychiatrist is only concerned with information of relevance to the diagnosis of mental disorder.

The medical language of the staff in these institutions, Goffman maintains, presents the nature of treatment as medical. When a person is admitted as a patient he/she is said to be mentally ill. However, the reasons that people enter psychiatric wards are multiple. The *People Living with Psychotic Illness: An Australian Study 1997-98* (Jablensky et al., 1999a), concluded that needs were multiple and it was the absence of provision of basic needs for housing and support services that resulted in admission to a service which is provided on a ‘crisis-response basis’.

The professional identity of psychiatrists as doctors also gains society’s confidence in the delivery of mental health services as medical treatment. The medical treatment model rests on the assumption that those who receive psychiatric care are receiving ‘treatment’ not ‘punishment’ from a doctor. However, inpatient admission is an occasion that induces trauma, recognised in the professional community by attempts to prevent admission and the trauma
associated with it, with the use of preventative drugs (McGorry, 1994). But this reliance on drugs by-passes the need to respond to social factors that may have a role in the precipitation of the problems, and raises other serious ethical concerns, such as the serious side effects from the administration of these psychotropic drugs.

Goffman argues mental health professionals develop a belief system that works to reinforce the medical account of the situation. Professional subjectivity limits their perspective to that in line with their professional identity. To validate the professional perspective, a professional narrative develops to support their belief system. 11 Tanenbaum (1994: 31) identified clinical medicine to be essentially interpretive in that a narrative is developed in an attempt to make sense out of an object of study. However, this medical narrative, as

11 Tanenbaum’s (1994: 32) research showed that ‘physicians organise and communicate their interpretative work through the telling of stories’.
demonstrated in sections one and two in this chapter, are at the expense of delegitimising the narrative from the patients’ perspective.

The concept of the subject that Goffman distinguished in psychiatry is one of a sick, fractured or split self, in contrast with the ideal of an unimpaired self. This split legitimises and constructs the psychiatrist as the guardian of the split object. Goffman goes on to say, that what psychiatry requires of a patient is ‘a change of self’. Succumbing to treatment voluntarily requires that the patient must admit to being ‘ill’.

Goffman acknowledged the hospitalisation of patients considered to be suffering a mental disorder as a difficult situation for both the patient and the doctor. The doctor is called upon as a medical officer to utilise a medical approach while the patient cannot afford to accept medical terms ‘if any sense is to be made of the hardships he is undergoing’ (Goffman, 1961: 369). And as has been discussed in chapter one, the resistance to medical terminology is centrally important for patients to retain some sense of their humanity.

The importance of resistance for patients was made clear by Merinda Epstein (1997: 38) who said ‘The only thing clear to me was that I would not survive if I succumbed to naming myself as a psychiatric patient’.
She later said:

I realise now that I made a very important decision when I decided that I couldn’t really afford to define myself as pathetic—or as victim or as any other things that were so tempting at the time. As an anthropologist I was able to keep what vestiges of professional identity and personal power I still had (Epstein & Shaw, 1997: 39).

Warning patients of the limits of knowledge from this powerful position

Goffman considered useless, as:

The medical role is defined otherwise in our society, and because the power the psychiatrist has over the patient is not readily understood as something that would be given to anyone who knew little (Goffman, 1961: 372).

Nonetheless, failure to accept the treatment model results in involuntary treatment. Significantly, Goffman (1961: 330) states ‘to be made a patient is to be remade into a serviceable object’, ‘the kind of object upon which psychiatry can be performed’. This, Goffman casts as an irony, as so little service is provided.

Goffman observed that the hospital utilised a disciplinary system with a small number of staff organising a large number of ‘inmates’ using coercive methods to regulate behaviour. Any deviation in behaviour, resulted in punishment. A consumer consultant, Jon Kroshel, identified in an interview the problems with this system and the problems with the process whereby one learns what constitutes breaking a rule.
No one tells you the rules. You find out once you break one what the rules are by being punished with an increase in drugs. Any expression of emotion in an acute ward is treated with an increase in drugs. If a family member comes to visit me while I am in hospital and I feel sad about the trouble I am for them, and am upset when they leave, my drugs are increased. If I am in for bipolar and I am happy when a friend comes to visit, my drugs are increased and I become a zombie. It is not seen as okay to have emotion in acute wards. Such treatment is inhumane (Kroshel, 2000).

Goffman describes the coercive nature of psychiatric services as counterproductive for the development of personal relationships within them. The patient experiences the use of coercive methods as a rejection. This means contact with professionals is experienced as threatening. Coercive treatment results in an experience of alienation for the patient which Goffman suggests, expresses itself in the patient’s unwillingness to leave hospital. This often has more significance for the patient and his/her family than the original problem. The threat of incarceration is also used as an ongoing threat against a patient by family members: ‘be good or else I’ll send you back’ (Goffman, 1961: 362). Similarly, psychiatry is often used by perpetrators’ to threaten victims with being ‘locked up’ and called ‘mad’ if they tell (Bass & Davis, 1988).

Goffman points out; it is patients’ complaints about these difficulties and their treatment that are considered inconsequential by
professionals who consider the principal issue as the ‘illness’.

Interpersonal happenings are transferable to the patient, establishing him as a relatively closed system that can be thought of as pathological and correctable (Goffman, 1961: 375).

This means that patient’s difficult engagements with staff are ascribed to problems located within the patient and which need to be ‘treated’. Staff are trained to interpret any problems the patient might be having with the delivery of the ‘service’ as the patient’s problem, and to ‘treat’ the problem in the person with medicine. This approach fails to consider the limitations of the service itself.

Taking complaints about coercive treatment seriously, Goffman explains, is not what psychiatrists are trained for. The professional’s role requires that these ‘outpourings’ be discounted and treated as evidence of illness. But:

To treat the statements of the patient as signs, not valid symptom reporting, is of course to deny that the patient is a participant as well as an object in a service relation (Goffman, 1961: 368).

This is important, as the denial of the validity of the patient’s account is the site of the denial of respect for him/her as a valid human being, and as a participant in his or her own care. Goffman (1961: 363) highlights, in contrast to Jaspers, how in psychosis the ‘interpersonal environment
is inseparable from the trouble he/she is experiencing’ and that to understand the symptoms requires observation of the patient’s ‘whole situation’. 12

Nonetheless, to describe the patient’s behaviour as forming part of a psychiatric syndrome labels it as ‘involuntary, non-responsible and non-culpable’ (Goffman, 1961: 317). Goffman appreciates that it is the technical schema, which disqualifies patients from participation, while creating patients as objects: this is the very opposite of what the consumer/survivors movement literature suggest as desirable (Wadsworth & Epstein, 1996a).

12The removal of the original environment makes observation of the person irrelevant. Though a change of scene may in itself be therapeutic, this usually is followed by a return of the patient to the same environment ‘of which his psychotic response is a natural part’ (Goffman, 1961: 363). Discharge, claimed to be due to effective treatment of a correctly identified problem, has left the specific needs of patients’ unattended.
Goffman appreciates the gap between the different perspectives of the patient and the psychiatrist as an ongoing struggle where one cannot find in the other what they want: ‘The psychiatrist and the patient tend to be doomed by the institutional context to a false and difficult relationship’ (Goffman, 1961: 368). The attempt by the psychiatrist to sustain polite appearances is experienced as a hypocritical insult according to contemporary consumer/survivor literature (The Melbourne Consumer Consultant’s Group, 1997). What would be desirable is direct engagement with patients’ perspectives while acknowledging the limitations of resources.

The psychiatrist is in a predicament where what is required of him or her is to act in a professional stance, which the patient cannot accept.

Each party to the relationship is destined to seek out the other to offer what the other cannot accept and each is destined to reject what the other offers (Goffman, 1961: 368).

Nonetheless, Goffman appreciates the plight of psychiatrists who attempt to be polite while administering coercive treatment as difficult. Negotiating this terrain results in a complex encounter: ‘All day long the psychiatric staff seems to be engaged in withdrawing from its [psychiatry’s] own implicit overtures’ (Goffman, 1961: 368).
Even so, the use of lobotomy and electric shock, Goffman insists, is used in psychiatry to ensure adherence to acceptable modes of behaviour:

In all of these cases the medical action is presented to the patient and his relatives as an individual service but what is being serviced here is the institution, the specification of the action fitting in to what will reduce the administrator's management problems (Goffman, 1961: 383).

The way lobotomy and electric shock is used is still an issue in current practice. For instance, The Mind Mental Health Charity (Pedler, 2001) recently conducted a survey of 418 people: *Shock Treatment: A Survey of People’s Experiences of Electro-Convulsive Therapy (ECT)*. One of those surveyed said:

I went in as a voluntary patient and was told: 'Do as you are told or you won't see your children for years' (Woman—Leicestershire, ECT 6 or more years ago) (Pedler, 2001: 11).

Another person said:

I was given no information and had to sign for it after all my medication at night so I was very drugged when I signed the form for my consent (Woman—Yorkshire, ECT 3–5 years ago) (Pedler, 2001: 11).

The serious and long lasting side effects from ECT lead the researchers in this study to conclude:

It seems impossible to predict who will be adversely affected, and given the seriousness and permanent nature of the potential side-effects
recorded above, we believe that it should no longer be able to be imposed without consent (Pedler, 2001).

Goffman says that whereas in the general hospital, physical ailment is the indication for treatment, in the mental ward, the failure:

To be polite to staff—tends to be taken as evidence that one is not ready for liberty and that one has a need to submit to further treatment. The point is not that hospital is a hateful place for patients but that for the patient express hatred of it is to give evidence that his place in it is justified and that he is not yet ready to leave it (Goffman, 1961: 385).

Goffman’s analysis has revealed a ‘systemic confusion’ in the way that treatment is conceptualised and delivered. This confusion, discussed in chapter two as a methodological confusion, is still evident in today’s acute public mental health services.

Goffman explained this confusion to be a result of the role of mental health services: the protection of the self-concept of professionals. As has been pointed out in sections one and two and will be discussed further in chapters five and seven, one’s professional identity blinds one to the limitations of a perspective and the burden that it might impose for those subjected to it. Goffman succinctly states: ‘Mental patients can find themselves crushed by the weight of a service ideal that eases life for the rest of us’ (Goffman, 1961: 386)
Goffman concludes, considering an acute mental health patient to be different from ourselves allows one to then ‘speak of him as being crazy, mentally ill, insane, psychotic, immature’ (Goffman, 1961: 365).

Psychiatry claims to maintain a stance of ethical neutrality while dealing with offences in society through sanctioning ‘the offender, negatively and correctively’ (Goffman, 1961: 318). These conflicting requirements of sanctioning offenders of the social order and ethical neutrality create ambivalence for the psychiatrists. Likewise, Szasz (1974) questions the conception of mental health in terms of ‘successful’ living and mental illness in terms of ‘bad’ living. He considers that whether the patient is considered ‘ill’ or ‘wrong’ is dependent on the perspective of the observer. Szasz also regards the medicalisation of problems a denial of dignity and human rights.

This chapter has identified the failure to recognise and validate patients as persons as contributing to a mental health patient’s experience of damage. A consumer/survivor comments:

I don’t think you can base a mental health system on the physical health system, which seems to be what’s happened. And taking people in, filling them full of drugs and sending them out again is not solving anything for a lot of people (Epstein & Wadsworth, 1994).

Consequently, while the articulation of the patients’ concerns are
considered symptomatic rather than authentic, patients will continue to embody their distress and be stigmatised (Johnstone, 1996). Goffman acknowledged the difficulty of the institutional setting which, aided by the legal and institutional power of the psychiatrist, is changing towards the ‘custodial’ aspects of institutionalisation, where contact with the patient is abandoned in favour of administrative roles and practices. The implications of this direction are discussed further in the next two chapters.
The last chapter identified how people in receipt of services are treated in acute public mental health services. The purpose of this chapter is to consider the conceptualisation of the subject utilised in mental health law which authorises the coercive treatment referred to in the last chapter. Although the law requires that all persons be considered equal before the law, the concept of mental illness undermines the concept of equality, as persons who are considered mentally ill are considered less than competent. This means that a patient’s autonomy is denied. It is the coercive treatment legitimised by law that the consumer/survivor movement claim is problematic. The totality of this power, authorised in mental health law is the major source of conflict and helps to account for the emergence of the consumer/survivor movement.

According to Habermas (1996) in Between Facts and Norms, the law regulates normative action through the institution of a system of knowledge and action. Individuals cannot maintain themselves as
subjects if they do not find support and reciprocal recognition in
cultural traditions: moreover, ‘culture, society and personality
presuppose each other’ (Habermas, 1996: 80). Habermas (1996: 104)
has identified citizenship rights as protecting the legal subject against
State infringements: ‘consociates under the law must be able to
examine whether a contested norm meets with or could meet with the
agreement of all those possibly affected’.

However, this is not the function of mental health law for those
admitted to an acute public psychiatric ward. For instance, once a
professional decides that all five of the section nine criteria of, for
example, the *Mental Health Act 1986* (Victoria, 1998) are fulfilled, and
schedule one and two are completed, the patient is admitted, and
‘treatment’ is authorised. The authority of the law deprives that person
of autonomy and dignity by authorising and prescribing involuntary
treatment (Okasha, 2000). Even those admitted ‘voluntarily’ are often
coerced to do so. This institutional style of treatment requires that the
psychiatrist accept a clinical responsibility for an individual, on the
basis of the determination of ‘mental illness’.

The determination of some one as ‘mentally ill’ also carries with it the
power to authorise, administer and execute ‘treatment’. The person appointed as a medical expert is at the same time endorsed with legal authority and administrator by the State, with the responsibility for the protection of the State. Responsibilities include those to the patient, the family, the institution, the State and the profession. Thus the psychiatrist is invested with a complex and contradictory set of responsibilities that are highly problematic in relation to mental health law. The example of the *Mental Health Act 1986* (Victoria, 1998) will be explored here in detail to examine the implications for the treatment of the patient as a person.

**The Admission Procedure**

The procedure for admission to an acute psychiatric service is determined by the *Mental Health Act 1986* (Victoria, 1998: 19) which authorises the use of ‘force as may be reasonably necessary’. This includes the authority to enter premises and to use restraint, and administer sedation for the purpose of transporting the person to a mental health service. Even without a formal recommendation for admission, a person can be taken to an approved mental health service if a registered medical practitioner is not available. This procedure
greatly undermines a person's sense of wellbeing and safety, which has negative and lasting effects (Kroshel, 2000).

According to the *Mental Health Act 1986* (Victoria, 1998), a person can be admitted and involuntarily detained by a registered medical practitioner where a request and recommendation has been made ‘until the authorised psychiatrist examines the person’ (Victoria, 1998: 24), which must occur within 24 hours. The examination of the person by the authorised psychiatrist then confirms or discharges the patient from involuntary detention. If admitted as an involuntary patient under section 12 of the Act, he/she can be forced to accept any medical or psychiatric ‘treatment’ that the psychiatrist deems necessary.

**Legal Requirements for Involuntary Admission**

The ‘criteria for admission and detention as an involuntary patient’, in section 8(1) of the *Mental Health Act 1986* (Victoria, 1998) that must be adhered to are:

(a) the person appears to be mentally ill; and

(b) the person’s mental illness requires immediate treatment and that treatment can be obtained by admission to and detention in an approved Mental Health Service; and

(c) because of the person’s mental illness, that person should be admitted and detained for treatment as an involuntary patient for his or her health or safety (whether to prevent a deterioration in the
person’s physical or mental condition or otherwise) or for the protection of members of the public; and
(d) the person has refused or is unable to consent to the necessary treatment for mental illness; and
(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person’s freedom of decision and action (Victoria, 1998: 16-17).

The first criterion for admission and detention according to the Mental Health Act 1986 (Victoria, 1998: 16) as an involuntary patient is ‘if the person appears to be mentally ill’. But this is a cyclic argument, as Richardson and Machin (1999) argue: ‘mental illness’ relies on medicine for its definition and application. The statement: ‘the person appears to be mentally ill’ is the judgement of a psychiatrist. As pointed out in the last chapter, what is perceived as ‘mental illness’, is a subjective judgement without independent verification and requires legitimisation. This legitimisation is only provided by the authority in mental health law. As Eastman (1999) states, ‘in short, definitional power under the Act rests on clinical judgement’.

The second requirement of admission is the need for ‘treatment’ that ‘can be obtained by admission to and detention in an approved mental health service’ (Victoria, 1998:16). However, the extent to which coercive ‘treatment’ is beneficial is under contention. The failure of patients to
respond to treatment may be due to the inadequacies of the treatment on offer, such that: ‘no alleviation or stabilisation can be achieved in the secure environment of a hospital’ (Richardson & Machin, 1999: 7).

Richardson and Machin (Richardson & Machin, 1999: 7) suggest treating involuntary detention as medical treatment means that admission is justified while the concept of medical treatment is debased. Importantly, they argue that ‘the law is using medicine as a shield, from a patient’s point of view’ (Richardson & Machin, 1999: 7).

The third requirement for admission is a judgement of the danger the patient poses to oneself or others, a central issue for the implementation of Act. This prerequisite highlights the divided loyalties of the psychiatrist to the institution on whose behalf he acts, and to the family and the patient. However, the determination of danger is a subjective judgement, made on the basis of the registered practitioner’s experience of the patient in question, this judgement is informed by their training. As was demonstrated in chapters two and three, there are no other reliable criteria whereby one can gauge ‘mental illness’ and the clinicians’ ability to predict violence is limited (Norko, 1998; Rabinowitz & Garelik-Wyler, 1999). Yet, mental health legislation
makes psychiatrists responsible for people perceived to be dangerous’ (Fulford & Sadler, 2000: 679).

Even though a registrar responsible for the admission procedure may be certain of his/her predictions, this confidence is ill placed in ninety percent of cases (Rabinowitz & Garelik-Wyler, 1999). Rabinowitz’s (1999: 105) study indicated ‘less confidence in such predictions is warranted’. Though measures or tools to estimate dangerousness are available (Appelbaum, 1994) and used, they have limited value (Mullen, 1996). Appleby has conceded that his risk assessment tools are only able to establish a four percent chance that the person is a risk to others which means that there is a ninety-six percent chance they are not (American Psychiatric Association, 1983).

The problem with the prediction of dangerousness is that such predictions are so inadequate, that the official policy of the American Psychiatric Association (1983) is that psychiatrists are incapable of making them. Miller (1991) states that as such, the coercive treatment based on these predictions might even constitute a breach of ethical conduct. However, to avoid being blamed for the consequences of failure to respond to a perceived threat, there is pressure on professionals in
mental health services to make such assessments and to intervene (coercively).

The clinician makes his/her assessment by consulting the family and considering the history. The more experienced psychiatrist, it is claimed, is more skilled in making these complex and difficult assessments. Although, as the last chapter identified, this may just mean the person is stereotyped. Moreover, the reliance on trainees in current acute mental health services means that the least experienced staff bears this significant responsibility. This role, increasingly imposed on psychiatrists through the limitations of alternative types of services and the increasing use of community treatment orders, is making ‘psychiatrists responsible for people perceived to be dangerous’, which ‘makes dangerousness a disease’ (Fulford & Sadler, 2000: 679).

The fourth requirement for admission is that ‘the person has refused or is unable to consent to necessary treatment’ (Victoria, 1998: 26). This prerequisite for involuntary admission is philosophically contentious as it makes a number of questionable presumptions. One presumption is that refusal is due to a lack of insight about one’s own state. This lack of insight, as has already been established, is one of the criteria for a
diagnosis of psychosis. But this assumption denies the very different perspective of the patient who considers the problem in terms of the events of their life, and not in terms of an illness. Added to this, is the disincentive as identified in chapter one, of the emotional burden and stigma associated with accepting a diagnosis of mental illness.

Another presumption is that the treatment is helpful, evidence for which has not been established. The consumer/survivor perspective even argues, supported with an array of evidence, such as the incidence of post-traumatic stress disorder associated with admission to an acute psychiatric ward (McGorry et al., 1991) to the contrary. Further, to deny a person the option to refuse treatment that has questionable, potentially traumatising and often damaging effects is a violation of the use of power, and precipitates a breach of trust in the one who authorises such.

Nonetheless, the fourth admission criteria presumes that if one were not ‘mentally ill’ or ‘in their right mind’, they would consent. The presumption of incompetence based upon ‘refusal’ to consent, is then used to endorse the fifth requirement for admission, ‘the person cannot receive adequate treatment’, ‘in a less restrictive’ manner (Victoria,
Fulfilment of these criteria to the satisfaction of the treating physician authorises him/her to detain the person involuntarily.

Community Treatment Orders

An alternative to or consequence of admission is that community treatment orders can be issued. This extends the power of psychiatrists to detain patients involuntarily in the community. Community treatment orders are another attempt to provide treatment with the least restriction to freedom, and ‘least interference with rights and dignity (McIvor, 1998). The patient under a community treatment order is deemed to be an involuntary patient of an approved mental health service (Victoria, 1998: 33).

Under the terms of a community treatment order a person, as an involuntary patient, is detained in the community. This order may include where the person must live, and specifies the doctor whom they must report to and how often this must occur. The duration of such an order must not exceed 12 months but the Mental Health Review Board may extend the order endlessly upon approval. If the order is revoked due to non-compliance with medical treatment, the person can be
returned to the mental health service as an involuntary inpatient.

McDonnell and Bartholomew (1997) showed that the main factor that predicts the use of community treatment orders is diagnosis, a history of poor compliance with medication, and the number of hospital admissions. But the recent review of one hundred and thirty cases heard by the Mental Health Review Board indicated that medication constitutes the sole form of treatment through the community treatment orders (McDonnell & Bartholomew, 1997). The consumer/survivor movement, dissatisfied with over reliance on medication, the side effects, and lack of negotiation, consider this unacceptable (McDonnell & Bartholomew, 1997).

Other problems identified by patients include ‘a sense of disempowerment, and a loss of dignity, identity and self-determination’; those who asked to be discharged from the orders cited the ‘invasive and stigmatic nature of the orders’ (McDonnell & Bartholomew, 1997: 31). Though it is claimed that community treatment orders provide treatment in the ‘least restrictive environment’, there is no restriction to the number of times an order can be extended. This interferes with liberties over a prolonged period which is contrary to United Nation
Principles (United Nations General Assembly, 1991). The use of community treatment orders, which erodes civil liberties, is apparently intended to compensate for inadequately resourced treatment services. Studies have shown that there is no difference in readmission rates between those on community treatment orders and others (McDonnell & Bartholomew, 1997). This suggests community treatment orders do not achieve their intention of reducing readmission rates and that these rates depend upon factors not addressed in the order. The use of orders continues despite the lack of evidence to show that they have reduced readmission rates or increase compliance (McDonnell & Bartholomew, 1997; McIvor, 1998). Using community treatment orders does not address the problems of readmission as it still does not address the issues people identify as precipitating their crises, or how involuntary treatment works against the person’s sense of autonomy (Holloway, Smukler & Sullivan, 2000).

Another problem with the implementing of community treatment orders is that there are no clinical guidelines as to which patients would benefit from them (McIvor, 1998). Well-designed studies comparing the efficacy of involuntary inpatient commitment to possible alternatives
have never been performed’ (Appelbaum, 2001). Thus, as involuntary
treatment extends to the community, the boundaries between hospital
and community blur.

The problem with the administration of involuntary ‘treatment’ and the
use of coercion in acute public mental health services, and the use of
community treatment orders, is a denial of a person’s liberty and
moreover their voice. Furthermore, the community treatment order,
consistent with its coercive status as an involuntary admission, is
considered counterproductive because it works against the interests of
a therapeutic alliance (McIvor, 1998). Meanwhile, services that respond
to a person’s needs as the person him/herself experiences them are not
provided.

The Mental Health Review Board, a statutory body constituted by the
Mental Health Act 1986 (Victoria, 1998) is responsible for monitoring the
implementation of community treatment orders. But the monitoring
approach of this statutory body is inadequate to deal with the failure of
services to address the needs of patients. That is because it not only
does not have the capacity for this type of evaluation but it authorises
and extends the very practices that patients consider abusive: namely,
enforced treatment. Furthermore, despite the necessity that all initial community treatment orders be reviewed in eight weeks, the Mental Health Review Board’s annual report documents that often this does not happen until the 12-month review (Mental Health Review Board, 1999). And although patients can request a review, this does not relieve the statutory body of its responsibility to ensure a review occurs within the statutory review period.

Jaworowski and Guneva (1999) observed that the Mental Health Review Board’s decision to extend community treatment orders:

> appears to be dictated more by the administrative demands of the mental health review board hearings rather than an active process of reviewing patient’s management plan, including the role of CTO (Jaworowski & Guneva, 1999: 134).

This study showed that the number of community treatment order extensions had jumped forty-three percent in the twelve months prior to the study. In the three-month period of McDonnell and Bartholomew’s (1997) study, only three percent of the community treatment order recipients were discharged. Ex-patients claim the lack of legal representation as the major factor in the Board’s decision to uphold involuntary status and consequently express dissatisfaction with the Mental Health Review Board process.
Despite these problems, and amidst doubts about their efficacy, the use of community treatment orders is growing internationally. The current increasing reliance on community treatment orders raises ‘the contemporary dangers of the political uses of psychiatry for purposes of social control rather than medical treatment’ (Fulford & Sadler, 2000).

Psychiatric Law and the Legitimisation of Coercion

Denial of autonomy in the form of freedom, basic human rights and respect occurs in both formal and informal admissions (Cascardi & Poytheress, 1997; Hoge et al., 1997; Hoge et al., 1998; Nicholson, Ekenstam & Norwood, 1996). The use of the law to administer ‘treatment’ against a person’s will and with coercion in Mental Health Services is claimed by professionals and community at large to be in a person’s ‘best interests’ (Fennel, 1998; Freckelton, 1998; McCubbin & Weisstub, 1998; McLaclan & Mulder, 1999). But a growing body of mental health law research literature, indicates that coercion works against treatment benefits and is harmful (Cascardi & Poytheress, 1997; Hiday, Swartz, Swanson & Wagner, 1997; Hoge et al., 1997; Hoge

This literature has also identified the experience of coercion not to be limited to involuntary legal status, but related to how a person is treated in public mental health services. Those people meaningfully involved in decision making, who felt they were respected and had an opportunity to tell their story, whether involuntarily admitted or not, experienced less coercion than those who had no such opportunity and were exposed to negative pressures such as threats and force (Hiday et al., 1997; Nicholson et al., 1996).

What has been found to be offensive to consumer/survivors is the use of violence and threats. In contrast, clinicians viewed coercion as necessary for carrying out their responsibilities. Coercive practices have many ongoing adverse affects for consumer/survivors, such as a reluctance to seek help. This aversion may explain the poor utilisation of psychiatric services as identified in the report: Mental Health and Wellbeing Profile of Adults: Australia 1997 (Australian Bureau of Statistics, 1998). It may also explain the unwillingness to continue with treatment once involuntary treatment regimes are lifted |Campbell,
Though psychiatrists agree that coercion needs to be minimised, how this is to be achieved is not agreed upon (Hoge et al., 1997; Hoge et al., 1998).

Psychiatrists defend themselves against patient complaints of the coercive nature of treatment by arguments such as the following:

Many psychiatric patients are cognitively disordered at the time of admission and may have impaired ability to perceive coercive interactions to understand the significance of events or to recall interactions in an undistorted fashion... we cannot safely conclude that patients have accurately perceived the circumstances of their admission (Hoge et al., 1998: 132)

However, there is in the same article, an acknowledgement that clinician perceptions are also distorted in self-serving ways, as was identified in the last chapter. Nonetheless, the patient’s perspective is discounted on the grounds that the patient is mentally ill: ‘patient’s perceptions may be affected by...cognitive disturbances associated with psychiatric symptoms’ [Campbell, 1989: 133]. Yet, the discounting of the patient’s perspective on the grounds of distorted thinking is to fail to consider that perspective. Blanch and Parish (1993) insist that there is no way to confirm patient’s anecdotal reports of coercion. Yet, in an ongoing cycle of claim and counter claim, clinicians also acknowledge that coercive practices need to be reduced.
The literature on mental health law and coercion makes clear that what people want is to be involved in their treatment, as anything less is experienced as coercion. Hoge (1998) did a study that explored the ‘Family Clinician and Patient Perceptions of Coercion in Mental Hospital Admission'. This research compared the different perspectives in mental health services and the determination of these differences. They found that families reported less coercion, threats and force had occurred compared with accounts by the involuntary patients or practitioners. Importantly, it was the involuntary patients who rated the lowest levels of procedural justice in comparison with either the family or professional, who rated procedural justice near the top of the scale.

Hoge offers two explanations. Firstly he argues defensively for clinicians, that the poor rates of procedural justice rated by patients could be blamed on unreasonable expectations or distress. But this denies the subjective nature of the experience of coercion on the person involuntarily admitted. And it would seem from the research questions Hoge asked that this was what he was attempting to identify in persons being admitted involuntarily: The research questions consisted of:

1. How much of a chance did you have to say everything you wanted to about coming into hospital?
2. How seriously did people consider what you had to say about coming
to the hospital?
How satisfied are you with the way people treated you when you were coming to the hospital
How fair was the process of coming into the hospital (Hoge et al., 1998: 136).

The process of involuntary admission by definition involves actions against a person’s will. Realistically, this would be experienced as lacking in procedural justice for the person involuntarily detained.

Hoge’s (1998: 145) second explanation for the lack of procedural justice experienced by the patient is much more satisfying: that family members and clinicians over-estimated the amount of procedural justice accorded to the patient ‘to justify their own behaviour in pursuing hospitalisation’. Hoge explores this idea further when he considers whether the determinants of family and clinician perceptions were the same as the patients’. The results of this analysis, supports the findings of another of Hoge’s (1997) studies, that procedural justice plays an important role in determining family and professional perceptions of coercion.

Nevertheless, the three groups in Hoge’s (1998: 145) study did not agree about how much procedural justice was provided. Their different perspective explained the differences between the three groups involved.
Moreover, it was the family and professionals that received the procedural justice, rather than the patient: admitted against their will. When patients did not experience procedural justice, they felt coerced. The same divergent views were found between patients, carers and staff perspectives in a study in the United Kingdom (Round et al., 1995). This study found poor agreement between the different stakeholders in beliefs about a given patient’s diagnosis and the purpose of his/her admission.

This is a similar finding to that of the review of consumer outcome measures conducted in Australia (Andrews et al., 1994). What was found to be important was the involvement of patients in the process of treatment. This notion of procedural justice is important in identifying what consumers want, which, if taken into account, involves the patient and eliminates their experience of coercion. It would be helpful to find ways to incorporate processes of procedural justice into current practice in public mental health services. This is attempted in chapters seven and eight.

Consumer/Survivor Rights
Despite the claim by mental health services that patient’s rights are protected, examination of the *Mental Health Act 1986* (Victoria, 1998), indicates that patients have few rights. The first item of patient’s right as stated by the *Mental Health Act 1986* (Victoria, 1998) includes the right to a printed statement, the right to obtain legal representation, the right to a second opinion and the right to information. The second item stipulates a printed copy of rights be administered to patients in their own language. The third item states that every person be given an oral explanation of these rights in terms they understand. The fourth item states it is the duty of the authorised psychiatrist to ensure these rights are complied with.

The *Mental Health Act 1986* (Victoria, 1998) states that ‘information to be provided’ to all patients include: copies of the Act, copies of the above statement, and addresses to which patients may write: the Review Board Tribunal, the Public Advocate, the Chief Psychiatrist, Community Visitors, Victorian Legal Aid, the Ombudsman and the Health Services Commissioner. The *Mental Health Act 1986* (Victoria, 1998) also states that (these) letters are to be forwarded without tampering.

However, according to Delaney (1999) of the Mental Health Legal Centre
in Melbourne, the Act does not identify how to go about getting a second opinion. The failure of the State to provide for an independent hearing and legal representation and for a second opinion would appear to be a breach of responsibility on behalf of the State. There also appears to be a contradiction in the expectation that the same person, allegedly admitted as ‘incompetent’ is able to organise an independent hearing, legal representation and a second opinion for themselves. The provision of these ‘rights’ is not standard practice, they are only provided if patients contact the Mental Health Legal Service and appeal. The failure to provide for these rights is in effect, a denial of them.

As demonstrated, the legal rights of patients are few, and even then, not provided for. The legal requirement that patients admitted involuntarily are reviewed by an independent body, is not fulfilled in the State of Victoria for eight weeks. For this to be sooner an appeal is required. Neither is legal representation automatically provided for in this process. Zifcak (1997), a member of the Mental Health Review Board, acknowledges that the process of review is much more considered when legal representation is present. Even so, Delaney (1999) considers there is no way of effectively protecting the civil liberties of an involuntarily detained patient in Victoria, as the *Mental Health Act 1986* (Victoria,
1998) protects providers from legal action by legalising coercive
treatment. She also states that this means there is no point in the
person taking civil action. Thus, there is no recourse against practices
patient’s experience as abusive.

The second part of the statement of peoples’ rights in the Mental Health
Act 1986 (Victoria, 1998) includes the right for information relating to
hospitalisation. However, consumer/survivors claim they are often not
told the side effects of drugs and treatments because doctors regard
such knowledge as prejudicial to compliance (Okasha, 2000). The
failure to provide for patient rights is highlighted in the
consumer/survivor satisfaction survey results, where fifty-eight percent
of respondents were not satisfied with the information received.
Moreover, fifty percent of patients were also not satisfied that their
rights were respected (Quadrant Research Services, 1997).

People considered ‘mentally ill’ may be subject to ‘invasion’ by a team of
‘service’ providers, the community assessment team (or CAT team). They
may with the authority of the State in the form of the Mental Health Act
1986 (Victoria, 1998) use whatever coercive measures they consider
necessary, to enter, subdue, restrain, sedate chemically and/or
physically and transport the person to hospital. The person may then be involuntarily admitted, secluded in a room and ‘treated’ with chemical and physical restraints. However, much of the treatment on offer is traumatic and may actually cause post-traumatic stress disorder (McGorry et al., 1991).

The recent response to these practices mentioned above and as raised by Burdekin (Human Rights and Equal Opportunity Commission, 1993; 1993; 1995), has been a reduction in accessible services, changes to the Mental Health Act 1986 (Victoria, 1998) and a relocation of services from independent institutions to mainstream hospitals. Appelbaum (1994) even argues that the law has moved too far in the direction of human rights. But the way the law has embodied human rights claims is by attempting to restrict access to services to the most ‘serious’ cases. In contrast to Appelbaum’s claim, the law has been revised to restrict access to mental health services to emergency cases. Disappointingly, this has not addressed the problems people identify with the service itself. The service needs to be restructured so that those who are in need of support do not experience abuse of basic human rights.

There is a difference between the States in the application of the law in
mental health services. An example of the discrepancy in the legislation is in regard to the administration of electroconvulsive therapy and consent. New South Wales uses the Mental Health Review Board to review the application for this procedure. In Victoria, no such process happens in relation to electroconvulsive therapy and consent although this is currently under review. In Victoria, a person can be given electroconvulsive therapy without consent on two grounds: if the person is considered ‘incapable of giving informed consent’ and if it is deemed ‘the performance of electroconvulsive therapy is considered urgently needed’ (Victoria, 1998: 91-92).

Another example of the differences in mental health law is from the United Kingdom. Recently, as stated in chapter three, Mind: The Mental Health Charity (Pedler, 2001) conducted a survey of 418 people who had experienced electroconvulsive therapy and published the results in: *Shock Treatment: A Survey of People’s Experiences of Electroconvulsive Therapy (ECT)*. Mind found:

84% of respondents said that they had experienced unwanted side effects as a result of having ECT.

40.5% reported permanent loss of past memories and 36% permanent difficulty in concentrating.

Among those receiving ECT within the last two years, 30% reported that it had resulted in permanent fear and anxiety.

A third (32.5%) of recent recipients felt hopeful before having ECT.
but 29% felt terrified and 22% felt that they were being punished.

In the short term, 36% of more recent recipients found the treatment helpful or very helpful and 27% unhelpful, damaging or severely damaging. However, in the long term, 43% of more recent recipients felt that it was unhelpful, damaging or severely damaging.

66.5% of the overall sample and 49% of those having ECT in the last 2 years would not agree to have it again.

Respondents from black and minority ethnic communities were more likely to be detained under the Mental Health Act 1986 and to have received ECT without consent. They reported a more negative view of ECT than the overall sample with 50% finding it unhelpful, damaging or severely damaging in the short-term and 72% in the long-term (Pedler, 2001: 3).

They concluded:

It seems impossible to predict who will be adversely affected, and given the seriousness and permanent nature of the potential side-effects recorded above, we believe that it should no longer be able to be imposed without consent (Pedler, 2001: 29).

The survey findings indicated that some people found electro-convulsive therapy helpful. However, the results indicated that it was impossible to predict who would be adversely affected. Given the serious and permanent nature of the potential side-effects recorded above, Mind recommended that electro-convulsive therapy should not be able to be imposed without consent (Pedler, 2001: 29). They also recommended a legal framework on decision making ‘be developed as a matter of urgency’ (Pedler, 2001: 30). They also suggest ‘there should be a legal requirement for an independent advocate to be made available to any
person for whom ECT is being considered’ (Pedler, 2001: 29) and that ECT not be given if there is any indication of objecting (Pedler, 2001: 30). Mind also recommended that safeguards be established in mental health for all those receiving electro-convulsive therapy and not just involuntarily detained patients (Pedler, 2001).

Benchmarking Victoria by the United Nations Principles

The recent changes made in the *Mental Health Act 1986* (Victoria, 1998) have been a result of Resolutions on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations General Assembly, 1991). These United Nations Principles can be used as a benchmark against which the Victorian legislation can be judged in terms of its claims to support the rights of the patient.

Delaney (1992) discusses the adherence of the *Mental Health Act 1986* (Victoria, 1998) to the United Nations Principles (United Nations General Assembly, 1991). She argues that admission of a person to a mental health facility on the grounds that a person refuses to consent to treatment denies that person the right of choice and constitutes
discrimination. This she claims, is a direct contradiction of the United Nations Principles.

Discrimination on the grounds of mental illness is prohibited by the Principles, and it is certainly arguable that this denial of freedom of choice is discriminatory (Delaney, 1992: 576).

She goes on to argue that this is also a breach of the United Nations Declaration of Rights of Disabled Persons, and the International Covenant on Civil and Political Rights.

The justification for not allowing mental health patients to refuse treatment is on the basis that patients lack insight into their own condition and the capacity to assess their own ‘best interests’. The Mental Health Review Board upholds this position. Delaney (1992: 577) attests ‘this does not, however, negate the need to protect the right to refuse treatment however small the group of patients affected might be’.

The United Nations Principles do not define the capacity to consent. This capacity seems to be more a function of who is doing the defining. This raises the question of ‘insight’.

Delaney (1992) points out that there is a distinction between whether a person accepts that they have an ‘illness’ and whether they refuse the treatment offered in light of the side effects of that treatment. Also, the
person may not consider what they are experiencing as an ‘illness’, due to the burden of stigma as identified in the first chapter. Health professionals identify a person’s experience as symptoms of an ‘illness’, whereas illness is just one way of understanding or conceptualising those symptoms. There are other ways. From the consumer/survivor perspective, symptoms are related to their life circumstances. The demand by professionals that their patients view his/her symptoms in terms of the professional perspective (i.e. to attain insight) is a reversal of responsibility: it is the professionals’ job to understand the patient’s distress rather than the patient’s to understand the professional perspective and expertise.

The United Nations Principles argue that restraint is to be used only to avoid ‘immediate harm to the patient or others’. Whereas the *Mental Health Act 1986* (Victoria, 1998) also permits the use of physical restraint to prevent the destruction of property, but how this danger is to be established is a problem as discussed earlier. Such measures of restraint are inconsistent with the United Nations Principles. The consumer/survivor movement literature indicates that drugs and seclusion are used as a punishment, as has been demonstrated; indeed,
Delaney (1992: 578) claims that this indicates ‘just how open to abuse are the Act’s broad criteria for such liberty denying practices’.

These coercive measures are experienced by people subject to such treatment as ‘intrusive and threatening to integrity’ (Delaney, 1992: 578). This highlights the need for recognition of patient autonomy through adherence to the United Nations Principles: ‘it also shows compellingly the desirability of the Principles’ stringency, and privileging of patient autonomy’ (Delaney, 1992: 578), which is not provided in the Mental Health Act 1986 (Victoria, 1998).

In New South Wales the admission criteria prohibits prescription of drugs beyond professional recommendations. But professional standards are based on what psychiatrists are trained to do, which, as indicated by the reported experiences of ex-patients themselves, is problematic. This does not mean that changes to legislation would not be of benefit, as changes in legislation would have practical outcomes, which would in turn impact standards of the treatment of patients and therefore training experience.

Under the United Nations Principles, the lack of capacity to consent to treatment must be decided by an independent authority but this
Principle is breached in the *Mental Health Act 1986* (Victoria, 1998). The United Nations document states: the decision to admit, is to be initially for a short period, pending review (United Nations General Assembly, 1991: 191). But the provision for review by the Mental Health Review Board does not routinely occur for eight weeks. By this time, few people are still under detention. So the decision for admission is entirely in the hands of the admitting psychiatrist.

The United Nations Principles also identify a person’s right to appeal to an independent authority against treatment decisions. However the only provision for this is the Mental Health Review Board. Unless the patient makes an application for an appeal in writing to the executive officer; or the chief psychiatrist; or the authorised psychiatrist; or a community visitor; or the Ombudsman; or the Health Services Commissioner, this basic right is denied.

Furthermore, the Mental Health Review Board’s independent authority is also open to question. The members include a legal professional, a psychiatrist and a community member, but no consumer/survivor representative. Delaney (1992: 580-581) states that this process denies the prerequisite to be impartial and becomes a ‘rubber stamp’ for
inordinate psychiatric discretion’, as the Board ‘will always give great
weight to the opinion of the treating doctors’. Indeed, the Mental Health
Review Board, Delaney argues, is effectively meaningless (Delaney,

Review boards and tribunals favour social protection over patient
autonomy: patient’s complaints are seen as evidence of mental illness.
‘Treatment’ is given a very broad interpretation. What is considered to
be in the patient’s interests by the professionals is favoured over a
person’s need for autonomy. The claim by a person for autonomy is
awarded little priority. The person as patient then has no effective
recourse, as coercive treatment and detainment are protected under the

By contrast with Victoria, the procedures in New South Wales’ mental
health services draw heavily on formal legal process. The main criterion
for admission in New South Wales is danger to self and others, which
includes the risk of financial harm. In New South Wales, a patient’s
commitment decisions are reviewed within 48 hours of admission by a
magistrate at a hearing, with legal assistance for the patient and
periodic review before a Mental Health Review Tribunal. This means
that the patient speaks to an independent authority within that time, which is more in line with the Principles than the Victorian system.

Even so, the New South Wales system has limitations. The New South Wales Mental Health Review Board is more formal and so in some ways counterproductive, though the convening of the Mental Health Review Board has the potential to provide a ‘hearing’ for patients, as its role allows for patients to voice their concerns and perspectives. An alternative model to the present system might combine the best of both approaches: the informality of the Victorian Board and the early sitting of the New South Wales Board, which has the potential to involve patients in a consensual approach to treatment. Including a consumer consultant and offering an independent hearing to validate patients’ views would provide an opportunity for patients to define what they think they need.

**Some International Comparisons**

It is instructive and helpful to compare the Victorian and New South Wales Mental Health Acts with those of Europe, the United Kingdom and United States of America. Appelbaum’s (1997: 136) review of the
state of mental health law internationally is instructive. He states the radical change in every state in the law of civil commitment in America has essentially altered the status quo. Involuntary commitment has been limited to persons considered dangerous to self or others. The historic category of ‘in need of treatment’ was abandoned. In its place, there has been introduced a set of procedural rights drawn from criminal law whereby patients have the right to a hearing, representation by an attorney, to testify on one’s own behalf and to have witnesses.

In England, commitment continues to be on the basis of health and safety of the patient or protection of others. Though patients can request post commitment reviews, only twenty-five percent do so. Reviews occur after six months and then every three years. Appelbaum reports, Europe has followed the trends in England and not those of the United States. Italy has explicitly rejected dangerousness as a basis for commitment because of the stigmatising effects. They also removed the legal provision for involuntary detention on the same grounds, although this is again under review (Tansella & Burti, 1999).

Nonetheless, despite the legal changes, Appelbaum notes there is little
evidence to suggest that the commitment law reform in the United States has had an impact. ‘Demographically and diagnostically, the groups look the same before and after reform’ (Appelbaum, 1997: 141). Any fall in commitment he attributes to limitations faced by most professionals, including the shutdown of State facilities. This appears to apply to Australian mental health services also.

Appelbaum struggles with the reason law reform has not reformed practice. He claims it is due to the fact that laws are not self-enforced. That is to say, implementation of involuntary commitment is according to how it is applied. The law is applied not according to the criteria of whether they are considered dangerous or not, but according to what is considered a ‘reasonable outcome’. Appelbaum identified the paternalistic behaviour of tribunals that Delaney also noted in the United States and England, to account for review tribunal’s decisions on commitment. Decisions were not made on the basis of whether patients meet criteria, but whether they thought patients would conform to treatment.

Appelbaum identified that the recent changes in the United States mental health law reflect the contest over the presumption that people
would be helped by treatment. This has meant that there is divergence between legal reform and moral sentiment in how the law is applied. The law is interpreted according to moral intuition rather than according to the letter of the law. This has meant that the conflicting interests in mental health law, of providing treatment while protecting a patient’s liberty to make decisions regarding their own care, despite legal reform, has been disregarded in the United States. This, according to Appelbaum, reflects a social consensus for the need for involuntary treatment.

Okasha (2000: 693) points out that the convention of the medical community is to attempt to protect a patient’s interests by refraining from ‘truth telling’. As has been demonstrated, the convention is that it is the opinion of the doctor that determines whether the patient is competent to give valid consent. But what, he asks, ‘is the perceived harm when members of the medical community violate cultural conventions and insist on telling the truth to their patient’ (Okasha, 2000: 693)? As Appelbaum (1997) and Okasha (2000) have indicated, public attitudes favour intervention, even if that intervention involves a violation of human rights and is coercive. But with the growing incidence of mental illness, this type of treatment is affecting more
and more people. Recent research (Martin, Pescosolido & Tuch, 2000) indicates mental illness signals dangerousness to the community and it is this coupling that needs to be addressed in public policy and legal agendas.

This analysis of the *Mental Health Act 1986* (Victoria, 1998) and the New South Wales Act, together with some international comparisons has revealed that the admission criteria rely upon the concept of mental illness to justify coercive ‘treatment’. But this does not take into account the negative impact on the wellbeing of the patient. This counterproductive situation for patients will be contemplated further in the following chapter through an analysis of the obligations of government, and how these currently are met. Considered in chapter eight is the governmental attempts to respond to the complaints made by ‘consumers’ of these involuntary received and coercively administered services.

**From Mental Health to Legal Control**

The Office of the Public Advocate is an independent statutory agency in Victoria that is responsible for dealing with complaints, regarding
‘treatment’ in mental health services. The Office of the Public Advocate also provides individual advocacy where it is required and not otherwise available. The office is also responsible for training community visitors, who constitute a monitoring system of mental health services. Community visitors are volunteers who visit psychiatric facilities and can make or respond to complaints according to strict and narrow guidelines. However, this is a limited means by which to monitor services, as coercion is authorised under the guise of ‘necessary force’ in the Mental Health Act 1986 (Victoria, 1998).

Despite these patient complaint mechanisms, complaints are not taken seriously. Kelly (2000) remarks that not a single complaint has been upheld since the introduction of the Mental Health Act 1986 (Victoria, 1998), reducing the complaint mechanisms to ‘paper tigers’. This leaves users of mental health services without effective advocates in the system. As patients’ complaints regarding their treatment are not considered legitimate, there is no effective accountability for poor or abusive practices. Further, the medical ‘treatment’ provided is defensively recorded in the person’s case history.

The chief psychiatrist’s role is to evaluate mental health services in
terms of their effectiveness for patient’s welfare and wellbeing. The chief psychiatrist has the authority to visit a psychiatric service if she/he has reason to believe:

(a) that a person with a mental disorder is not being provided, or was not provided with proper medical care by the service; or

(b) that the welfare of a person with a mental disorder is being, or has been endangered by the service (Victoria, 1998: 131).

As raised in the introduction and in the discussion so far throughout the thesis, consumer/survivors claim these criteria are not adhered to in acute public mental health services. Consumer/survivors claim their experience of receiving services is that treatments are not helpful but harmful, and endangers welfare. Other sources that support the claim that services are damaging are the documented levels of post-traumatic stress, which occur as a result of treatment (McGorry et al., 1991).

The Burdekin report (Human Rights and Equal Opportunity Commission, 1993; 1995) also identified the on going and problematic issues in relation to receipt of mental health services. There is also growing evidence of an increase in suicide rates after contact with mental health services (Appleby et al., 1999; Whiteford, 2000). In the period 1993–97 there was a one hundred and thirty-five percent (135%) increase in calls to lifeline and crisis lines where the caller was
seeing a psychiatrist. In the same period there has been an eighty percent increase in calls where there was specific mention of psychiatric disability (Hocking, 1998).

What these figures tell us is how dependent society is on psychiatric services and how inadequate these services are for meeting the needs of those diagnosed with a psychiatric illness. The coercion law literature discussed also makes clear that the coercive methods used in an attempt to fulfil a duty of care, work against consumer interests (Hoge et al., 1997; Lidz et al., 1995). Chris Burford (2000) suggests that the current monitoring of mental health services in Britain is so ‘rudimentary as to be useless’. Statistics are limited as to how many people require a caseworker. This works as an incentive to discharge people because there are not enough caseworkers. He suggests:

This failure to properly monitor creates a perverse incentive to leave vulnerable people with inadequate support, and perpetuates the revolving door, with well over half of admissions readmissions (Burford, 2000).

Burford complains, the British Mental Health Act does not use its power to find out what goes wrong and that the statistics that are taken are inadequate to identify the problems with the service itself. A similar situation is the case in Australian States where the gross statistics are
limited to admission and follow up services (Victoria’s Mental Health Services, 1996; Victoria’s Mental Health Services, 1997).

The authorisation of the psychiatrist with State power informs every aspect of psychiatric practice in public mental health services, as medical interventions are delivered with the authority and protection of the State. Conversely, Szasz (2000) says that mental illness is a myth to substantiate ‘ceremonial chemistry’, that is, the substitution of medical control for legal and religious ones. He suggests responding to problems either as legal issues where the law is broken, or as psychiatric ones which should receive voluntary treatment. He suggests the myth of mental illness allows people to avoid personal responsibility and enable forced treatment in the interests of family or practitioners and not patients.

Szasz (1974) recommends the establishment of a support service for people to work out their own problems in living, rather than involuntary commitment. This is a tough line as there is little room for compassion or for the difficulties that exist between these two extremes for both families and people who are struggling with problems in living. However, the personal cost for involuntary medical treatment for the patient,
though largely unconsidered in mental health, is substantial. The best solution would be to find a way somewhere between, that both empowers and supports people to be responsible.

Nonetheless, public attitudes favour coercion, and as Appelbaum’s review identified, even legal reform does not necessarily change practice. Legislation is an articulation of both human rights and an attempt to protect infringement upon others’ rights. Yet the use of the law to authorise coercive treatment is an abuse of justice and a contradiction in terms. So how are the conflicts of interests between the protection of the rights of the public and the rights of the ‘patient’ to be overcome?

What remains problematic is the way that patients in terms of their personhood are regarded. Szasz says that it is because of the threat of involuntary admission that it is not possible to say there is a genuine voluntary patient. He states that this accounts for the continued disregard of acute psychiatric patients as people. Likewise, the Understanding and Involvement Project referred to in chapter one, identified the powers of psychiatric professionals such as to detain, imprison, forcibly inject, and administer ECT as ‘a critical source of the stigma pervading the system and all who use and provide its services’
(Wadsworth & Epstein, 1996b: 157-8). Changes in mental health law have not gone far enough. Wadsworth suggests:

the stigma will recede when the powers are only used and only able to be used in humane ways—that is, when they are used only as a very last resort by people who understand that their use reflects a society's lack of alternative resources, they are used in the most minimal way possible, their use is accompanied with respect and kindness and not dislike and fear, there is aftercare to heal the trauma and their use is understood to be not the fault of the person on whom they are used (Wadsworth & Epstein, 1996b: 158).

It is the use of force, which is experienced by consumer/survivors as abusive. The use of force makes a mockery of the rights of men and women, and as Levinas (1993b: 123), whose work will be more fully discussed in chapter seven suggests, ‘the promise of an ultimate return to the rights of man is postponed indefinitely’. This highlights the need for the defence of human rights from outside the State. What is required is:

a vigilance totally different from political intelligence, a lucidity not limited to yielding before the formalism of universality, but upholding justice itself in its limitations (Levinas, 1993b: 123).

Only then is the ‘conjunction of politics and ethics intrinsically possible’ (Levinas, 1993b). This is what is evidenced in the United Nations Principles and in the consumer/survivor movement in particular.
CHAPTER 5

GOVERNMENTALITY, RISK AND THE LEGITIMISATION OF PSYCHIATRY

Governmentality and the techniques of government have become the only political issue, the only real space for political struggle and contestation (Foucault, 1991b: 103).

The previous chapter identified how the law is utilised in mental health to authorise involuntary treatment through the coupling of ‘serious mental illness’ with ‘dangerousness’. This means that immediate medical intervention in the form of certification, medication and seclusion is considered legitimate. The result is a paradox of legally authorised coercive medical services devoid of therapeutic value. This paradox it is argued in this chapter, is a product of the role of government attempting to protect ‘public safety’ through coercive interventions in the face of a perceived ‘danger’, ‘threat’ or ‘risk’. The reliance on the distinction between public safety and risk to legitimise coercive interventions has become more acute since
deinstitutionalisation. The extent of this problem has become one that fulfils Touraine's (1978: 85) last condition for a social movement: that it is a concern of the whole society. The interventionist logic discussed in terms of ‘governmentality’ is defined as the logic of government.

1. A Population at Risk

The government’s view of the subject Foucault suggests is implicit in government techniques or ‘Governmentality’. ‘Governmentality’ refers to the rationalisation of programs and strategies to justify acting upon others’ actions to achieve certain ends (Foucault, 1982; Foucault, 1991b; Rose, 1996). Rose urges that psychiatry is best understood by recognising its role in social regulation, which explains the intersection with human rights abuses and raises the problems of political and ethical issues. Rose suggests that in general, such disciplines are:

- best understood when their very existence is first of all treated as a problem to be explained and where their functioning is understood in relation to a wider field of systems of social regulation, political domination and ethical judgments (Rose, 1988: 183).

In the context of social control, the government’s choice of what services to provide is not necessarily rational or neutral. Foucault (1991)
considers claims of neutrality, which hide the specific interests that have produced knowledge, a political violence. This needs to be revealed in order to be opposed. The political task according to Foucault:

is to criticise the workings of institutions which appear to be both neutral and independent: to criticise them in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked, so that we can fight them (Rabinow, 1991: 6).

Foucault (1991b) states that policies, projects and laws of governance are used to control, subdue, discipline and normalise the conduct of individuals. Therefore the collection and use of ‘information’ is important in justifying what services are provided. Foucault (1991b) declares that it is these techniques, procedures, methods and practices of government that determine, maintain, construct and transform identity. ‘Governmentality’ then, is central to the construction of subjectivity. This raises the question of the concept of the subject in government.

According to Foucault (1991b) the subject of government is not an individual objective entity but a population. The first priority of this population is the maintenance of security. In other words, from the point of view of the administration of government, the protection of the
population is of primary importance. As a primary concern, a threat to this subject is a concern for which evidence is sought. From this point of view, mental health patients are perceived in terms of their potential ‘dangerousness’. It is not that people considered to be ‘mentally ill’ are actually dangerous (Holloway et al., 2000; Rabinowitz & Garelik-Wyler, 1999), but that this is a major concern from the point of view of governance. Hence, it is from this primary concern that a threat to the safety of the population becomes a problem.

Systems for evaluating and regulating risk

The government’s conceptualisation of the subject as population renders people who present themselves distressed to services or in the community, in terms of ‘risks’ to this primary concern. This primary concern with threat has given rise to a whole new range of tactics and techniques, as Castel (1991), Rose (1988) and others (Samson, 1995) have identified as to do with the management of ‘risk’. The emphasis on regulation of risk ‘dissolves the notion of the subject or a concrete individual and puts in its place factors of risk’ (Castel, 1991: 281), or ‘risk factors’. That is to say there is a move from a focus on the individual to the prevention of undesirable events such as deviant
behaviour that puts the population ‘at risk’. This denotes the transition from a clinic of the subject to that of epidemiology (Castel, 1991: 109).

Castel (1991: 28) highlights ‘there is in fact no longer a relation of immediacy with a subject because there is no longer a subject’, but rather factors of risk. The government’s conceptualisation of the subject as population therefore requires strategies to detect ‘risks’. The potential risks factors in populations are ‘based on the collation of a range of abstract factors deemed liable to produce risk’ (Castel, 1991: 281). It is in the context the statistical collation of this entity—population—which is not an objective reality, but a construction around which factors of risk associated with this ‘population’, that factors of risk can be assessed, prescribed, and determined. This has resulted in an increased reliance on experts to detect ‘risks’. Castel (1991) goes so far as to claim experts have constructed risks in order to create new sites of intervention. This new preventative strategy of social administration, Castel maintains, provides a subtle mode of population regulation and multiplies the sites for intervention.

Risk is the effect of a combination of factors. Risks are not things as such but predictions that are socially defined and constructed. The
dispute over risks’ definition is because what is at stake is the social, economic and political consequences of these definitions. Calculations of risk can be made on the basis of biological facts or through scientific means that fail to take into account the social and cultural concerns. The failure to take into account these concerns amount to, ‘a loss of social thinking’ (Beck, 1986: 25). The focus on a biological definition of risk at the expense of what is meaningful, means that ‘dealing with a multitude of troubling, troubled and troublesome individuals’ (Rose, 1998: 181) becomes a paradoxical management issue.

It is paradoxical in that the coercive techniques used to subdue patients who are considered mentally ill, ‘risky’ or at risk of violence, is justified as needed in the interests of the safety of the population. This coercive treatment creates a vicious cycle of violence. The use of violence to deal with the distressed patient, perceived as dangerous, is a violation of the patient’s person. Involuntary detention of a person, who is already distressed, overrides their rights to protection of his/her personal safety. It is the coercive and disrespectful techniques that are utilised in response to ‘risks’ that the consumer/survivor movement have identified and experienced as problematic.
Yet the literature on risk has identified the conceptualisation of risk as inherently subjective:

Risk does not exist ‘out there’ independent of our minds and cultures, waiting to be measured. Human beings have invented ‘risk’ to help them understand and cope with the dangers and uncertainties of life. There is no such thing as real risk or objective risk (Slovic, 1992: 119).

Beck (1986: 26) also points out that the concept of the risk carries a very negative logic of ‘disposition, avoidance, denial and reinterpretation’. Though a qualified expert is required to determine risk ‘objectively’, risks are neither visible nor perceptible. What this results in is the abandonment of ‘victims completely to the judgments, mistakes and controversies of experts while subjecting them to psychological stressors’ (Beck, 1986: 27). The reliance on the language of risk, Castel (1991: 181) contends, subordinates specialists to executants of managerial forces.

In the field of mental health, the task of risk management is delegated to psychiatrists who are considered authorities in identifying ‘dangerousness’ or ‘riskiness’. To achieve this task, these medical professionals are also empowered with the legal authority to remove or threaten to remove the liberties of those considered to pose a threat.
These same professionals then, authorised with State authority, arbitrate over who is to be subject to carceral ‘treatment’. The authorisation of medical experts with legal authority in mental health services is an attempt to justify and legitimise the coercive administration of State power.

Psychiatrists’ diagnostic expertise then is a tool used to serve the interests and purposes of government to maintain social order. The authorisation of the psychiatrist through the Mental Health Act 1986 (Victoria, 1998) with State power achieves the governments’ primary objective: protection of the population. Castel (1991) outlines that psychiatric patients carry a certain threat, the realisation of which is somewhat unpredictable as noted in the last chapter. The rational schemas of hospital treatment, he states, are about programmed prescriptions of the regulation of behaviour. Psychiatry has provided a system of rationalisation for practices and technologies utilised to legitimise and authorise coercive practices in the governing of conduct. However, the difficulty of predicting dangerousness understood as an internal pathological quality of person, and the unreliable, inaccurate and over-diagnosis of its assessment has not provided an adequate
basis for intervention. Rather, the concept of risk offers the mental health professionals the ability to think in probabilistic terms. This risk thinking has resulted in an important shift from legal to administrative decision making and as Rose (1998: 178) points out, has had great significance for ‘our way of understanding and responding to mental health problems’. The task of psychiatry is now ‘less therapeutic than administrative: administering problematic persons on this complex terrain in an attempt to control future conduct’ (Rose, 1998: 179). The concept of risk now extends into the community with ongoing assessments of people’s ‘riskiness’.

The logic of risk prediction, then, has been superimposed on the logic of diagnosis. The role of the mental health professional has become one of risk assessment. The ‘risk assessment’ is a defense if something goes wrong. This form of professional practice is what Rose (1998: 190) describes as a new mode of regulation of professional judgment.

Professional practice is governed through enwrapping professionals in a bureaucratic nexus of reports, forms, monitoring, evaluation and audit, under the shadow of the law, thus governing them according to the logics which are not their own, in the interests of community protection (Rose, 1998: 192).

The concept of risk has inextricably linked care and control. It is part of
‘a new style of control’ (Rose, 1998: 181). It is concerned with the management of dangerousness. The change in the practices of control, the management of mental health and mental health professionals Rose makes clear, does not mean that psychiatry does not continue to perform its clinical or legal functions. Rather, the concept of risk has reshaped, but not replaced, medical and legal logic. Risk strategies are an attempt to ‘identify, classify, and if possible, neutralise the riskiness of the individual pathological person’ (Rose, 1998: 181).

The role of the psychiatrist is now to do with the assessment of risk. This responsibility involves:

the continuous and unending management of permanently problematic persons in the name of community safety. It is here that the clinical language of diagnosis and treatment is increasingly replaced with the probabilistic language of risk assessment. And it is here that the professional vocation of therapy is replaced with that of administration (Rose, 1998: 183).

The coercive measures used in psychiatry result in a reaction of fear by the patient who is not understood but restrained by a variety of coercive means: chemical, physical, electrical and often with long lasting and detrimental results. The coercive measures used on the wards, as has been established so far in this thesis and as Quirk (Quirk & Lelliot, 2001) and many other studies have identified (Allen et al., 1999;
Victoria’s Mental Health Service, 1996a), introduces another set of traumas for the patients. This contradiction of control and care is central to the current crisis in psychiatry internationally.

The role of mental health professionals has been transformed by the demands of risk assessment and risk management. Risk assessment is an attempt to objectify decision making in response to a prediction of violence. It is the attempt to increase the capacity of clinicians to make objective decisions ‘in a climate of doubt and criticism from those outside the field of knowledge itself’ (Rose, 1998: 187). The push for risk assessment is:

- to help sustain the bureaucratic and political assertion of the mental health professional that, potentially at least, they have the capacity to make objective, impersonal and unbiased assessments (Rose, 1998: 187).

Risk classifications then become the means by which professionals justify their decisions. This means clinical decision making is ‘formatted by the demands and objectives of non-clinical authorities’ (Rose, 1998: 187). This means that the system of risk calculation has authority over the clinicians, subordinate to expert systems. Control agencies become connected through ‘circuits of surveillance’, ‘designed to minimise the riskiness of the most risky’, within a ‘regime of perpetual surveillance’
(Rose, 1998: 187). The logic of risk, is that these assessments constitute individuals as actually or potentially risky.

2. Medical legitimacy

In the field of mental health, risk assessment requires clinical assessment. The responsibility for assessing and managing this ‘risk’ is delegated to social control experts—psychiatrists—who medicalise deviant behaviour. As demonstrated in chapter two, the failure to understand psychosis or to recognise patients’ accounts of their needs as legitimate, leads professionals to rely on medical explanatory discourses. The medicalisation of people’s distress objectifies and alienates the person subject to treatment. Denied other sources of understanding, becomes a source of identity. This diagnostic-identity constitutes a profile with a trajectory of ongoing assessment. The claim for diagnostic control adds an additional dimension to the analysis of risk so far laid down by Rose. This additional dimension is the claim for legitimacy by psychiatric professionals themselves.

The question of the legitimacy of the powerful authorisation of medical professionals is discussed by Willis (1990) in *Medical Dominance*. Willis
claims that the alliance between doctors and the State is at the root of
the dominance of medicine (Willis, 1990: 27). The autonomy and
authority of medicine he claims, is a product of a legally created
monopoly ‘to penetrate the body...physically, chemically or with drugs’
(Willis, 1990: 2). Thus, medical ‘sovereignty’ is claimed by the medical
profession, which includes psychiatry, on the basis that it contains the
knowledge on which healing is based. In contrast, Willis argues, that
medical domination is a result of its control within the field of mental
health generally, which is ‘sustained at three levels: over its own work;
over the work of others; and in the wider health sphere’ (Willis, 1990: 2).

Medicine’s powerful position involves it having control by demarcating
territorial boundaries of other health occupations. Moreover, medicine’s
position of authority denies an evaluation of it by others. This ‘ideology
of expertise’ informs the ‘hierarchical division of labour’ so that those
who claim to be the ‘experts are the obvious controllers of the division of
labour’ in health care (Willis, 1990: 25). The equation of professional
authority with expertise, Willis (1990: 25) claims, ‘legitimises the health
division of labour’ and the authoring of medical professionals with
power.
Furthermore, medicine’s dominance has been secured by the rise of science as a form of legitimacy. This buttressing of psychiatry’s claims by science has meant that an attack on one is seen as an attack on the other. Until recently, the lack of scrutiny within medicine had been unquestioned by a belief that doctors act in the interests of their patients. However, this belief has been undermined by evidence that doctors act in their own interests, evidenced by excessive pathology testing and surgical intervention (Bates & Linder-Pelz, 1990: 175-177).

Although Willis’ work is an analysis of the medical profession more generally, his work also applies to the medical specialty of psychiatry. In psychiatry, behaviour previously considered ‘wrong’ is considered an ‘illness’ that requires treatment. This medical rationalisation of social life encourages scientific explanations for a wide range of problems (Zola, 1972: 487). For instance, Szasz (1961: 204-220) suggests that this replacement overlays deviance or riskiness with medical terminology. Szasz claims that the myth of mental illness obscures difficulties actually located in social relationships.

Other critics argue that psychiatry is used as a form of social control to depoliticise social problems [Kleinman, 1988; Fulford, 1994; Foucault,
1991; Willis, 1990]. Foucault highlights how the clinical gaze enables a redefinition of reality in terms of disorder (Foucault, 1975). Psychiatry became a medical discourse as a product of what Foucault (1991c) described as ‘effective history’: the political and economic forces resulting in the domination of the medical perspective. Psychiatry depends upon medical discourse for its power, status, and professional legitimacy, which is attributed to scientific discourse (Foucault, 1991c; Willis, 1990).

Foucault (Rabinow 1991: 73, 162-166) argues the medicalisation of the subject in psychiatry is not because of a logical progression of thought within medical knowledge as is assumed. It is because of what has been referred to as, ‘the politics of truth’, that is, ‘the political, economic, institutional regime of the production of truth’ that is internal to medicine’s claim for legitimacy [Rabinow, 1991: 74-75]. Likewise, Willis suggests that legitimacy is established not through ‘truth value’, but through a political process whereby a practice is accepted as authoritative and therefore the practices associated with it are justified. Freidson (1970: 139) in an analysis of the professional dominance of medicine considers the question of how ‘professional practices
contribute to the unhappy experiences of the patient?’ He suggests, as this thesis does, that a patient is unhappy when ‘treated as if’ he were an object’ (Freidson, 1970: 139). That is, as if there were no capacity for understanding. This indicates a failure of communication based on the one-sided power of medical knowledge. Freidson states

if the staff do not communicate to the patient the meaning of and justification for what is done to him, it in essence refuses him the status of a responsible adult or of a person in the full sense of the word (Freidson, 1970: 139).

In contrast an ‘explanation by the staff constitutes acknowledgement of the client’s status as a responsible adult capable of intelligent choice and self-control’ (Freidson, 1970: 140).

The question of this failure to communicate to the patient in hospital Freidson suggests does not lie in the:

financing, understaffing or bureaucratisation. Rather it lies in the professional organisation of the hospital and in the professional’s conception of his relation to his clients (Freidson, 1970: 141).

The professional dominance of medicine is, as outlined according to Willis, is a product of medicine’s control of information. Other health occupations are not permitted to divulge any medical information. But as Freidson states ‘while he (the doctor) does not want anyone else to
give information to the patient, neither is he himself inclined to do so’ (Freidson, 1970: 141).

As Freidson argues, the reason professionals do not want to communicate to their patients ‘is based on characteristically professional assumptions about the nature of their clients’ (Freidson, 1970: 142). The patient is assumed to be:

> too ignorant to be able to comprehend what information he gets and is in any case too upset at being ill to be able to use the information he does get in a manner that is rational and responsible (Freidson, 1970: 142).

The result of this is that providing information to the patient is considered to create problems of management. Thus: the patient is not given information and viewed as responsible but treated as a child.

The failure to provide explanation then, Freidson points out, puts the expectation on the client to have faith in the professional. Failure to have faith results in denial of service. The insistence on faith in the service provided ‘constitutes insistence that the client give up his role as an independent adult’, which also functions to maintain the ‘profession's institutionalised authority’ (Freidson, 1970: 143). This kind of domination makes clear that the source of a patient’s alienation is not bureaucratisation but professionalism. The medical profession
alienates other occupations through this kind of dominance. This is in contrast to the meaning and identity that the dominant profession offers its own members.

The authority and dominance of medicine has resulted in medicine having authority over the planning and financing of services. This servicing involves a self-enclosed circularity. What professions offer is limited to what defines a profession and services are defined in the terms of a profession. Medicine can only offer healing in its own terms.

Professionalism is:

constituted by commitment to occupationally defined knowledge and technique and occupationally defined public service, to a particular occupation's view of correct knowledge and ethicality (Freidson, 1970: 153).

The medical profession has a professional pride and imperialistic attitude over the value of this knowledge, which is jealously guarded. Medical professionals, through their proud identity with their work, are committed to the institutions within which they work. This professional approach has inherent weaknesses which Freidson (1970: 156) notes, because it is inherent to the profession itself, cannot be rectified from within.
Further, the distribution of health resources is also organised according to the medical profession, which is totalitarian in that it limits other discourses. This totalitarianism is not ‘automatically self-correcting’.

Quite the contrary, ‘expertise establishes office and hierarchy analogous to that of bureaucracy’, such that ‘ideology and technology combine to produce bureaucracy-like consequences’ (Freidson, 1970: 157).

The problem with the autonomy of the medical profession is that it is not bound by rules outside its profession. This avoidance of accountability results in the failure to communicate with patients, which patients experience as objectifying. The objectification of patients through bureaucratic practices are subject to appeal, but professional practices, imputed to have ‘unquestioned objectivity of expertise and scientific truth’ and so are ‘not routinely subject to higher review or change by virtue of outside appeal’ (Freidson, 1970: 159). But as has been demonstrated, experts’ knowledge is not neutral. ‘It is the practice of a knowledge organised socially and serving as the focus for the practitioner’s commitment’ (Freidson, 1970: 159-160).

Freidson identifies that the weakness of professions is not due to the lack of resources, but is a consequence of the demands of
professionalism. In this context the medical professional becomes committed not only to the ideals of the profession, but moreover ‘to a concrete career and to concrete, historically located institutions’ (Freidson, 1970: 155). This limits the problems a professional can perceive as they also have a sense of great pride about their work. The combination of ideals, career and features of professionalism then become a source of the weakness of the profession itself.

Freidson’s (1970: 170) analysis of medicine identifies the depersonalisation of the client, central to service provision, as most marked ‘when the client is most helpless’. That is, ‘when the choice and arrangement of services are an exclusive prerogative of management’ (Freidson, 1970: 170). This is especially the case for mental health patients, though there has been a shift in recent times in service delivery from that of therapy to: ‘an activity of expertise which serves to label an individual, to constitute him or her a profile which will place him or her on a career’ (Castel, 1991: 290).

The dovetailing of medical knowledge and dominance and the newer language of risk in the field of acute public psychiatry entails that there is no longer a function of care but only of identification of risk through
diagnosis. Treatment is replaced by the practice of ‘administrative assignation’ (Castel, 1991: 290) on the basis of the diagnosis of mental illness. These diagnoses can only function through an expertise. This expertise eliminates the problem of care while increasing control through the ‘autonomised management of populations’ (Castel, 1991: 291).

As has been discussed in this chapter, the organisation of relationships between patients and staff are structured by the administrative and professional view of the patient. The involuntary or coerced position of the patient depersonalises and denotes him/her as incompetent and unable to enter into negotiations (Freidson, 1970: 177). It is argued here that the organisational aspects of institutions stem from the profession’s practice of expertise, as well as administration as such: ‘the social establishment of expertise permits the organisation of services around its authority independently of purely administrative organisation’ (Freidson, 1970: 181). This type of administrative control in acute mental health services is a major source of discontent, as it entails a failure to treat people with respect.

Although there has been an attempt by government to improve quality
assurance through the institution of interventions such as outcome measures, this attempt has re-established the problem by relying on clinical methodology, rather than an independent and external evaluation of practices. To avoid the influence of the demands of administration that conflict with those of the client and the professional, evaluation by users needs to be strengthened, so that services are responsive to the ‘immediate human needs of the patient’ (Freidson, 1970: 212). This requires building in to the process mechanisms whereby there is direct feedback from users.

As has been argued above, governments bestow psychiatrists with the authority to incarcerate people considered ‘dangerous’ or ‘risky’ as ‘ill’ and ‘incompetent’. That commitment carries a responsibility of care. But the current mode of intervention with coercive ‘medical treatment’ does not fulfil its ‘duty of care’ but rather, produces trauma. Furthermore, the government’s alliance with, and authorisation of medical sovereignty, means that the problems or limitations of the approach are not recognised but denied. The consumer/survivor movement claims that services fail to meet needs, and are traumatizing. These reports are not taken seriously and are considered further evidence of pathology. Instead of responding to peoples needs with
face-to-face interviews, current practice offers incarceration and the examination of the patient’s record.

3. Problems with Governmentality: Risk and Medical Legitimacy

The conception of the role of psychiatry as that of community protector fails to conceptualise the obligation to protect those with mental health problems from the ‘actual and symbolic violence they face at the hand of the community’ (Rose, 1998: 183). This failure is a failure to empower those who use services and replicates the logic that ‘equates difference with danger’ (Rose, 1998: 183). The result is that the rationale for confinement is security. Yet the coercive methods used against consumer/survivors are not considered a violation of human rights because this action is considered a legitimate use of power in the interest of the safety of the population.

Action taken against those defined as ‘mentally ill’ is justified through the legalisation of coercion in mental health law, as the example from the Mental Health Act 1986 (Victoria, 1998) has demonstrated. The identity of the patient is forfeited in the interests of the protection of
society from risk. The diagnosis of mental illness authorises the imposition of violent and coercive practices, under legal protection. The imposition of ‘treatment’ under the pretence of medical care is incongruous with the negative effects such coercive methods have on the patient’s already traumatised sense of identity and subjectivity. As Castel (1991: 289) has noted, there has not been ‘a trace of reflection on the social and human cost of this new witch-hunt’ for risk factors. Castel (1991: 202) argues that the focus on the case record has highlighted a ‘shift from presence to memory, from the gaze to the objective accumulation of facts’. The focus is on factors that produce risk and not the person. This means that the aim of intervention is that:

which, at other times or in other circumstances might be considered intrusive, oppressive, discriminatory or paternalistic, can be justified as being for the protection of the ‘at risk’ individual and ultimately of benefit to ‘society’ as a whole (Peterson, 1996: 56).

Meanwhile people detained in an acute public psychiatric hospital are then subject to further ‘risks’, as indicated in the introduction: violence, sexual abuse and drug and alcohol use (Quirk & Lelliot, 2001). The problems experienced by the patient with coercive routines in mental health services, do not result in time allocated to consultation, but as noted in chapter 4, in ‘ceremonial chemistry’ (Szasz, 2000). Castel
(1991: 202) also states the resulting situation might be called ‘a crisis of clinical medicine, a crisis affecting the personalised relation between professional and client’ which ‘supplants the old doctor-patient relation’ with a ‘clinic of the subject to an epidemiological clinic’, marking a transformation in medical practice.

This shift from individualised clinical practice is also noted by Willis (1990) and Illich (1975) and is evident in the more recent changes in health, whereby health services are run on a corporate model. This involves the psychiatrist’s role being subordinate to that of a manager (Castel, 1991) dealing with reduced resources (in terms of bed numbers and length of stay). This has meant that psychiatrists can offer only crisis and emergency management in an acute psychiatric admission. Nonetheless, admission is the only available resource to respond to acute crises.

Rose (1998: 190-192) makes three points about the shift toward the management of risk in mental health services. The first point is that risk management shapes the role of mental health professionals. The fear of prosecution by patients, victims and families is the driving force behind the risk-based technologies. Participation in the ‘ideology of risk’
however makes a priority of public protection, at the expense of the duty of care owed to patients, and ‘to the myth that risk-based practice will actually enhance public safety’ (Rose, 1998: 190).

Secondly, Rose points out that significant ethical consideration is bypassed in the assessment of risk around the issue of the moral and social judgment of what does and does not count as dangerous and the uncritical acceptance of the ‘objectivity’ of such scales. Thirdly, Rose points to the way the debate has been structured in terms of the rights and security of the general public as potential victims and the demand for protection. Psychiatry has been forced to satisfy the public and political demand to identify ‘the potentially dangerous’ in the name of community safety because of the proposed danger. The intervention of incarceration does not involve reform. The concept of risk transforms the responsibilities of psychiatry and its roles and responsibilities to that of coercively managing risky individuals (Rose, 1998: 192).

The government’s conceptualisation of the subject as population means that risk to the population is of primary concern. Clinical epidemiology combines medicine and governmentality to evaluate risk in the population. It is an evaluation of the incidence of health problems in the
community in order to provide government services. Though clinical epidemiology provides information about the incidence of mental illness in the population, that level of evaluation is inadequate as a means to understand these problems and therefore is an inadequate means by which to establish a response to these problems. The problem is that analysis at the level of clinical epidemiology as Koegel (1992: 1) asserts, provides an incomplete and even ‘distorted perception’ of problems.

Moreover, the language of risk and the language of ‘population’, when tied to clinical epidemiology provide little understanding about ‘what patients think, what their beliefs and values are, and what meaning they impute to their existence’ (Koegel, 1992: 4). Koegel (1992: 4) goes on to say, that what is worse is that there seems to be little notion that the attitudes and values in mental health services affect how people considered mentally ill behave, and ‘even less of a notion that such people have something important to say about their own lives’.

Koegel, for one, states what is needed is a framework for understanding behaviour that otherwise would seem bizarre. This requires finding out about the meanings people have of their lives and what is meaningful to people. He (Koegel, 1992: 4) points out that the preoccupation with
‘pathology, disintegration and disaffiliation’ has also brought attention to what is wrong with people without knowledge of ‘what may be right’, that is the strengths and creativity that enable people to survive. The conception of the subject as population by government means the identity of the patient is forfeited in the interests of dealing with risk factors, a task delegated to psychiatrists. It also explains the use of community treatment orders and the rise in the use of antipsychotics and preventative mechanisms of surveillance directed towards children in a ‘system of systemic predetection’ (Turner, 1995: 227).

An example of the limitations of the epidemiological and clinical approach is that the only attempts to understand the ‘homeless mentally ill’ have been through a reliance on epidemiological and clinical perspectives (Koegel, 1992: 2). Research into understanding how these people live their lives and make sense of them is missing. Koegel’s (1992: 8) study of the ‘homeless mentally ill’ identified that behaviour
labelled ‘psychotic’ made sense when considered in context and ‘may even be adaptive’. Understanding requires studying behaviour in context. 13

Link and Phelan (1995: 80) question the current emphasis on risk factors and argue that ‘greater attention must be paid to basic social conditions if health reform is to have its maximum effect’. This claim is made on the basis that risk factors must be contextualised to understand what ‘puts people at risk of risks’ (Link & Phelan, 1995: 80). Further, they argue that social factors are fundamental causes of

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13 This need for understanding of the context and meaning of symptoms was what was found to be missing from psychiatry in chapter two in Jaspers phenomenology, and identified as centrally important in Goffman’s analysis in chapter three.
disease through multiple mechanisms. Medicalising patients’ problems as risk factors has implications for both those who provide and those who receive mental health services. The authorising of professionals by the State with legal authority to enforce coercive ‘treatment’ has implications for the identity and subjectivity of both the patient and the professional.

Moreover, the subjectivity of the psychiatrist is just as much taxed in the encounter or in the distribution of these techniques as the patients themselves. To identify the role of coercive practices in the construction of the subject is to recognise the political nature and responsibility of what is authorised. The conflicting responsibilities to patients and families that institutions of government require of psychiatrists, disregards the ethical dilemma this produces for professionals in this ‘hierarchy of coercive power’ (Thomas, 2001).

The coercive regime of treatment services and instruction for trainees, results in psychiatrists leaving public mental health services in preference for private psychiatry (McKay & Associates, 1996). The National Mental Health Strategy, Optimum Supply and Effective Use of Psychiatry (McKay & Associates, 1996) indicates that this movement of
psychiatrists to private practice is explained by a number of factors. Psychiatrists are disempowered in public mental health services whose managerial roles have been taken over by managers and other health professionals. The negative image and relative lack of status have also been cited as factors as well as the responsibilities, coercive nature of treatments and relative isolation of registrars and the stress this induces. The taxing nature of the engagement between patients and psychiatrists has led practicing psychiatrists to avoid personal involvement especially with public patients. The failure to provide patients with a personal level of support denies satisfaction for both parties.

Furthermore, this study (Optimum Supply and Effective Use of Psychiatry, (McKay & Associates, 1996)) identified that the determinants of access to mental health services were socio-economic factors not clinical ones. Even though those in the public mental health system are generally of a lower economic status, those experiencing some form of serious mental illness such as psychosis, need specialist psychiatric care. However, as the report identifies, few specialists stay in the public mental health services, preferring the more lucrative and more rewarding practices of private treatment. From this perspective,
admission of public psychiatric patients is not a function of ‘illness’ but of a lack of social, emotional and economic resources. In other words, socio-demographic factors may predict health service use better than diagnosis (Kisely, Preston & Rooney, 2000).

In a retrospective analysis of diagnostic related groups and outcome, Faulkner (1994) found that the length of stay of hospital admission was related to social variables rather than diagnosis. Likewise Goldney (1998) found that problems with daily living rather than a specific diagnosis was related to depression. Rather than provide housing, and other supports as the study People Living with Psychotic Illness: An Australian Study 1997-98 (Jablensky et al., 1999a) identified as needed, people identified as mentally ill are considered dangerous and admitted for lack of alternative resources.

Since the introduction of Medicare in 1983 the use of private psychiatry has been rising (McKay & Associates, 1996). Forty-five percent of private practitioners provide long-term psychotherapy for people in the other high status professional occupations, while only five percent of the lowest socioeconomic group received the same therapy, though these have been the group identified with the most serious mental
illness. Utilisation rates parallel the socio-economics status, as those who use private psychiatry are privately insured (McKay & Associates, 1996).

What this amounts to is an economically driven service: people in the highest socio-economic brackets get specialist therapy on Medicare while those most disabled are channelled into the hospital system that offers little support. Notably, between 1984 and 1993 there has been a 44 per cent increase in the number of registered psychiatrists (McKay & Associates, 1996) and Victoria has the highest per capita level of consultations by consultant psychiatrists, 25 percent above the national average (Commonwealth Department of Health and Aged Care, 1996: 156). Importantly, the programs and practices offered have real effects in the lives of those completely subjected to those with authority.

**Contesting Governmentality: Risk and Psychiatric Legitimacy**

People subject to services are invalidated, without rights or a voice, completely disempowered and without means to establish the legitimacy of their own experience. Expressing concerns carries with it the fear of
an increase in coercive psychiatric treatments. The rationality used to justify practices utilised in mental health services has not taken the implications for user and provider subjectivity into account. This failure leaves services unaccountable for the negative outcomes for which it is responsible. What discussions about risk make clear is the ‘fissures and gaps between scientific and social rationality in dealing with the potentially hazardous potential for civilisation. The two sides talk past each other’ (Beck, 1986: 30). It is left up to new social movements to ‘raise questions that are not answered by risk technicians’ (Beck, 1986: 30). New social movements highlight the varied interests of the current political terrain.

As a new social movement, the consumer/survivor movement contests the techniques and knowledge’s that authorise the processes that are imposed on them. The consumer/survivor movement is an attempt to impact on policy and break the vicious cycle of the conceptualisation of people with ‘mental health’ problems as dangerous, and the enforcement of coercive practices in the interests of ‘security’ as: the treatment of human beings in public mental health services has grave results for those so subjected. Failure to recognise the effects in terms of costs for the personal subjectivity of those that currently practice
in them or are subject to them is a failure of government to be accountable for the very practices it-endorses. The consumer/survivor movement contests the use of force against them, because of the negative subjective consequences. As the authorising body, the negative effects are the responsibility of government.

According to Touraine (1978), the reason this discontent has not been taken seriously is because those in power oppose whatever restricts their action, while disowning this power. He argues that the powerful are only prepared to replace the system of historical action with a system of corresponding interests. As has been shown above, this is the case with the mental health system. The conflict in mental health services is over the legitimacy of social, cultural, political and legal decision making in the treatment of the ‘mentally ill’ by those working in the mental health system. The positioning of psychiatrists in the system works to defend professionals through the use of the law, and protect them through claims to knowledge and truth, which limits the possibilities for social transformation. Professional stakeholders are able to maintain power by manipulating society’s needs while rejecting the autonomy of participants and other professionals. Mental health consumer/survivors are in conflict with professionals who control
the social and cultural organisation of practices’ political and legal decisions.

However, perhaps the incommensurability between the stakeholders’ perspectives can be addressed. People using services have identified the most important factor of their experience was that they felt that they were not respected or treated as human beings. A theory of the subject is required that conceptualises patients as legitimate subjects within acute psychiatric services. This would provide the means for those who use services to acknowledge their needs as they identify them. This would require the availability of methodologies that access consumer/survivor narrative knowledges, which requires ‘know how, knowing how to speak and knowing how to hear’ (Lyotard, 1984): that is, tools that recognise the subjectivity of the patient, as person is required.

The practices prescribed and enforced in the mental health services construct the subjectivity of mental health users as risky, threatening and dangerous. This conception is responded to with the authoritative and coercive force of the law, which has negative implications for the subjectivity of patients and providers. The consumer/survivor
movement as a new social movement is directed at the level of the system of action, challenging the social definition of the roles of politics and the social order. This is in opposition with the dominant cultural model that coincides with the economic interests.

The actors in a social movement want both to create and control a system by overcoming an adversary who is preventing them from doing so, thus challenging the traditional system of social and economic relationships. The system is maintained on the basis of what is practical. A strong new social movement is a struggle against a practice, which is counter-productive for the wellbeing of those subject to it. Even though economic arguments are used to defend the current problems in mental health services, this defense is inadequate to defend a call to address the important moral and political issues raised by uses of these services. In an attempt to respond to this call, alternative conceptions of the subject that could be utilised in acute psychiatric services will be considered in the next two chapters.

The next chapter is a detailed analysis of RD Laing’s reconceptualisation of problems experienced by acute public psychiatric patients. This counter paradigm to the medical conception of problems
is important, as the conceptualisation of patient’s problems has implications for treatment in a double sense. Laing’s reconceptualisation of psychiatric problems in the light of a person’s biography, not only makes psychiatric problems understandable, but also offers a conceptualisation of the subject as one who is comprehensible in terms of their biography. This alternative conceptualisation raises the question of the way patients are treated at two levels: the question of the appropriateness of biological treatments; and the question of ethics in the way people are treated in acute public psychiatric services in general.
I am not fond of the word psychological. There is no such thing as the psychological. Let us say that one can improve the biography of the person (Jean-Paul Sartre in Laing, 1965a: 120).

In his memoirs Ronald David Laing (1985) recalls how he struggled with psychiatric treatment regimes for psychiatric patients: insulin injections, padded cells, locked wards, ECT, and codes of practice that involved not talking to patients. Laing could not accept such dehumanising practices in the name of psychiatry. He tried to understand how psychiatrists justified such treatment of psychotic people. Laing found treatment was justified on the basis that people who experience psychosis are considered different. This difference, as outlined in chapter two, Laing (1985: 7) attributed to Jasper’s claim, that there was ‘no greater difference’ in the psychic life of human beings than ‘that between the normal person and the psychotic’.

In an analysis of this ‘difference’, Laing (1985: 7) asks, ‘what sort of difference do we take the difference between us to be?’ Laing notes the
difference associated with psychiatric problems was considered to be
due to biology. But Laing notes:

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this psychiatric doctrine of the abyss of difference between us and
them takes us to the brink of another sort of abyss. How do 'we' treat
'them' (Laing, 1985: 7)?
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Laing came to the conclusion that:

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I would not like to be treated the way my own patients had to be
treated. I would not like to be locked up in a psychiatric ward under
observation. I could not believe that the drugs, the comas, the
electric shocks I was expected to prescribe and administer were the
recent advances in psychiatry that I was led to believe they were... I
knew what a psychiatrist like me was supposed to conclude about
my patients' state of mind if he were to tell me my treatment was
destroying him. But I agreed with him (Laing, 1985: 9).
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Laing recognised the conceptualisation of patients as ‘different’ to have
implications in terms of interpersonal relations in psychiatry. It meant
that the doctor’s opinion is considered legitimate, while the patient’s is
not. There are two aspects of the doctor-patient relationship that Laing
considered significant in the process of diagnosis. Firstly, he considered
the (ever-present) imbalance of power to be important. He considered
the term ‘patient’ to refer to the power imbalance of those subject to
psychiatric practices. Secondly, he considered diagnosis to occur in and
through a relational process, and not a mechanical, objective, neutral
one, as is claimed.
For example, Laing suggested diagnosis of schizophrenia is made on the basis that the person with schizophrenia is considered ‘autistic’, that is, incapable of forming a human bond. Laing argues that this lack of willingness to bond is as much a product of the disinclination of the practitioner to bond with the patient as the patient with the practitioner. A psychiatrist, states Laing, makes a diagnosis:

in the role of a diagnosing psychiatrist, about a person, in the role of patient-to-be-diagnosed. It is made across a gulf between them. The sense of human bond with that patient may well be absent in the psychiatrist who diagnoses the patient as incapable of any such bond with anyone (Laing, 1985: 9).

The failure of the psychiatrist to see his own role in the construction of such ‘autism’ means for Laing (1965a: 33) that ‘we are already’ (speaking as a psychiatrist), ‘behaving in a manner analogous to the way we regard him as treating us’. It is this power differential, Laing claims, that has made what is acceptable for one, pathological in another.

Laing points out that if the practitioner is unwilling to enter into a relationship, why should the diagnosed be? Nonetheless, failing to be willing to enter into the one-sided relationship with the practitioner lands the patient as no longer person, with the diagnosis of mental
illness. Nonetheless, Laing (1965: 34) highlights the importance of the interpersonal in the doctor-patient relationship: ‘what the schizophrenic is to us determines very considerably what we are to him, and hence his actions’.

In an attempt to bridge the ‘abyss of difference’, and respond to psychiatry’s failure to understand the patient, the central concern of this thesis, Laing’s attempt to address the limitations of biological psychiatry will be examined. Laing developed a number of different accounts of psychiatric problems over the course of his career. The first two will be analysed here in an attempt to consider an alternative to the current paradigm of psychiatry. ‘Ontological insecurity’ was Laing’s first alternative conception of psychiatric problems based on a ‘science of person’. Here psychosis or a split sense of self was seen as due to the failure to achieve a sense of ontological security.

The section: From the Case Study to the History of the Subject is an example of how taking a biography facilitates understanding. This example also shows how ontological insecurity is the product of a person’s interpersonal relationships. Interpersonal relationships become the focus of his next conceptualisation of problems for the psychiatric
subject. Each of these accounts involves a different conceptualisation of psychiatric problems with implications for the conceptualisation of the subject. These conceptualisations will be considered through a detailed analysis of Laing’s work. This close reading is important as it provides a counterbalance to the psychiatric paradigm. It also lays the foundation for an alternative conceptualisation of the subject that takes into account the social and the personal which come together in the concept of a narrative subject in the following chapter.

1) Ontological Insecurity

Laing (1965a) first attempted an alternative conceptualisation of the problems people were experiencing in *The Divided Self*. Here he described the split nature of schizoid and schizophrenic conditions as
‘ontological insecurity’: the terminology of existential-phenomenology. 14 Laing’s (1965a) aim in *The Divided Self*, was to ‘make madness, and the process of going mad, comprehensible’. Ratna (1994) considered *The Divided Self* to make three contributions to understanding schizophrenia. Firstly, that schizophrenese, the so-called language of schizophrenia, was made understandable. Secondly, that the fragmented personality of the schizophrenic was made understandable. Thirdly, that ambivalence, a diagnostic sign that characterises schizophrenia, was clarified.

Laing described ambivalence as the deep need for, and fear of, love. For a person experiencing schizophrenia, ambivalence results in withdrawal from relationships. Laing understood the need to be loved and understood is, at the same time also a source of terror that the same

14 Laing was well versed with existential-phenomenology and translated Sartre’s works in *Reason and Violence* with David Cooper (Laing & Cooper, 1971).
love will overwhelm: ‘The critical test of whether or not a patient is psychotic is the lack of congruity, and incongruity, a clash between him and me’ (Laing, 1965a: 129).

Laing identified the terminology in psychiatry as central to the failure to understand psychiatric conditions. Laing argued the reason a person’s behaviour is read as symptomatic of a pathological problem, is because the scientific discourses do not provide other terms within which to conceptualise the interrelationship of the mind on the body. Clinical terms, he (Laing, 1965a: 18) said: ‘isolate and circumscribe the meaning of the patient’s life to a particular clinical entity’.

Laing considered the terms utilised to conceptualise psychiatric problems as dualist: mind and body, self and other. These terms, he thought, failed to conceptualise the interaction of the mind on the body, the other on the self. In other words, discourses available to articulate mental health problems are either biological or phenomenological, without adequate conceptualisation of the interaction of the two in a social context. Psychiatric concepts, he suggested, precluded an alternative conceptualisation of the issues because of the monism that reduces one term to another.
For example, biological approaches to a problem prevent phenomenological and/or social ones. The language of psychopathology:

precludes the possibility of understanding patients disorganisation as a failure to achieve a specifically personal form of unity... (which) perpetuates the very dualism that most psychopathologists wish to avoid and is clearly false. Yet this dualism cannot be avoided within the psychopathological frame of reference except by falling into a monism that reduces one term to another, and is simply another twist to the spiral of falsity (Laing, 1965a: 24).

Laing’s analysis highlighted the limitations of pathology as a way to understanding the experience of the psychiatric subject. ¹⁵

¹⁵ These issues about the importance of the subjective experience of the schizophrenic are the same kinds of issues more recently being debated in philosophy. In Philosophical Perspectives on Psychiatric Diagnostic Classification, Sadler, Wiggins and Schwartz (1994) take the issues of the subjectivity of diagnosis as a promising area of development for psychiatry. Bolton and Hill (1997), Graham and Stephens (1994), and Sadler, Wiggins and Schwartz (1994), collectively argue for the role of meaning to be considered in ‘psychopathology’. Bolten and Hill (1997), in particular, argue that intentional purposes are central to representational processes, and that the subjective
Laing goes on to argue that Kraepelin’s view of psychosis was only one way of perceiving schizophrenic behaviour. To challenge this view, Laing, attempted to ‘reconstruct the patient’s way of being himself in his world’ (Laing, 1965a: 25). To this end, Laing reinterpreted Kraepelin’s precedent-setting study, thereby undermining the very foundation of psychiatric concepts and practice. To do this Laing first outlined Kraeplin’s quote from a person in a catatonic state:

“When asked where he is he says, ‘You want to know that too? I tell you who is being measured and is measured and shall be measured.’

nature of these processes need to be made central to the conceptualisation of mental health and illness.

Mishara (1994: 130) argues that the DSM’s claim to be phenomenologically ‘descriptive’ is wrong as ‘it harbours an array of concealed theoretical assumptions about the nature of mental disorder and its classification’. Stephens and Graham (1994) argue that hearing voices is a product of a subject’s disturbed sense of self rather than an auditory hallucination. This is remarkably close to what Laing was saying as will be demonstrated.
I know all that, and could tell you, but I do not want to (Laing, 1965a: 29-30).

Kraepelin’s judgement of this scenario is that:

He has not given us a single piece of useful information. His talk was... only a series of disconnected sentences having no relation whatever to the general situation (Laing, 1965a: 30).

In contrast, Laing reinterpreted the quote as suggesting that the person resented being used as a sign of disease. Laing’s interpretation was that the person was responding to an experience of being subject to an interrogation. Consequently Laing suggested that the person: ‘feels, that Kraepelin is objecting because he is not prepared to prostitute himself before the whole classroom of students’ (Laing, 1965a: 30). Laing interpreted the patient’s response as a send up of the interrogator.

Kraepelin asks him his name. The patient replies by an exasperated outburst in which he is now saying what he feels is the attitude implicit in Kraepelin’s approach to him: What is his name? What does he shut? He shuts his eyes... Why do you give me no answer? Are you getting imprudent again? You don’t whore for me (Laing, 1965a: 30)?

Laing argued that the same behaviour can be seen either as signs of disease (as Kraepelin did), or in an existential-phenomenological way as representing the frustration of his relationship with Kraepelin. Laing’s approach was to recognise that the person was tormented and
desperately objecting to being treated as an object to be classified and that 'he wants to be heard', not classified (Laing, 1965a: 31). Laing protested ‘we will find no intelligibility in behaviour if we see it as an essential phase in an essentially inhuman process’ (Laing, 1965a: 25). Using existentialist-phenomenology, Laing reconceptualised the problems experienced by people requiring psychiatric services as an internalisation of interpersonal experience, rather than biology.

In Laing’s framework of understanding, ontological insecurity is a product of a person’s relatedness to and separateness from others, which is central to the construction of one’s sense of self. Laing identified interpersonal relationships as central to mental health problems. He argued that relatedness and separateness are ‘an essential part of our being’ (Laing, 1965a: 26). Laing defined ontological security as a place of ‘being’ secure. This security offers a state of autonomy and separateness in relation to others. However, as this sense of autonomy is developed in relationship to others, this places the role of interpersonal relations as central to the development of ontological security.

Laing explains, interpersonal relationships are central to the concept of
self, because a sense of self is established in the pattern of relationships at a micro level.

A lack of a sense of autonomy implies that one feels one’s being to be bound up in the other, or that the other is bound up in oneself, in a sense that transgresses the actual possibilities within the structure of human relatedness. It means that a feeling that one is in a position of ontological dependency on the other (i.e. dependent on the other for one’s very being), is substituted for a sense of relatedness and attachment to him based on genuine mutuality. Utter detachment and isolation are regarded as the only alternative to a clam—or vampire like attachment in which the other person’s life-blood is necessary for one’s own survival, and yet is a threat to one’s survival. Therefore the polarity is between complete isolation or complete merging of identity rather than between separateness and relatedness. The individual oscillates perpetually between the two extremes, each equally unfeasible (Laing, 1965a: 53).

The ontologically insecure person does not feel connected to the body, and ‘is preoccupied with preserving rather than gratifying himself: the ordinary circumstances of living threaten his low threshold of security’ (Laing, 1965a: 42).

The ontologically insecure person experiences others as a source of anxiety because of the fear that relationships with others will lead to ‘engulfment’, ‘implosion’, ‘petrification’ and ‘depersonalisation’ (Laing, 1965a: 43-47). For example, engulfment refers to the ontologically insecure person’s sense of a threat to identity in any relationship. ‘Being loved, or simply being seen’ can mean being destroyed (Laing, 1965a: 44). Isolation is an attempt to preserve identity ‘to prevent himself
losing his self’ (Laing, 1965a: 42-43). As security is not found, separateness is not achieved. The person experiences him/herself as ontologically insecure, which involves a compensatory mechanism of splitting into a mind and body, or of separation of the self into a ‘false’ embodied self, in contrast with the ‘true’ disembodied self.

This split will be seen as an attempt to deal with the basic underlying insecurity. In some cases it may be a means of effectively living with it or even an attempt to transcend it (Laing, 1965a: 65).

The absence of the true self from the body means the body is observed by the disembodied self, which becomes hypervigilant, and develops complex relationships with the body, which are unique to the individual.

Instead of being the core of his true self, the body is felt as the core of a false self, which a detached, disembodied, ‘inner’, ‘true’ self looks on at with tenderness, amusement or hatred (Laing, 1965a: 69).

The person split in such a manner has a complex relationship to the ‘inter-personal’ relationships of the split sense of self within.

In all this there is an attempt to create relationships to persons and things within the individual without recourse to the outer world of persons and things at all. The individual is developing a microcosm within himself: but, of course, this autistic, private, intra-individual ‘world’ is not a feasible substitute (Laing, 1965a: 74).

In other words, Laing (1965a: 43) is saying, not that the person is
loosing contact with reality, but that their reality is a reality ‘he can no longer share with other people’.

The schizoid state is a person’s way of dealing with a threatening situation, from which there is otherwise no escape. This psychic escape is by way of detaching from the body. But this split creates some problems: ‘His false self does not serve as a vehicle for the fulfilment or gratification of the self. The actions of the false self do not, however, ‘gratify’ the ‘inner self’ (1965a: 96). Laing describes the schizoid individual disembodied self as an attempt to preserve the self, but this involves a paradox:

The tragic paradox is that the more the self is defended in this way, the more it is destroyed. The apparent eventual destruction and dissolution of these schizophrenic conditions is accomplished not by external attacks from the enemy (actual or supposed), from without, but by the devastation caused by the inner defensive manoeuvres themselves (Laing, 1965a: 77).

The false-self system is not straightforward. The false self of the schizoid is compliant to the will of others:

It is felt as alien; the unrealness, meaninglessness, purposelessness which permeate its perceptions, thoughts, feelings, and actions and its overall deadness are not simply productions of secondary defences but are a direct consequence of the basic dynamic structure of the individual’s being (Laing, 1965a: 96).

It is the self that others want him/her to be. These persons experience
themselves as denied the right to their own subjective life by saying: ‘I was merely a puppet of her reality’ (Laing, 1965a: 97). The false self is not an attempt to be good, but a ‘negative conformity’ to another’s will, ‘prompted by the dread of what might happen if one were to be oneself in actuality’ (Laing, 1965a: 97). Such compliance means that one’s self is denied outward expression and concealed within the imaginary.

But this false self marks the split between the inner and outer life. This outer compliance is an attempt to ‘preserve himself from total extinction’ (Laing, 1965a: 97). What explains this split Laing suggests, is fear and hatred. Fear is the response to forced compliance by an other, and hatred is then directed toward the self, thereby endangering life. ‘However, the anxiety to which the self is subject precludes the possibility of a direct revelation of its hatred, except... in psychosis’ (Laing, 1965a: 99-100).

In this context of hatred driven inward, the false self is a characterisation of the behaviour despised in the other, but denied as part of the self through the notion of the divided false self. This, according to Laing, is in order to protect or deaden the vulnerable, frightened self. Laing identifies the paradox at the heart of the false self-
system: where the “inner’ secret self hates the characterisation of the false self”, the inner self fears the intrusion of the false self, but, in actuality, ‘the inner self is not more true than the outer’ (Laing, 1965a: 102-103). In David’s case the:

inner secret self turned into a most controlling manipulating agency, which used to be his false self, very much like the puppet he felt he had been for his mother. That is, the shadow of his mother had fallen across his inner self as well as his outer self (Laing, 1965: 103).

What had been the compliance of the false self, becomes an attack by the use of a mocking caricature of the other. The false-self system then ‘is a way of not being oneself which seems to offer security’ and ‘does tend to occur with particular insistence and compulsiveness on the basis of the schizoid false-self system’ (Laing, 1965a: 104).

Laing (1965a: 105) explains schizophrenic behaviour as a ‘patchwork of other people’s peculiarities made more peculiar by the incongruity of the setting in which they are reproduced’. He likens these patchwork fragments to pieces of shrapnel that:

get embedded in the individual’s behaviour as pieces of shrapnel in the body. While maintaining an apparently happy smooth relationships with the world, the individual is forever picking at those alien fragments which (as he experiences it) are unaccountably extruding from him. These behavioural fragments fill the subject with disgust and horror... this little ‘introjected’ action fragment or particle cannot be attacked without violence to the subject’s own being (Laing, 1965: 105).
Laing (1965a: 105) describes the experience of schizophrenia as one where behaviour is completely consumed by ‘compulsive mimicry, impersonating, caricaturing’. Catatonia is described as an attempt to avoid this behaviour.

Laing (1965a: 106-119) identified self-consciousness to be central to ontological insecurity. He stated that on one hand, there is a need to be seen to be reassured of existence, but on the other hand, being seen is also experienced as a dangerous threat to identity, resulting in the false-self system. Being somebody else, or absent from the body, or incognito, are defenses in schizoid and schizophrenic conditions. Laing (1965a: 111) argues that though such defence mechanisms offer an ‘avenue of escape’ from ontological insecurity, the result is a ‘source of weakness’ and cost a coherent sense of self.

People with schizoid and schizophrenic conditions even more so, remain ‘compulsively preoccupied with the sustained observation of one’s own mental and/or bodily processes’ (Laing, 1965a: 112). That is:

he turns the living spontaneity of his being into something dead and lifeless by inspecting it. This he does to others as well and fears their doing it to him (petrification) (Laing, 1965a: 112).

Hypervigilance is an attempt to lessen the danger of being in ‘someone
else’s power and control’ (Laing, 1965a: 113). The self is not embodied, though because despite ‘his longing to be known’, ‘this is also what is most dreaded’ (Laing, 1965a: 114).

Laing (1965a: 115-119) discusses the role of the other in the construction of the self by drawing from Freud’s (1920) discussion of a little boy playing with a reel and string, his image in a mirror, and his mother’s disappearance. The loss of the mother is associated with the loss of the sense of the self as the self is constructed as a person as in the eye of the mother. His game of making his self/image disappear in the mirror, is a crucial phase of developing self identity which is to an extent confused with the image of the mother as ‘other’. Laing goes on to argue that when a person experiencing schizoid schizophrenia feels threatened that the other may ‘go away or die or not reciprocate one’s feelings for him’, the person seeks another to mirror him/herself to ‘turn his self, a quasi-duality with an overall unity, into two selves, i.e. an actual duality’ (Laing, 1965a: 117).

For a child, the caretaker is the source of his/her identity. Laing maintains that the identification of the self with the caretaker, is what informs the characteristics of the ‘observing self’ (Laing, 1965a: 117).
This understanding recognises the role of interpersonal relationships in the development of schizoid or schizophrenic conditions. But the implications of this claim are serious, as what happens is the child internalises the destructive observer.

It may be that the child becomes possessed by the alien and destructive presence of the observer who has turned bad in his absence, occupying the place of the observing self, of the boy himself outside the mirror (Laing, 1965a: 117).

Through this understanding Laing (1965a: 117) explains that the extraordinarily critical observing self ‘has now a persecuting observer in the very core of his being’. The child becomes an object to himself by observing him/herself as other.

He retains his awareness of himself as an object in the eyes of another by observing himself as the other: he lends the other his eyes in order that he may continue to be seen; he then becomes an object in his own eyes. But the part of himself who looks into him and sees him, has developed persecutory features he has come to feel the real person outside him to have (Laing, 1965a: 117).

Laing (1965a: 117) suggests that ‘the child becomes possessed by the alien and destructive presence of the observer’, which references an ‘alien’ observer whereby the child, ‘then becomes an object in his own eyes’. The consequence is that ‘the part of himself who looks into him and sees him, has developed the persecutory features he has come to
feel the real person outside him to have’ (Laing, 1965a: 117). The absence of the mother for the young child is associated with fear of the absence of the consciousness of his/her own being: ‘not to be conscious of oneself, therefore, may be equated with nonentity’ (Laing, 1965a: 119).

What Laing suggests then is that if in the developmental phase the environment provides security, the person develops a sense of ‘being’; but if this security is not provided, the person achieves this sense of being that is not otherwise available, through a ‘special strategy’ of remaining self-conscious.

The schizoid individual is assuring himself that he exists by always being aware of himself. Yet he is persecuted by his own insight and lucidity (Laing, 1965a: 119).

Laing argues that providing ontological security later in life is an opportunity for this developmental phase to be achieved. However this is not to overestimate the success or underestimate the difficulty of reversing problems that arise early in life.

Laing outlines the problem central to the schizoid and schizophrenic’s conditions as the internalised other, which has a profound effect on the self. Laing uses this idea to identify the central role of interpersonal or
intersubjective relationships in the construction of the self. Problematic conceptions of the self, he suggests, can be understood as the result of problematic interpersonal relationships. This theme he goes on to develop further and is discussed in the next section.

Beforehand, the case study of Peter in chapter eight of *The Divided Self* (Laing, 1965a: 129-133) provides an example of how one person coped with his split sense of self. That is, he felt he had to stop being the false self he felt others wanted him to be and to be the nobody he thought he really was. He described himself as ‘on the fringe of being’ (Laing, 1965a: 125). This, Laing (1965a: 120) supposed, was because ‘he had been treated as though he wasn’t there’. The lack of responsiveness from those around him meant he saw himself as ‘not seen’ (Laing, 1965a: 126). Compliance with others’ wishes in the false-self system meant that he began to hate others and himself. His lack of being handled early on had left him with a:

compulsive preoccupation (which he felt as extremely unpleasant) with being touchable, smellable, etc., to others was a desperate attempt to retain that very dimension of a living body: that it has a being-for-others (Laing, 1965a: 131).

This ‘being-for-others’ he had to pump up as a:

dimension of his experience that had not become established in a primary sense out of the original infantile situation, and the gap was
filled, not by any later development of a feeling of being loved and respected as a person, but by a feeling that practically all love was disguised persecution, since it aimed to turn him into a thing of the other (Laing, 1965a: 131).

Laing (1965a) goes on in the third part of *The Divided Self* to discuss the concept of the divided sense of self in relation to psychotic conditions. Laing provides examples of his notion of the split self in someone experiencing psychosis to provide insights into the acute phenomenology of the split self. For someone experiencing psychosis, the dissociation from the body means that:

the body is conceived not only as operating to comply with and placate others, but as being in the actual possession of others. The individual is beginning to be in a position to feel not only that his perceptions are false because he is continually looking at things through other people’s eyes, but that they are playing a trick on him because people are looking at the world through his eyes (Laing, 1965a: 144).

The person at this point experiences a lack of realness in life. There is an enviable hatred toward those who do experience life, as their experience of life is empty, dry and unfulfilled. Despite the envy there is also fear of life, as this threatens the self, so simultaneously there is an attempt to acquire and destroy the real. Laing (1965a: 144) proposed that acquiring life through these experiences, is by the magical means of touching, copying and imitating and stealing, or of experiencing
terror.

Laing (1965a: 147) describes the experience of the person living with psychosis to be one where ‘everything he approaches becomes dead’. This leaves two equally psychotic options available: ‘He may decide to be himself despite everything’, or ‘He may attempt to murder his self’ (Laing, 1965a: 147). Importantly, statements considered delusional in psychiatry, Laing (1965a: 149) argues, contain ‘existential truth’–’they are to be understood as statements that are literally true within the terms of reference of the individual who makes them’.

For instance, committing suicide for the schizophrenic would not result in the death of self, as the self is not located in the body but in the soul and is therefore immortal. One way the schizophrenic tries to preserve his self is to deny his being. ‘The schizophrenic feels he has killed his ‘self’ and this appears to be in order to avoid being killed. He is dead, in order to remain alive’ (Laing, 1965a: 150). A person feels compelled to kill themselves, according to Laing, from anxiety and guilt.

For Marie, a girl who ‘presented unequivocally the clinical picture of dementia praecox or schizophrenia simplex’, to suddenly transform, would be explained by psychiatry according to Laing (1965a: 156), as
‘an arrest in the process of the progressive schizophrenic deterioration probably on an organic basis’. But:

from an existential point of view, one could say that she had stopped trying to murder herself. She saw that her life had become a systemic attempt to destroy her own identity and to become a nobody... she attempted to reduce herself to vanishing point by never doing anything specific. She acted as though it was possible not to put herself into her actions. The effort to dissociate herself from her actions comprised everything she did. By these means she sought to become nobody (Laing, 1965a: 156).

Laing goes on to discuss how the split sense of self, impacts on perception, and how this ‘other self’ is the basis of hallucinations. The thinking of the other self, Laing explains, has the quality of a perception:

since it is received by the experiencing self neither as a product of its imagination nor as belonging to it. That is, the other self is the basis of an hallucination' (Laing, 1965a: 158).

It is from this other source that the individual says ‘he has been murdered, or that ‘he’ has murdered his ‘self’ (Laing, 1965a: 158).

What may happen is that the place and function of the inner phantom ‘self’ becomes almost completely taken over by archetypal agencies which appear to be in complete control and dominate all aspects of the individual's being (Laing, 1965a: 158).

Laing describes the split self as the ‘kernal’ of psychosis. Laing (1965a: 158) conceives the task of therapy is to ‘make contact with the original
However, when the centre fails to hold, neither self-experience nor body-experience can retain identity, integrity, cohesiveness, or vitality, and the individual becomes precipitated in to a condition the end result of which we suggested could best be described as a state of ‘chaotic nonentity’ (Laing, 1965a: 162).

Laing explains that the structure of the perceptual experience of a person with schizophrenia makes dialogue difficult to follow. This is made more difficult, Laing argues, by the person with schizophrenia who plays at being psychotic, to protect the self. Despite longing to be loved, ‘any form of understanding threatens his whole defensive system’ (Laing, 1965a: 163). Hiding the self is to keep it ‘safe from being smothered or engulfed by love, as much as from destruction from hatred’ (Laing, 1965a: 164). The schizophrenic plays at being mad ‘to avoid at all costs the possibility of being held responsible for a single coherent idea, or intention’ (Laing, 1965a: 164).

However, Laing found, like Jung:

The schizophrenic ceases to be schizophrenic when he meets someone by whom he feels understood. When this happens most of the bizarre which is taken as the ‘signs’ of the ‘disease’ simply evaporates’ (Laing, 1965a: 165).

Until then:

Everything the patient is is felt to be ‘not-me’. He rejects all that he is, as a mere mirror of an alien reality... ‘He can’t be real’... This false self
system is the breeding ground of paranoid fears since it follows easily that the false-self system, which has spread to include everything and is disavowed by the self... as an alien presence or person in possession of the individual (Laing, 1965a: 168).

The self becomes alien, enemy territory, controlled by a hostile agent. The self exists in a vacuum that becomes a torture chamber. It is not that the 'I' does not exist but that it has no body, no ‘me’, no identity.

One of Laing’s patients expressed:

I only felt real because of the reactions I could produce in you. If I had scratched you and you didn’t feel it, then I’d be really dead. I could only be good if you saw it in me. It was only when I looked at myself through your eyes that I could see anything good. Otherwise, I only saw myself a starving, annoying brat whom everyone hated and I hated myself for being that way. I wanted to tear out my stomach for being so hungry (Laing, 1965a: 174).

Laing (1965a: 176) describes the schizophrenic as having two motives for ‘promoting a state of death-in-life’. First is the primary guilt of having no right to life in the first place, and second of being entitled at most to a ‘dead life’ (Laing, 1965a: 176). An example was Joan. Her parents wanted her to be a boy, and since she could not be she said ‘I tried to die by being catatonic. When I was catatonic, I tried to be dead and grey and motionless. I thought my mother would like that’ (Laing, 1965a: 176). What is being demonstrated in this analysis is in contrast with the biological conception of the subject utilised in acute psychiatric
services.

The biological conception leaves the capacity of the person to identify the internalisation of the meaning and significance of behaviour for themselves unrecognised. This failure also leaves these needs unmet. Laing (1965a) in *The Divided Self* has demonstrated that even for the most disturbed person, behaviour has a meaning, a context and a history, which has been internalised. The person him/herself has the capacity to identify and express these meanings and significance given a safe context and the opportunity to do so. What is required is an unconditionally loving and nonjudgemental commitment to understand that person’s perspective.

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From the Case Study to the History of the Subject

These case studies mark an intersection between Laing’s first analysis of psychotic symptoms to do with ontological insecurity and Laing’s next analysis of the important role of the intersubjective in producing symptoms. The implication of Laing’s existential-ontology of psychotic symptoms presented here from *The Divided Self* (Laing, 1965a) is that the appropriate approach for physicians to take to ‘mental health’
problems, is a biography. He argues, psychotic symptoms though ontological or internal, are existential, in that they are rooted in the social context of (discourse with) a family. Laing argues importantly that:

> it is only when one is able to gather from the individual himself the history of his self, and not what a psychiatric history in these circumstances usually is, the history of the false-self system, that his psychosis becomes explicable [Laing, 1965: 148].

To this end, the role of narrative in understanding the historical nature of the self is explored further here and in the next chapter.

Laing (1965a: 178-205) demonstrated the role of biography in providing understanding in the last chapter of *The Divided Self*, a case study of Julie. This study brings out the interchange between these two levels of analysis, that is, how the interpersonal context is internalised. Julie was a person who had been diagnosed with chronic schizophrenia. She described her trouble as one of not being ‘a real person’, of ‘being empty’ and ‘worthless’ (Laing, 1965a: 178-179). In response to this, Laing took a ‘clinical biography’, not case notes for a medical history of pathology, but an account of her history as a subject.

In Julie’s case, both parents colluded to deny the validity of their daughter’s complaints against them. Julie’s mother and the other
adults in her life praised behaviour as ‘good’, which Laing considered as existentially dead’. This, Laing (1965a: 187) explained, led to a lack of ‘genuine self-action’ that ‘seems never to have become established to any extent, but instead all action is in almost total compliance and conformity with outside directives’.

Julie’s total lack of disobedience, is evidence for Laing (1965a: 187), that Julie was ‘too terror stricken to become a person’. Laing (1965a: 187) explains that what this resulted in for Julie was that though her actions had been trained by her mother, ‘she’ was not ‘in’ them. What this meant for Julie was that she could not be ‘herself neither in her mother’s presence nor in her absence’ (Laing, 1965a: 186). Denied the

16 This is a reference to Laing’s knowledge of philosophy. He was also a first rate athlete, pianist, dramatist, poet and by all accounts, comedian (Laing, 1994; 1968; 1976; 1982; 1985; Mullan, 1995).
control of presence and absence, Laing (1965a: 186) argues she never
developed a sense that she did not need the presence of another to have
a sense of her own existence. ‘If an individual needs another in order to
be himself, it presupposes a failure to fully achieve autonomy’ (Laing,
1965a: 186). Laing held that this ontologically insecure situation
explains why Julie was not able to attain the autonomy necessary to
have a mind of her own.

Laing identified Julie’s schizophrenic cryptic statements as indicative of
her accounts of her problem. She called herself ‘Taylor’ to refer to how
she felt ‘tailor-made’ by her mother (Laing, 1965a: 192). Julie did not
have anyone in her life that acknowledged her. Her problem with her
parents was not to win an argument, but to ‘achieve existence’ (Laing,
1965a: 193). As she was not allowed existence, she could not develop
what one might call ‘the ability of common sense’ (Laing, 1965a: 193).
For instance, ‘when her mother said she was bad, Julie felt this as
murder. It was the negation of any autonomous point of view on her
part’ (Laing, 1965a: 193).

Laing discusses the ‘praecox feeling’ that earlier psychiatrists wrote
about, a feeling of inaccessibility to the person, sometimes referred to as
autism, mentioned earlier. Laing describes being with Julie as similar to being with ‘different personalities in operation at the one time’ (Laing, 1965a: 196). Laing (1965a: 196) understood the way Julie spoke ‘to be the result of a number of quasi-autonomous partial systems striving to give expression to themselves out of the same mouth at the same time’. This understanding made her expression comprehensible.

Laing goes on to say Julie’s state of disintegration was not static:

She would sometimes marvelously come together again and display a most pathetic realisation of her plight. But she was terrified of these moments of integration, for various reasons. Among others, because she had to sustain in them intense anxiety; and because the process of disintegration appeared to be remembered and dreaded as an experience so awful that there was refuge for her in her unintegration, unrealness and deadness (Laing, 1965a: 196-197).

Laing describes each of the fragments of her personality as acting independently of and as unaware of the others. Identification of these made Julie’s behaviour explicable.

The absence of a total experience of her being as a whole meant that she lacked the unified experience on which to base a clear idea of the ‘boundary’ of her being... Rather each system seemed to have a boundary of its own (Laing, 1965a: 197).

Each system seemed to be structured differently, and autonomously. All these systems were perceived as not her but as operating outside her. That is to say, she was ‘hallucinated’. 
The fragmented personality and the experience of hallucination and delusion Laing identified as understandable when the historical, social and inter-personal settings were defined. Voices and hallucinations considered products of biologically induced delusions in psychiatry, are here deemed by Laing as fragments of the self that are not recognised as such because the fundamental conception of the self as split and abstracted from the body. Laing’s account validates a person’s experience of these ‘voices’, and ‘vision’, as experiences of a different person, the embodied person, which is not identified by the disembodied ‘true’ self as self. Laing’s (1965a: 178-205) work offers an understandable and meaningful account of the process whereby hallucinations, such as the experience of ‘voices’, arise.

Laing (1965a: 198) described the implications of being split to mean that one has a tendency to ‘become what one perceives’ whether that is the ‘rain’, a ‘chair’, and the ‘wall’. As Julie stated ‘I could be that wall. It’s a terrible thing for a girl to be a wall’ (Laing, 1965a: 198). Laing explains, for Julie:

all perception seemed to threaten mergence and all sense of being perceived by the other threatened her similarly. This meant that she was living in a world of constant persecution and felt herself to be doing to others what she dreaded as happening to her (Laing, 1965a: 198).
This in turn, contributed to her confusion.

Almost every act of perception appeared to involve a confusion of self with not self. The ground was prepared for this confusion by the fact that, since large aspects of her person were partially outside her ‘self’ it was easy to confuse those split-off aspects of her being with other people (Laing, 1965a: 198).

For Laing (1965a: 198), that meant, to be in a relationship with her was complex as ‘if she likes me, she is like me, she is me’. Laing called all the personalities that constructed Julie an ‘intra-personal group’. This group in Julie’s case was dominated by what Laing called ‘a bad internal mother’. ‘She was basically an internal female persecutor who contained in concentrated form all the bad that Julie ascribed to her mother’ (Laing, 1965a: 200).

She also had a system which called Julie ‘her little sister’, and another system that was the compliant little girl. Her ‘inner’ self had diminished into ‘pure possibility’. Yet there were times when Julie’s own ‘pathetically scared’ person spoke. For example:

I was born under a black sun. I wasn’t born, I was crushed out. It’s not one of those things you get over like that. I wasn’t mothered, I was smothered. She wasn’t a mother. I’m choosy who I have for a mother. Stop it. Stop it. She’s killing me. She’s cutting out my tongue. I’m rotten, base. I’m wicked. I’m wasted time (Laing, 1965a: 200).

Laing understood Julie through piecing together the partial systems of
Julie’s personality through her biography. When she talks about her mother as a black sun, he identifies the reference as her destructive mother. The interruption to which she cries ‘Stop it, stop it’, is from this bad mother (Laing, 1965a: 200). This is then followed by a referring back to her conversation with Laing: ‘She’s killing me. She then goes on to degrade herself as her bad mother would’ (Laing, 1965a: 200).

Once when Laing interrupted the bad internal mother’s response to Julie’s accusations about her, she stopped and answered from her perspective:

Julie’s frightened of being killed by herself for saying these things... that’s my conscience killing me. I’ve been frightened of my mother all my life and always will be. Do you think I can live (Laing, 1965a: 201)?

Julie’s insanity, Laing argues, consists in the lack of integration of her being. Her schizophrenia, Laing (1965a: 202) argues, is in her reference to herself as in the third person, and the interruption by another (for example, ‘I’m a good girl’). The self that was left consisted of cryptic statements; Laing described these as the psychotic remains of the inner self of schizoid states. Laing (1965a: 205) saw her language as ‘an expression of the way she experienced being-in-her-world’.
This analysis highlights the inadequacies of the current conception of the subject in mental health in biological terms and points to the crucial role of the intersubjective in the internal construction of the self.

This existential-phenomenological understanding of symptoms has evaded acute psychiatry, and marks the transition into the next analysis Laing offers. Laing goes on to explore the role of the intersubjective in his next account of the subject. Recognising the role of intersubjective relationships in the break down of mental health is important as it calls attention to the need to focus on the interpersonal as the means by which to restore well-being, a topic that is taken up in chapters seven and eight.

A significant feature of Laing’s account of family life for those experiencing what has been labelled schizophrenia, is that access to discourses other than their own family discourse is lacking. This is a significant feature of the case studies in his next series of studies. Laing identified that understanding a person was facilitated by recognising the possibilities, or lack of them, for developing a self-concept in the context of the family. That is, understanding a person is facilitated through an examination of a person’s life ‘in her own interpersonal
microcosms’ (Laing, 1965a: 180). Laing states ‘it is just as important to discover the way the people in the individual’s world have regarded her behaviour as it is to have a history of her behaviour itself’ (Laing, 1965a: 182).

This next approach is not an attempt to blame the mother, as has been implied by Mitchell (1975). On the contrary, Laing (1965a: 190) recognises the importance of the entirety of the family context: ‘father or other significant adults may play a decisive role in the child’s life, either in direct relation with the child or, indirectly through the effects on the mother’. Laing in his first analysis identified the important role of the dynamics of the family as a whole, rather than to the mother in particular in precipitating problems labelled as mental illness. Neither does this discount the influence of the broader social and socio-economic factors. These, Laing (1965a: 182) agrees, ‘profoundly influence the nature of the family and hence the patient’. His intention was to identify the important role of inter-personal relationships on the structure of the internal world of someone experiencing psychosis. This was an attempt by Laing to humanise the way psychiatrists’ treat their clients.
2) The Intersubjective: The Primacy of the Interpersonal

In *The Divided Self*, Laing (1965a) identified the intrapersonal world of the psychiatric subject as crucial to understanding the individual’s relationship to the world. Then Laing moved the focus from the individual to the social context where he considered the role of the intersubjective as central to psychiatric problems. In Laing’s first analysis, the focus was interpersonal relationships) from the point of view of the subject, in the second analysis; Laing focused directly on the role of interpersonal relationships to explain a person’s ‘mental health problems’.

Laing argues that science does not account for the subjective meanings that humans apply and the intersubjective nature of the relationships between persons. Science can only deal with objects, not the subjective interaction of persons. For Laing, the self is intersubjective, dependent on others’ reflections for its own self-consciousness. Laing (1968: 83) in *The Politics of Experience* states: ‘There are no basic emotions, instincts, or personality, outside of the relationships a person has within one or
other social context’.

This approach developed when Laing was working at Glasgow's Gartnavel Royal Mental Hospital with patients who had been there since the turn of the century. He describes the scene as like a scene from Homer, where there are ghosts across ‘their oceanic abyss, across our rivers of fear’ (Laing, 1985: 112). Laing gained the confidence of one old lady, who prior to this had ranted and raved up and down the ward. Now, she sat beside Laing, and Laing (1985: 113) asked her to fill him in on the other patient’s actions: ‘she took me on. She became my mentor’.

Laing sat in the day room of that ward for one or two hours every day for several months with more than fifty patients. He states: ‘it began to dawn on me that the autism of each patient, although autistic, was interwoven with that of the others’ (Laing, 1985: 114). Once recognising this he wanted to see what would happen if he had ‘a few patients together with the same nurses day after day in less distressing surroundings’ (Laing, 1985: 114).

Laing tried an experiment with eleven of the most withdrawn people in the ward, who had been there for over four years. He allocated two
nurses to work nine a.m. to five p.m. Monday to Friday, in a separate room, which was nicely decorated, comfortably furnished and well equipped with materials for activities. Laing met the nurses once a week to talk about the patients and made informal visits. This is what happened.

On the first day, the eleven completely withdrawn patients had to be shepherded from the ward across to the day room. The second day, at half past eight in the morning, I had one of the most moving experiences of my life on that ward. There they all were clustered around the locked door, just waiting to get out and over there with the two nurses and me. And they hopped and skipped and twiddled around and what not on their way over. So much for being ‘completely withdrawn’ [Laing, 1985: 115-116].

It was here that Laing (1985: 115) became aware of the exquisite sensitivity of these people to ‘nuances that some people never notice’. In the room, the patients now wore ordinary clothes, make-up and had coiffured their hair. Within eighteen months, all eleven patients had left hospital. Within another year, they were all back. Laing (1985: 117) asks ‘had they found more companionship ‘inside’ than they could find ‘outside’?’ Laing discussed the split between experience and behaviour as the essence of psychopathology.

Violence attempts to constrain the other’s freedom, to force him to act in the way we desire, but with ultimate lack of concern... We are effectively destroying ourselves by violence masquerading as love (Laing, 1965: 50).
Laing saw further evidence for the powerful role of the intersubjective in his work. A particularly striking example was when he worked at the Glasgow University Department of Psychiatry. There he met a fourteen-year-old boy who on returning from school found his mother having died in a pool of blood from an haemoptysis. She had had tuberculosis. His father, for the next three months accused the boy of the mother’s death by exhausting her, by his life, from conception. The boy then found his father had hanged himself. Within six months he was in the Glasgow University Department of Psychiatry.

He was incontinent of urine and faeces, self absorbed, silent or stuttering incoherent sounds, and had peculiar ways of walking and gesturing. At times he was hyper-alert, other times he would ‘flutter’. He was diagnosed catatonic schizophrenic. Laing said:

He was broken up, shattered to pieces by what had happened. He was staggering. He had been through a literally staggering experience. He was staggered. He had been struck—not quite dumb. He could utter sounds, but nothing coherent came out of his mouth. Just scraps, shreds, drive, a sudden bellow, a moan, a laugh (Laing, 1985: 139).

Laing saw him every day for six weeks. Writing his clinical notes, he became aware of how the clinical picture of acute catatonic
schizophrenia had transformed during the interview into the ‘clinical picture of a quiet guy sitting in a chair talking about calculus’ (Laing, 1985: 139).

He was astonished at ‘how extraordinary that interview was and how extraordinary that I could take it so blandly for granted’ (Laing, 1985: 139). He noted that, if this miraculous transformation had happened anywhere else it would have been ‘heralded as a medico-psychiatric, biochemical, scientific breakthrough of the first order’ (Laing, 1985: 139-140). Laing thought if he left this fourteen-year-old in a mental hospital, he would only get worse. So he took him home to his wife and three children. His incontinence stopped immediately, as did his shaking. He spoke coherently, and in three months was together enough for foster care. He visited Laing fifteen years later. He was married, with two children, had a job, and was studying psychology.

What these examples demonstrate is the powerful role of the history of interpersonal relationships in the destruction and in the restoration of the self. These themes are present in The Self and Others (Laing, 1961), revised as Self and Others (Laing, 1971b), Interpersonal Perception (Laing, 1966) and Sanity, Madness and the Family (Laing, 1965b), Knots
Laing’s stated aim was to outline the role that others have in constructing the self. Laing argued that the interdependence of persons could be seen, in the subjective reliance on others for recognition. This means that intersubjective relationships have the potential to construct or destruct others.

I shall try to depict persons within a social system or ‘nexus’ of persons, in order to try to understand some of the ways in which each affects each person’s experience of himself and of how interactions take form. Each contributes to the other’s fulfilment or destruction (Laing, 1971b: 9).

Kirsner (1976) has pointed out how Laing’s influences changed in this period. He no longer relied on existential-phenomenology, but drew from the work of psychoanalysts such as Klein and Winnicot. Goffman’s work on asylums was also influential as well as communication theorists such as Bateson and other colleagues whose work centred on the ‘double bind’, research into schizophrenia. Bateson (1973) states that:

According to our thesis, the term ‘ego functioning’ is precisely the process of discriminating communication modes either within the self or between the self and others (in Kirsner, 1976: 173).

Bateson (1973) explained the problems of schizophrenia as occurring in the conflict between three areas of communications: those sent, those
received and those experienced internally. Bateson attributed these problems to learning in the family of origin. These contradictory communications are then re-enacted in the psychiatric hospital where the interests of the staff take precedence over those of the patient, which are claimed to be in the interests of the latter (in Kirsner, 1976).

In *Self and Others*, Laing (1971b) discusses ‘unconscious experience’ as a contradiction in terms on the grounds that experience informs conscious life. Laing argues that it is not useful to explain problems produced by ‘experience’ through reference to mechanisms such as the unconscious, as it only further obscures problems. In *Self and Others* (1971b), the ways in which conflicting attributions by others, place the person concerned in a false position is examined. Contradictory communications, Laing argues, have the potential to drive people crazy. This is especially the case if it is a conflict that cannot be resolved. They tend to undermine a person’s confidence in their own emotional reactions and perceptions of reality (Searles in Laing, 1971b: 139). This means that the false self is confirmed at the expense of the true self.

This collusion is:

> Always clinched when self finds in the other that other who will ‘confirm’ self in the false self that is trying to make real and vice versa. The ground is then set for prolonged mutual evasion of truth and true fulfilment. Each has found an other to endorse his own false
notion of himself and to give this appearance a semblance of reality (Laing, 1971b: 111).

In the next book on this theme, *Interpersonal Perception*, Laing (1966) identifies the significant role of others in the construction of self-identity. This is claimed to be in contrast to Freud’s focus on egoism, which excludes, according to Laing, the concept of you. Laing writes:

Some philosophers, some psychologists, and more sociologists have recognised the significance of the fact that social life is not made up of a myriad of I’s and me’s only, but of you, he, she, we and them, and also that the experience of you or her or them or us may indeed be as primary and compelling (or more so) as the experience of ‘me’ (Laing, 1966: 3).

He goes on to say: ‘psychoanalytic theory has no concepts for the dyad as such, nor indeed for any social system generated by more than one person at a time’ (Laing, 1966: 6). Laing argues that the id, ego and superego are internal objects, and that the way they relate to each other is unexplained, leaving interpersonal relationships and their impact on self-identity untheorised.

Laing used the concept of meta-perspectives: ‘my view of the other’s (your, his, her, their) view of me’, and meta-identity: ‘how I think you see me’, to conceptualise the theoretical construction of self-identity as a product of both of these views (Laing, 1966: 7). Laing argues that
behaviour needs to be seen in context as a function of the behaviour of the other. He argues that:

The failure to see the behaviour of one person as a function of the behaviour of the other has led to some extraordinary perceptual and conceptual aberrations that are still with us. For instance, in a sequence of moves in a social interaction between person (a) and person (b)... is in turn explained as an *intrapersonal sequence* (process) due to *intrapsychic pathology* (Laing, 1966: 8).

Laing, as is evident above, identifies one’s behaviour as a response to another’s. In recognising the impact of one person on another, Laing is developing an account of subjectivity as a product of intersubjectivity. Laing argued that in relationship there is ‘no isolated individual person... The other is at one and the same time a threat and necessary to self’s identity’ (Laing, 1966: 27). The impact of the experience of someone else’s behaviour occurs through interpretation. Laing explains that the person’s present interpretations are based on past learning within the family context. As Laing understands, the experience of mental disorder is the outcome of a relationship of contradictions that are internalised. This insight is central to understanding a person’s consequent behaviour.

For instance, for a person who is experiencing a situation of relational contradictions as untenable, a decision is made as to how to cope with
it. A behavioural response, or ‘special strategy’ according to Laing, is based on a decision of how to cope. Once this strategy is established as a persistent pattern, if it is not socially acceptable may be labelled as pathological. This ‘special strategy’, then, becomes the source of the label of ‘mental illness’. For example, delusions are based on a ‘special strategy’, a decision about how to cope, which affects subsequent experience (Laing, 1966).

The central issue is whether a safe environment has been provided to allow a person’s subjectivity to develop. Laing argued that this is missing in the case of those considered to have a ‘mental illness’. This is why Laing finds the role of identification of a member of a family as ‘schizophrenic’ to be misleading. Recognising mental health problems as the outcome of a situation, and not an individual’s problem alone, is to recognise that pathologising a person becomes a form of scapegoating or labelling.

*Sanity Madness and the Family* (Laing, 1965b) was a study that examined the relationships that precipitated a person’s symptoms. Identifying the role of context in precipitating symptoms has brought intelligibility and understanding to the symptoms people experiencing
schizophrenia suffer. This work highlighted the need for identification of
the social history for symptoms to be understandable. More than that,
Laing and Esterson (1965b:13) stated ‘we believe that the shift of point
of view that these descriptions both embody and demand has an
historical significance’.

Laing’s recognition of the role of the social context and relationships as
the site of a person’s mental health problems reintroduces the
importance of the interpersonal in mental health. Omitting the
interpersonal from the understanding of human beings Laing sees as
‘violence and mystification’. It is in Laing’s (1966) shift of focus, from
the patient to the context, which makes the patient’s behaviour
understandable. In an attempt to understand the individual, Laing
looks at the interaction of the family. This is not an attempt to describe
the family as pathological, but to identify counterproductive family
interaction as the site where the problems in construction of the
subjectivity of the vulnerable member develop.

Conclusion

Laing’s extensive writings on clinical psychiatry offers an alternative
paradigm to explain the internal and interpersonal life of someone considered ‘mentally ill’. Laing (1965a: 17) developed a theoretical framework for understanding a person experiencing psychosis by considering ‘the context of his whole being-in-his-world’: a context missing from Jaspers and subsequent acute public psychiatric theory and practice. The context, Laing explains, includes the important role of the interpersonal in the constitution of the experience of psychosis. As has been discussed here, Laing reconceptualised psychosis as an intelligible praxis in the context of an otherwise untenable social position.

Laing’s understanding approach to people experiencing acute psychiatric episodes, involved setting up alternatives to mental health services such as community houses, which it could be argued, have been the model for deinstitutionalisation. However, though Laing’s work can be seen as constituting ‘a bridge between past and future efforts in the understanding of madness’ (Laing, 1965b: 26) his theories have not provided an adequate basis for alternative praxis. So although Laing drew attention to the importance of context in the development of and understanding of psychotic experiences, he did not articulate just how
this understanding approach might be practiced.

The counter paradigm Laing developed pointed towards conceptualising a subject as one constituted through a biography or narrative that operates internally at two different levels at least—the social or contextual, and the internal or at the level of the self. Laing made clear that the failure to acknowledge another person’s dialogue, narrative, account or response to a situation, results in a denial of that person’s being, and produces an autistic or enclosed or disturbed sense of self. Hence, the failure to recognise a person’s narrative, which is the site of the identity of the self, is also a failure to recognise and respect a person.

As Laing’s discussions indicate, the development of the capacity of a subject to experience him/herself as a self relies on the social environment to recognise him/her as a person through a narrative account. In chapter seven, this idea is developed further as the role of narrative is recognised in the development of the concept of the self, such that narrative is recognised as the site of identity. The ethical implications of the concept of the subject as a narrative subject will be taken up in chapter eight where the importance of the role of listening
is theorised as central to the recognition of the ethical subject in acute public mental health services.
Most consumers remain angry about their knowledge that they have not been heard and that their understandings of their own story was often not even sought. All of us seem to need to tell (and often retell) our own personal stories until we believe we have at last been adequately heard. (Wadsworth & Epstein, 1996a: 73).

Self-identity forms a trajectory across the different institutional settings of modernity. Each of us not only has but lives a biography reflexively (Giddens, 1991: 14).

The failure to listen to the recipients of acute psychiatric services as identified throughout this thesis and which Laing attempted to redress, is central to the formation of the consumer/survivor movement. What people as patients find offensive is that their stories are ‘not even sought’ (Wadsworth & Epstein, 1996a: 73). What people using services say they need is to tell their stories ‘until...we have at last been adequately heard’ (Wadsworth & Epstein, 1996a: 73). This chapter is an attempt to validate the consumer/survivor movement’s claim of the importance of story telling for well being. This is achieved through utilising Laing’s understanding of the importance of the recognition
of the personal or biographical account of an interpersonal context as outlined in the previous chapter. This understanding is developed here through an examination of the interpretative conception of the subject in the work of Charles Taylor in the first part of the chapter, and through the narrativisation of the subject in the work of Paul Ricoeur in the second part of the chapter. Integral to the telling of a story is listening. The third part of the chapter considers this practical aspect of relating through the work of Emmanuel Levinas.

As has been demonstrated throughout the thesis, the rivalry between psychiatric and consumer conceptualisations is not just about different perspectives. The battle to define theory is complex and requires recognition that the debate over theory is about an attempt to define practice as ‘the description offered by the theory is constitutive of the practice we seek to realise’ (Taylor, 1985f: 110). The contest over the reigning theory, requires a recognition that: ‘what is at stake is more like rival maps of the terrain’ (Taylor, 1985f: 110), with the different theoretical perspectives attempting to seek evidence and agreement to establish credibility.

Credibility is established in a context of shared ends, where the
‘significance of our action escapes us’ (Taylor, 1985f: 97). In the field of psychiatry, adherence to the medical approach of biological psychiatry in acute psychiatric services is an attempt by professionals to maintain a positive self-definition due to an association with the social value and status of the medical profession. Even so, devaluing the patient’s perspective acts as a distancing technique for professionals and as a source of resistance to the ethical demand for change in the way acute psychiatric care is delivered. Further, this approach involves a disregard of the patient’s perspective which as has been identified, results in disregarding the patient as a person and accounts for the frustration and anger noted by Wadsworth (1996a: 73) above.

The problem of self-definition, at the heart of both the consumer/survivor and professional perspectives, arises in response to problems at the level of practice, as self-definition is established within ‘a set of institutions and practices’ (Taylor, 1985f: 93). The recognition of the role of self-definition is vital, because it recognises the constitutive role identity plays for both providers and consumers, which in turn constitutes practice. Taylor even suggests, as is hinted at earlier, that the way a problem is conceptualised is driven by professional investment in status, because a professional’s identity
is acquired through professional activity. These unacknowledged, implicit and pre-theoretical and common-sense understandings inform social life, and ‘do much more than explain social life, they also define the understandings that underpin different forms of social practice’ (Taylor, 1985f: 108).

Practices of society require participants to have ‘self-descriptions’ (Taylor, 1985f: 107). Commonsense understandings are formulated in descriptions of ‘self and other’ and inform ‘what is going on among the members of society’ (Taylor, 1985f: 93). These common sense understandings are constitutive for how a self is perceived by both oneself and others. Making these underlying common sense theories explicit ‘can alter our self-descriptions and our self-descriptions can be constitutional of our practices’ (Taylor, 1985f: 104-105). Even though the features of these practices may not be explicit in ‘the reigning theory’ (Taylor, 1985f: 100), a change in theory could mean an alteration in practice. This is important as, Taylor (1985f: 105) states, theories have the potential to ‘transform the constitutive features of practices’ because they change self-definition and identity through the provision of ‘the constitutive understanding necessary for the
continuing of reformed or purified practice’ (Taylor, 1985f: 105).

The way forward then, is to move from the examination of the pathological subject as delineated by Laing to a theorisation of the taken-for-granted theory of the self, to establish the basic principals of what a self is and how this self might be conceptualised. This exploration of an alternative theory offers a way to transform the constitutive features of current acute psychiatric practices toward the interests of those to whom the service is provided. This chapter is an exploration of the theories and concepts that validate patient perspectives, knowledges and experiences in an attempt to overcome the limitations of biological psychiatry in current acute public psychiatric practice.

What the consumer/survivor movement literature identifies as missing from mental health services is the need to be treated with respect. This requires considering what makes human beings worthy of respect. This issue lies at the base of what users of these services identify as problematic. The demand for respect involves a very different view of the subject from that advanced in the psychiatric paradigm as outlined in previous chapters. This chapter attempts to provide legitimacy for the
consumer/survivor movement demand, through identification of the role of interpretation and narrative in the constitution of identity.

**Respect, autonomy and meaning**

In his *Sources of the Self: The Making of the Modern Identity*, Taylor (1989) argues that respect is due to human beings because they are autonomous. Autonomy refers to the ability to make sense of one’s life for oneself (Taylor, 1989: 12). That is, it is according to one’s self-understanding that one acts. Further, Taylor (1985a: 103) defines a person as someone ‘who has a sense of self’, and ‘who can evaluate their life and make choices’. These aspects of selfhood involve self-reflection in giving meaning and value to events in his/her life, in an attempt to make sense of his/her life for him/herself (Taylor, 1985e). Taylor goes so far as to say:

> To make someone less capable of understanding himself, evaluating and choosing is to deny totally the injunction that we should respect him as a person (Taylor, 1985a: 103).

In other words, autonomy involves the process of a person him/herself giving significance to events in their life. This significance or meaning then informs and directs behaviour. Therefore, to understand another
person as a person, one has to enquire into the significance and meaning an event or thing has for that person. As Taylor (1985a; 1985e) asks, how can we ever know that humans can be explained by any scientific theory until they actually explain how they live their lives in their terms? To respect a person’s autonomy then is to recognise the role of meaning and significance in informing a personal action. The importance of the role of this self-reflection has traditionally been associated with describing human beings as rational. Yet the traditional focus on the role of the ‘rational’ denies or represses the subjective element from within reason (Taylor, 1985d; Taylor, 1989).

In contrast, Taylor [1985a] says one’s subjective interpretation of the world is fundamental to one’s sense of self. He says one’s interpretations of the events in the world inform one’s interpretation of who one is. So this interpretation cannot be considered as separate or ‘merely a view on reality’ or as separate from one’s view of oneself (Taylor, 1985e: 47).

Our interpretation of ourselves and our experience is constitutive of what we are and therefore cannot be considered as merely a view on reality, separable from reality, nor as epiphenomenon, which can be by-passed in our understanding of reality (Taylor, 1985e: 47).

The way the world is experienced by a person, therefore, corresponds to
the subjective meanings or interpretations that he/she gives to it. That is not to say that the meanings themselves are completely divorced from the world itself. Rather, they emerge in and through interaction with the world (Taylor, 1985e: 47).

There are two dimensions to experiencing a situation: the situation itself, and the interpretation or judgement of that situation (Taylor, 1985e). The experience of a situation interacts with how it is judged. For example, the valuation of an experience as shameful means it is not an objective event, but a value laden one. The judgement of an experience as one of shame produces an emotion, which then marks the experience as being shameful. This experience is then relayed in ways that communicate emotion through the body and (emotionally laden) language. The interpretation given to an event also informs a person’s sense of self. A person’s sense of self is characterised by the valuing of some things over others, which then shapes or constructs a person’s moral map of his/her life (Taylor, 1985e).

Values involve defining one’s interests, which then shapes one’s self-understanding. Whether a person lives up to his/her own set of values affects their own sense of self worth. Evaluations of self worth are then
embodied in a person’s emotions, behaviour and motivation (Taylor, 1985e: 51). These conceptualisations of self worth, in turn, inform one’s self-identity. Taylor (1985b: 3) says that being human is, ‘to exist in a space defined by distinctions of worth’. A person’s assessment of their own worth is acquired through one’s appropriation of social, cultural, family experiences and patterns of meaning. It is a person’s own response to the moral evaluation and judgements of life, made by those around him/her which informs one’s moral sense of self (Taylor, 1985e). These are then incorporated into one’s self-definition and self-concept. Taylor (1985d: 54) asserts: as persons ‘we are self-defining beings and we are what we are by virtue of the self-definitions that we have accepted; however we have come by them’. That is to say, a person is defined by the moral values they hold in their lives. Therefore, a person’s response to an event depends on the unique value, meaning and significance that it has for that person: ‘an agent can be a respondent because things matter for it in an original way. What it responds out of is the original significance of things for it’ (Taylor, 1985a: 99).

Emotionally driven evaluations discriminate and regulate motivations.
Furthermore, ‘Feelings offer insight into what is considered important as they function as an internal judgement of the importance a predicament bears’ (Taylor, 1985a: 71). Thus feelings provide an internal monitor of one’s values, which also inform self-understanding. Accordingly, decision-making is not a result of objective processes but is ‘embedded in feeling’ (Taylor, 1985a: 72). Taylor (1985a: 76) declares: ‘This subjective way of relating to the world is not optional but central to what it is to be human’. So the indication of the significance of an event is not conscious or rational but emotional. Moreover emotions provide a marker of the significance of an event (Taylor, 1985a).

Taylor (1985a: 101) goes on to explain that the emotion integral to each situation is indicated in a situation-description. Though the significance of an event is not always clear, language is the means whereby the importance of something is made clear. What language does is to ‘articulate or make manifest the background distinctions of worth we define ourselves by’ (Taylor, 1985c: 11). The articulation of a situation-description provides insight into the meanings, significance and values which are communicated in the emotion with which an event is described. Language provides the means whereby this insight is gained which itself, transforms the emotion: ‘we do not experience the same
things, we can even say we cannot have the same feelings before and after such breaks (insight)' (Taylor, 1985e: 71).

Consequently, the insight revealed through articulation, results in the transformation of meaning and a change in judgement which results in an alteration of the experience and the situation-description (Taylor, 1985a). Taylor (1985e: 74) makes the point that as feelings are shaped by articulations and can be changed, so too can the experience. What is emphasised is that this is not an arbitrary process, but central to acquiring insight and self-understanding: ‘So we can understand why, in this domain, our formulations about ourselves can alter’ (Taylor, 1985a: 101).

This understanding of a human being as an ‘interpretative-animal’ means that humans can never be specified in objective terms as human emotions are embedded in an interpretative language. ‘What a given human life is an interpretation of cannot exist uninterpreted, for human emotion is only what it is refracted as in human language’ (Taylor, 1985e: 75). This means that humans ‘cannot be understood simply as an object among objects’ (Taylor, 1985e: 75), but only as constituted in self-interpretation. This self-interpretation is more than the
interpretation of events. It is a framework of self-constitution of who one
is as a moral identity. This suggests a radically different
conceptualisation of the subject than what is currently being utilised in
acute psychiatric services. As Taylor says:

A being who exists only in self-interpretation cannot be understood
absolutely; and one who can only be understood against the
background of distinctions of worth cannot be captured by a
scientific language which essentially aspires to neutrality (Taylor,
1985c: 3).

To understand a person, then, what is required is to know a person’s
own frame of interpretation and meaning. Understanding a human
being requires knowing the kinds of interpretations a person makes,
which provides insight into understanding their experience. This
requires listening to the kinds of meanings and significance that a
person gives to their life. The role of interpretation is critical, as
understanding a person as a subject of significance means that the
qualitatively different concerns of patients and professionals can be
explained as different points of view.

The moral being

Taylor’s conceptualisation of the subject as a moral or interpretative
being contributes to the debate between stakeholders in acute psychiatric services over theory and practice. It does so in three ways. Firstly, it provides recognition of the constitutive role of self-definition for the identity of both patients and professionals, which explains the conflation of the professional treatment modality with the way professionals treat patients. Secondly, it accounts for a patient’s struggle with diagnosis as an issue of identity while professionals, with a preference for a diagnostic label, discard the significance of an event for a person. Thirdly it acknowledges the importance of a person’s sense of moral identity to their sense of self.

Moral identity involves the capacity to evaluate between right and wrong (Taylor, 1989). Taylor argues that a person’s way of being is an indication of whether one has fulfilled one’s own evaluation of right and wrong and that one’s own determination of value is assessed interpersonally. Until these internalised judgements against oneself are made explicit, negative symptoms continue without being understood (Taylor, 1985e). It is contended here that the failure to take patients’ meanings into account in a systemic way has the potential to replicate and contribute further to a person’s negative evaluation of self.
Diagnosis is a formal means whereby the significance and experience of an event for a patient is disregarded. However, the failure by professionals to understand these processes in persons who present to an acute psychiatric service exacerbates their problems. Even if a person is terribly distressed, a person’s behaviour does not justify the denial of a respectful response to a person as a person. Similarly, consumer/survivor (Wadsworth & Epstein, 1996b) activists suggest, as Freidson (1970) does, ‘lack of insight’, is a professional commitment to and investment in (the authority of) a medical perspective and its diagnostic system. It also notes a failure of insight by professionals into the important role of the meanings and significance in the life of patients. The pressure to accept the diagnosis then contributes to the heavy social burden and negative personal consequences imposed on those diagnosed.

Persons by definition are autonomous moral subjects and therefore, no matter how distressed, require treatment with respect.

Even those who through some accident or misfortune are deprived of the ability to exercise these capacities are still understood as belonging to the species defined by this potentiality. The central importance of this for our moral thinking is reflected in the fact that these capacities form an important part of what we should respect and nourish in human beings (Taylor, 1985a: 103).
As such, all persons, including those distressed in an acute psychiatric crisis, require being treated as beings worthy of respect. Nonetheless, it seems that what is overlooked in acute psychiatric practice is basic respect for patients as people. What is required to introduce respectful practices in the treatment of acute psychiatric patients?

**Where to from here?**

In the last chapter it was demonstrated that Laing’s work showed that even for those experiencing psychosis, understanding was possible when detailed contextual historical knowledge of the family and society, customs and mores was identified through a biography. Yet Laing’s understanding approach failed to offer a sustainable praxis. What has been identified in this thesis as necessary in acute psychiatric services is a respectful means for understanding and responding to people’s accounts of their history. It is claimed here that the present distancing techniques in acute psychiatric services may be overcome through an approach that accords personhood. To capture the complex amalgam of emotions, understandings and definitions which characterises human beings, what is required is participating in the act (or art) of narrative
It is through the concept of narrative, that Ricoeur broadens and deepens Taylor’s idea of the self-interpreting subject. Narrative involves the utilisation of a complex matrix of literary devices in a seemingly simple workable approach. Here, the role of interpretation, which involves a range of complex activities, is pulled together in a seemingly simple concept and an authentically feasible system. These concepts are then used to explain, through the configural notion of emplotment—that is the interpretation of events in a story—the importance of narrative for identity. As will be discussed under the concept of plot, a series of disjointed contingencies and events require a frame or explanation: to ‘extract a configuration from a succession’. Ricoeur explains that:

This structure is so paradoxical that every narrative can be conceived in terms of the competition between its episodic dimension and its configurational dimension, between sequence and figure (Ricoeur, 1981b: 279).

That is to say, explanations are woven into events giving them the coherence of a double hermeneutic. There is an interaction between events and narrative as one interprets the other in a narrative structure.
Thus: the complexity of events ‘is subsumed to the interpretation which the agents themselves give of their actions’ (Ricoeur, 1981b: 279).

The configural or episodic dimension enables narrating as well as following a story, which requires being able ‘to extract a configuration from a succession’ (Ricoeur, 1981b: 178). The paradoxical structure of the narrative involves ‘competition between its episodic dimensions and configurational dimensions, between sequence and figure’ (Ricoeur, 1981b: 279). The narrative through these configurations incorporates reflexive judgement. That is to say, narrative is a reflection upon events as ‘successive totalities’ (Ricoeur, 1981b: 279). Thus: the events of life are experienced as more than disjointed events. Events are incorporated by the reflective judgement of the narrator him/herself into a totality of meaning.

The narrative is constructed out of the contingencies themselves, which in turn contribute to the story. It is in retrospective reflection that the events become a necessity to the story:

This necessity is a narrative necessity whose meaning effect comes from the configuring act as such; this narrative necessity transforms physical contingency, on the other side of physical necessity, into narrative contingency, implied in narrative necessity (Ricoeur, 1992: 142).
Ricoeur identifies the narrative as an account of the contingencies or events themselves. Unforeseen events threaten to disrupt this totality, while the contingency of events contributes in retrospect to the narrative.

That is to say, the narrative approach is able to overcome methodological limitations of Laing’s work, whilst building upon and going further than Taylor’s interpretative conception of the subject. This is achieved through the recognition of the ethical subject as embedded in a narrative-identity. This conception of the subject as an ethical subject embedded in a narrative validates, legitimises and supports the consumer/survivor movement’s demand to be listened to. Listening is discussed in the third part of this chapter with practical implications considered in the next chapter.

How the concept of narrative achieves an ethical end will be discussed here in detail. This discussion includes defining narrativity and what it refers to, the elements of narrative (plot, interpretation, character and point of view), and the way in which these elements together constitute identity. Thus: issue of identity is important not only in terms of theoretical ethics but also in a practical sense for the legitimisation of
the respectful treatment of acute public psychiatric subjects as persons.

Narrativising the Person

In ‘The Narrative Function’, Ricoeur (1981b) elucidates that narrativity is central to being human. His discussion focuses on how understanding a human being requires understanding a person’s story. However, the mechanism and art of narrative is not straightforward. It is difficult to access and identify. Ricoeur argues that the narrative schematism ‘is an art hidden in the depths of the human soul and it will always be difficult to extract the true mechanism from nature to lay it before our eyes’ (Ricoeur, 1981b: 287). Even so, Ricoeur explores the narrative nature of being human. Narrative is defined as a ‘language-game’, constituted in ‘historicity’, which incorporates both the doing and the being of the historical. Narrative includes both the meaning and events, which as seen in chapter 6, Laing also recognised as important. The recognition of human beings as located in history is centrally important as ‘we belong to history before telling or writing history’ (Ricoeur, 1981b: 294). That is to say; ‘the form of life to which the
narrative discourse belongs is the historical condition itself’ (Ricoeur, 1981b: 288). In establishing the narrative genre as historical, the disjuncture between subject and object is subverted. This is because the subjective nature of the historical account conflates the subjective and objective in history. Even so, Ricoeur claims that the genre of narrative is relevant to the historical condition of human beings as a whole.

Nonetheless, to define narrative in terms of the historical, does not immediately resolve the problem of what ‘history’ refers to (Ricoeur, 1981b: 291). There are still two seemingly distinct types of narrative: the true and the fictional. The asymmetry between true and false narratives, Ricoeur (1981b) revokes on three grounds. Firstly, all narratives are referential. Secondly, there is fiction even in positivistic history. Thirdly, these positivistic and narrative fictions are based on a mimesis. Mimesis refers to creative imitation in regard to what meaning is made of events. In this way, interpretation offers a ‘kind of metaphor of reality’ (Ricoeur, 1981b: 291). The effect is like creating a piece of art, ‘an iconic augmentation of the human world of action’ (Ricoeur, 1981b: 291). A person, then, is a creative being who constructs a personal
picture of events out of the various contingencies available.

The claim being made here is that, because of the creative utilisation of mimesis, the paradigm on which narrative always relies is fiction. Although fictional images are only indirect referents of the mental, they nonetheless have a distinct intentionality. They offer a ‘model for perceiving things differently, the paradigm of a new vision’ (Ricoeur, 1981b: 291). Fiction then, does not merely reproduce but creates images, providing for the possibility of new perceptions. This role is important as ‘symbolic systems make and remake reality’ and, Ricoeur (1981b: 293) goes on, ‘all symbolic systems have a cognitive value, they make reality appear in such and such a way’.

Fiction then, offers new symbolic systems through mimetic or creative images. This is of great consequence as the world is organised and reorganised according to a signifying dimension. Fiction offers symbolic systems within which to ‘reorganise the world in terms of works and works in terms of the world’ (Ricoeur, 1981b: 293). Every model employs symbols with organising power, which generates a grid for interpreting or producing experience. In other words, although ‘history is both a literary artifact (and in this sense a fiction) and a
representation of reality’ (Ricoeur, 1981b: 291), the two are not necessarily separate. History, as an attempt to uncover the past ‘explores the field of imaginative variations which surround the present and the real’ (Ricoeur, 1981b: 295). Yet despite the reliance on fictional elements, history claims to represent reality. This suggests that the historical features of human experience mean that narrative can only be considered as a cross between truth and fiction.

In other words, in both fiction and history there is a metaphor of reality, which draws on events and applies meaning to it. Thus:

If our historical condition requires nothing less than the conjunction of two narrative genres, it is because of the very nature of our experience of being historical (Ricoeur, 1981b: 294).

Ricoeur argues that historical events derive their meaning not only from their singular invocation but from their position in a larger narrative. The narrative makes sense of these otherwise disparate events by using literary devices through which the narrative superimposes interpretative structures retrospectively on events.

This highlights the historical nature of events and the interpretative role of the narrative, which work together in the construction of the narrative account. The narrative aspects of history are to facilitate the
following of the story, as, without this capacity, the history is lost. Analysis of the narrative is organised according to literary devices. The structure of the narrative includes plot, point of view, and character.

Narrative Elements

The Concept of Plot

The concept of plot establishes a link between history and fiction. Ricoeur (1981b: 292) argues that the plot has a ‘master role in the narrative’. Ricoeur’s intention is to highlight the sequential elements of the narrative. The plot is constituted through ‘contingency and consecution, of chronology and configuration, of sequence and consequence’ (Ricoeur, 1981b: 292). Ricoeur argues that ‘it is the irreducible chronological factors which narratives the plot itself’ (Ricoeur, 1981b: 285). As such, it is the ‘status of events that distinguishes the narrative model from every other attempt to analyse the self’ (Ricoeur, 1981b: 285). The story holds the attention through the suspense of contingencies. Emplotment as raised earlier, refers to a paradox whereby contingencies are inverted into narrative necessity. Emplotment offers the first level of explanation in that events begin to
be explained as they are turned into a narrative (by emplotment).

It is the quest that renders the plot possible. It enables the story to be grasped in terms of its temporality. To facilitate following a story, narratives are not bound by chronology but by the combination of episodic and configural dimensions. The episodic dimension contributes to the development of a story. But the narrative is not constructed out of adding events to one another, but in constructing ‘meaningful totalities out of scattered events’ (Ricoeur, 1981b: 278). That is, following a story is facilitated through the addition of meaning through the narrative in order to grasp successive events. It is the complex organisation of facts around themes or schemes which ‘constitute the historical imagination’ (Ricoeur, 1981b: 278).

Point of view

In the distance between the teller and the tale and the teller and the listener, lies ‘narrative distance’ (Ricoeur, 1981b: 280). ‘Narrative distance’ makes possible a number of different ways to tell the tale and the possibility of a shift in point of view. The possibility of a shift taking place in narrating a tale is within the very concept of ‘point of view’ (Ricoeur, 1981b: 280). This means for the narrator, there is more than
one way of telling the story. Moreover, point of view identifies the adjusting of the narration according to the target audience. Point of view also characterises the narrator. As Ricoeur (1981b: 280) points out, this is just as important as the configurable and reflective aspect of the narrative act. The role of listening is also highlighted here, as how one is listened to elicits a different rendition of the narrative (Ricoeur, 1981b: 280).

Character

Another aspect of the structure of narrative is character. Here we ask along with Ricoeur (1992: 140): ‘what then does the narrative category of the character contribute to the discussion of personal identity’. The narrative produces the identity of a character. Ricoeur (1992: 143) says that character is formed in the ‘narrative understanding of the plot’. Character draws identity from the two domains of plot and interpretation, which is experienced as a unique singularity. Narrative offers a conceptualisation of the subject as a character constructed in a plot, through the notion of emplotment: ‘The identity of the character is comprehensible through the transfer to the character of the operation of emplotment’ (Ricoeur, 1992: 143).
In this way, narrative accounts for the correlation between the plot and character: ‘characters we will say, are themselves plots’ (Ricoeur, 1992: 43). Character thus can be understood as the outcome of the narrative of events and their history in which ‘chance is transmuted into fate’ (Ricoeur, 1992: 147). This transmutation highlights the internal relationship between events and character in the narrative-identity. So a person’s identity is not distinct from his/her narrative of experiences. In fact the person’s identity is in the narrative. The narrative constructs the character through the telling of the story. ‘It is the identity of the story that makes the identity of the character’ (Ricoeur, 1992: 148): the narrative-identity.

The narrative, character and plot are of relevance to the capacity of an agent. Characters adhere to a life project characterised by the exchange between the whole and the part in a double determination characteristic of narrative. The unity of the narrative incorporates the dynamics of identity and diversity and thus accounts for ‘the organisation of intention, causes, and chance’ (Ricoeur, 1992: 179). It is through this mimesis, the creative interpretation of events, that the plot becomes meaningful.
Narrative then, generates cognitive structures or symbolic systems wherein experiences are interpreted. These narrative structures then become the symbolic view through which the person sees the world. These symbolic systems then inform a person's concept of self. But the role of the narration on identity is not a conscious one, but integral to the internal relation between narrative and identity. Narrative is a way of not only making sense of events but also of reconstructing them. The narration is not just a series of disjointed events, but a reality created through a narrative, which is itself a reconstitution of the events with unique meaning for the subject.

To hear another's narrative, requires putting one's own 'point of view' aside, as it is only through listening with openness that the narrative account can be delivered. The function of the narrative explanation, as stated earlier is to help the listener as well as the narrator to follow the story. Narrating does not just simply add episodes on to one another in an attempt to grasp them. The narrative schemata through its 'impossible logic' offers intelligible forms upon which reflective judgement can be applied (Ricoeur, 1981b: 287). So what is the value of
a narrative conception of the subject, especially in acute mental health services?

Narration as Identity

As Ricoeur (1992: 116) states in *Oneself as Another*, ‘solutions to the problem of personal identity which do not consider the narrative dimension fail’. This, according to Ricoeur (1992: 137-139), is because they do not address the question: ‘Who?’ It is for this reason that Ricoeur maintains that the role of the narrative is central to the construction of identity. The narrative understanding of identity accounts for the internal dialectic between the events and character. In order to explain the integration of the dimensions of identity through the use of narrative further Ricoeur (1992: 115-125) in ‘The Self and Narrative Identity’ returns to the notion of *emplotment*.

Identity, Ricoeur (1992: 149) states, is a dialectic of selfhood (ipse) and sameness (idem). The concept of narrative, Ricoeur (1992: 116) explains, addresses the disjuncture in these two (sameness and selfhood) aspects of identity. This is achieved through the notion of emplotment, whereby events are explained via a story. Emplotment
accounts for the dialectic of selfhood and sameness in the characters, even though there are points at which these two aspects dissociate (Ricoeur, 1992: 115-125). The sameness or self-constancy of character refers to what others can count on me for, such that, I am accountable for my actions to others (Ricoeur, 1992: 165). Selfhood refers to an identity created from nothing but a narrative account of contingencies.

Ricoeur (1992: 118-119) argues that it is the polarity between these two aspects of identity that opens up the space that narrative identity fills.

Ricoeur (1992: 167) uses the opposition between the selfhood and sameness concepts of identity to contrast the moral questions of personal identity (‘Who am I?’) with ethical issues of responsibility (‘Here I am!’) (Levinas, 1981). The concept of responsibility unites these two aspects of identity. Ricoeur drawing from Levinas, who will be discussed in the third section of this chapter, states that the ethical reply to the question ‘Where are you’, is the responsible ‘Here I am’ (Ricoeur, 1992: 165). An ethical problem arises if self-constancy is not substantiated. What results is the ‘hypothesis of our own nothingness’ (Ricoeur, 1992: 166). But the nothingness experienced by an ‘I’ is very different from nothing at all. It is ‘a self deprived of the help of sameness’ (Ricoeur,
1992: 166). It is a self confronted with the ‘crucible of this nothingness of identity’ (Ricoeur, 1992: 167).

In the instance of a personal crisis, Ricoeur (1992: 167) suggests, that the question ‘Who am I?’ becomes a naked question. The problem becomes how can someone ask: ‘Who am I?’ and at the same time say: ‘Here I am!’ (Ricoeur, 1992: 167)? The gulf between these two questions is central to the opposition between the two concepts of selfhood and sameness, identity and narrative. Becoming aware of the disjuncture between these two aspects or poles of identity is also to become aware of the power of the space within which transformation of identity is possible. These concepts are in contrast with the current limitations of acute public psychiatric services where cerebral manipulations with drugs which challenge sameness while breaching and undermining selfhood violate ‘the right of a person to his or her physical integrity’ (Ricoeur, 1992: 151).

Accordingly, Ricoeur (1992: 137) argues that theories of the self, which do not first work out the conception of the subject are limited. He attests, ‘the entire weight of the ethical question falls back upon the question of identity’ (Ricoeur, 1992: 137). This means that the priority
concern is ‘what sort of entities persons are’, for the answer to this question has ethical implications (Ricoeur, 1992: 163). Thus: ‘what is at stake here is indeed the self in its ethical dimension’ (Ricoeur, 1992: 167). Yet, there are no ethically neutral narratives. The ethical subject, Ricoeur states ‘is none other than the one to whom the narrative assigns a narrative identity’ (Ricoeur, 1992: 178). Consequently, the narrative method declares Ricoeur (1992: 115), has the potential to: ‘describe, narrate, prescribe—each moment of the triad implying a specific relation between the constitution of action and the constitution of the self’.

In this way the *narrative-identity* in contrast to the imputed objectification of the *diagnostic-identity*, accounts for a person’s moral and ethical relationship to the world. The moral judgement associated with the events, on which a narrative is based, exposes the subject to a system of rewards and punishments. Recognition of the subjective interpretation of morality is important, as it carries a judgement with implications for one’s self-concept. The judgement of acts as good or bad in a narrative provides a frame for the moral interpretation of the self. Praise for actions results in a boost to the self-esteem of the actor, while disregard results in disdain. The concept of narrative
highlights the relation of the interpretation of events with one’s self-interpretation, which in turn informs self-esteem. That is, ‘self-esteem follows the fate of interpretation’ (Ricoeur, 1992: 179).

Hence the moral judgement inherent in the narrative has implications for how one regards oneself and how one is treated by others. Even so, Ricoeur (1992: 167) identifies an essential asymmetry between the one who acts and the one acted on. One can either be the agent of events or affected by them. The narration of events governs the roles of agents, and determines whether actions are considered good or evil. It is in the evaluation of these events (as worthy of either praise or curse) that reward or punishment is metered out to the agent and those affected by them. In response to the casting of these roles, Ricoeur says ‘I never forget to speak of humans as acting and suffering’ (Ricoeur, 1992: 167). Suffering is not defined by physical or mental pain, ‘but by the reduction, even the destruction of the capacity for acting, of being-able-to act, experienced as a violation of self-integrity’ (Ricoeur, 1992: 190).

Like Taylor, Ricoeur recognises that the valuing of events as good or evil occurs within a social context. But the essential asymmetry identified between the one who acts and the one acted on, can become blurred for
those affected by an agent’s actions. This is because, when the events someone at a formative age is subject to are judged as ‘evil’, this moral evaluation can inform the victim’s judgement of him/herself. Hence, it is the ethical subject who has been treated badly, that tends to conceive of him or herself as bad. This negative self-judgement tends to work against wellbeing, and when the moral judgement implied in the narrative works against the wellbeing of a person, Ricoeur warns that in such a crisis the tendency is to substitute self-hatred for self-esteem (Ricoeur, 1992: 168). Laing also described in his discussion of social binds the tendency to transform self-esteem into self-hatred. This moral problem arises where the characterisation of selfhood is in the context of a relation of ownership (such as in involuntary detention). In such a context, Ricoeur (1992: 168) suggests the dialectic of ownership and of dispossession, of care and of carefreeness, of self-affirmation and of self-effacement otherwise becomes ‘the ‘nothingness of the self’, as has been witnessed in the consumer/survivor movement accounts of acute public psychiatric services, ‘the existential crisis of the self’.

Ricoeur’s narrative concept of the subject shares an affinity with Taylor’s concept of self-interpretation, an understanding of the relationship between the moral evaluation of events and self-esteem.
Ricoeur says this internalisation of the value of events is central to ethics, as self-interpretation becomes self-esteem. However, the benefits of the narrative in mediating between description and prescription are only relevant if the ethical implication of the centrality of narrative to identity is put into practice. Thus: ‘The broadening of the practical field and the anticipation of ethical considerations are implied in the very structure of the act of narrating’ (Ricoeur, 1992: 115).

It is through a narrative-identity that Ricoeur asserts we place ourselves morally and ethically in the world. It is the narrative-identity that provides a moral and ethical frame for the interpretation of the self. This is important as this moral/ethical frame in turn informs self-esteem, whereas the diagnostic-identity along with other negative forms of valuing as Laing pointed out, incites self-hatred. Ricoeur’s concept of the subject as a subject of self-interpretation connects past, present and future in a story, which renders reality as meaningful for a subject. Ricoeur demonstrates how the narrative conception of identity overcomes the limitations of other theories of personal identity by addressing the self in its ethical dimension. The ethical response is a question of identity. The importance of the narrative method then is
recognition of the ethical subject in the act of narrating (Ricoeur, 1992: 115).

Conceptualising the subject as a narrating ethical subject acknowledges a person’s autonomy and responsibility in the construction of identity. Such a conceptualisation would suggest providing an opportunity for patients to identify the diverse and dynamic dimensions of selfhood (as plot and character) and self-constancy (as permanence over time and as promising) in identity construction. This concept of the narrative-identity provides the theoretical basis on which to provide practical assistance to patients to explore the events in their lives that have informed their moral sense of self, and in contrast with diagnostic practices, offers an opportunity to explore choice in the matter of identity.

**Configuring a (Narrative) Space of (for) Listening**

Notably, Ricoeur (1992: 157-168) cautions against the use of the term ‘author’ in reference to the narration of real life autobiography. Ricoeur’s preference is to conceptualise the narrator as co-author, as real life narratives are entangled with the lives of others. However, as we
have seen, Ricoeur also argues that fiction helps to retrospectively organise narratives providing examples of what is possible in areas not previously experienced. Fiction, he suggests, actually teaches behaviour. He concludes that narratives and life histories are not mutually exclusive but complementary. This complementarity occurs in a shared space, which takes place as an interaction between listening and being listened to (Ricoeur, 1992: 157-168).

Because a person’s identity is embedded in a narrative, understanding a person requires listening for the meaning and impact of events as expressed in his/her narrative. It is only through listening for the meanings attributed in a person’s narrative that his/her identity is revealed. Ricoeur (1981c: 47) notes that what is to be listened for, is not the language or words or commonalities as such, but ‘the subjectivity of the one who speaks’. Narrative is the net to catch something else: being itself. How you listen and what is listened for configures the space of listening. So much so that Ricoeur (1981c: 59) agreeing with Heidegger (1962: 206) states ‘hearing is constitutive of the discourse’.

Hence, listening to understand, as Jaspers acknowledged, requires empathy. An empathetic stance is required to orientate oneself to the
other’s experience related in the narrative. Josselson (1995: 32) states: ‘to understand another with the empathetic stance means being able to understand their stories’. Only through an empathetic stance toward peoples’ narration of their experiences:

  can we uncover the dialogical nature of the self—the dialogue both within the self and the dialogue with the world that is the centre of process in development and in living (Josselson, 1995: 42).

What this calls for is an empathetic response to people; especially people who have not been heard and do not have access to resources for being listened to.

Josselson (1995: 30) says an empathetic stance ‘takes hermeneutics as its epistemological ground’. She points out that the study of human beings involves interpreting people as they interpret themselves. She states:

  I was wary of anyone who presumed that their understanding of my experience could be known without an empathetic awareness of my meaning-making efforts. The prevailing assumption at the time was that science could learn more about me by abstracting me out of my context than by studying me within it (Josselson, 1995: 31).

This distinction points to the violence perpetrated by those who claim to know another without an empathetic understanding of one’s location in a given context. Empathy is an attitude of attention, which recognises
the relationship between self and other in a context and as such, offers compassion and understanding.

Conversely, Ricoeur identified that the one listening to a person’s experience of weakness is benefited by their reserves of strength. Failing to listen to a person’s narrative, which reveals a person’s strength, is to deny what benefits are available for both parties. Ricoeur (1992: 192) argues that ‘it is in the search for equality in the midst of inequality,’ whatever the sources between self and other, that ‘defines the place of solicitude along the trajectory of ethics’. Ricoeur argues to this end that to maintain self-esteem, we need practitioners who act with empathetic attitude of friendship or solicitude. Solicitude adds the dimension of value. However, if this is not spontaneous, it becomes duty and is counterproductive.

Herein resides the cost of what is involved in this conception of the subject: preparedness by professionals to get involved and relate as a friend, to be a friend, and believe in another as myself. Believing that as myself one is capable of making a difference. Ricoeur calls this preparedness similitude. This similitude:

\[
\text{is the fruit of the exchange between esteem for oneself and solicitude for others. This exchange authorises us to say that I cannot myself have self-esteem unless I esteem others as myself (Ricoeur, 1992: 192)}\]
This means that it is equivalent to esteem the other as oneself and as stated in the title of Ricoeur’s (1992: 194) text, Oneself as Another.

To establish such an empathic practice in acute psychiatric services is to do so in the most difficult and taxing circumstances. To this effect, Buber (1992: 34) suggests a useful philosophical anthropology where subjectivity is not left behind, where ‘man himself is given to man in the most precise sense as a subject’. Buber says:

> but the philosophical anthropologist must stake nothing less than his real wholeness, his concrete self. And more, it is not enough for him to stake himself as an object of knowledge. He can know the wholeness of the person and through it the wholeness of man only when he does not leave his subjectivity out and does not remain an untouched observer (Buber, 1992: 34).

The recognition of intersubjectivity is important as the domain of human beings is one where one is continually reconstituted in the face of the other. This recognition of the importance of relationship for human beings is because as Levinas (Levinas, 1998a: 105) states, what is encountered, in the face-to-face relationship is the presence of the divine. Likewise Buber states that ‘we may come nearer to the answer to the question ‘what is man’ when we come to see him as the eternal meeting of One with the Other’ (Buber, 1992).
Moreover, Levinas (1998a: 87-88) states that the comprehension of the other is dependent on and inseparable from his/her invocation/expression. That is to say, to understand a person is to speak with and listen to them. The two are intertwined and speech is central to understanding. It is impossible to approach the other (autrui), without speaking as without language it is impossible to understand (Levinas, 1998b: 6-7). It is through language that being is intelligible: ‘It is because being is intelligible that here is humanity’ (Levinas, 1998b: 2). To deny intelligibility is to deny humanity. The demarcation of understandability is a political line of commitment to the other as a subject or to the denial of that person’s subjecthood.

Psychiatry’s failure to comprehend the subject and its reliance on objectification means that the patient experiences violence and a negation and a struggle for identity as an independent person. Levinas (1998c: 85) maintains the claim to ‘know’ the other is violence: ‘an ontological empiricism’ with ‘political implications’. It is a philosophy of power and domination where the other is defined in a totalising way. In contrast, the ethical subject is defined, Levinas says, in relation to the Other. This involves respect for the Other’s heterogeneity: the
importance of difference. This requires being open to uncertainty and being open to the demand of the other (Levinas, 1998c).

What needs to be acknowledged and practiced in psychiatry is a conception of the subject that acknowledges and respects the patient as a person. Levinas (1998b: 7) argues a being can only be in a relationship where ‘I speak to him’. That is to say that to understand a person is to speak to him/her. To understand is not to ‘know’. The encounter with being is distinguished from knowledge. As Heidegger (1962) identified, comprehension rests on the openness of being. Understanding comes through openness to the particular as opposed to the universal. It is here, in relationship with the other, irreducible to comprehension, that the infinite, the sacred, the transcendent, the divine is present, in the face of the other (autrui) (Levinas, 1981).

The failure to anticipate the patient as understandable as a person results in a loss of the psychiatrist’s ability to be with the person as an intelligible being. This results in a failure to acknowledge the being of the person at all. The relationship to the other is not merely a perspective. The relationship to the other is established in the invocation in how the other is addressed or ‘called’. In meeting with

Understanding the patient as a person has not been part of the tradition of practice in acute public mental health services, instead the latter have been consumed by a ‘nostalgia for totality’ (Levinas, 1981: 13-17). In psychiatry this has meant that the patient has been reduced to an object through the reliance on an objectively constructed knowledge: diagnosis. But as Levinas has highlighted, some knowledge’s are not objectivistically synthesizeable, for instance, a face-to-face interaction. These face-to-face encounters are identified by Levinas as ethical relationships (Levinas, 1981; Levinas, 1998a; Levinas, 1998b).

Levinas (1998a: 77) maintains that an ethical and aesthetic space exists not in an attempt at synthesis, but ‘in the face-to-face of human relationships, in sociality, in its moral signification’. He states, ‘access to the face is ‘straight away ethical’: ‘it is uncontainable and leads you beyond’ (Levinas, 1998a: 85). It is in this ‘signification of the face’ that it
‘makes it escape from being, as a correlate of a knowing’ (Levinas, 1998b: 87). Levinas (1998a: 85) suggests, it is through testimony not representation or knowledge that the revelation of the subjective occurs. Levinas (1998a: 108) declares that the ethical testimony is not about knowledge but the ‘Other’ or ‘the Infinite’ manifesting itself in subjectivity: ‘It is through this testimony that the very glory of the infinite glorifies itself’ (Levinas, 1998a: 107). The presence of the infinite Levinas (1998a: 106) argues is not in ‘disclosure’ but when ‘in the presence of the other I say, ‘Here I am!’ this ‘Here I am!’ is the place through which the infinite enters into language’. Ethical testimony then according to Levinas is a revelation of the infinite, the divine.

Testimony is a way of breaking totality: ‘The face speaks’ and ‘it is in this that it renders possible and begins all discourse’ (Levinas, 1998a: 87). In this way, the ethical relationship is beyond empirical, objective, final knowledge. This ethical relationship is only authentically assumed
through discourse and a response in discourse. Levinas uses this term to draw attention to the necessity in the face-to-face encounter of ‘saying’ something. 17

The face-to-face encounter is an ethical encounter with subjectivity as responsibility. ‘It is discourse and, more exactly, response or responsibility which is this authentic relationship’ (Levinas, 1998a: 88). Levinas (1998a) in *Ethics and Infinity* addresses responsibility as ‘the essential, primary and fundamental structure of subjectivity’: a description of subjectivity in ethical terms. An ethical practice is a face-to-face encounter. Levinas (1998a: 95) insists the ‘very node of the subjective is knotted in ethics understood as responsibility’. Levinas understands this as responsibility to be with the other, as opposed to

17 Saying responds to the face. Saying is a term Heidegger refers to in *On the Way to Language* to highlight the quality and creative power present in the expression of spoken words as outlined by Ricoeur.
acting on the other. Levinas’ notion of responsibility offers an appropriate approach for psychiatric practice and ethics.

Levinas says ethics is about responsibility:

Since the Other looks at me, I am responsible for him, without even having taken on responsibilities in his regard: his responsibility is incumbent on me. It is responsibility that goes beyond what I do... This means that I am responsible for his very responsibility (Levinas, 1998a: 96).

This type of responsibility built on similitude could be built into psychiatric practices in place of current practices, which currently practice responsibility as involuntarily admission. This is distinguished from the similitude argued for here, as an ethical relationship does not reduce the subject to an object. Responsibility as Levinas puts it:

It is a structure that in nowise resembles the intentional relation which in knowledge’s attaches us to the object—no matter what object, be it a human object (Levinas, 1998a: 97).

The ethical relationship with the Other is differentiated from current practice by a responsibility to the other as ‘human spirit’: that is, ‘the incarnation of human subjectivity guarantees its spirituality’ (Levinas, 1998a: 97). This responsibility for the other does not extend to the requirement for their responsibility for you. There is no reciprocity built into this ethics. The responsibility, as Levinas describes it, lies with the
‘I’ alone and is not transferable. This exclusively self-conscious responsibility for the other is beyond knowledge. It is beyond objectifying and synthesising. It is an interpersonal, inter-subjective space of the face-to-face relationship that constitutes an ethical situation.

Such proximity to the Other represented by a face (which refers to the whole human body) ‘orders and ordains me’ as though ‘someone’s asking for you’ (Levinas, 1998a: 97). It is a responsibility that, as Levinas says, ‘I am subject to’, that is, ‘a total subjection to the other’ (Levinas, 1981; Levinas, 1998a: 95-101). Ethically, such responsibility cannot be refused. An ethical encounter with the other requires one to be responsive to the Other or face (This means testifying to the presence and the glory of the infinite) (Levinas, 1998a: 105). Saying ‘Here I Am’ is recognition of the responsibility signified in the face of the Other (Levinas, 1981; Levinas, 1998a: 106). The demand of the other arises in a particular context and calls for unique, creative invention in every specific, according to universal principals (Levinas, 1998c). According to Critchley (1999) the ethic that is called for, is in relationship to the other’s infinite demand made on me within the finite context. The action
taken must be dependent on and in relation to the context.

For Levinas (1981), being is devoting oneself to another; being is being-for-the-other. This existing for the other, Levinas (1998b: XII) states, is stronger than the threat of death: ‘the fellow human being’s existential adventure matters to the I more than its own, posing from the start the I as responsible for the being of the other’. Levinas (1981) talks about a place that is not a place of being yet not a place of non-being: it is a place Otherwise than Being. It is this ‘shattering of indifference’, the ‘possibility of one-for-the-other that constitutes the ethical event’ (Levinas, 1998b: XII).

Concluding Remarks

The consumer/survivor movement claims that the failure to listen to patients’ narratives in acute psychiatric services is experienced as disrespectful because it is a failure to recognise the patient as an ethical subject. Likewise, involuntary and coercive practices of electroconvulsive therapy, drug administration and isolation are not experienced as therapeutic but traumatic as they do not respond ethically to the subject. This chapter has attempted to respond to
consumers’ accounts of these negative experiences of mental health services by introducing the conceptualisation of the subject as an ethical subject embedded in a narrative through the works of Taylor, Ricoeur and Levinas.

Consumer/survivors themselves have said healing comes through the telling of the story. This chapter has highlighted that failure to listen to patients constitutes a failure to provide ethical services. Conversely, the recognition of the patient as a narrative subject in acute public psychiatric services would provide an ethical response to the demands of the consumer/survivor movement. This ethic would require the introduction of the practice of listening to consumer narratives. It may be, then, that:

> to recognise the values of the past in their differences with respect to our values is already to open up the real toward the possible. The ‘true’ histories of the past uncover the buried potentialities of the present (Ricoeur, 1981b: 295).

Identifying narratives in the complex formulation laid out in Ricoeur’s work implies that they are central to the identity of people. This approach offers an alternative metaphorical, theoretical and explanatory schema that could be utilised in acute public psychiatric services. What this conceptualisation requires in practice is a two-fold approach to
treatment: a response to the real life events in terms of social and material resources; as well as resources to identify the subjective meaning and interpretations of a person’s experiences. Providing these skills would require the development of positive discourses and practices. The acknowledgement of the subject as an ethical subject would require opening a space for listening to patients’ narratives.

Conceptualising the subject as an ethical subject and listening to consumer/survivors ‘explanatory narratives would open up the possibility of legitimately’ being with and ‘listening to’ consumer/survivors: the consumer/survivor as a subject can only be introduced if we let ‘the other speak’ (Fiumara, 1990: 107). Listening to consumer/survivor accounts of their subjective experience would be an acknowledgement of a person’s narrative as a legitimate account from their point of view. Patients’ narratives would be understood as providing coherence, meaning, structure, and identity for the otherwise incomprehensible and uninterpretable events of life. Narrative would be recognised as having a central role in describing and explaining a person’s life and would make psychiatric symptoms comprehensible and understandable within the life narrative of the particular subject.
Only with a preparedness to be open to discover the uniqueness of every individual is there the possibility of understanding. Utilising diagnostic categories to diagnose mental illness creates an illusion of understanding while avoiding the necessity of being with a prolonged state of not knowing required to facilitate understanding. Bion (1975) discusses ‘binocular vision’ as the holding together the knowing and not knowing where—with one eye you see what you know and with the other listen for the unknown. This is a powerful image of holding-in creative tension—both the knowing and not knowing of the practice of psychiatry.

The concept of a narrative subject offers the possibility of transformation for the patient, the profession and the service. But such methodologies are insufficient in themselves. What is required is recognition of the subject as an ethical subject who is constituted narrativistically. This recognition requires a professional commitment to a practice in which the acute psychiatric patient is respected as an autonomous human being. Only then is there the possibility of transformation, not only of the person in the receipt of services, but of the culture of service delivery as well. The introduction of such a conceptualisation would require development and implementation of
an ethics of practice in line with consumer/survivor movement demands addressed in the next chapter.
CHAPTER 8

THE CONSUMER/SURVIVOR MOVEMENTS’ STRUGGLE FOR RECOGNITION

Democracy is the battle waged by subjects in the context of their culture and their liberty, against the domineering logic of systems (Touraine, 1997: 12).

Give people opportunities to tell their stories privately and really listen and listen and listen. Our experience suggests that when we do genuinely feel heard we will be ready for the next action stage: ‘what are we going to do about it’ (Wadsworth & Epstein, 1996a: 74).

The consumer/survivor movement’s claim that the failure to listen to patients in acute public mental health services is a failure to recognise the patient as a subject is supported by Touraine (1997). This failure has resulted in some governmental and World Health Organisation incentives to improve the institutional organisation of relationships, the fundamental source of the problem according to Touraine (1997), in acute mental health services. These incentives and their success are outlined below. The consumer/survivor movements’ initiatives and their limitations are also considered. The failure of these incentives to so far transform the ethos of practice demands further inquiry into the reason for the failure to recognise acute psychiatric patients as subjects. This
is a problem this thesis has attempted to address. How a reversal of this stigmatising process is to be accomplished, will be considered in the third part of the chapter through the work of Alex Honneth where the importance of recognition in overcoming stigma and facilitating recovery is discussed.

**Governmental and World Health Organisation Initiatives for Recognising the Consumer/Survivor Perspective**

The consumer/survivor movement makes a claim for a right to democracy and social justice through participation. The World Health Organisation (1978) has supported the claim that people have both the right and duty to be involved in decisions that affect their daily lives. The consumer/survivor literature argues that consumer/survivors have a unique perspective (Wadsworth & Epstein, 1996a). The World Health Organisation identifies that this perspective provides a critical contribution to service development, because, it argues, if those who use the service are involved in the planning, development and implementation, the service will be more responsive (World Health
Organisation, 1993). There is even recognition that this type of participation provides greater efficiency, effectiveness, equity and self-reliance (World Health Organisation 1989). The World Health Organisation recognises that consumer/survivors are more able than any other to:

Provide checks and balances in the design, delivery and evaluation of services, which introduces validity to the system that can be achieved in no other way (WHO, 1993: 3).

In response to the World Health Organisation’s (1978) declaration, the need for participation has been recognised as a high priority by governments and mental health services internationally. This has involved a growing recognition of the importance of introducing consumer/survivor respecting practices (Allen et al., 1999; Kinderman & Cooke, 2000; Mental Health Commission, 2001; Sozomenou, Mitchell, Fitzgerald, Malak & Silove, 2000; Verna, 2000).

For instance, in 2001, The Mental Health Commission in New Zealand published *Recovery Competencies for New Zealand Mental Health Workers* (Mental Health Commission, 2001). This document defined the skills and competencies required to incorporate the perspective of those who use mental health services in the delivery of services. The United
Kingdom has also released a report (Kinderman & Cooke, 2000) identifying the central importance of responding at a personal level to the complexity of mental illness. In the United States there is a growing and active consumer/survivor movement with increasing resources allocated for consumer/survivors to establish their own treatment responses supported through the National Empowerment Center (Verna, 2000).

In Australia there has been a number of State and National initiatives to develop consumer/survivor participation in mental health services. The Mental Health Council of Australia (MHCA) was established in 1997-8 under the National Mental Health Strategy to represent and promote the interests of the mental health sector and advise on mental health in Australia. This took over the function of the National Community Advisory Group. The State Community Advisory Group continues to provide input into local and national policy development. Whether these Community Advisory Groups actually influence decision-making, however, is uncertain. Participants find this uncertainty demoralising.

The *National Mental Health Report 2000*: (Commonwealth Department of Health and Aged Care, 2000) identified the poor resourcing of these
advisory groups as an impediment to consumer/survivor participation in them. Adequate training of people for these roles was also identified as lacking although an initiative is underway to address this. The Community Development Project is an initiative that aims to equip consumers (and carers) with the skills and confidence to participate in decision-making forums. The Mental Health Council of Australia is distributing *The Kit*, a resource for this purpose (Commonwealth Department of Health and Aged Care, 2000).

Another concern of the national consumer/survivor movement has been the lack of user involvement at a local service delivery level. Despite the government policy initiatives, twenty-six percent of national services had no consumer participation program in 1998, (an improvement from 47 percent in 1994) (Commonwealth Department of Health and Aged Care, 2000: 124). For those programs that do offer participation, until now this has only involved advisory roles in committees (Commonwealth Department of Health and Aged Care, 2000). Consumer/survivors also argue that it is not enough to evaluate services that are already established. Consumer/survivors also want to be involved in developing, evaluating and articulating policy and
designing services (Epstein & Shaw, 1997).

The *National Mental Health Report 2000*: (Commonwealth Department of Health and Aged Care, 2000) identified that stigma and discrimination have not improved and that treatment planning has not been collaborative. The participation that has occurred has usually involved an endorsement of pre-determined plans. In the report, participation in decision making has been acknowledged as tokenistic, and a great source of frustration for those involved in the consumer/survivor movement. For government policies of consumer/survivor participation to be substantiated, not only in Australia but internationally, services require participatory practices in line with consumer/survivor perspectives. The real site of transformation, as Foucault has defined it, is ‘the subject who acts—the subject of action through which the real is transformed’ (Foucault, 1991d: 84).

**Initiatives for Recognising the Consumer/Survivor Perspective**

The consumer/survivor initiatives to change the culture of acute psychiatric services have focused on advocating for patient participation
in the mental health system. Consumer/survivors are not happy with
the level of participation facilitated by governmental organisations in
services so far. In response, consumer/survivors argue that for change
to occur in mental health practices in the interest of recipients of
services, it is necessary that change be user-driven (Wadsworth &
Epstein, 1996a: 10-12). Provider-driven changes, they argue (which
includes a reference to the influence of Laing), have been only partial.
Complete transformation, they continue, needs to be from the patient
perspective, involving consumer/survivors as equals (Wadsworth &
Epstein, 1996a: 10-12). These activists maintain that it is not that they
want to jeopardise the delivery and/or availability of services but that
they want a change in the culture of service provision (Epstein & Shaw,

The consumer/survivor literature insists that the way forward is to
change the culture of present practices to one that reflects the
recognition of the acute psychiatric patients’ right to respect as a person
(Epstein & Shaw, 1997; Sozomenou et al., 2000). The movement
indicates that patients desire to be treated as persons, whether in a
psychiatric crisis or not. This means listening to patients with respect:

If you were treated as a person, they would listen to what your
concerns were when you entered and that would become part of your treatment plan (Wadsworth & Epstein, 1996c: 157).

One consumer/survivor put it thus: ‘I want to be treated with respect as a human being, not like how the elephant man was treated’ (McGuiness & Wadsworth, 1992: 19).

Prevalent in consumer/survivor literature is the view that distress is due to problems that need to be solved. The counsel offered is: ‘always take the consumers seriously (that is if the consumer is upset they...have a reason to be upset no matter what anyone else thinks)’ (Epstein & Shaw, 1997: 76). The Developing Effective Consumer Participation in Mental Health Services: The Report of the Lemon Tree Learning Project (Epstein & Shaw, 1997) holds that patients are the experts on their needs if they are given an opportunity to express them.

The Orientation and Job Manual: Staff-Consumer Consultants in Mental Health Services (Wadsworth & Epstein, 1996a), tells that people who have utilised services:

Have important insights, understandings, and assessments of their experiences essential to point services in the direction of improved quality (Wadsworth & Epstein, 1996a: 10).

12) argues that as ex-patients have user experience, these views need to be sought.

Central to the consumer/survivor agenda is that patients:

- define their own experiences, defining the questions as well as the answers, having a determining say in the settings, form and design of the efforts and the programs (Epstein & Shaw, 1997: 12).

But it is only when consumer/survivors are recognised as legitimate subjects with a legitimate voice is there a possibility that what the patient defines as needed will be addressed and that practices they identify as needed in the provision of mental health services will be provided. This means building in sites where client’s views can be heard in practice. However, as identified in chapter one, the system itself inadvertently works against hearing from patients about their needs. The *Understanding and Involvement Project* concluded with a recommendation that mechanisms be built in to prevent the ‘tendencies to contradict its fundamental healing purposes’ (Wadsworth & Epstein, 1996b: 213).

The Developing Effective Consumer Participation in Mental Health Services: The Report of the Lemon Tree Learning Project (Epstein & Shaw, 1997: 21) discussed how to incorporate the findings of the
Understanding and Involvement Project in patient participation. Here patient participation is defined as ‘consumers offering to help services improve their practice’ (Epstein & Shaw, 1997: 21). Epstein goes on to argue that quality assurance is the model that could best respond to the expressed needs of users.

It is only when we think of consumer participation in the context of quality assurance activity that we can start to understand that the argument made by consumers, that part of the necessary change is that our participation must be seen as work and therefore respectfully remunerated. The Lemon Tree Project has developed this aspect as a major theme (Epstein & Shaw, 1997: 86).

The Report of the Lemon Tree Learning Project (Epstein & Shaw, 1997) discussed changing the culture of psychiatric service provision through consumer/survivor participation in quality assurance as ‘changing things that are taken for granted in the way services are practiced’ (Epstein & Shaw, 1997: 88). This requires that there be a ‘fundamental change in the way service providers see and are able to be with consumers’ (Epstein & Shaw, 1997: 88). For instance, desirable services are defined as ‘consumer-inclusive’ rather than ‘consumer-exclusive’ and as ‘self-confident and inquiring rather than fearful and resistant’ (Epstein & Shaw, 1997:89).
Effective patient participation depends on a model of practice that is:

Reflective and self critical, asking questions and searching for answers from consumers rather than guessing, observing through professional perspective eyes or assuming righteous authority simply because of an affiliation with an established professional base (Epstein & Shaw, 1997: 18).

The Understanding and Involvement Project (Epstein & Wadsworth, 1994; Wadsworth & Epstein, 1996b; Wadsworth & Epstein, 1996c) showed that, people primarily want services that are responsive to their needs. What consumer/survivors prefer is:

To be asked and listened to (‘they communicated about that with me’) rather than stating, being told and informed (‘they communicated to me’); being invited, included and trusting we can contribute... having things explored with us (iterative, tentative dialogue) rather than commands and being given to conclusive ‘discussion’ or compelling argument; preferring safe, honest talk and unimposed and offered options, rather than being tested and exposed, or having unwelcome or compulsory courses of action prescribed, often with a hidden and insulting agenda (e.g. to aid ‘insight’ or ‘ventilation’); being respected rather than dismissed or patronised; having connection (eye contact, body language) which is warm rather than distanced and cold (answering a pager, checking a watch or shuffling paper); and being collaborated with, rather than ‘managed’ or manipulated (Wadsworth & Epstein, 1996a: 69).

Wadsworth and Epstein (1996b) and Epstein and Shaw (1997) found that for such change to occur, there needed to be the presence of some form of ongoing research or evaluation to provide the opportunity for reflective practices, otherwise professional staff maintained a distance from patients.
The result of this research was the introduction of the position of consumer consultants into mental health services (since November 1996) to facilitate the beginning of patient participation in psychiatric services. The role of the consumer consultant according to theOrientation and Job Manual: Staff-Consumer/survivor Consultants in Mental Health Services (Wadsworth & Epstein, 1996a), is to provide a feedback mechanism between consumers and staff for reviewing and improving the quality of services. The point being that:

It is their driving interest in the services which is most likely to energise the effort to seek consumer/survivor feedback, promote staff-consumer communication and assist staff to make the subsequent necessary changes to services (Wadsworth & Epstein, 1996a: 10).

The role of consumer consultants has been designed to provide feedback mechanisms of how people actually experience services. This feedback could be built into everyday practice to ‘challenge the assumption service providers make in relating to consumers’ (Epstein & Shaw, 1997: 105). The attempt was to involve patients in decision making so that: ‘consumer participation is respected, valued and even sought' (Epstein & Shaw, 1997: 23). A further role of the consumer consultant according to theOrientation and Job Manual: Staff-Consumer Consultants in Mental Health Services (Wadsworth & Epstein,
Consumer consultants were also considered to be a mechanism for reviewing and improving the quality of services.

**Evaluation of Consumer/Survivor Initiatives**

Despite the current policy initiatives that claim to recognise the role and importance of ‘consumer’ participation; this has not transformed services into what is considered ‘consumer’ friendly places in acute public psychiatric services. Failure to listen to patients as valuable human beings is a failure to recognise and validate patients’ already vulnerable sense of self. For this to occur, as highlighted there needs to be the presence of some form of research or evaluation to provide the opportunity for ‘reflecting on practices and making changes’ (Epstein & Shaw, 1997: 14).

Self-reflection was found to be vital for change as: ‘All new practice involves a pause and conceptual shifting and distancing from old practice’ (Epstein & Shaw, 1997: 15). The introduction of consumer
consultants was an attempt to provide the opportunity to acknowledge the patient perspective in the hospital culture. This has also been found to offer a positive role model for patients (Sozomenou et al., 2000). And though this initiative has been positive in itself, it has not transformed the ethos to one that respects patients as persons.

Though it is the consumer consultant’s role to question the assumptions of the culture of acute psychiatric service by introducing the consumer/survivor perspective, such consultants usually feel ‘overwhelmed by the entrenched culture in which they find themselves’ (Epstein & Shaw, 1997: 91). According to a review of this role, over-worked consumer consultants have found themselves subject to practicing the same defensive strategies identified as problematic by medical staff (Kroschel, 2000). This highlights the failure of the system to address the needs of not only the people who it is intended to service, but also those who serve in it. Epstein and Shaw (1997) argue, for culture to change a supportive network of reflective practice involving practitioners would be required.

The aim of *The Lemon Tree Project* (Epstein & Shaw, 1997) was the education of the staff. Though promising, and reputedly effective, such
an approach is expensive, time consuming, retrospective, slow and not unproblematic. For instance, patient participation:

should not be a further occasion for consumers to experience abuse... yet these problems are frequently experienced by consumers in such settings (Epstein & Shaw, 1997: 26).

The Lemon Tree Learning Project involved training sessions with service providers in patient participation. Trainers quickly came up against the problem of the conceptualisation of consumers by providers. They found service providers could not make the conceptual leap of going from seeing patients as objects... dictated by the classifying, therapeutic and limiting language of the medical model to seeing consumers as people with a range of experiences and opinions to contribute, including their involvement with mental health services (Epstein & Shaw, 1997: 33).

The Department of Human Services Victoria has recently released an independently conducted research report on the Evaluation of Consumer Participation in Victoria’s Public Mental Health Services (Service Quality Australia, 1999) to assess the effectiveness of the policy of consumer participation in mental health services. Four hundred and fifty contributions were made to the consultation process. The report did not offer a specific analysis of consumer consultant contribution as such, but an overview of the impact of the effectiveness of the policy from
responses received. A problem identified was that the need for patient participation was not clear for some managers and staff in mental health services.

Neither was it clear what constituted consumer participation in the report. Another problem of the report is that it did not distinguish between the distinctly different perspectives of consumers and carers. The significant finding of the report was that it identified that services had no aim or sense of direction in their policies. There was a clear need to clarify ‘what constitutes effective consumer/survivor participation in public mental health services and what should be the intended outcomes’ (Service Quality Australia, 1999: 15).

The report recognised the purpose of participation as the empowerment of users. But what was found was a failure to listen and to respect the views of service users and that this worked against mental wellbeing. Listening was recognised as facilitating better outcomes by allowing voice, choice and responsibility as aids in recovery. The best outcomes were for those who were involved in service delivery at both an individual and systemic level. For this to occur would require consumers to participate at both these levels which would require
recognition of and respect for the consumer/survivors point of view.

However, participation as a ‘consumer’ was not unproblematic. In forums where people were invited to participate in a discussion, those who had utilised services were still stigmatised. For instance, though participation ‘should not be a further occasion for consumer to experience abuse...these problems are frequently experienced by consumers in such settings’ (Epstein & Shaw, 1997: 26). Further, participation as a ‘consumer’ requires identification as a ‘consumer’. This positioning relocates participants as subject to the stigma of psychiatric illness, which works against incorporating the wealth of knowledge and understanding available from the consumer/survivor perspective into practice.

Neither were consumers/survivors happy with the way they are treated at an individual level. The consumer/survivor movement indicates that people desire to be treated as persons, whether in a psychiatric crisis or not. This would mean listening to patients with respect:

If you were treated as a person, they would listen to what your concerns were when you entered and that would become part of your treatment plan (Wadsworth & Epstein, 1996b: 157).

Yet only when patients are recognised as legitimate subjects and
listened to as such, will practices identified as problematic in the provision of mental health services be improved. But how is this impasse to be overcome? What will it take for people who use acute psychiatric services to be engaged with as legitimate human beings? Organisational and/or participatory consultative roles will not be effective until real change in the culture of mental health services takes place. This change requires recognition of the autonomy and equality of all human beings including acute public psychiatric consumer/survivors. This recognition requires building concepts and practices into the system, which are based on mutual respect. To identify practices of respect we will turn to the work of Alex Honneth.

Recognising the Subject

As demonstrated in chapters two and three, the institutional organisation of acute psychiatric services depends on the conception of the subject as ‘mentally ill’, the premise upon which a person’s status as an equal is called into question. This premise undermines the legitimacy of the patient as a person. What is required to overcome stigma, it is argued here, is to recognise the patient, though traumatised and distressed, as an equal. Touraine (1997) has
highlighted the need for recognition as a subject as a democratic necessity. Recognition for psychiatric patients would require putting into place democratic practices of dialogue and communication where the patient as a person is listened to and engaged with. The concept of the subject identified in chapter seven through Taylor, Ricoeur and Levinas’ work provide the basis for this ethos in acute psychiatric services. The question of practices that facilitate the basic human necessity to be recognised as a subject will be considered here through reference to the work of Alex Honneth.

Alex Honneth (1995) in *The Struggle for Recognition: The Moral Grammar of Social Conflicts* suggests all social struggles are over a struggle for recognition as legal, ethical and social subjects. Morality involves, he suggests, all subjects having their opinions heard equally as individual, autonomous subjects. What is meant by the *ethical* is the ethos of a ‘particular lifeworld’. New social movements, such as the mental health consumer/survivor movement contest the devaluation of a particular lifeworld. Ethical problems according to Honneth (1995: 172) are structural, in that they disable ‘communicative enabling self-realisation’. Notably what Honneth suggests is required for an ethical
approach is that it:

has to contain everything that is subjectively presupposed in order for subjects to know that the conditions for their self-realisation are safeguarded (Honneth, 1995: 172).

Honneth, like Taylor and Ricoeur, identify the patterns of approval and recognition, internal to language, as central to the integrity of human beings. The self-descriptions of those that consider themselves as treated wrongly by others share the failure of recognition as legal, ethical and social subjects at the source of their experience of disrespect. Disrespect is incurred through human beings vulnerability and need for recognition. Intersubjective negativism injures the positively acquired understanding of oneself. This is important because self-image depends on:

the possibility of being continually backed up by others; the experience of being disrespected carries with it the danger of an injury that can bring the identity of the person as a whole to the point of collapse (Honneth, 1995: 131-132).

The diagnosis of mental illness carries a stigma demonstrated through the withdrawal of recognition by others and this denigration of respect has implications for respect for self. Honneth (1995: 172) identifies the negative emotional reaction to the experience of disrespect as typical in
driving a new social movement such as the consumer/survivor movement.

Three Sites of Disrespect

Honneth (1995) identifies three sources of disrespect: physical abuse, denial of rights and social value. This model of disrespect provides a framework in which to understand the ways in which consumer/survivors feel that they have been disrespected. The three sites of disrespect that Honneth identifies are the sites that the consumer/survivor movement identifies as the sites that they experience as disrespectful in acute psychiatric service. Identifying the site of the problem also facilitates providing a way to overcome the problem. Practical examples of these three sources of disrespect, which consumer/survivor’s claim both precipitate mental health problems and perpetuate them will be discussed in the following section.

i) Physical abuse

One source of disrespect that people who receive services report as precipitating their ‘mental health problems’ is physical and sexual abuse. Physical and sexual abuse is a lasting source of damage to one’s
sense of self-confidence and undermines one's sense of autonomy. This, along with the accompanying shame about being abused, results in a loss of trust in oneself and the world, which affects relatedness with the world (Honneth, 1995). Herman (1992) identifies traumatic events such as physical and sexual violence as violating autonomy at the level of bodily integrity such that a person considers that their view counts for nothing. ‘Traumatic events thus destroy the belief that one can be oneself in relation to others’ (Herman, 1992: 53). The shame of untold tales and unrepresented traumas are embodied as helplessness. The taboo of abuse means the trauma is not articulated or incorporated in a constructive narrative to provide coherence and meaning. But rather internalised into a negative sense of self-shame.

There is established evidence of the high incidence of sexual abuse in acute psychiatric patients (Brier, 1992; Everett & Gallop, 2001; Graham, 1994; Read, 1997; Read, 1998). The prevalence of sexual abuse in clinical samples of acute psychiatric patients ranges from fifty to eighty percent depending on the study (Everett & Gallop, 2001; Hawthorne et al., 1996; Herman, 1992). Research also indicates that those considered unresponsive to treatment for mental illness have a
history of sexual abuse (Everett & Gallop, 2001; Read, 1997; Read, 1998; Read & Fraser, 1998; Tooth et al., 1997).

Even though there is acknowledgement in the psychiatric literature of the significant contribution of abuse to psychiatric problems (Geller, 1992; Hawthorne et al., 1996; Herman, 1992; Kleinman, 1988; Mitchell, Grindel & Laurenzano, 1996), these events are rarely addressed or responded to in a way that people feel recognises or responds to their plight (Graham, 1994; Read & Fraser, 1998). McFarlane states:

Patients with schizophrenia and bipolar disorder who have a history of abuse have high rates of suicide attempts, show more aggressive behaviour and have longer hospitalisations. At this point in time, there is little or no attention to these observations in mental health delivery in Australia. This is perplexing and a matter of concern (McFarlane, 2000: 897).

Consumer/survivor accounts as described in chapters one and three, affirm patients’ claims that they have stories to be told that are often traumatic tales of suffering. According to these consumer/survivor accounts, recovery occurs through the telling of these stories. As argued in chapter seven, it is through the telling of these stories that the self is discovered and recovery occurs. Survivors claim they are experts on their own experience and healing. That expertise needs to be acknowledged in a conception of the physical, sexual, emotional, and
spiritual damage caused by life events which legitimises survivors’ discourses. As already raised, legitimisation for these experiences springs from the linguistic practices and discourses, communication and critiques of the consumer/survivors themselves (Lyotard, 1979).

But in acute psychiatric services, these stories are not legitimised and remain unheard. The experience of clinicians who work with people who have survived sexual abuse have found that it is not that the memories cannot be retrieved; the problem is finding a safe place to do so where the stories are believed. Survivor speech, as has been demonstrated throughout this thesis, presents a violent confrontation to the dominant conceptions of mental illness in mental health services. Even so, in a preliminary investigation of a therapy that provided acceptance, belief, understanding, confidentiality, a safe environment, honesty, respect, trust, and a stable and available service, had extraordinary success (Smith, 2000).

The need to be listened to, to process and articulate one’s narrative as was demonstrated in chapter seven, is essential for the development of the human subject. This process is required for victims of abuse to overcome their trauma. Even though it is a more complex process in
acute psychiatric patients, it is all the more important. An ethic of practice is required to provide acute public psychiatric patients with an opportunity to articulate their narrative. Taylor, Ricoeur and Levinas demonstrated that the telling of the narrative allows for the communication of something more: the human spirit. Listening to people’s narratives provides access to a person’s subjecthood, personhood and identity. Moreover, the narrative provides for genuine human relatedness between human beings and facilitates through understanding, recognition of the ethical subject.

The failure to provide listening in acute psychiatric services through coercively delivered involuntary treatment, or the threat of such, adds further trauma to the loss of self-confidence and autonomy. Ricoeur identified the kind of suffering consumer/survivors recount as ‘the reduction, even destruction, of the capacity for acting, of being-able-to-act, experienced as a violation of integrity’ (Ricoeur, 1992: 190). Being able to act he defined in reverse: the attempt to share another’s pain. This ‘suffering-with’ is an alternative response to another’s need.

For from the suffering other there comes a giving that is no longer drawn from the power of acting and existing but precisely from weakness itself (Ricoeur, 1992: 191).
‘Suffering-with’ is what is required in acute psychiatric services in response to people’s distress. However, instead of this ‘suffering-with, what happens in acute psychiatric services is just the opposite.

ii) Denial of Rights

The second form of disrespect Honneth identified was the denial of rights. Involuntary admission or the threat of involuntary admission denies a person their rights as a citizen. Formal or informal admission denies the rights and responsibilities of a person as a functioning participant of the social order. What the denigration of rights signifies is: ‘a violation of the intersubjective expectation to be recognised as a subject capable of forming moral judgements’ (Honneth, 1995: 133-134). This creates an inability to relate to one self and others as equals.

Thus the acute admission of someone with a diagnosis of mental illness under the Mental Health Act 1986 (Victoria, 1998) works to denigrate a person’s sense of self-respect through institutionally imposed discrimination. The authorisation through the Mental Health Act 1986 (Victoria, 1998) the use of coercive measures against a patient, and the punitive way of relating to patients and their families in acute psychiatric services, is identified as institutionalised discrimination.
(Campbell, 1994) and is debasing. This physical abuse combined with the ‘feeling of not enjoying the status of a full-fledged partner to interaction’ (Honneth, 1995: 133), leads to an overwhelming sense of demoralisation.

The failure to recognise patients’ rights in a legal sense has at least in part generated the consumer/survivor movement. The consumer/survivor movement’s claim for a right to participate at the individual and systemic level is, as has been demonstrated in this chapter central to the attempt to gain back a sense of self-respect for oneself and in the eyes of others. The failure to recognise a person’s distress as meaningful and valid but rather as symptomatic by professionals leads to a failure to respond appropriately to consumers of those in acute psychiatric services. The failure to respond with legal means of protection for people, who have experienced a violation of their rights through past abuse, indicates to the person that they do not matter and that what has happened to them does not matter.

Read (1998) showed that appropriate legal support is often needed to protect acute psychiatric patients’ interests. Yet rarely is legal or protective action taken. Traumatic events are rarely asked about,
acknowledged, recorded or responded to (Graham, 1994; Hawthorne et al., 1996). Rather, a further denial of rights to a person already traumatised occurs through institutionalised practice in mental health services, which further undermines a person’s moral sense of self-respect. This occurs through the mechanism as outlined by Taylor and Ricoeur in the last chapter. The events that happen to people are interpreted and given a moral value and these values inform one’s own sense of value and worth. Negative events, such as trauma and abuse, impute a negative value toward the self.

Everett and Gallop (2001) have demonstrated that nursing staff feel ill equipped to respond to peoples’ accounts of abuse. The failure to act on the reports of abuse and domestic violence in an appropriate way is central to the continuation of abuse in the system (Read, 1997; Read, 1998; Read & Fraser, 1998). Learning to respond appropriately is a skill that needs to be learnt. The failure to respond appropriately to patients’ accounts of abuse is a further denial of a person’s rights. To live without rights, according to Honneth, is to have no chance of developing self-respect. Recovery of a sense of self-respect involves responding appropriately to people’s accounts of abuse.
Read (1998) considers the failure to take the appropriate action and report these crimes against clients to the police as a failure of the system. The problem is not only that peoples’ traumas are not listened to, but also those problems are decontextualised, pathologised and stigmatised as symptoms in a system that re-traumatises. Conversely, the recognition of the trauma that people have suffered, offered through listening to peoples’ narratives, offers healing through understanding. Symptoms then become understandable as meaning is revealed through appreciation of the context as Laing (1965a; 1965b) identified.

### iii) Social Value

The third type of disrespect refers to the denigration of the social value of an individual or of a group. Honneth relates that a person’s sense of their unique value and worth is established in community. Community, he suggests, provides the site for self-realisation, a process whereby one can be convinced of one’s value. Self-assurance comes from internalising a shared concept of value. Value is intersubjectively established by the ethical convictions of a community.

One cannot conceive of oneself as a unique and irreplaceable person until one’s own manner of self-realisation is recognised by all the interaction partners to be a positive contribution to the community (Honneth, 1995: 89-90).
The difficulty of achieving recognition consists in recognising in the other ‘a common good that puts everyone in the same position to understand his or her value for the community’ (Honneth, 1995: 90).

Human subjects: ‘always need a form of social esteem that allows them to relate positively to their abilities and traits’ (Honneth, 1995: 121).

The denigration of the value of a person, identified as stigma in the first chapter, has been shown to be a pervasive form of denigration and personal disrespect for people relying on psychiatric services.

Honneth goes on to say that such social devaluing ‘robs the subjects in question of every opportunity to attribute social value to their own abilities’ (Honneth, 1995: 134). Thus:

The result of this evaluative degradation of certain patterns of self-realisation is that these persons cannot relate to their mode of life as something of positive significance within their community (Honneth, 1995: 134).

This sense of demoralisation is embodied, and entails the loss of a sense of personal self-esteem. Social approval requires recognition within a group context for self-realisation. Failure of recognition accounts for the lack of social approval. Forms of disrespect are historically mediated through institutionally established patterns of valuing.
The institutionalised totality of medicine in acute psychiatric services constitutes disregard for acute psychiatric patients’ perspectives. The denial of a person’s perspective, is a failure to recognise a person’s integrity. This shame carries the metaphor of ‘social death’ for the person, manifest in the symptoms people present to psychiatric services with (Johnstone, 1996). The need to be recognised as a subject is integral to the human being, such that Honneth (1995: 135) attests: ‘The experience of being socially denigrated or humiliated endangers the identity of a human being’.

This highlights how a person is constitutively dependent on the recognition of others’ (Honneth, 1995: 138) such that the converse is also true—that relationships of recognition are able to protect subjects from suffering disrespect. The dependence of humans on social recognition for a successful relation-to-oneself makes interpersonal relationships central: ‘one is dependent on the intersubjective recognition of ones’ abilities and accomplishments’ (Honneth, 1995: 136). What results for the person whose experience is denied recognition is that the individual fails to validate his or her own experience. From this lack or gap, the negative emotions of shame or
rage emerge. These feelings then further lower one’s feeling of a sense of self-worth.

The shame that accompanies participating in, or being subject to, another’s violation of norms, also violates one’s own sense of self-respect. As Taylor, Ricoeur and Honneth ascertain, actions that violate moral norms affect a subject’s moral sense of self. As human subjects, social injuries result in emotional responses. The disrespect entailed in the withholding of recognition causes an affective reaction, resulting in the impetus for social actions to reclaim self-respect such as that evident in the consumer/survivor movement.

According to Casement (1985), psychosis is the attempt to avoid reliving the shame of previous events triggered in the present. However, Casement suggests that the failure to process these events maintains them intact. This means that the unnarrated or unexpressed experiences of past traumas are re-experienced in the present as real and immediate. To process painful memories means reliving them and this requires having supportive personal resources. Although there is some recognition of these processes in acute psychiatric services, providing support services needs to be facilitated through conceptual
and practical resources not currently available.

Casement (1985) identifies relationship as the source of that which triggers this overlap from past to present. This occurs to different degrees for both staff and patients in acute public psychiatric wards. The objectification of the other as identified in chapter two, is to some degree, an attempt by staff to avoid this experience (Main, 1977). Everett and Gallop (2001) supported this claim in their research which showed that nurses resist hearing accounts of abuse due to their own sense of vulnerability. Casement (1985) in response to mental health professionals’ tendency to this distortion, raised the question whether the patient individuality was being respected and preserved, or overlooked and intruded upon (Casement, 1985: 25)?

There is another dimension to this self/other relationship that Casement noted, which was not communicated through narrative, but through affect. This affective communication refers to what is beyond words and relates to unspeakable and/or pre-verbal experiences. Affective communication is a form of projective identification that particularly applies to psychotic states as a form of unconscious communication. This explanation accounts for why providers
experience distress in dealing with acutely ill clients. Projective identification is a powerful form of affective communication where a patient has unarticulated or unconscious feelings that need to be expressed. The person's unconscious desire is for these overwhelming feelings to be contained, by them being responded to.

The sequence unfolds as follows: the patient has unmanageable, uncontrollable or uncontainable feelings; the patient has a fantasy of these being contained, listened or responded to; there is a desire that the other has these feelings instead of him/herself; this is communicated by projective identification (this is where the professional's feelings take on the same quality as the client's based on affective identification); this sameness is established projectively by the patient and experienced by the mental health professional to whom the projection is directed, which they experience as intolerable.

What is projected is any feeling that might be experienced as unmanageable by the client: acute distress, helplessness, fear, rage, or a contemptuous attack upon the self (Casement, 1985: 82). These feelings are projected in order for them to be expressed. The client requires that these feelings be acknowledged. Affective communication
is achieved if the one to whom it is transferred identifies the emotion in
this projection. When this happens, previously unmanageable and
terrifying feelings become less terrifying and more manageable because
there has been an acknowledgement and social recognition and
validation of the person and their feelings.

The client can then take back the feelings along with the recipient’s
capacity to tolerate being with such previously intolerable feelings.
Projective identification as a means of communication requires a
therapeutic response. Casement identifies a number of possible results
to this unconscious projection. If the projection is not met with an
acknowledgement, there is no therapeutic response and the patient
continues to experience the feelings as unmanageable. If mental health
professional experienced the patient’s projected emotions as intolerable,
the patient’s feelings are traumatically confirmed as unmanageable: the
hope to overcome these ‘demons’ is lost and there is a new state of
hopelessness and despair (Casement, 1985: 82). When acute
psychiatric patient’s attempt to communicate distress is misunderstood
or punished, the distress is recreated as present in current
relationships.
Distressed and distraught patients who cannot manage the excesses of their emotions end up in acute psychiatric services as a last resort, often in response to those around them feeling overwhelmed by this process of projected feelings. Yet this distress is rarely responded to therapeutically in acute public psychiatric services. The failure to understand this process partly explains why acute public psychiatric patients do not find the help they are looking for. It is a further missed opportunity to understand and respond to the patient’s distress. This failure may well explain the high incidence of suicide of people using psychiatric services both here (Victorian Task Force Report, 1997) and overseas (Whiteford, 2000) as well as the high rate of calls to life/crisis lines of those in recent contact with psychiatric services (Hocking, 1998).

Patients’ experience of receiving psychiatric services as one of disrespect is due to the failure of those services to take their experiences seriously. Patients’ expression of emotion and behaviour are not given credibility. This lack of recognition works to further undermine their sense of wellbeing. The three sources of disrespect Honneth has identified are central to the issues that consumer/survivors raise in relation to acute psychiatric services. This indicates that what is required for
wellbeing is that the three dimensions of respect be offered to acute psychiatric patients.

Even when there is an apparent absence of an ability to communicate in a meaningful way this still applies. The possibility of relatedness between equals is paramount. This model of respect is not dependent or reliant on narration, but is recognised as a precondition for relatedness. This respectful approach recognises the person as valid even where the art of narration is not possible due to the unarticulated and damaging effects of trauma. In these instances, the use of creative art such as: music, art, movement, and dance may facilitate relatedness when through the conditions of relatedness—an acknowledgement of and recognition of a patient as a person—is re-established. Establishment of listening in the face-to-face relationship, consumer/survivors claim and as discussed here and in chapter seven, is critical for healing.

Respect for patients narratives require being prepared to forfeit established concepts of knowing in preference for understanding. This requires professionals being willing not to know, but to learn from the patient, in the moment, what is needed for healing. This practice would require providing a supportive working environment for staff.
Understanding requires allowing participants to identify for themselves through listening to their own experience as expressed in narrative and other expressive, creative or artistic forms. Allowing patients to identify their own needs provides understanding of what they consider is needed provides an opportunity of responding respectfully to this.

The failure to provide recognition for a person results in a failure of self-realisation, which gives rise to a sense of disenfranchisement and a lack of self-respect. The failure to be recognised as a valuable and worthwhile human being—stigma—is often associated with the experience of receiving acute public psychiatric services, as this thesis has outlined. Users of these services have responded to the failure of respect with political mobilisation as a social movement to regain respect. The logic of such movements Honneth (1995) argues can only be explained by an analysis of social conflict on the basis of moral experiences. The moral neglect of those most vulnerable is demonstrated in the *People Living with Psychotic Illness* (Jablensky et al., 1999a), is demonstrated in the failure to provide community-based rehabilitation services such as: behavioural and psychosocial treatment, management modalities (such as occupational therapy) cognitive
remediation, social skills training, psychoeducation and supportive therapies.

The current government and consumer initiatives have failed to transform the moral culture of acute psychiatric services. This culture functions on the premise of the inequality of those receiving services. Honneth’s (1995) analysis of the three dimensions of recognition addressed these shortcomings through identifying the importance of recognition through intersubjective respectful relationships. Acute psychiatric services require the provision of intersubjective conditions whereby both patients and staff find new ways to relate positively to each other and themselves. A positive relationship to oneself depends on others’ recognition of one’s own abilities, which one can then internalise. The experience of recognition intersubjectively constructs a relationship to one’s self.

The only way in which individuals are constituted as persons is by learning to refer to themselves from the perspective of an approving or encouraging other (Honneth, 1995: 173).

A positive experience of recognition is the source of self-confidence, self-respect and self-esteem, but this is not autonomously established; rather it is dependent on others. For self-realisation, a ‘lack of coercion’
(for both patients and staff) is required. This is so as not to sabotage the need for individuals to internalise a sense of trust so that their own needs can be articulated and abilities exercised. Psychiatric clients and staff alike have this need for recognition.

What would provide this recognition in acute psychiatric wards is structures that facilitate an ethos of practice that all patients and staff are recognised for their particular abilities. As Honneth (1995) has indicated, each relationship potentially offers affirmation for a different aspect of the self and different relationships confirm different aspects of self-realisation. The indication of whether one has successfully developed a sense of self-recognition is the degree to which ‘subjects mutually experience themselves to be loved in their individuality only in so far as they are not afraid of being alone’ (Honneth, 1995: 176). As Laing stated, acute psychiatric patients do not have an established sense of being loved; consequently they find being alone a source of terror. Counterproductively, isolation is used as a form of ‘treatment’ in acute psychiatric services. This is despite reports of patients ‘head banging’ (in some instances to a degree that causes facial swelling), but this does not seem to bring the practice of isolating distressed clients
into question.

The experience of love is a basic prerequisite for the development of the self-confidence necessary to articulate needs. The experience of love, free of coercion, is the basis of an ethical life. Legal relationships, which protect civil rights, are the central conditions for the development of self-realisation. Self-realisation is dependent on legally guaranteed autonomy. Only then, Honneth contends, can subjects conceive of their own desires. This highlights the need for the legal provision of an adequate structure of rights for acute psychiatric patients, while accommodating the particular circumstances of individuals and their families.

Mental health law needs to protect individuals subject to an authority from abuse, not authorise it. Intersubjective conditions need to be protected to facilitate personal growth. It is the failure to provide for these basic needs that has united consumer/survivors in an attempt to reclaim self-respect. It is only through community recognition that consumer/survivors can gain self-realisation, self-confidence and self-esteem.

An ethical practice requires commitment to a set of values to provide
the intersubjective conditions for self-realisation. This pattern of recognition must include social solidarity, which can only come from ‘collectively shared goals’ subject to legally sanctioned autonomy. These goals coexist with the need for other forms of recognition: love and rights. The consumer/survivor movement is a response to the experience of all three forms of demoralisation as identified by Honneth (1995). The reversal of stigma involves the recognition of the patient as an ethical, legal and social subject.

The recognition of the ethical subject involves the need for the person to articulate narratives of trauma. The recognition of the legal subject involves respect for a patient’s rights to protection from harm. The recognition of the social subject entails the support of a community of people so that the person can be reassured of their own sense of value and worth. These three sites of recognition—the ethical, legal and social—are available through listening to the narrative.

The inability of a patient to articulate a narrative does not mean there is not a narrative or that respect is not demanded. What has to be provided is listening. Laing showed that understanding is possible if the time is taken to hear the biography. Access to recognition and
understanding is through the narrative of lived experience. To abstract the person out of their context is a violation of the humanity of the person, for, as Ricoeur has established, the recognition of humanity resides in a narrative account. For people receiving mental health services, these accounts are often of victims of sexual, physical and mental abuse and/or emotional neglect, which has been denied a voice and narrative, and therefore identity as an ethical subject.

Several experimental attempts have been made to provide a more therapeutic milieu than the traditional hospital environment. For example, Harry Stack Sullivan established a small ward for schizophrenic men that was staffed with hand-picked attendants, set apart from the rest of the Sheppard Pratt Hospital in the 1920s (Barton Evans III, 1996). He gave his staff autonomy to operate on their own with patients. As Sullivan (1962) stated:

[W]e found intimacy between the patient and the employee blossomed unexpectedly, that things I cannot distinguish from genuine human friendship sprang up between patient and employee, that any signs of the alleged apathy of the schizophrenic faded, to put it mildly, and that the institutional recovery rate became high (Barton Evans III 1996).

Sullivan’s experimental ward could be seen as a precursor of the therapeutic community movement, whose influence came to be
integrated with mainstream psychiatry (Jones 1952, van Putten 1973). This emphasis on the social aspects of treatment, though, is much less obvious in the current climate of risk assessment and psychotropic drug management (Clark 1974). RD Laing recognised that all forms of behaviour are understandable if we are willing to go to the trouble of taking a biography. Laing’s (1965a) case study of Julie in *The Divided Self*, and others in *Sanity Madness and the Family* (Laing, 1965b) highlighted that a person experiencing psychosis is understandable, if we make an effort to understand them.

**Practical implications**

The failure to conceptualise the consumer/survivor as equal is embedded in a complex social, political and economic organisational structure around acute mental health services. Institutional organisations impose limitations on the recognition of the subject, through limitations in resources for communicative relationships between subjects. These constraints include inadequate resources to identify and respond to the social, structural, personal and traumatic precipitants of mental health problems. To amend this inadequacy would require providing adequate and appropriate training of and
support for the subjective needs of patients and staff alike. The failure to do so results in as has been seen, professionals, ill-equipped for any other response, discounting consumer/survivor accounts of their needs as illegitimate.

Providing services that consumer/survivors deem as necessary for recovery has the potential to legitimise and destigmatise the delivery and treatment and diagnosis of people with mental health problems. However, what is needed for this ethical practice is ‘know how, knowing how to speak and knowing how to hear’ (Lyotard, 1979), that is, practices that recognise the consumer/survivor narratives and knowledge’s as a legitimate perspective. The consumer/survivor movement as a new social movement argues for equality and respect for mental health consumers through the recognition of the patient as a person. In Australia, this push for innovative practices has been established collaboratively with governmental organisations. This is because as activists such as Wadsworth (1996a) argue, it only when staff do not feel defensive will there be support for consumer/survivors’ participation both at an individual and institutional level.

Incorporating the consumer/survivor perspective into a conceptual and
practical framework within acute psychiatric services has the potential
to transform services to be efficient, effective, equitable, self-reliant and
responsive to consumer/survivor needs as they define them. A
consumer/survivor perspective-orientated practice would involve
‘listening to’ the consumer/survivor narrative and ‘being with’
consumer/survivors as an authentic response to distress. This would
also involve consumer/survivors participating in defining their own
needs, and being involved in the design and evaluation of those same
services.

So far, consumer/survivor and government initiatives have been
unsuccessful in transforming the culture and ethics of practice in acute
psychiatric services. What this thesis has identified as problematic is
the premise that someone who is mentally ill does not deserve equal
respect as a person. This premise, built into the institutional
organisation of the relationships between subjects, undermines the
regard for the patient as a person. What is required to address this
institutional discrimination, is a shift in the institutional organisation of
relationships from that which punishes people for their distress, to one
that responds to people in respectful ways. As discussed above,
Honneth’s (1995) multidimensional model of respect addresses this need.

The concept of the subject as a *narrative-identity* as opposed to the concept of the subject constructed in relation to a *diagnostic-identity*, allows for all the dimensions of respect to be met through endorsing the practice of listening. The importance of providing listening is not to do with listening to the narrative as such, but in providing the opportunity for recognition of the ‘other’, which is the means by which a person develops a sense of self-respect. This involves listening (for presence), as explained by Levinas in the previous chapter, which offers the narrator an opportunity for self-discovery and self-identity. The autonomous role of meaning-making, that Taylor identified as central to the respect due to a person will not be discovered if it is not presupposed, as both Laing in chapter six and Ricoeur in chapter seven attest. This requires facilitating the time, space and opportunity for listening, which is a respectful practice because it acknowledges a person’s autonomy and value. In other words, the recognition of the value of a person is achieved through listening to the narrative only if this value is assumed.
In sum, recovery from acute ‘mental illness’ requires providing the means of recognition for a patient's value and worth as an ethical subject which further implies recognition of a person’s value as a legal and social subject. Recognising acute psychiatric patients as equals requires supporting patients as people; this would require innovations in the institutional organisation of relationships. It is in relationship that provisions for recognition for a person’s identity, rights and social value occurs.

Narrative is a powerful means through which to pursue the recognition of the ethical subject in a context where the strengths of people in the face of extreme suffering can be realised. The very practice of listening provides recognition for a person’s value as an ethical, legal and social subject. Recognition of acute psychiatric patients on grounds of equality is the key to the problem of stigma, and this recognition of equality is provided through listening and responding appropriately to people’s needs and through the provision of adequate socio-cultural supports. Empowering a person through providing a sense of their own social value and worth:

leads to a dramatically different means of helping people through their emotional distress. Instead of a heavy emphasis on maintenance-oriented medication compliance, the Empowerment Model is oriented towards finding ways to help the person achieve a
significant role in society independent of the mental health system (Fisher & Ahern, 1999).

The model of recognition proposed in this thesis, is offered in response to the current domination of the medical approach and the current crisis facing the delivery of acute public psychiatric services in Australia and throughout the world today.
CONCLUSION

AN ‘OTHER’ ETHIC

Simply by listening to and supporting our consumers, we helped them achieve more therapeutic success than could ever have been possible through conventional means (Macek, 2000).

Touraine’s account of new social movements has highlighted issues of identity as central to the new social movement’s opposition to totality. The consumer/survivor movement attempts to disrupt the accepted power and legitimacy of mental health services in preference for a model of recovery. To achieve this, the consumer/survivor movement, characteristic of other social movements: ‘draws strength from its past in order to hurl itself toward a future that is to abolish the present dependence’ (Touraine, 1977: 324). Similarly, psychiatric professionals draw on their own past learning and experience in order to persuade consumers of the benefits of ‘biological treatments’. Consequently, the consumer/survivor movement continues to battle with its adversary in an attempt to redress the abuses of the past by redefining the future. As Touraine states:

A social movement can be recognised by the fact that it speaks both in the name of the past and in the name of the future, never solely within the categories of the present social organisation (Touraine,
The conception of the subject is at the heart of the debate in acute psychiatric services and, as identified in the preceding chapters, varies according to the social, political and economic factors that influence what conceptions are valued or legitimised. Dominant conceptions of the subject are necessarily driven by professionals’ vested interests. The consumer/survivor movement articulates a perspective otherwise silenced through social and legal sanctions. The failure to recognise the ethical, legal and social subject in acute public psychiatric services has resulted in coercive, involuntary and impersonal treatment. The removal of civil rights through social practices and involuntary detention, authorised by mental health law, leaves inpatients without voice and without recourse. It is time for the limitations of the psychiatric perspective to be conceded and the consumer/survivor perspective recognised.

According to Rorty (1979: 318), social processes rather than epistemology account for the ‘transaction between the knowing subject and the reality’. Psychiatry’s epistemology justifies the technical approach of diagnosis and treatment but this prevents understanding
the patient as a person. The conception of the professional as ‘knowing’ is denied to patient and this means the patient is predetermined: he/she is reduced to an object and, in the process, eliminated as a subject. The way to address this problem is by disarticulating the power and legitimacy conflated in culturally acceptable mental health practices hidden from appearance through legal and cultural sanctions. This in turn facilitates the acknowledgement and validation of consumer/survivor ways of knowing.

To acknowledge the view of consumer/survivors is not to deny the validity of professional knowledges—indeed these have their place—but to entirely disregard the views of consumer/survivor promotes a passive ignorance of the differences between them. That is, utilising a scientific epistemology alone is problematic as it assumes that consumer/survivor needs are commensurable with the scientific ones, which as we have seen, they are not. Any dissenting views are constructed as irrational, cognitively disordered or illogical, rather than as having an inherent logic. Epistemology, then, assumes totality and commensurability and to suggest the possibility of incommensurability questions the rationality of traditional epistemology in its own terms.
The incommensurability of psychiatric and consumer understandings of problems is due to the fundamental difference in the *way of seeing* or philosophy between them which has implications for how the subject is treated. The differences between these approaches are entrenched in the different traditions of practices and methods accompanying these different conceptualisations. Understanding is incongruous with a scientific methodology, which is dependent on what is seen.

What is required to respond to the consumer movement’s demands is a different rationality and practice: rationality based on dialogue or conversation in an exchange based on consent. This is reached, as Levin notes through an:

> open democratic processes of communication in which all those affected, concerned or influenced by the matter in question have been able to participate without coercion (Levin, 1989: 35).

The implication of the recognition of a consumer/survivor perspective is an ontological approach that legitimises *being with* and *listening to* a person in distress as opposed to doing something.

To listen to a consumer/survivor and their perspective is to affirm the incommensurability of these discourses with scientific ones. If the gap between the consumer and provider discourse is a difference in
perspective, this gap is not going to be bridged by a single all-encompassing discourse or an alternative conceptualisation as such. What is required is to not interpret consumer/survivor accounts into professional epistemology, but to ‘pick up the language of the interlocutor rather than to translate it into one’s own’ (Rorty, 1979: 103). This requires alternative methods and approaches in mental health services, which attend to the different conceptualisations utilised by the consumer/survivor perspective.

In practice, this would call for recognition of the acute psychiatric subject as an ethical, legal and social subject. This recognition would be made available through listening to consumer/survivor narratives. Listening is the portal, access or doorway through which people get to experience themselves as ethical, legal and social subjects. It is the route through which a person experiences him/herself as a subject. Listening to peoples’ narrative accounts involves valuing being with people. It is about understanding a person through being in their world. It is convivial rather than interventionary. This requires listening not for the narrative as such, but for subjectivity. It is being-with, being-understood and being-connected that facilitates recovery, as it validates the person in their world as a human being. Failure to provide this
validation through an absence of listening indicates a lack of respect for the patient as a person.

Listening to a person’s narrative can also identify breaches to the ethical, legal and social subject. Listening to a consumer/survivor reveals what is meaningful for him/her and acknowledges, rather than disregards the processes of identity formation and recreation. What facilitates recovery is working with processes of identity through identifying and responding to the meaning of symptoms. This requires discovering what is meaningful for a person. This requires being with a person and providing an opportunity for a person to express and therefore process what he/she experiences as causing symptoms. This ethical approach is urgently needed in acute psychiatric services.

Structures need to be put in place that facilitate this process. As we have seen, professional dependence on explanatory models in the process of psychiatric hospitalisation, diagnosis and treatment mean: ‘there is only as much movement toward the object as is necessary for distancing it even more’ (Fiumara, 1990: 107). The problems of the professional failure to understand could be overcome by deploying as professionals as has been outlined in chapters six, seven and eight.
through the work of Laing, Ricoeur, Levinas and Honneth, what Fiumara (1990) calls the ‘listening subject’. Otherwise, Fiumara (1990: 67) suggests ‘there are no listening subjects but simply objects in a relation that is not founded upon dialogue but possibly a sadomasochistic interaction’.

What has been suggested here is that people with ‘mental health problems’ are no different from other humans: all human beings give meanings to events in an attempt to bring order to the chaos of their lives. These meanings have implications for identity. As such, the humanity of mental illness could be reintroduced back into psychiatric treatment by inculcating an ethic of practice in line with the concept of the subject as a narrative subject. Narrative methodology is the means whereby the patient as a person can be understood in terms of their own interpretative framework. Recognising the context of symptoms in terms of the history of events makes symptoms understandable, while the narrative provides coherence, meaning and structure for the otherwise uninterpretable events of life.

This narrative understanding of the subject explains why practices, which disregard the narrative, are experienced as patronising,
disrespectful and damaging and makes clear the importance of narrative practices to mental health services. With this in mind it seems an ethical imperative to add to current practices in mental health services the opportunity for patients to articulate their narrative account of events, and to provide patients with the opportunity to explore the function of the narrative in the construction of identity. This revised conception of the subject in acute psychiatric services requires an ethic respectful of patients’ autonomy.

Introducing narrative practices into acute psychiatric services would be a means of introducing ethical practices. This would involve the introduction of services that offer respect for the patient as a human being, rather than as an ill object. That is, practices of being with and listening to patient narratives would become legitimate in acute public mental health services. Survivors claim they are experts on their own experience and healing. That expertise needs to be framed within rather than excluded from a conception of the physical, sexual, emotional, and spiritual damage caused by life events to survivors, thereby legitimising their discourse.

Evidence of an ethical practice would include recognising patient
narratives as a legitimate point of view. Under this model, expression of acute psychiatric patients' unarticulated feelings would be made possible through a variety of artistic means such as through the use of music, dance and painting. Patients' narratives would be understood as providing coherence, meaning and structure for the otherwise uninterpretable events of their lives. The role of patient narratives in describing, explaining and predicting life would be central and to some extent, would make psychiatric symptoms understandable and predictable. Further, such an ethical practice would involve patients in every aspect of clinical services.

In the context of Australia’s National Mental Health Plan, a strategic innovation could be the introduction of the consumer perspective, a goal which consumer/survivors, scholars and psychiatric professionals alike could pursue. Ultimately, the goal here is for respectful relationships in mental health services. These need to be based not only upon free will, but upon positivity emerging from love. The *unique* and *absolutely other*, as Levinas (1993b: 95) reminds us, ‘can only mean their meaning in the loved one and in oneself’. That is to say, there is to be recognition of difference without indifference and recognition of the responsibility to the other which is an ‘inexhaustible responsibility’
which is ‘never settled’ (Levinas, 1993a: 95). As I have argued throughout this thesis, it is this ethic of the other or other based ethic that is required to address the current state of crisis in the delivery of acute public psychiatric services in Australia and internationally.
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